OHIO STATE DENTAL BOARD
BOARD MEETING

September 13, 2017

Contents

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Attendance

The Ohio State Dental Board (Board) met in Room 1960, of The Vern Riffe Center for Government and the Arts, 77 South High Street, 19th Floor, Columbus, Ohio on September 13, 2017. Board members present were:

Constance Clark, R.D.H., President
Ashok Das, D.D.S., Vice President
Patricia Guttman, D.D.S., Secretary
Kumar Subramanian, D.D.S., Vice Secretary
Bill Anderson, D.D.S.
Michael Ginder, D.D.S.
Burton Job, D.D.S.
Susan Johnston, R.D.H.
Jamillee Krob, R.D.H.
Andrew Zucker, D.D.S.

Ann Aquillo, the Board's Public Member was not in attendance to the meeting.

The following guests were also in attendance: Katherine Bockbrader, Esq. and Steve Kochheiser, Esq. of the Ohio Attorney General's Office; Nathan DeLong, Esq. and Henry Fields, D.D.S. of the Ohio Dental Association (ODA); Kelly Long, Executive Director of the Ohio Physicians Health Program; Mary Ellen Wynn, D.D.S., ADEX Representative; Martin Chambers, D.D.S., former Board Member, Harry Kamdar, M.B.A., Executive Director, Lyndsay Nash, Esq., Deputy Director, Zachary Russell, Legislative and Communications Coordinator, Barb Yehnert, Kathy Carson, and Erica Yehnert, Dental Board Enforcement Officers, and Malynda Franks, Administrative Professional, of the Ohio State Dental Board and other guests.

Call to Order

Constance Clark, R.D.H. introduced herself as the Board President and a dental hygienist from Dublin. After extending greetings to everyone, President Clark noted that there was a quorum present and called the meeting to order at approximately 1:53 p.m.

Board Business

Introduction of Board Members

President Clark then introduced the rest of the Board members. She introduced Dr. Ashok Das, the Board's Vice President and a general dentist from Mason, Dr. Patricia Guttman, the Board's Secretary and a general dentist from Columbus, Dr. Kumar Subramanian, the Vice Secretary and an Endodontist from Upper Arlington, Dr. Bill Anderson, a general dentist from Findlay, Dr. Michael Ginder, a general dentist from Athens, Dr. Burton Job, an Oral and Maxillofacial Surgeon from Akron, Ms. Susan Johnston, a dental hygienist from Columbus, Dr. Jamillee Krob, a dental hygienist from Canton, and Dr. Andrew Zucker, a general dentist from Sandusky.

President Clark stated that Ms. Ann Aquillo, the Board's Public member from Powell, was unable to attend the meeting.

Introduction of New Staff Member

Director Kamdar took a moment and introduced Steven Kochheiser, Esq. as the new Deputy Director for the Board and stated that Mr. Kochheiser will officially start working with the Board on Monday, September 18, 2017. Board members welcomed Mr. Kochheiser.

Approval of Agenda

President Clark stated that she had previously reviewed the agenda for the day and asked if there was a motion to approve the agenda with the caveat to amend the agenda due to any extenuating circumstances.

Motion by Ms. Johnston, second by Dr. Das, to amend the September 13, 2017 Board meeting agenda to allow the Scope of Practice Committee to report to the Board prior to the Policy Committee report.

Motion carried unanimously.

Motion by Ms. Johnston, second by Dr. Subramanian, to approve the September 13, 2017 Board meeting agenda as amended.

Motion carried unanimously.

Review of Board Meeting Minutes

July 26, 2017 Meeting

President Clark informed everyone that the draft Minutes from the July 26, 2017 meeting had been forwarded to the Board members for review prior to the meeting and asked if there was a motion in regards to the Minutes from the July 26, 2017 meeting.

Motion by Dr. Krob, second by Dr. Subramanian, to approve the July 26, 2017 Board meeting minutes as presented.

Motion carried unanimously.

Public Comment/Presentations/Correspondence

Presentation – Mary Ellen Wynn, D.D.S., American Board of Dental Examiners Testing Committee

President Clark welcomed former Board member and current Representative to the American Board of Dental Examiners (ADEX) Testing Committee, Dr. Mary Ellen Wynn and asked her to provide her report on the changes to the ADEX bylaws and examination.

Dr. Wynn began by thanking President Clark and the members for giving her the opportunity to represent the Board at the ADEX House during their annual meeting last month. She provided the members with a brief background update to her involvement in the examination processes which includes expanded roles for the Commission on Dental Competency Assessments (CDCA) examinations for both the Perio/Restorative and Endo/Pros portions, as well as the dental hygiene examinations, including the Expanded Function Dental Auxiliary examination. She stated that she also examines for the Council on Interstate Testing Agency (CITA) for the Perio/Restorative sections, which also administers the ADEX examination. Dr. Wynn stated that she serves as the Chair of CDCA's Ad Hoc Audit Committee and is also a member of the American Dental Association's House of Delegates. She indicated that this will be her last year in the House of Delegates.

Dr. Wynn stated that she had provided three (3) documents for their review prior to the meeting:

1. 2017 ADEXHR Bylaws Recommended Revisions [Appendix A]

2. Highlights of the 13th Annual American Board of Dental Examiners, Inc (ADEX) House of Representatives [Appendix B]
3. A Response to the American Dental Association's Proposed use of an Objective Structured Clinical Exam [Appendix C]

Dr. Wynn then reviewed highlights of the documents with the members.

2017 ADEXHR Bylaws Recommended Revisions

In review, Article 2 of ADEX's bylaws states that its purpose is to develop valid, reliable and uniform national examinations and other examinations to be administered to candidates for initial licensure as dentists and dental hygienists by Member Boards, and to develop standards for the administration of those examinations by state dental boards and regional testing services. Currently, CDCA and CITA are the only regional boards administering these exams.

Some of the changes to the bylaws addressed ADEX's budget challenges. ADEX does not have a revenue source. CDCA and CITA fund ADEX based on the number of first time candidates each organization tests. The changes eliminated consumer district members, which resulted in a reduction of 13 people. There will be only two (2) consumer member positions, and the consumer member must be an active member of State Dental Boards. Additionally, ADEX will only pay for one person appointed by a State Board to attend the meeting. A State Board could have a dentist, dental hygienist, and consumer member attend the meeting. ADEX is returning to one vote per state. Also, the Dental Exam Subcommittees. Exam Committee, Dental Hygiene Committee, and House of Representatives will meet on one day next year, Saturday, August 11, 2018.

Other changes are in a new selection processes for the Board of Directors by District, Dental Hygiene Exam Members, and District Educators. One minor amendment delayed the election of these positions until the 2018 ADEX House of Representatives, therefore, everyone retained their 2016 position through 2017.

Regarding the officers, the bylaws state that the President and Vice President must be dentists. The Treasurer and Secretary could be a dental hygienist or consumer member. The bylaws also enabled the Board of Directors to request bonding for an officer.

Bylaw changes clarified appointments made by the President and then approved by the ADEX Board of Directors, addressed inconsistencies, addressed some housekeeping changes regarding Corporate Laws and provided clarification on some items that were previously not clear.

The ADEX's Executive Committee remained the same until the 2018 annual meeting:

President: Dr. Stan Kanna, HI

Vice-President: Dr. William Pappas, NV

Secretary: Dr. Jeffery Hartsog, MS

Treasurer: Dr. Conrad McVea, President of CITA, LA

Immediate Past President: Dr. Bruce Barrette, WI

Highlights of the 13th Annual American Board of Dental Examiners, Inc (ADEX) House of Representatives

Dental Exam Committee and Dental Hygiene Committee

Dental Subcommittees

Scoring

The committee clarified the 18 Month Rule: A candidate must complete the entire exam within an 18-month time frame. They clarified the start date, which resulted in not changing the existing criteria.

The 3 SUB Rule was discussed. Regarding some exam criteria, such as pros, if a candidate has 3 subs on specific criteria, the candidate fails. However, if the candidate has 2 subs and a def, the candidate would pass. This was reviewed, a process was finalized and approved.

Endo

Starting in 2018, there will be a new #14 Accudental typodont tooth. The anatomy of the #14 presented a challenge when the candidate tried to meet the exam criteria. The committee defined the size of the "too small" access opening for #14 which did not have measurements associated with it.

Pros

Custom candidate fabricated stents will be used to verify failures where appropriate and minor undercuts, less than 0.5 mm, will not result in failure unless they compromise the margin when blocked out.

Perio

The committee is working on developing new periodontal OSCE examination.

Restorative

The committee created separate criteria for mandibular incisor preparation vs maxillary anterior teeth and mandibular cuspids and recommended changing all grading criteria from ACC to ATC, Adhering To Criteria. This will be implemented for all exam criteria. All restoration criteria for marginal deficiencies were redefined as greater than 0.5 mm is a DEF. A SUB will be less than or equal to 0.5mm

Dental Hygiene Exam

Starting in 2018, the periodontal probing exercise will be conducted Post-Treatment by both the candidates and examiners. The exam will be stopped at the time of the Pre-treatment evaluation if the candidate does not have enough surfaces to successfully pass the exam and the scoring of the Case Presentation will be all or none. All 3 criteria must be met to be awarded 3 points. The criteria utilized to determine the diagnostic quality of radiographs will be published prior to the 2018 exams.

A Response to the American Dental Association's Proposed Use of an Objective Structured Clinical Examination

Dr. Wynn indicated that the final document provided for their review was a white paper, "A Response to the American Dental Association's Proposed Use of an Objective Structured Clinical Exam", which was distributed at the meeting by Dr. Chad Buckendahl, the psychometrician for CDCA. She stated that Dr. Buckendahl and his colleagues work with all the regional examining boards and the National Dental Examining Board (NDBE) of Canada.

Dr. Wynn indicated that as they all know, the ADA intends to develop an Objective Structured Clinical Exam, commonly referred to at the OSCE. The ADA references the Canadian OSCE exam when offering reasons for their exam. She made a few comments regarding the Canadian licensing process by stating that there are only 9 dental schools in Canada, with obviously a much smaller population of candidates. The NDBE of Canada is responsible

for defining competencies, overseeing accreditation, and maintaining the licensing examination program. She stressed that the NDBE defines the competencies.

Dr. Wynn stated that the accreditation agency in the U.S. is the Commission On Dental Accreditation (CODA) which has established "Accreditation Standards for Dental Education Programs". Each school establishes its curriculum to meet those standards and therefore, the schools define the competencies. For example, the endodontic competency requirement may be different from one dental school to another. She stated that in Canada, candidates who are not from Canadian accredited schools are still required to take a clinical skills examination in addition to the OSCE as part of the licensure process.

ADEX is an educational product audit vs CODA is a process audit. The current dental exam content is based on a national task analysis completed in 2011, and it's being redone in 2017/2018. The dental hygiene exam content completed their analysis in 2017.

Dr. Wynn concluded by stating that she only touched briefly on the issues brought forth in the white paper and it is her understanding that the members have received information regarding the ADA'S intent to create an OSCE type of exam. She stated that she believed this white paper addressed many of the ADA's positions and questioned if this board would want to approve an exam sight unseen. She then thanked the members again for the opportunity to represent Ohio and for having her present this information to them.

Correspondence

President Clark informed the members that the Board executive office had received the following correspondences:

- American Association of Oral and Maxillofacial Surgeons – Douglas W. Fain, D.D.S., M.D., F.A.C.S., President - regarding the safe delivery of office-based anesthesia [Appendix D]; and
- Ohio Society of Oral and Maxillofacial Surgeons – Kelly S. Kennedy, D.D.S., President – regarding the safe delivery of office-based anesthesia [Appendix E]

President Clark asked if the members wished to discuss these two (2) letters. Dr. Anderson questioned if the letters from the two (2) oral and maxillofacial surgeon groups were in response to an issue or matter that was pending before the Board or a specific matter that had been brought to the Board's attention. President Clark indicated that it was her understanding that there were no issues before the Board in this regard and that these letters were received as proactive information in response to recent items in the news media.

President Clark then stated that she had included two documents in the Board Meeting Notebooks for their review:

- Response to the ADA DLOSCE Talking Points [Appendix F]; and
- ADA OSCE Proposal Rebuttal Talking Points [Appendix G]

President Clark noted that there were no comments from the Board members regarding these two (2) documents.

Lastly, President Clark shared a copy of the "Summary of 2018 Dental Exam Format Changes" of the Western Regional Examining Board [Appendix H]. She indicated that this was informational for the Board members.

Action Items

Supervisory Investigative Panel Expense Report

President Clark asked if Dr. Guttman and Dr. Subramanian, the Board's Secretary and Vice Secretary, attested to having each spent at least twenty (20) hours per week attending to Board business. Both Secretaries affirmed they had spent the hours attending to Board business.

Motion by Dr. Anderson, second by Ms. Johnston, to approve the Supervisory Investigative Panel Expense report.

Motion carried with Dr. Guttman and Dr. Subramanian abstaining.

Enforcement

Personal Appearances

Jonathan J. Runion, D.D.S.

Ms. Yehnert gave the members a brief history in the matter of Dr. Jonathan Runion. She stated that this was Dr. Runion's first appearance before them on his first consent agreement with the Board. She informed the members that Dr. Runion signed a standard impairment Consent on July 6, 2017, entered treatment on July 14, 2017, and was discharged August 11, 2017. Ms. Yehnert indicated that Dr. Runion is receiving Intensive Out Patient (IOP) therapy, is registered with the Ohio Physicians Health Program (OPHP), and attends AA/NA and Caduceus meetings weekly.

Ms. Yehnert informed the Board that Dr. Runion's return to work assessment was received August 28, 2017 and that his physician, Marc Whitsett M.D., indicated that Dr. Runion is capable of practicing dentistry. She stated Dr. Runion complies with the terms of his Consent to date and that he is before them to request reinstatement of his license with work privileges.

Upon questioning by the Board, Dr. Runion thanked the Board members for allowing him to appear before them for consideration of reinstatement of his license to practice dentistry. He explained that this has taught him humility but appreciates the opportunity to evaluate his life, not only professionally but personally and spiritually. He explained that he has achieved almost three (3) months of sobriety and during that time he has been able to take the skills he learned during his inpatient treatment and apply them to his everyday life. Dr. Runion has identified his triggers as taking on too much responsibility with his family and growing practice, but he now has systems in place and the help of counselors and professionals to help keep him from relapsing. He offered that he used opiates as a way to relax and get away from his stressors which was the easy solution but not the answer. He stated that part of what he learned about the disease of addiction and the pathophysiology is that the pain receptors can be triggered by other mood altering drugs and therefore, he abstains from their use.

President Clark stated that they appreciated Dr. Runion's sharing with the Board and then asked if there were any additional questions from the Board. Hearing none, she asked Dr. Runion to remain as they would be discussing his request during the Executive Session immediately following the next Personal Appearance interview.

Rudyard C. Whipps, D.D.S.

Ms. Yehnert gave the members a brief history in the matter of Dr. Rudyard C. Whipps. She stated that this was Dr. Whipps first appearance before them on his third consent agreement with the Board and then detailed Dr. Whipps' history with the Board as follows:

- April 2010 – Dr. Whipps signed a standard Impairment Consent Agreement

- November 2010 – Dr. Whipps was issued a Notice of automatic suspension and opportunity for a hearing for noncompliance with the April 2010 Impairment Consent Agreement
- May 2011 - Dr. Whipps signed a second standard Impairment Consent Agreement
- June 2017- Dr. Whipps signed his third standard Impairment Consent Agreement

Ms. Yehnert explained that Dr. Whipps entered treatment as a condition of this third consent agreement on June 17, 2017 and was discharged July 15, 2017. She informed the members that Dr. Whipps is receiving IOP, is registered with OPHP, and is currently attending AA/NA and Caduceus meetings. She stated that Dr. Whipps Return to work assessment was received August 28, 2017 and that his physician, Theodore Parran, M.D., has indicated that Dr. Whipps is capable of practicing dentistry. She stated Dr. Whipps continues to comply with the terms of his Consent to date and he before them today to request reinstatement of his license with work privileges.

Upon questioning by the Board, Dr. Whipps thanked the Board members for this opportunity to share where he was in his recovery and the process. Dr. Whipps shared that his financial situation was dire and he is anxious to get back to work. He explained that his "back to work assessment" from GlenBeigh and progress notes from Cornerstone of Recovery summarized his recovery as very solid and they both strongly recommend that he get back to practice.

Dr. Whipps informed the members that he has signed up with the Ohio Physicians Health Program (OPHP), attending Alcoholics Anonymous (AA) meetings every day, as well as intensive outpatient meetings at Cornerstone of Recovery since his discharge. He has worked diligently with my sponsor and with his dad, who is also his attorney, in this matter. He has strong support in his personal life, family, and the other people in recovery.

When asked what would be different about his recovery this time versus the first two (2) times, Dr. Whipps stated that the other times he was in recovery he was just going through the motions but after going through this most recent relapse, he is willing to do whatever it takes to stay in recovery.

Dr. Whipps indicated he ordered diazepam through the internet from someone in New Jersey with an online pharmacy which gave him the opportunity to order medication through the mail. Dr. Whipps informed the members that his wife and his office manager became aware of it and called the Board. He explained that Ms. Yehnert came that same day and they had a meeting on the next day at his attorney/dad's office to sign the paperwork to get him back in recovery again.

Dr. Job informed Dr. Whipps that with three (3) strikes going forward, he could not speak for the rest of the members, but Dr. Whipps had to realize on this third attempt that this would be his last. Dr. Whipps stated that he does not want to jeopardize his license to practice or his life as he recognizes that this is a fatal disease.

Dr. Whipps explained that his trigger is generalized anxiety that he has had for years and as long as he actively participated in his recovery he did very well. However, he stopped going to meetings and cut himself off from his sponsor which led to his relapse.

President Clark thanked Dr. Whipps' sharing with the Board and then asked if there were any additional questions from the members. Hearing none, she concluded the Personal Appearances discussions.

Executive Session

Motion by Ms. Johnston, second by Dr. Anderson, to move the Board into executive session to consider the investigation of charges or complaints against a licensee pursuant to Section 121.22(G)(1) of the Ohio Revised Code.

Roll call vote: Dr. Anderson – Yes
Ms. Clark – Yes
Dr. Das - Yes
Dr. Ginder – Yes
Dr. Guttman – Yes
Dr. Job – Yes
Ms. Johnston – Yes
Dr. Krob – Yes
Dr. Subramanian – Yes
Dr. Zucker – Yes

Motion carried unanimously.

Open Session

At 3:43 p.m. the Board resumed open session.

President Clark noted for the record that Dr. Guttman and Dr. Subramanian had not attended the executive session and, therefore, were not present during the deliberations in these matters.

Decision in the Matter of Jonathan J. Runion, D.D.S.

Motion by Ms. Johnston, second by Dr. Krob, to deny Dr. Runion's request for reinstatement of his dental license at this time, and that he is requested to return for a personal appearance before the Board at the November 2017 Board meeting, and that he will remain in full compliance with the terms of his consent agreement with the Board.

Motion carried with Dr. Guttman, Dr. Subramanian, and Dr. Zucker abstaining.

Decision in the Matter of Rudyard C. Whipps, D.D.S.

Motion by Ms. Johnston, second by Dr. Krob, to deny Dr. Whipps' request for reinstatement of his dental license at this time, and that he is requested to return for a personal appearance before the Board at the November 2017 Board meeting, and that he will remain in full compliance with the terms of his consent agreement with the Board.

Motion carried with Dr. Guttman and Dr. Subramanian abstaining.

President Clark then turned the meeting over to Director Kamdar to present the Enforcement matters before the Board for September.

Proposed Motions

Director Kamdar indicated that the first enforcement matter before the Board was a Notice of Opportunity for hearing that was issued in December 2016 to Mohsin Ali, D.D.S. He stated that Dr. Ali had originally applied for a limited teaching license for an appointed teaching position at an unaccredited dental program. Dr. Ali was denied his original application, a Notice of Opportunity for Hearing was issued, and Dr. Ali requested a hearing in the

matter. Since that time, Dr. Ali withdrew his original application for a limited teaching license and his request for a hearing, as he was able to submit a new application for a limited teaching license reflecting his appointment as an educator at an accredited dental college. Since his application now met the requirements for said license, Dr. Ali was granted a limited teaching license on August 4, 2017. The Board executive office was now requesting that the original Notice of Opportunity be rescinded as no longer applicable.

Motion by Ms. Johnston, second by Dr. Subramanian, to rescind the Notice of Opportunity for Hearing that was issued in December 2016 to Dr. Mohsin Ali.

Motion carried unanimously.

Proposed Consent Agreement(s)

The Board reviewed six (6) proposed Consent Agreements. The names of the individuals/licensees were not included in the documents reviewed by the Board. The names of the individuals/licensees have been added to the minutes for public notice purposes. Ms. Nash provided a brief summary of any charges and the proposed orders.

Disciplinary

Bradley E. Cohn, D.D.S.

Motion by Ms. Johnston, second by Dr. Ginder, to approve the proposed consent agreement for Bradley E. Cohn, D.D.S., license number 30.018206, and case number 17-18-1121.

Motion carried with Dr. Guttman and Dr. Subramanian abstaining.

Robert L. Sturkey, D.D.S.

Motion by Dr. Ginder, second by Dr. Krob, to approve the proposed consent agreement for Robert L. Sturkey, D.D.S., license number 30.016265, and case number 16-17-1217.

Motion carried with Dr. Guttman and Dr. Subramanian abstaining.

Ryan Slaten, D.D.S.

Motion by Ms. Johnston, second by Dr. Anderson, to approve the proposed consent agreement for Ryan Slaten, D.D.S., license number 30.023155, and case number 17-28-1253.

Motion carried with Dr. Guttman and Dr. Subramanian abstaining.

Non-disciplinary

Marwa Abdeldayem, B.D.S.

Motion by Ms. Johnston, second by Dr. Krob, to approve the proposed consent agreement for Marwa Abdeldayem, B.D.S., license number 30.025248.

Motion carried with Dr. Subramanian and Dr. Guttman abstaining.

Hania Alkudmani, B.D.S.

Motion by Ms. Johnston, second by Dr. Krob, to approve the proposed consent agreement for Hania Alkudmani, B.D.S., license number 30.025249.

Motion carried with Dr. Subramanian and Dr. Guttman abstaining.

Mark Hebeish, B.D.S.

Motion by Ms. Johnston, second by Dr. Krob, to approve the proposed consent agreement for Mark Hebeish, B.D.S., license number 30.025247.

Motion carried with Dr. Subramanian and Dr. Guttman abstaining.

Enforcement Update

Director Kamdar began the Enforcement Update by informing the Board that there were nine (9) cases pending hearings and that there were no cases awaiting a Hearing Examiners Report and Recommendation. He stated that there were still forty-seven (47) licensees and certificate holders under suspension and that there were one hundred and thirty-six (136) active cases. Director Kamdar said that there were two (2) new referrals and one (1) licensee actively participating in QUIP. He informed the members that there were thirty (30) cases which have been investigated and reviewed by the Board Secretaries and are recommended to be closed with two (2) warning letters having been issued. Director Kamdar noted that of the thirty (30) cases listed to be closed, eight (8) cases were being brought back before the members due to numerical discrepancies and they were being brought back before them to ensure closure of the correct cases.

90-Day Report

Director Kamdar provided the Board members with a report of the cases that were older than 90 days. He expressed that there were a number of cases that were listed as over 180 days. He stated that they would be following up with external parties in an effort to reduce the numbers of those cases to a more manageable amount.

Closed Cases

Due to the requirement in Chapter 4715.03(B) of the Ohio Revised Code, that "A concurrence of a majority of the members of the board shall be required to… …(6) Dismiss any complaint filed with the board.", President Clark reviewed the cases to be closed with the Board.

The following cases are to be closed:

17-09-1174	17-41-1208	17-77-1193 - WL
17-18-1232	17-48-1221	17-77-1216
17-18-1233	17-52-1163	16-38-1108
17-23-1246	17-57-1245	17-18-1179
17-25-1209	17-60-1199	17-18-1230
17-25-1215	17-66-1181	17-31-1158
17-25-1238	17-72-1176 - WL	17-50-1192
17-25-1239	17-76-1188	17-52-1058
17-31-1162	17-76-1227	17-52-1134
17-31-1171	17-77-1016	17-57-1182

Prior to the vote to close the above listed cases, President Clark inquired as to whether any of the Board members had any personal knowledge that the cases that were being voted on today involved either themselves or a personal friend.

Roll call: Dr. Anderson – No
Dr. Das – No
Dr. Ginder – No

Dr. Guttman – No
Dr. Job – No
Ms. Johnston – No
Dr. Krob – No
Dr. Subramanian – No
Dr. Zucker – No
Ms. Clark – No

President Clark then called for a motion to close the cases.

Motion by Dr. Subramanian, second by Ms. Johnston, to close the above thirty (30) cases.

Motion carried unanimously.

President Clark thanked Director Kamdar for providing the Enforcement Report and Update.

Licensure

Licensure/Certification/Registration Report (Issued by the Licensure Section)

Samantha Slater, Licensing Manager, had prepared a report of the licenses, certificates, and registrations issued since the previous Board meeting in June.

Dentist(s) – (28)

30.025203	Mark Carter	30.025215	Mark Mathews
30.025206	Daisy Thomas	30.025218	Ah Cho
30.025204	Ali Azar	30.025219	Brooke Pancer
30.025205	Gena Pineda	30.025223	Amy Wong
30.025209	Peter Amin	30.025220	Deena Sher
30.025207	Martina Gerges	30.025222	Patrick Sedlar
30.025208	Amani Alsaery	30.025221	Tyler Canales
30.025210	Daisy Bachala	30.025225	Shane Roche
30.025212	Meghna Narayanan	30.025224	Johnny Amazan
30.025211	Oliver Sun	30.025226	Siddiq Karim
30.025213	Sarah Brobeck	30.025227	Kevin Marshall
30.025214	Michael Cook	30.025228	Blake Kuiper
30.025217	Lindsay Desantis	30.025230	Yaelim Park
30.025216	Peter Grumbos	30.025231	Daniel Krueger

Dental Hygienist(s) – (20)

31.015575	Jenna Fabian	31.015578	Leonda Richardson
31.015574	Anh-Tu Nguyen	31.015579	Kaitlin Starcher
31.015577	Molly Mihlbachler	31.015580	Dakota Smith
31.015576	Katrina Biviano	31.015581	Angela Powell

31.015582	Jennifer Hanlin
31.015583	Jenna Williams
31.015584	Laura Whitley
31.015587	Kellie Krugman
31.015586	Ali Governor
31.015585	Chelsea Kuck
31.015588	Hannah Miller
31.015590	Randi Alexander
31.015589	Mackenzie Rummell
31.015591	Analee Goldstein
31.015592	Rachel Nelson
31.015593	Michelle Coutts

Dental Assistant Radiographer(s) – (179)

51.031996	Taylor Longstreth
51.031991	Amber Cokley
51.031995	Kiara Davison
51.031997	Wayne Lee
51.031992	Syeda Razvi
51.031994	Baraa Habbas
51.031989	Amethyst Upchurch
51.031990	Paul Geuy
51.031993	Casey Abernathy
51.032001	Patricia Johnson
51.031998	Jaelin Knight
51.031999	Stephanie Taylor
51.032000	Nancy Knab
51.032008	Lisbeth Pacheco
51.032009	Brandey Lockhart
51.032004	Madisun Jordan
51.032002	Antonia Lombardozzi
51.032003	Karyna Gonzalez
51.032005	Courtney Hall
51.032006	Shanique Simpson
51.032007	Sherry Winters
51.032019	Abby Rowles
51.032013	Amy Weaver
51.032022	Shelby Van Dyke
51.032016	Kelsi Smith
51.032017	Breanna Williams
51.032018	Autumn Caffie
51.032020	Donna Swinehart
51.032021	Tenisha Taylor
51.032011	Lauren Smith
51.032015	Ava Uhrig
51.032010	Breanna Dunlap
51.032014	Casey Blosser
51.032012	Julie Hartsock
51.032024	Haley Cutlip
51.032023	Allison Dauterman
51.032025	Alexis Kinder
51.032028	Kimberly Angle
51.032030	Tina Jurcevic
51.032029	Colleen Yasenchack
51.032031	Rachelle Brakeall
51.032026	Kimberly Williams
51.032027	Staci Trunko
51.032032	Iesha Ficklin
51.032035	Kyla Ivory
51.032036	Harlee Reese
51.032034	Allison Stroup
51.032033	Katlin Unkefer
51.032037	Susan Lecomte
51.032040	Tara Murphy
51.032039	Alexis Morgan
51.032038	Alayna Morelock
51.032041	Abigail Schlick
51.032042	Chanel Williams
51.032043	Dawn Singleton
51.032045	Felisha Lea
51.032046	Liliya Fatkhullina
51.032047	Ashanti Shabazz
51.032044	Elmira Lomanova
51.032048	Kayla Dial
51.032060	Alexis Blackburn
51.032056	Samantha Katzler
51.032050	Alexandria Gruhler
51.032062	Bailey Mccoy
51.032052	Linda Finley
51.032061	Zainab Al Obaidi
51.032054	Asia Kerr
51.032055	Kathleen Jackson
51.032057	Allyson Pamer
51.032058	Brandy White

51.032059	Alexis Mckellop
51.032051	Trisha Arnold
51.032053	Clark VanMatre
51.032049	Erin Henson
51.032066	Kristen Campbell
51.032073	Ashley Matthews
51.032071	Kelsey Phillips
51.032072	Terri Booth
51.032070	Terra Armstrong
51.032074	Ieasha Gilmore
51.032065	Thomas Carroll
51.032068	Huan-Yu Chen
51.032067	Aleah Davis
51.032069	Shania Snipes
51.032064	Juliana Opoku
51.032063	Amber Elmore
51.032083	Patrice Chandler
51.032082	Kyla Boyd
51.032078	Jessica Correa
51.032081	Paul Myers
51.032080	Kaylee Woodgeard
51.032079	Rafia Rahman
51.032077	Melanie Conkle
51.032075	Lauren Bauserman
51.032076	Dana Jacobs
51.032086	Morgan Leathers
51.032091	Morgan Prather
51.032085	Casey Draeger
51.032088	Shandora Norris
51.032087	Sukhvir Kaur
51.032089	Rose Thomas
51.032090	Dontia Calhoun
51.032084	Tara Fout
51.032093	Klarissa Smiddy
51.032092	Christy Browning
51.032103	Aubrey Zunk-Sullivan
51.032104	Jania Grier
51.032097	Bailey Spearman
51.032096	Abigail Farmer
51.032105	Misty Pullins
51.032099	Hayle Harless
51.032094	Tristen Krouskoupf
51.032100	Teri James
51.032095	Tiesha Carter
51.032102	Shawna Godfrey
51.032098	Trina Bowers
51.032101	Sangita Adhikari
51.032120	Kelsey Werner
51.032108	Margaret A Albanese
51.032109	Brittany Barnett
51.032110	Chelsey Fritz
51.032111	Edralin Moore
51.032112	Amanda Mosier
51.032113	Eviana Paulo
51.032118	Tianna Watkins
51.032107	Kaitlyn Herr
51.032106	Pamela Chatman
51.032116	Ylva Louise Estrellado
51.032119	Ruthanne Conner
51.032114	Kristen Funk
51.032117	Erion Redding
51.032115	Robert Fuellhart
51.032122	Emily Stanfield
51.032121	Patricia Schack
51.032123	Lauren Prati
51.032124	Alexis Bennett
51.032130	Troy Showalter
51.032125	Megan Wells
51.032126	Monica Reynaga
51.032128	Kyla See
51.032131	Tarrah Belfast
51.032127	Zachary Rickett
51.032129	Claire Young
51.032134	Michelle Mccormick
51.032135	Garett Patterson
51.032133	Chiquita Dunlap
51.032132	Tiffany Holsclaw
51.032136	Lauren Cox
51.032137	Amber Faul
51.032138	Faith Groff
51.032139	Lindsey Kiger
51.032140	Jenita Milton
51.032141	Chelsie Porter
51.032142	Megan Scott
51.032143	Lyndsey Williams
51.032146	Tynetta Saahir
51.032144	Czara Thomas
51.032145	Kelsee Rittenhouse
51.032148	Crystal Cambra
51.032147	Alexis Nichols

51.032153	Kodi Babbs	51.032159	Zhamila Lumanova
51.032151	Jessica Gibbs	51.032158	Kayla Molitor
51.032149	Lesley Helvey	51.032155	Carrigan Critten
51.032150	Dasiza Bell	51.032161	Chantel Streeter
51.032152	Kylie Matthews	51.032167	Alexandra Roberts
51.032154	Zavaughn Smith	51.032163	Emily Flores
51.032160	Catrina Barrett-Frederick	51.032164	Courtney Peters
51.032162	Emily Clark	51.032165	Ruth Schaffhauser
51.032156	Elizabeth Smith	51.032166	Nadia Mahan
51.032157	Verdun Small		

Limited Resident's – (9)

RES.003912	Dalal Alhajji	RES.003917	Chadi Bachour
RES.003913	Qian Wang	RES.003918	Alvaro Rodriguez
RES.003914	Mohamed Elsalhy	RES.003919	Manhal Eliliwi
RES.003915	Abdulaziz Mohammad	RES.003920	Marian Khalil
RES.003916	Yu-Chen Ling		

Limited Teaching – (2)

71.000255	Mohsin Ali	71.000256	Thiago Porto

Limited Continuing Education – (2)

LCE.000330	Christopher Maestro	LCE.000331	Timothy Garvey

Coronal Polishing – (16)

CP.001800	Christina Donadio	CP.001808	Ashley Luster
CP.001801	Ashley Collins	CP.001809	Emily Cyphers
CP.001802	Virginia L Bender	CP.001810	Anai' Bennett
CP.001803	Nichole Best	CP.001811	Schae Frazee
CP.001804	Brittney Hunsicker	CP.001812	Shelby Taulbee
CP.001805	Laiken Mourer	CP.001813	Amber Vukovich
CP.001807	Traci M Spahr	CP.001814	Scot Lucas
CP.001806	Kylie Maykowski	CP.001815	Diana Shinn

Expanded Function Dental Auxiliary – (36)

EFDA.002703	Marcia Marosek
EFDA.002704	Chelsea Mccoy
EFDA.002705	Camyla Sarensen
EFDA.002706	Madelyn Trummer
EFDA.002707	Carrie A Gauntt
EFDA.002722	Jenna M Didelot
EFDA.002726	Jaclyn Hug
EFDA.002717	Nichole Best
EFDA.002708	Jessica Michel
EFDA.002709	Jessica Burgett
EFDA.002723	Brandie Femia
EFDA.002711	Shaina Shedlock
EFDA.002710	Tanya Henderson
EFDA.002712	Autumn Burton
EFDA.002724	Jennifer Sheets
EFDA.002713	Sara Richardson
EFDA.002719	Kadie Simon
EFDA.002721	Lauren Bowsher
EFDA.002714	Virginia L Bender
EFDA.002715	Amy B Lanum
EFDA.002716	Andrea Sullivan
EFDA.002725	Kelly Ann Bischoff
EFDA.002720	Cheyenne Flowers-Smith
EFDA.002718	Kanisha Walker
EFDA.002728	Brandy Henderson
EFDA.002730	Jessica Phillips
EFDA.002731	Brittney Hunsicker
EFDA.002729	Chelsea Floro
EFDA.002727	Alison Brashear
EFDA.002732	Brittany Baltzer
EFDA.002737	Miranda Stuart
EFDA.002734	Susanna Mazey
EFDA.002733	Schae Frazee
EFDA.002735	Hazrat Fatima Riley
EFDA.002738	Rebecca K Montgomery
EFDA.002736	Heather Dickson

Motion by Dr. Subramanian, second by Ms. Johnston, to approve all licenses, certifications, and registrations as listed that have been issued since the July Board meeting.

Motion carried unanimously.

Graduates of Unaccredited Dental Colleges Located Outside the United States

The Board's Licensing Division has reviewed dental license applications from graduates of unaccredited dental colleges located outside the United States who have met all the requirements for dental licensure as set forth in Ohio Administrative Code Rule 4715-18-01. They are recommending issuing licenses to practice dentistry in the State of Ohio for the following individuals:

Dr. Daniel Escovar
Dr. Ankita Kathpalia
Dr. Yas Saleem
Dr. Ahmed Elkhaweldi
Dr. Muhanan Kassim

Motion by Dr. Job, second by Dr. Das, to grant a licenses to practice dentistry in the state of Ohio for the individuals as listed.

Dr. Anderson noted that one of the applicants had completed two 1-year programs at different dental colleges in Advanced Education in General Dentistry and questioned whether that was acceptable. Dr. Subramanian clarified that this was acceptable under the current law for these types of graduates. However, this rule was being reviewed currently by the Law and Rules Review Committee and this issue has been discussed.

Motion carried unanimously.

General Anesthesia/Conscious Sedation Permit(s)

President Clark stated that the Board's Anesthesia Consultant had vetted the following individuals who have applied for General Anesthesia and Conscious Sedation Permits, evaluations have been conducted, and the applicants are recommended to receive Permits for the specified modality.

General Anesthesia

Bryant Cornelius, D.D.S., Columbus, Ohio

Conscious Sedation

Matthew Croston, D.D.S., Uniontown, Ohio – Intravenous
Shayer Shaw, D.D.S., Newark, Ohio – Intravenous

Motion by Dr. Subramanian, second by Dr. Anderson, to grant permits to the licensees for General Anesthesia and Conscious Sedation in the appropriate modality as listed.

Motion carried unanimously.

Oral Health Access Supervision Permits

President Clark stated that the Board's Licensing Manager had reviewed the applications and recommended that the following individuals receive Oral Health Access Supervision Permits:

Dentist(s)

Corey Young, D.D.S. - Galion, Ohio

Motion by Ms. Johnston, second by Dr. Krob, to grant an Oral Health Access Supervision Permit to Dr. Corey Young.

Motion carried unanimously.

Reinstatement Application(s)

President Clark stated that the Board's Licensing Manager had reviewed the application and recommended that the following dental hygiene license be reinstated:

Dental Hygienist(s)

Wintana Tecle, R.D.H.

Motion by Ms. Johnston, second by Dr. Zucker, to reinstate the dental hygiene license of Ms. Wintana Tecle to practice in the state of Ohio.

Motion carried unanimously.

Executive Session

Motion by Ms. Johnston, second by Dr. Subramanian, to move the Board into executive session pursuant to Ohio Revised Code Section 121.22 (G)(3) to confer with Board counsel regarding a pending or imminent court action.

Roll call vote: Dr. Anderson – Yes
Dr. Das – Yes
Dr. Ginder – Yes
Dr. Guttman – Yes

Ms. Johnston – Yes
Dr. Job – Yes
Dr. Krob - Yes
Dr. Subramanian – Yes
Dr. Zucker – Yes
Ms. Clark – Yes

Motion carried unanimously.

President Clark stated that the Board would now go into Executive Session and requested Ms. Bockbrader, Director Kamdar and Mr. Kochheiser to attend. She requested all other guests and staff to leave the meeting and to take all personal items, including briefcases, purses, cell phones, tablets, etc. with them when exiting the room. She stated that they would be invited back in upon conclusion of the Executive Session.

Open Session

At 4:51 p.m. the Board resumed open session.

Certificate of Appreciation – Martin Chamber, D.D.S.

President Clark amended the agenda and took a moment to recognize and acknowledge the work of former Board member, Martin Chambers, D.D.S. She presented him with a certificate of appreciation and stated:

"The Ohio State Dental Board proudly presents this Certificate of Appreciation to Honorable Dr. Martin Chambers on the 13th day of September, 2017 for dedication and outstanding public service to dental consumers, and to the profession of dentistry across the great State of Ohio from 2014 to 2016."

Dr. Chambers thanked the members and Director Kamdar for inviting him that day. He stated that once you are on the Board for a few years you start to understand the phrase "service to the board" and how that encompasses many hours that you never thought you had available. Dr. Chambers said that you meet a lot of great people and learn a lot from everybody. He especially wanted to thank Director Kamdar for the great job that he has been doing and also wanted to say a special "thank you" to Dr. Das, as they worked together for two (2) years on the supervisory investigative panel and accomplished a lot.

Dr. Chambers congratulated Director Kamdar on bringing forth the idea of levying fines on dentists and others who have violated the Dental Practice Act, as he feels that the levying of fines will help keep down the amount of repeat offenders that are seen by SIP. He also thinks that fining authority will help continue to provide for the excellent staff that we have at the board on a day-to-day basis as they employ excellent people behind the scenes to keep the Board providing the state with excellence in protecting the public.

Lastly, Dr. Chambers wished to thank Governor Kasich for having the confidence in him to put him in the position to help the Board's mission. He felt that during his time on SIP they were ahead of the curve in helping the opioid crisis and he knows that Dr. Guttman and Dr. Subramanian are continuing that excellent work that is very important to the Governor. He again thanked the members of the Board for inviting him and their recognition.

Director Kamdar stated that the Board also has certificates for former board members Dr. Marybeth Shaffer and Dr. Charles Smith who were unable to join them at the meeting that day. He indicated that they would be mailing their certificates of appreciation directly to them.

Motion Regarding Settlement Offer

Motion by Ms. Johnston, second by Dr. Job, that the Board reject opposing counsel's offer of a settlement in the case of Kiser vs. Kamdar.

Motion carried unanimously

Committee Reports

Ad Hoc

President Clark requested Dr. Das to provide his report on the activities of the Ad Hoc Committee that day. Dr. Das stated that the Committee met that morning at 11:45 a.m. in room 1914. He stated that they had continued their review of the draft revisions of the Disciplinary Guidelines. He noted that the Committee had again briefly reviewed and finalized the sections reviewed during previous meetings; Categories 1, 2, 3, 4, and 6. Dr. Das stated that under New Business they went through and changed some of the minimum penalties under Criminal Convictions, CE Violations, and Miscellaneous Violations. He stated that now that the Committee has determined the minimums and maximums for each category, the information will be drafted into the final document for the Committee's final review prior to presentation to the Board. He indicated that once approved, should the Board be able to obtain fining authority, they will revisit the disciplinary guidelines in order to redo the category minimums.

Motion by Ms. Johnston, second by Dr. Anderson, to approve the Ad Hoc Committee report as presented.

Motion carried unanimously

Education

Review of Application(s)

President Clark stated that the Committee had met at 9:15 a.m. that morning in Room 1924 with all members present and began the meeting by reviewing nine (9) Biennial Sponsor Applications for consideration of approval. She indicated that six (6) of the applications met the requirements as set forth in the law, rules and guidelines of the Board. However, three (3) applicants will be requested to submit clarifying information. The Committee recommended approval for Biennial Sponsorship of continuing education for the following:

The Carroll Center
BeTrice Casada, R.D.H., B.A., M.A.
Central Ohio Pediatric Study Club
Marshall Family Orthodontics
Oral & Maxillofacial Surgery Centers
Periogenius, L.L.C.

Review of Course(s)

Dental Assistant Radiographer Initial Training Program

President Clark stated that the Committee had reviewed a request for approval of an application for a Dental Assistant Radiographer Initial Training Course. The curriculum submitted was reviewed and is recommending approval for the following:

Forest City Dental Society

"VIP Dental Assisting School"

Content Review

Stark County Dental Society – "Positive Psychology: The Secret of Happiness"

President Clark indicated that the Committee had been requested by Stark County Dental Society to review the course for acceptable content. She stated that the Committee determined that the course "Positive Psychology: The Secret of Happiness" does not fall within the guidelines in the Dental Practice Act and we will be sending them a response that the course would not be considered acceptable towards continuing education credit for licensure renewal.

Elite Continuing Education – "Periodontitis and Systemic Health Conditions"

President Clark stated that the Committee had received a complaint from a licensee, Nancy Kiehl, R.D.H., regarding the course "Periodontitis and Systemic Health Conditions" that is being provided by Board-approved Biennial Sponsor; Elite Continuing Education. She informed the members of the Board that Ms. Kiehl had taken the initiative to contact the sponsor regarding her concerns about misinformation and stated that the Committee has reviewed the course information as requested and that an appropriate letter will be drafted to Ms. Kiehl. Unfortunately, President Clark stated, the Board does not have the resources in determining course by course the accuracy of each course and all the information involved to ensure that it is all safe. She indicated that we will be sending a response to Ms. Kiehl in that regard and that Elite Continuing Education has already been made aware of the perceived concerns about the inaccuracy of the information by Ms. Kiehl.

Practicum Education

President Clark stated that the Committee had furthered their discussions on practicum education and they intend to have the draft guidelines for an approval process at the next meeting.

Acceptable Continuing Education – Discussion

President Clark stated that the Committee had a robust discussion about acceptable continuing education (CE), sponsors, and content. She indicated that they would like to look at the rules about CE for both Biennial and Permanent Sponsors and to also look at initial vs. continuing education vs. remedial education and try to see how the law and rules on education may be rewritten, for better understanding, and have better guidelines. She stated that the Legislature has made it clear that they want our licensees to have scientific based information for our relicensure. She stated that as the Committee begins their review and discussions, they will want to try to make sure that tracking our CE is more efficient in order to also help with our auditing.

Request For Proposal for Continuing Education Tracking

President Clark informed the members that the Committee had been provided with the responses to the Request For Proposal (RFP) for Continuing Education Tracking. The Committee is recommending that the Board award the contract to CE Broker based on the following:

1. The services are being offered at no cost to the Board;
2. They have prior experience with other state dental boards;
3. They have the infrastructure in place for solid customer service for large numbers of licensees; and
4. They are already working with other licensing boards within the State of Ohio eLicense system and are familiar with it.

Motion by Dr. Krob, second by Dr. Zucker, that the Board enter into an agreement with CE Broker for the purposes of tracking and monitoring continuing education for regulated dental individuals.

Motion carried unanimously.

Motion by Ms. Johnston, second by Dr. Krob, to approve the Education Committee report and the recommendations for applications and courses as presented.

Motion carried unanimously.

Law and Rules Review

Review and Update Statute and Rules

Dr. Subramanian stated that the Law and Rules Review Committee had met that morning between 10:15 a.m. and 1:45 p.m. and received a status update on the Omnibus bill. He stated that the Committee had also completed most of their clean-up revisions to the rules under review. He indicated that there was some discussion on the length of time that records should be stored, the "one-bite" legislation bill, and had a lengthy discussion on how long the disciplinary actions should be kept online.

Specialty Designation and Advertising Rules

Dr. Subramanian stated that the Committee had discussed a survey that the Committee had directed Executive Director Kamdar to research and retain a vendor able to perform the survey and relevant data evaluation. The Director had contacted a number of agencies and was in the final process of working with the state in finding the perfect vendor to do this survey to help us with the specialty designation matter. He then asked if the members wanted to make a motion in regards to the rule Options B and D and waiting until the survey is done and completed to vote on this particular matter.

Motion by Dr. Job, seconded by Dr. Das, that the Board delay a vote on Options B and D until the survey commissioned is completed.

Discussion followed wherein Dr. Krob commented that they may consider not necessarily waiting until the survey to be completed but rather on when the results would be available. Dr. Subramanian stated that the vote would be on the results not completion of the survey.

Dr. Job stated that he wanted the minutes to reflect that Director Kamdar had made every effort to retain the services of an agency to perform the requested survey but at the last minute the firm had dropped out and so any delay in this matter has been outside of the Board's control.

Motion carried with Dr. Anderson opposed and Ms. Johnston abstaining.

Viewable Disciplinary Actions

Dr. Subramanian stated that the Committee had also discussed how long disciplinary records should be available online. He stated that some of the members of the Board feel that for the disciplinary actions taken by the Board to be viewable indefinitely can be overly punitive and they were suggesting that the Board consider a process wherein the licensee may petition the Board to have the action removed from the website. He explained that the action would not be "expunged" but just taken down as viewable documents. The public would still be able to obtain a copy of these actions through a public records request.

Motion by Ms. Johnston, second by Dr. Zucker, to remove records on line that are at least three (3) years old on a case by case basis but they would not be expunged.

Discussion followed wherein Dr. Job asked for clarification of three (3) years' time duration and that the disciplinary action would only be considered for removal upon petition to the Board.

Dr. Guttman raised concerns that they would be opening themselves open to an insane number of records requests. Director Kamdar explained that they currently have public records requests made by parties that have disciplinary action taken against them that go back 10-12 years. He explained that some of the requests are taking high-priced staff such as attorneys that are having to vet through voluminous amount of information, along with assistance from the Department of Administrative Services and their Information Technology staff to go through emails. He stated that he understands that this will create work for the Board but if there are those who want their records online removed beyond 3 years, the Law & Rules Committee has discussed guardrails to put into motion to have the dentists petition to the SIP, then SIP would decide whether to honor it before the full board votes on it, and finally it would be given to the Board staff to remove the information and maintain it in a separate database if the full Board approves. He stated that this does make sense as we are already spending an immense amount of time, effort, and money on what basically amounts to a multitude of public record requests worked on by high-priced help.

Dr. Zucker stated that he thinks the Board has made great progress with the disciplinary guidelines in standardizing our disciplinary procedures for everyone. He feels that regardless of the decision, he feels that there should be standardized guidelines for the process so that the Board does not end up in one of those situations where maybe this year they are removing a lot of things from the website and then next year with two (2) different SIP people making those decisions, they are not consistent in their decisions remove the disciplinary action from the website. He felt that we need to find a way to ensure that the process is standardized moving forward as the members of the Board may change and the standards of the guidelines remains the same. Director Kamdar agreed but stated that standardization of the SIP process and investigative process is something that the Board is working on already.

There was a question regarding whether the original motion reflected that the Board must be petitioned prior to any consideration for removal of the disciplinary action from the Board website.

Motion by Ms. Johnston, second by Dr. Krob, that the Board consider removing the disciplinary records from the website after three (3) years upon petition by the dentist or dental hygienist and referred to SIP and then voted on by the Board.

Ms. Bockbrader voiced her concerns regarding the motion as stated without further discussion on the standardized process in place for removal of records, whether there would be anything listed on the website indicating that after three (3) years, some of the records would be only available upon public record requests, and when did the three (3) year timeframe begin; upon ratification by the Board, upon completion of any suspension, or upon fully satisfying the terms and conditions as stipulated in the disciplinary agreement.

Dr. Anderson and Dr. Zucker inquired as to whether radiographers and expanded function dental auxiliary would be afforded the same opportunity to have their disciplinary action removed.

The motion was amended by Ms. Johnston to include all licensees, registrants, certificate holders. Ms. Franks made an editorial change to reflect all regulated individuals by the Board.

Dr. Job called the question.

Motion carried with Dr. Anderson and Dr. Krob opposed.

Operations

President Clark stated that the Operations Committee had not met that day.

Policy

Ms. Johnston stated that the Policy Committee had met earlier the morning from 11:45 a.m. to 12:30 p.m. with all Committee members present. She stated that the Committee had finalized revisions on previously discussed policies as follows:

- A-502 Policy Regarding Treatment Within the Scope of Dental Practice - eliminating the language referring to specialties;
- B-503 Policy Regarding Treatment Within the Scope of Dental Hygiene Practice – eliminating the language referring to specialties; and
- A-620 Policy Regarding Termination of the Dentist-Patient Relationship – eliminating the sentence requiring the dentist to "offer emergency care up to a reasonable amount of time" due to the vague nature of the sentence and because some of the Committee members had expressed that the termination of the relationship might be hostile in nature.

Ms. Johnston stated that four (4) policies are ready for full consideration. They are as follows:

- A-610 Policy for Non-Dentist Licensed Healthcare Providers Assisting a Licensed Dentist;
- B-501 Policy Regarding Dental Hygienists Performing Periodontal Maintenance When the Supervising Dentist is Not Present;
- K-701 Policy Regarding Legislative Representation; and
- Policy Regarding Employee Response to an Active Aggressor

Ms. Johnston informed the members that the Committee had begun drafting the policy on remedial education and that they projected to have the draft finished by the next meeting. They had discussed drafting policies regarding the disposal of extracted teeth and dental waterline guidelines but the Committee had determined that these matters should be addressed in best practices within a dental office.

Ms. Johnston stated that the Committee also discussed drafting policies on sterilization of High-speed and Slow-speed handpieces and the disposal of sharps. It was determined that sterilization of handpieces was sufficiently covered within the infection control rules so a policy was not needed. However, Ms. Johnston had provided the Committee with information on the disposal of sharps and it was the recommendation of the Committee to draft a policy on the disposal of sharps that will be based on the EPA Guidelines with the exception of eliminating any language that references the guidelines set forth by the Public Utilities Commission of Ohio.

Ms. Johnston projected that the Committee will have several of the draft policies in their final form for Board review at their next meeting in November.

Motion by Dr. Subramanian, second by Dr. Ginder, to approve the Policy Committee report as presented.

Ms. Clark commented that in regards to the policy on termination of the dentist-patient relationship, she would like the Committee to reconsider the elimination of the "emergency care" and rather rewrite it to include a specific time such as 60-90 days.

Motion carried unanimously.

Scope of Practice

Silver Diamine Fluoride

Dr. Ginder informed the members that the Scope of Practice Committee had met earlier that day in room 1914 from 8:00 a.m. to 8:45 a.m. with all members in attendance. He stated that the Committee had been provided a packet of informational literature on the Board member portal regarding Silver Diamine Fluoride (SDF) from The Ohio State University. He explained that SDF is an FDA-approved liquid antibiotic that helps with active tooth decay and tooth sensitivity. SDF kills the bacteria causing the cavity and strengthens that part of the tooth by hardening the tooth structure in the area of decay so the cavity does not get bigger and the tooth becomes less sensitive. Essentially, the use of SDF "buys time" to properly address the decay and multiple applications may be necessary.

Dr. Ginder stated that SDF treatment can benefit many patient-types, including:

- Children with high caries risk, including those with salivary dysfunction;
- Pre-cooperative children;
- Medically compromised patients;
- Difficult to treat dental carious lesions;
- Geriatric patients; and
- Patient-related access barriers.

Dr. Ginder said that while this may not be pertinent to Scope of Practice, this was important to consider in determining who may apply SDF, specifically in an access to care setting. The Committee agreed that licensed dentists and dental hygienists are permitted to apply SDF and that Expanded Function Dental Auxiliary with additional training may be permitted to apply SDF as a result of pending legislation. The Committee expressed that the use of informed consent forms is very important in regards to SDF treatment. Specifically, it is recommended that the licensed dentist obtain written and verbal consent and that it is a good idea to include color before and after photographs prior to treatment when explaining treatment to the patient as this may alleviate complaints about the treated tooth turning black.

Dr. Ginder stated that the Committee had discussed whether dental hygienists with permits may be permitted to perform SDF treatment within the Oral Health Access Supervision Program. Concerns were raised since there is no immediate diagnosis by a dentist subsequent to the SDF treatment being provided. However, the Committee recognized that this is an access to care issue and providers are likely serving an area with limited access to care. Concerns were also raised about SDF being applied in medical offices by nurse practitioners or physicians. He stated that the Committee discussed the importance of defining the use of SDF and how this may apply as teledentistry becomes more prevalent in underserved areas.

Sleep Apnea

Dr. Ginder stated that the Committee had recapped their discussions on sleep apnea and the need to define a standard of care, continuing education guidelines, and address concerns that qualified dentists are fabricating sleep appliances and not non-dentist physicians. He said that dentists do not prescribe CPAP machines and likewise, physicians should not be fabricating oral appliances. He stated that the Committee still recognizes the need to develop a multi-disciplinary approach to the diagnosis and treatment of sleep apnea.

Motion by Ms. Johnston, second by Dr. Zucker, to approve the Scope of Practice Committee report.

Motion carried unanimously.

President Clark took a moment to thank all of the Chairs on their comprehensive Committee reports.

Executive Updates

President's Update

Governor Kasich Announcement on Opioid Prescribing

President Clark stated that she had participated in Governor Kasich's media event along with representatives from the Ohio Board of Pharmacy, State Medical Board of Ohio and the Ohio Board of Nursing regarding the new rules on opioid prescribing and the opioid addiction crisis in Ohio. She stated that it was very nice that we were able to say how our partnership with the Ohio Dental Association (ODA) has been very fruitful and helpful in getting all the information out there to all of the dentists about the OARRS and about the training that the ODA would also be providing along with continuing education on the opioid prescribing rules and the Ohio Automated Rx Reporting System during their Annual Session meeting that weekend.

Executive Director's Update

Welcome New Deputy Director Steven Kochheiser, Esq.

Director Kamdar opened his update by again welcoming Mr. Steve Kochheiser, the Board's new Deputy Director. He stated that he is impressed already with Mr. Kochheiser's ability to dissect our statute and indicated that the members can expect a robust effort on his part. He stated that one of our strategic priorities is to update the statute and rules of the Board and that Mr. Kochheiser has already begun a review of them.

Mr. Kochheiser thanked Director Kamdar for his comments and stated that he was really looking forward to his work with the Board and furthering the work that former Deputy Director Nash had already accomplished.

New Rules on Acute Prescribing

Director Kamdar stated that the new rule and amended definitions rule regarding acute prescribing went into effect on August 30th, 2017 and stated that all licensees should be aware of them.

Renewal Cards

Director Kamdar informed the members that due to our migration to the new eLicensing system, the Board would no longer be issuing renewal cards. Dentists and hygienists will have their initial license certificates that are emailed at the time of initial licensure and while they are used to having their renewal cards mailed out to them, we will no longer have that ability. He stated that the Law and Rules Review Committee will need to make appropriate changes in our rules to reflect that change. He indicated that if anyone needs to verify whether they are licensed or not, they now need to log-on and view the licensure information online.

Visit From the Oregon Board of Dentistry

Director Kamdar informed the members that the investigative staff recently had the opportunity to host a guest from the Oregon Board of Dentistry who was a dentist investigator. He stated that the staff really enjoyed their time with him asking questions and answering his questions of us. It was interesting learning how they handle things, especially enforcement, the way they do investigations, and how their Board goes about making decisions on investigations. He stated that they would be sharing that information and any new ideas they picked up with the SIP and with Mr. Kochheiser when he gets started.

2017-2018 Strategic Map

Director Kamdar stated that his last item to discuss was the distribution of the most recent Strategic Map that was developed based upon the discussions and decisions made during the Board members Strategic Retreat in July.

He stated that on behalf of Chairwoman Aquillo, he was pleased to present them the 2017-2018 Strategic Map [Appendix I]. He stated that the Vision, Mission and Core Values are the same as before, but that they would notice a plethora of priorities. He commented that, as they should remember, they came up with approximately 16-17 priorities which did not actually rise to the level of strategic priorities but rather some of them were actually tasks. Director Kamdar stated that for that reason he had renamed the category as "Major Priorities and Key Action Items". He indicated that there were now 16 priorities and action items and one Executive Priority, "Elevate Awareness of Ohio's Opioid Epidemic and Reduce Overprescribing of Opioids and Benzodiazepines." He then requested the members to take some time to study the Strategic Map. He encouraged them to send him an email letting him know their thoughts as they will be assigning the priorities and action items to the various committees to help champion these causes similar to what they did last year.

Anything for the Good of the Board

2018 Board Meeting Calendar – Proposed Dates

President Clark stated that the Board members needed to make a decision on finalizing the Board meeting dates for 2018. She asked Mr. Russell to share the results of his Doodle Poll of the Board members for the proposed dates and proposed alternate dates. Ultimately, the poll resulted in the majority of the members of the Board being available to attend the February 7, 2018 date with two (2) Board members being unable to attend. President Clark asked if any of the members had any comments about the results of the poll or of any of the other suggested dates. There being no further comment, President Clark stated that the Board meeting dates for 2018 were as follows:

February 7	July 25
March 7	September 12
May 9	November 7
June 13	December 5

Director Kamdar stated that he had shared with President Clark that given how robust the most recent Strategic Map turned out, there are enough priorities to continue for two (2) years and he had suggested that they do not hold a Strategic Planning meeting again until 2019 for efficiency and cost savings reasons. He also stated that this would also help with the Board's budget for next year.

President Clark thanked all the members for their and then asked if any other members had anything to report for the good of the Board. Noting that there were no additional items for discussion, President Clark called for a motion to adjourn.

Adjourn

Motion by Dr. Das, second by Dr. Zucker, to adjourn the meeting.

Motion carried unanimously.

President Clark adjourned the meeting at 4:36 p.m.

Constance Clark RDH

CONSTANCE CLARK, R.D.H.
President

Ashok Das DDS

ASHOK DAS, D.D.S.
Vice President

Appendix A

2017 ADEXHR Bylaws Recommended Revisions

ADEX

AMERICAN BOARD OF DENTAL EXAMINERS, INC.

DATE: May 1, 2017

TO: Presidents/Chairs, Member State Dental Boards, ADEXHR Representatives

FROM: Renee McCoy-Collins, DDS, Chair ADEX Bylaws Committee

SUBJECT: 2017 ADEXHR Bylaws Recommended Revisions

The ADEX BOD requested that the ADEX Bylaws Committee develop some changes to the ADEX Bylaws. The ADEX Bylaws Committee completed its' work and submitted a report to the ADEX BOD. The ADEX BOD is recommending the proposed Bylaws Revisions to the ADEXHR for consideration and a vote at the ADEXHR on Sunday, August 13, 2017.

The ADEX Bylaws Committee has worked to ensure the Bylaws revisions provide the organization with governance and support for the relationships ADEX has built in its success. ADEX is committed to the nationally recognized examination and has formed principles in governance giving each client (Member State Board) an equal voice.

Attached to this Memo are two documents that outline the specific recommended changes.
I urge you to review this memo which highlights some of the major changes along with those two documents.

If you have questions about the proposed changes you can feel free to contact me at office@adexexams.org or questions will be fielded at the ADEXHR Meeting.

- Effort to streamline Bylaws after many years of amendments causing some inconsistency in the Bylaws.
- Returning to one vote per state.
- Allowing State Boards to designate dentist, RDH or Consumer, to represent a member board, but ADEX will only fund one person so if they want someone on the Dental Exam Committee and the ADEXHR Rep is not a dentist, they will have to fund one of the persons.
- Elimination of consumer district members. Reduction of 13 people who will not have to be funded for the ADEXHR.
- Consumer members of the Board will now fill public member roles on the Dental and Dental Hygiene Examination Committees on a rotational basis
- Consumer Members must be active members of State Dental Boards.
- New selection process for Board of Directors by District and then by state on alpha basis, one 3-year term except for Districts that only have one state. If state in alpha order does not want to appoint someone moves to the next state in alpha order.
- New selection process for RDH Exam Members again by district and then by state on alpha basis one 3-year term. If state in alpha order does not want to appoint someone moves to the next state in alpha order.
- New selection process for District Educators Representatives to the ADEX DEC again by district and then alpha order by state for one 3-year term. If state in alpha does not want to appoint someone moves to the next state in alpha order.
- Treasurer and Secretary could be a RDH or Consumer Member, but President and Vice-President must be a dentist.
- Ability for BOD to request bonding for an officer.
- Clarification on the appointments made by the President and then approved by the ADEX BOD.
- Some housekeeping changes regarding Corporate Laws and clarification on some items that were previously not clear.

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ADEXOFFICE@aol.com
www.adexexams.org

BYLAWS
OF
AMERICAN BOARD OF DENTAL EXAMINERS, INC.

ARTICLE ONE. NAME

The name of the Corporation is the American Board of Dental Examiners, Inc. (the "Corporation").

ARTICLE TWO. PURPOSE

To develop valid, reliable and uniform national examinations and other examinations to be administered to candidates for initial licensure as dentists and dental hygienists by Member Boards, and to develop standards for the administration of those examinations by state dental boards and regional testing services.

ARTICLE THREE. MEMBERS

SECTION 1. General. The members of the Corporation are the Member Boards.

A. Member Boards. The term Member Board shall mean the Board of Dental Examiners for each Jurisdiction which by statute, regulation, resolution, order, or written agreement, accepts the results of the dental and/or the dental hygiene examination (each a "National Uniform Examination") licensed by the Corporation, and which has heretofore been, or hereafter may become, admitted to the Corporation as provided herein (each a "Member Board"). Any Board of Dental Examiners which meets the criteria for membership as a Member Board may, upon application to the Corporation, be admitted as a Member Board by majority vote of the Member Boards.

B. Associate Members. The following organizations, and any other organizations which may be approved by the Board of Directors as eligible for Associate Membership, shall be eligible for non-voting associate membership in the Corporation upon payment of such admission fees and annual dues as may be determined by the Board of Directors from time to time:

American Dental Association
American Student Dental Association
American Dental Education Association
American Dental Hygienists' Association
National Examining Board of Canada
Canadian Dental Association

National Board of Medical Examiners
Federation of State Medical Boards

Associate Members shall be entitled to designate one (1) representative (each an "Associate Member Representative") to attend and participate in the Annual Meeting (hereinafter defined) with voice but without vote. Any organization not listed in this section may apply to the Corporation for admission as an Associate Member. The decision to grant or deny any such application shall be in the sole discretion of the Board of Directors. Any organization listed in this section, or hereafter granted Associate Member status, may have such status terminated by majority vote of the Board of Directors at any duly constituted meeting.

C. Representatives. The term Representatives shall include Member Representatives, Associate Member Representatives and District Dental Hygiene Representatives. The term "House of Representatives" refers to the collective body of all of the Representatives.

SECTION 2. Districts. Member Boards shall be divided among thirteen (13) districts (each a "District"). The District assignments in effect as of the date of adoption of these Bylaws are set forth on Exhibit A to these Bylaws.

Changes to the allocation of Member Boards among Districts may be proposed by the Board of Directors, or by any Member Board. Any proposed change to the allocation of Member Boards among Districts must be approved by a two thirds (2/3) vote of the Member Boards present at an Annual Meeting. Alternatively, the Member Boards may, by a two-thirds (2/3) vote, direct that the Board of Directors redistribute the Member Boards among the Districts as the Board of Directors deems appropriate. Any redistribution by the Board of Directors of Member Boards among Districts pursuant to this Section shall become effective as of the opening of the next Annual Meeting.

Any Board of Dental Examiners that hereafter becomes a Member Board shall be provisionally assigned to a District by majority vote of the Board of Directors, which assignment may be changed by a majority vote of the Member Boards present and voting at the next Annual Meeting following the admission of such Member Board, or left undisturbed; thereafter, any change to such assignment must be made in accordance with the otherwise applicable provisions of this Section.

SECTION 3. Annual Meeting. An Annual Meeting of the Member Boards and House of Representatives (the "Annual Meeting") shall be held on a date designated by the Board of Directors. The Board of Directors shall not schedule the Annual Meeting for any date that conflicts with the date of the annual meeting of any testing agency that is authorized to administer any of the National Uniform Examinations. At the Annual Meeting, except as otherwise set forth herein, the Member Boards shall transact such business as may come before the meeting.

SECTION 4. Special Provisions Relating to Annual Meetings. The Member Boards may, by majority vote, adopt such rules and procedures as may be deemed necessary or appropriate, from time to time, for the orderly conduct of the business at the Annual Meeting. The rules and procedures adopted for the Annual Meeting may include provisions regarding limitation of debate.

SECTION 5. Special Meetings. A special meeting of the Member Boards may be called by majority vote of the Board of Directors, and shall be called by the President upon the request of twenty-five percent (25%) of the Member Boards. The purpose of any special meeting shall be set forth in the notice of such meeting, which shall be given in accordance with these Bylaws. The business conducted at any special meeting shall be limited to the matters specified in the notice for such special meeting.

SECTION 6. Place of Meeting. The Board of Directors may designate any place, unless otherwise prescribed by law, as the place of any Annual Meeting or special meeting of the Member Boards.

SECTION 7. Notice of Meeting. Written notice stating the place, day and hour of the Annual Meeting shall be given to each Officer, Director, Member Board, and Representative or other person entitled to attend, at least Fifty (50) days before the meeting date, and no earlier than the conclusion of the previous Annual Meeting.

Notice of any special meeting of the Member Boards shall state the purpose or purposes for which the meeting is called, and shall, unless otherwise prescribed by statute, be given to each Member Board not less than ten (10) days, nor more than thirty (30) days before the date of such special meeting. Notice given pursuant to this Section shall be either by mail, email, or commercial delivery system.

Notice of any meeting shall be deemed given when dispatched by email to the email address of record on the Corporation's records, deposited with the United States Postal Service or reputable commercial delivery system, addressed to the recipient at the recipient's address as it appears in the records of the Corporation, with postage or other delivery charges prepaid.

It shall be the duty and obligation of each Member Board, Associate Member and Representative to ensure that the Secretary has current address and email information for such Member Board, Associate Member, and/or Representative.

SECTION 8. Presiding Officer; Order of Business. The President shall be the chair of all meetings of the Member Boards, meetings of the Board of Directors and meetings of the House of Representatives, including the Annual Meeting, and any special meeting of the Member Boards. If the President is absent or declines to preside, the Vice President shall serve as chair of the meeting. If both the President

and Vice President are unable or unwilling to preside, nominations shall be taken for Member Representatives willing to serve as chair of the meeting, and the Member Boards present shall elect a chair by plurality vote.

The Secretary of the Corporation shall act as secretary of every meeting. If the Secretary is not present, the chair of the meeting shall appoint a substitute to act as secretary of the meeting.

The Executive Committee shall propose an order of business for each Annual Meeting to the Board of Directors. The Board of Directors shall approve an order of business for each Annual Meeting at its meeting most immediately preceding the Annual Meeting.

The Secretary shall determine the order of business for any special meeting of the Member Boards, and shall publish the order of business in the notice of such special meeting.

SECTION 9. Quorum. A majority of the Member Boards shall constitute a quorum at any Annual Meeting or special meeting of the Member Boards.

If less than a quorum is present at a meeting, a majority of the Member Boards present may adjourn the meeting provided that at least ten (10) days written notice of the date, time and place of the reconvening of the adjourned meeting shall be given to all persons entitled to notice of the original meeting. At the reconvened meeting, those Member Boards present shall constitute a quorum, regardless of number, and any business may be transacted which might have been transacted at the adjourned meeting but for the lack of a quorum. The Member Boards present at a properly noticed meeting may continue to transact business until the earlier of adjournment or loss of a quorum.

SECTION 10. Voting Rights. Each Member Board shall have one (1) vote at any Annual Meeting or special meeting of the Member Boards, which vote may be cast only by such Member Board's Member Representative. A Member Board shall not be entitled to vote with respect to any matter exclusively related to a National Uniform Examination that such Member Board does not accept.

A. Member Representation. Each Member Board shall be entitled to appoint one of its members (each a "Member Representative"), to speak and vote on its behalf at the Annual Meeting and any special meeting of the Member Boards. To be eligible to represent a Member Board, a Member Representative shall be, or have been, an active member of such Member Board.

Member Representatives shall serve three (3) year terms, however, a Member Board may change its appointed Member Representative at any time in a writing signed by the president or chair of such Member Board containing the name and

address for notices for such Member Representative. Any change or appointment shall take effect only after notice of such appointment or change is actually received by the Secretary of the Corporation.

If a Member Board's duly appointed Member Representative is unable to attend any Annual Meeting or special meeting of the Member Boards, such Member Board may, in a writing signed and dated by the president or chair of such Member Board, appoint an alternate member of such Member Board to attend and vote in his or her place, provided such designation is actually received by the Secretary in advance of such meeting.

B. Dental Hygiene.

The Member Boards that accept the National Uniform Examination for dental hygiene in each District shall appoint one (1) dental hygiene member (each a "District Dental Hygiene Representative") as set forth herein. Each District Dental Hygiene Representative shall be from a state that accepts the National Uniform Examination for dental hygiene.

For each District, the right to appoint the District Dental Hygiene Representative shall rotate among the Member Boards comprising such District in ascending alphabetical order based on the names of the Jurisdictions associated with the Member Boards in each District. In the event a Member Board entitled to appoint a District Dental Hygiene Representative does not, for any reason, appoint a District Dental Hygiene Representative by the close of an Annual Meeting, the right to make such appointment shall pass to the Member Board that would be entitled to appoint the next Dental Hygiene Representative for such district. For the Annual Meetings in 2017, 2018 and 2019, the District Dental Hygiene Representative positions that come open shall be filled by appointment by the Member Boards whose associated Jurisdictions come first alphabetically among those in each District.

Each District Dental Hygiene Representative shall serve one three (3) year term and be entitled to attend and participate as a member of the House of Representatives at the Annual Meeting. In the event a District Dental Hygiene Representative is also a Member Representative, such person shall have but one (1) vote with respect to any matter to be voted on jointly by the Member Representatives and District Dental Hygiene Representatives.

Terms of District Dental Hygiene Representatives shall be staggered such that approximately one third of the District Dental Hygiene Representatives will be appointed at each Annual Meeting. For the 2017 Annual Meeting, Districts 1, 4, 7, 10 & 13 shall appoint District Dental Hygiene Representatives. For the 2018 Annual Meeting, Districts 2, 5, 8 & 11 shall appoint District Dental Hygiene Representatives. For the 2019 Annual Meeting, Districts 3, 6, 9 & 12 shall appoint District Dental Hygiene Representatives.

SECTION 11. Termination of Membership or Association. Notwithstanding any other provision of these Bylaws, the membership of any Member Board, and the association with the Corporation of any Representative or Associate Member may be terminated as follows:

A. Termination of a Representative's or Associate Member's association with the Corporation must be approved by a two-thirds vote of both the Board of Directors as well as a two-thirds vote of the other Member Boards, and only where it is determined by each body that it is in the best interest of this Corporation to terminate such association. Prior to a vote by the Member Boards and the Board of Directors to terminate a Representative's or Associate Member's association with the Corporation, written notice of the proposed termination must be given in the manner set forth in Section 7, above, for Member Boards, and in Article Three, Section 10 for Directors, not less than ninety (90) days before the meeting of each body at which the question will be submitted to a vote. Termination of a Representative's or Associate Member's association with the Corporation shall be effective immediately upon the later to occur of the vote by the Board of Directors or of the Member Boards, for such termination.

B. The membership of any Member Board shall automatically terminate if all of the Corporation's agreements with such Member Board have terminated, if that Member Board ceases to meet the qualifications for membership set forth in Section 1, above, or upon the occurrence of any event which causes the Jurisdiction associated with such Member Board to cease to recognize the results of all National Uniform Examinations developed by this Corporation. Termination of a Member Board's membership pursuant to this provision shall be effective on the date the event triggering termination occurs or comes into effect. In the event a Member Board's membership is terminated pursuant to this provision, such termination shall also terminate the appointments of any Representatives from such Member Board.

ARTICLE FOUR. BOARD OF DIRECTORS

SECTION 1. General. The Corporation shall have a board of directors (the "Board of Directors") that shall manage the property and affairs of this Corporation. The Board of Directors shall have, and is invested with, all and unlimited powers and authorities, except as may be expressly limited by applicable law, these Bylaws, or by the Corporation's Articles of Incorporation, to supervise, control, direct and manage the property, affairs and activities of this Corporation, determine the policies of this Corporation, to do or cause to be done any and all lawful things for and on behalf of this Corporation, to exercise or cause to be exercised any or all of its powers, privileges or franchises, and to seek the effectuation of its objects and purposes; provided, however, that (1) the Board of Directors shall not authorize or commit the Corporation to engage in any activity not permitted to be transacted by a not-for-profit corporation, nor any activity that would cause the Corporation to forfeit its tax exempt status under Section

501(c)(3) of the Internal Revenue Code; (2) none of the powers of the Corporation shall be exercised to carry on activities, otherwise than as an insubstantial part of its activities, which are not in themselves in furtherance of the purposes of the Corporation; (3) all income and property of the Corporation shall be applied exclusively for such charitable, educational, and scientific purposes as the Board of Directors may deem to be in the public interest in any manner or by any method which the Board of Directors may from time to time deem advisable. No substantial part of the activities of the Corporation shall be the carrying on of propaganda or otherwise attempting to influence legislation. The Corporation shall not participate in or intervene (including the publication or distribution of statements) in any political campaign on behalf of any candidate for public office. No part of the net earnings or other assets of the Corporation shall inure to the benefit of any Director, Officer, Member Board, Associate Member, Representative, or other private person having, directly or indirectly, a personal or private interest in the activities of the Corporation.

The duties of the Board of Directors shall include, but shall not be limited to, the responsibility of causing the creation, maintenance and improvement of the National Uniform Examinations.

A. The Board of Directors shall direct the activities of the Dental and Dental Hygiene Examination Committees. The Board of Directors shall ensure the National Uniform Examination content is within the scope of practice common in the Jurisdictions associated with the Member Boards.

B. The Board of Directors shall cause corrected and approved minutes of each Board of Directors meeting to be sent to each Member Board, Associate Member, and Representative following approval.

SECTION 2. Number, Tenure, Qualifications and Election/Appointment Procedure. The number of Directors of this Corporation shall be at least seventeen (17). There shall be three classes of Directors, each as more fully defined below. One class of Directors shall be elected/appointed at each Annual Meeting. Directors shall serve terms of three (3) years, or until their successors have been duly elected or appointed and shall have qualified. The Directors shall be comprised of one dentist from each District, two (2) dental hygienists, and two (2) consumer representatives, divided amongst the classes as follows:

Class 1 - ___ dentists, ___ dental hygienists and _____ consumer representatives
Class 2 - ___ dentists, ___ dental hygienists and _____ consumer representatives
Class 3 - ___ dentists, ___ dental hygienists and _____ consumer representatives

The persons to be elected to the Board and their manner of election shall be as follows:

A. Dentist Directors. There shall be one (1) director who is a dentist appointed by each District (each a "Dentist Director"). The right to appoint the Dentist Director for each District shall rotate among the Member Boards in such District that accept the National Uniform Examination for dentists in ascending alphabetical order based on the names of the Jurisdictions associated with the Member Boards in each District. For the Annual Meetings in 2017, 2018 and 2019, the Dentist Directors shall be appointed by the Member Boards whose associated Jurisdictions come first alphabetically among those in the District. In the event a Member Board entitled to appoint a Dentist Director to fill a vacancy does not make such an appointment by the end of the Annual Meeting at or prior to which it had such right, the right to appoint shall shift to the next Member Board in the rotation which shall have fifteen days to make an appointment. If no appointment is made, the right to appoint shall shift again to the next Member Board in the rotation, and so on.

Each Dentist Director shall be a dentist licensed by the Member Board that has appointed him or her, and shall reside or practice in a Jurisdiction that accepts the National Uniform Examination for Dentistry.

Terms of Dentist Directors shall be staggered such that approximately one third of the Dentist Directors will be appointed at each Annual Meeting. For the 2017 Annual Meeting, Districts 3, 6, 9 & 12 shall appoint Dentist Directors. For the 2018 Annual Meeting, Districts 1, 4, 7, 10 & 13 shall appoint Dentist Directors. For the 2019 Annual Meeting, Districts 2, 5, 8 & 11 shall appoint Dentist Directors.

B. Dental Hygiene Directors. There shall be two (2) directors who are dental hygienists (each a "Dental Hygiene Director"). Each Dental Hygiene Director shall be, or have been, a member of a Member Board that accepts the National Uniform Examination for dental hygiene. In the year that the term of a sitting Dental Hygiene Director expires, the open Dental Hygiene Director position shall be filled by plurality vote of the Member Representatives and District Dental Hygiene Representatives present at the Annual Meeting held that year.

Except as otherwise set forth herein, the Dental Hygiene Directors shall rotate among the Districts such that each Dental Hygiene Director elected at an Annual Meeting, shall be from the next higher District number than the Dental Hygiene Director he or she is replacing. For the first two Dental Hygiene Directors elected following the adoption of these bylaws, the first shall be from District 1 and the second shall be from District 7.

C. Consumer Directors. There shall be two (2) directors who are consumer representatives (each a "Consumer Director"). In the year that the term of a sitting Consumer Director expires, the open Consumer Director position shall be filled by plurality vote of the Member Representatives and District Dental Hygiene Representatives present at the Annual Meeting held that year.

Except as otherwise set forth herein, Consumer Directors shall rotate among the Districts such that each Consumer Director elected at an Annual Meeting, shall be from the next higher District number than the Consumer Director he or she is replacing. For the first two Consumer Directors elected following the adoption of these bylaws, the first shall be from District 4 and the second shall be from District 10. A Consumer Director must be a member of a Member Board; if a Consumer Director ceases to be a member of a Member Board for any reason, his or her successor on that Member Board shall serve the balance of his or her three year term, but shall be ineligible for re-election.`

D. Each of the following shall serve on the Board of Directors ex officio, with voice (including the right to bring motions before the Board of Directors) but without vote: the Officers of the Corporation, the Chair of the Dental Examination Committee; and the Chair of the Dental Hygiene Examination Committee.

SECTION 3. Regular Meetings. A regular meeting of the Board of Directors, including any newly elected directors, shall be held without other notice than this Bylaw immediately after, and at the same place as, the Annual Meeting.

The Board of Directors may provide, by resolution, the time and place for the holding of additional regular meetings without notice other than such resolution. All meetings of the Board of Directors shall be open to the Member Boards' designated representatives, unless an Executive Session is called for by any Director, and approved by majority vote of the Board of Directors.

Meetings of the Board of Directors (except the meeting immediately following the Annual Meeting) may be held by telephone conference call, provided all Directors have been given notice of the meeting as required by these Bylaws, a quorum is present and those participating can hear and be heard by all other participants.

SECTION 4. Resignation. Any Director may resign at any time by submitting a written notice of resignation to the Secretary of the Corporation. Such resignation shall be effective as of the date and time specified in such notice. Consent of the Board of Directors shall not be necessary to make a Director's resignation effective.

SECTION 5. Removal. Any Director may be removed by two-thirds vote of the other Directors at any regular, annual or special meeting of the Board of Directors. To the extent any provision of Kansas law applicable to non-stock corporations conflicts with this procedure, such provision of law shall control.

SECTION 6. Vacancies. A vacancy on the Board of Directors resulting from the death, resignation or removal of a Director may be filled by majority vote of the Board of Directors with a person meeting the requirements and criteria of the person whose death, resignation or removal has created such vacancy. Any Director so elected shall serve until the next Annual Meeting at which time the vacancy shall be filled as though

such directorship was up for election at such Annual Meeting, however the Director elected at such Annual Meeting shall serve only the balance of the original term in order to maintain the class distribution set forth herein.

SECTION 7. Location of Meetings. Meetings of the Board of Directors shall be held at such times and places, and by such means (including telephonic), as the Board of Directors may determine.

SECTION 8. Special Meetings - Notice. Special meetings of the Board of Directors may be called at any time by the Secretary upon the request of the President or Vice President, or upon the written request of not less than six (6) Directors. The time, place and manner of a special meeting shall be set forth in the notice of such meeting.

Written notice of a special meeting of the Board of Directors, stating the purpose thereof, shall be sent to each Director at least twenty-one (21) days before the day on which the meeting is to be held, delivered by registered or certified mail, return receipt requested, by e-mail or by a reputable commercial delivery system, to each Director's address as it appears on the records of the Corporation.

Notice shall be deemed to have been given on the date notice is sent by email, deposited in the mail, placed with a reputable commercial delivery system, with postage or other delivery charges thereon prepaid. At any special meeting of the Board of Directors, the business conducted shall be limited to such business as may be specified in the notice of such meeting, and any action incidental thereto.

SECTION 9. Waiver of Notice. Whenever any notice is required to be given to any Director under the provisions of these Bylaws, the Articles of Incorporation, or applicable law, a waiver of notice in writing, signed by a Director shall be deemed equivalent to the giving of such notice. Attendance of a Director at any meeting shall constitute a waiver of notice of that meeting, except where the Director attends for the express purpose, stated at the opening of the meeting, of objecting to the transaction of any business because the meeting is not lawfully called or convened.

SECTION 10. Quorum. A majority of the Directors shall constitute a quorum at any meeting of the Board of Directors. In the absence of a quorum, those Directors present may adjourn the meeting to a future date, but must provide at least seven (7) days written notice of the new date, time and place to all Directors. At the adjourned meeting, if a quorum is present, any action may be taken which might have been taken at the meeting as originally called.

SECTION 11. Voting. Each Director, other than the ex officio members, shall be entitled to one vote on all questions coming before the meeting. The act of the majority of Directors present at a meeting, at which a quorum is present, shall be the act of the Board of Directors. Proxy voting is not permitted.

SECTION 12. Actions Without a Meeting. Any action that may be taken by the Board of Directors at a meeting may be taken without a meeting if consent in writing, setting forth the action to be taken, shall be signed by all of the Directors.

SECTION 13. Compensation. Directors shall not receive a salary for service on the Board of Directors, but per diem and travel expenses may be allowed for attendance at regular or special meetings of the Board of Directors in accordance with policies adopted by the Board of Directors. Nothing herein shall be construed to preclude any Director serving the Corporation in any other capacity and receiving reasonable compensation therefor.

SECTION 14. Reports to Members. The Board of Directors shall cause to be prepared an annual report of the activities and operations of the Corporation (the "Annual Report"), which shall include a detailed financial statement prepared by certified public accountants retained by the Corporation showing in summary form the financial affairs and transactions of the Corporation, as well as its financial position as of the close of its immediately preceding fiscal year. The Board of Directors shall approve an Annual Report no later than the last meeting of the Board of Directors preceding the Annual Meeting. The Annual Report shall be presented by the Officers of the Corporation, in both oral and written form, at the Annual Meeting. No confidential information shall be included in the Annual Report.

SECTION 15. Committees. The President, with the advice and consent of the Board of Directors, shall have the authority to appoint, in addition to the standing committees authorized by Article Five of these Bylaws, such committees as the President and the Board of Directors shall deem necessary for the operation of this Corporation.

SECTION 16. Authority Over Examinations. The Board of Directors shall have the authority, only in exigent circumstances (as determined in the discretion of the Board of Directors), to seek input from the Corporation's psychometrician and make such changes to the National Uniform Examinations as may be reasonably necessary to carry out the purposes of the Corporation. The authority over the National Uniform Examinations granted in this provision is not intended as a substitute for the role and function of the Dental Examination Committee or Dental Hygiene Examination Committee, but is intended solely to permit adjustment of the National Uniform Examinations between Annual Meetings in order to prevent unintended consequences or manifest injustice.

ARTICLE FIVE. OFFICERS

SECTION 1. Qualifications, Nomination and Election. The Officers of this Corporation shall be a President, a Vice President, a Secretary a Treasurer, a Chief Executive Officer and a Chief Operating Officer. The Officers, other than the Chief

Executive Officer and Chief Operating Officer, shall be elected by majority vote of the Member Boards at the Annual Meeting. The Chief Executive Officer of the Corporation; and the Chief Operating Officer of the Corporation shall be appointed by the Board of Directors and serve at the pleasure of the Board of Directors. Each person nominated and elected as either President or Vice President, must be:

a) licensed as a dentist by at least one Member Board;

b) have been a Member Representative; and

c) be or have been a voting member of a Member Board.

None of the Officers of the Corporation may concurrently serve as a Director.

SECTION 2. Term of Office and Limitation of Terms. Each Officer, other than the Chief Executive Officer and Chief Operating Officer, shall serve for one year, or until a successor is elected, or until their death, resignation, or removal, whichever first occurs. The term of office shall commence on the first day of the month following the Annual Meeting. An Officer, other than the Chief Executive Officer and Chief Operating Officer, may be re-elected for up to three (3) additional one year terms. No term limits shall apply to the Chief Executive Officer or Chief Operating Officer.

SECTION 3. Duties of Officers:

A. The President. The President shall preside at all meetings of the House of Representatives, meetings of the Member Boards and meetings of the Board of Directors. The President shall only be entitled to vote at a meeting of the Board of Directors in the event that the Directors present and voting cast equal numbers of votes for and against a question which has been put to a vote. The President shall serve as an ex-officio member of each committee, shall have the power to call meetings as set forth in these Bylaws, and shall have the power to appoint the standing committees of the Corporation, subject to the approval of the Board of Directors. In addition, the President shall have such other powers, duties, and responsibilities as may be delegated to him by the Board of Directors.

B. The Vice President. The Vice President shall preside at all meetings where the President is absent or declines to preside. If the Vice President is presiding over a meeting, he or she shall have the same right to vote as the President if the President were so presiding. In the event of the death or incapacity of the President, the Vice President shall exercise all the powers and duties granted to the President hereinabove. The Vice President shall have such other powers, duties and responsibilities as may be delegated from time to time by the Board of Directors.

C. Secretary. The Secretary shall: (a) keep minutes of all meetings of the Corporation, including Annual Meetings, meetings of the Member Boards, and meetings of the Board of Directors in one or more books provided for that purpose; (b) see that all notices are duly given in accordance with the provisions of these Bylaws and as otherwise required by law; (c) be custodian of the corporate records of the Corporation; (d) keep a register of the post office address of each Member Board, Associate Member and Representative; (e) have general charge of the books and records of the Corporation; and (f) perform all duties incident to the office of Secretary and other duties from time to time assigned by the President or by the Board of Directors.

D. Treasurer. The Treasurer shall: (a) have charge and custody of and be responsible for all funds of the Corporation; (b) receive and give or cause to be given receipts of monies due and payable to the Corporation from any source whatsoever, and deposit or cause to be deposited all monies in the name of the Corporation in banks, trust companies or other depositories selected in accordance with the provisions of Article V of these Bylaws; and (c) in general perform or cause to be performed all of the duties incident to the office of the Treasurer and other duties assigned by the President or by the Board of Directors.

SECTION 4. Resignation. Any Officer may resign by delivering a written resignation to the President or Secretary of the Corporation. The resignation shall take effect from the time of its receipt by the President or Secretary, unless some other time is fixed in the resignation, and then from that time. Acceptance of the resignation by the Board of Directors shall not be required to make it effective.

SECTION 5. Removal. Any Officer elected or appointed by the Board of Directors, and any employee of the Corporation, may be removed or discharged by a majority vote of the Directors present at any regular meeting or special meeting of the Board of Directors called for that purpose, whenever in their judgment, the best interest of the Corporation would be served thereby. Any such removal shall be without prejudice to the contract rights, if any, of the person so removed.

SECTION 6. Vacancies. In the event an office becomes vacant due to the death, incapacity, resignation, or removal of the individual holding the office, the Board of Directors may elect an individual to hold that office.

SECTION 7. Bond. The Board of Directors may require that any Officer give a bond for the faithful discharge of his or her duties in a sum and with a surety or sureties determined by as the Board of Directors.

ARTICLE SIX. GENERAL PROVISIONS

SECTION 1. Fiscal Year. The fiscal year of the Corporation shall begin on July 1 and end on June 30.

SECTION 2. Banking Authority. The Board of Directors shall, from time to time, determine the rules and regulations governing the Corporation's banking authority, including the establishment and maintenance of bank accounts and safe deposit boxes, and the safekeeping of escrow funds.

SECTION 3. Vote by Ballot. At any meeting of the Board of Directors, upon motion duly made and carried by a majority of those entitled to vote, the voting upon any matter or question shall be by written ballot, which may in the discretion of the Board of Directors be transmitted by email.

SECTION 4. Loans. The Corporation shall not loan money to any Officer or any Director.

SECTION 5. Conflict of Interest. No Officer, Representative, Director, or member of any committee of the Corporation may be an officer, director, or member of an operational, governance, or policy-making committee of an organization that:

(a) Develops and/or administers clinical licensure examinations for dentists or dental hygienists; and

(b) Is not authorized to administer any of the National Uniform Examinations.

ARTICLE SEVEN. COMMITTEES

SECTION 1. Executive Committee. There shall be a standing Executive Committee consisting of the President, Vice-President, Secretary, Treasurer, Chief Executive Officer, Chief Operating Officer, and Immediate Past-President of this Corporation as well as such other Directors as may be from time to time designated by the Board of Directors. The Executive Committee shall meet at such times and in such places as it shall deem necessary for the conduct of the affairs of the Corporation between meetings of the entire Board of Directors. The Executive Committee shall exercise the authority of the Board of Directors between meetings of the Board of Directors subject to such restrictions and guidelines as may be adopted, from time to time, by the Board of Directors. The Executive Committee shall keep regular minutes of its proceedings and the same shall be recorded in the minute book of the Corporation. The Secretary of the Corporation shall act as the Secretary of the Executive Committee.

SECTION 2. Articles of Incorporation and Bylaws Committee. The President may appoint, subject to approval by the Board of Directors, a standing committee to consider and make recommendations on proposed changes or amendments to the Articles of Incorporation and Bylaws for action by the Board of Directors and by the Member Boards.

SECTION 3. Budget Committee. The President may appoint, subject to approval by the Board of Directors, a standing committee to review the reports of financial operations of this Corporation and to develop an annual budget to be presented to the Board of Directors for review and approval on a schedule established by the Board of Directors. In developing the annual budget, the Budget Committee shall be guided by the principle that the Corporation will pay the reasonable expenses (as determined in the sole discretion of the Board of Directors) for the attendance at the Annual Meeting of each person entitled to attend either to participate in the Annual Meeting or in connection with the Dental Examination Committee or Dental Hygiene Examination Committee, or requested to attend by the Board of Directors, except that if a Member Board's Dentist Representative is not also its Member Representative, the Corporation will only pay the expenses of one of those two individuals for attending the Annual Meeting.

SECTION 4. Calibration Committee. The President may appoint, subject to approval by the Board of Directors, a standing committee to establish standards and procedures for the calibration of all those persons conducting, administering, and grading any of the National Uniform Examinations.

SECTION 5. Quality Assurance Committee. The President may appoint, subject to approval by the Board of Directors, a standing committee to establish procedures for and conduct of a post examination analysis to be completed annually after the close of the examining season. The information developed from the examination analysis necessary for examination improvement, as determined in the discretion of the Quality Assurance Committee, shall be provided to the Dental Examination Committee and the Dental Hygiene Examination Committee, as well as the Board of Directors. The proceedings of the Quality Assurance Committee shall otherwise remain confidential and all meetings of the Quality Assurance Committee shall be restricted to members of the committee and Officers of the Corporation.

SECTION 6. Examination Review Committee. The President may appoint, subject to approval by the Board of Directors, a standing committee to develop standards for the review of complaints received with respect to the National Uniform Examinations and the resolution or disposition of those complaints.

SECTION 7. Patient Ethics Committee. The President may appoint, subject to approval by the Board of Directors, a standing committee to review and address issues involving patient ethics.

SECTION 8. Ad Hoc Committees. The President may appoint, subject to approval by the Board of Directors, such other committee or committees, for such purposes, with such composition, and for such periods of time, as the President may determine to be necessary or in the best interest of the Corporation.

SECTION 9. General Provisions - Committees. Except as otherwise set forth herein, for each committee, the Board of Directors shall establish the size of the committee and the President shall appoint the members of each committee, subject to approval by the Board of Directors. Except to the extent otherwise set forth in these Bylaws, or in the Articles of Incorporation, the President shall have the authority to implement procedures and rules for the operation of any committee, however in the absence of direction from the President, each committee may set its own internal operating procedures and rules.

SECTION 10. Dental Examination Committee.

A. Chair. The Chair of the Dental Examination Committee shall be appointed by the President and approved by majority vote of the Board of Directors. Any person nominated to serve as Chair of the Dental Examination Committee must be a dentist who is, at the time of appointment licensed to practice by one of the Member Boards. The Chair of the Dental Examination Committee shall serve a three (3) year term, and thereafter continue until a successor has been duly appointed and qualified. No person who has any affiliation with any agency that develops and/or administers clinical licensure examinations for dentists or dental hygienists; and is not authorized to administer any of the National Uniform Examinations, shall be eligible to serve as Chair of the Dental Examination Committee.

B. Composition. Except as otherwise set forth herein, each member of the Dental Examination Committee shall have the right to cast one (1) vote on all matters coming before the committee, except the Chair who shall only vote in the event of a tie. The Dental Examination Committee shall be comprised of:

i) One Dentist appointed by each Member Board (each a "Dentist Representative"), each of whom shall be or have been a member of such Member Board and shall be a dentist licensed to practice by such Member Board;

ii) One of the two Consumer Directors (the other of whom shall serve on the Dental Hygiene Examination Committee) who shall rotate annually, immediately following the Annual Meeting, onto the Dental Hygiene Examination Committee;

iii) One (1) dentist educator from each District, elected by the Member Boards for each District as set forth below;

iv) The Chair of the Dental Examination Committee;

v) The Corporation's psychometrician (non-voting).

C. Subcommittees. The Dental Examination Committee shall appoint such subcommittees as it deems necessary or appropriate for the conduct of its work. The members of each subcommittee shall be appointed from among the members of the Dental Examination Committee.

D. General Provisions.

1. Appointments to fill vacancies on the Dental Examination Committee, other than Dentist Representatives, shall be made at the Annual Meeting, and shall become effective as of the first day of the month following the Annual Meeting. Each member of the Dental Examination Committee, other than a member who is on the committee by virtue of his or her status as a Dentist Representative, shall serve a three-year term, and shall not be eligible for re-election.

2. Qualifications. Each dentist educator on the Dental Examination Committee must be a licensed dentist serving on the faculty of a dental school located in a Jurisdiction corresponding to a Member Board.

3. The dentist educators on the Dental Examination Committee (each a "Dentist Educator") shall serve three year terms. The right to appoint the Dentist Educator for each District shall rotate among the Member Boards in such District that accept the National Uniform Examination for dentists in ascending alphabetical order based on the names of the Jurisdictions associated with the Member Boards in each District. For the Annual Meetings in 2017, 2018 and 2019, Dentist Educators shall be appointed by the Member Boards whose associated Jurisdictions come last alphabetically among those in the District. In the event a Member Board entitled to appoint a Dentist Educator to fill a vacancy does not make such an appointment by the end of the Annual Meeting at or prior to which it had such right, the right to appoint shall shift to the next Member Board in the rotation which shall have fifteen days to make an appointment. If no appointment is made, the right to appoint shall shift again to the next Member Board in the rotation, and so on.

E. Consultants. The Dental Examination Committee is empowered to secure the assistance of such consultants as the committee or its Chair may deem necessary from time to time. Consultants are not members of this Committee and shall not vote.

F. Duties. The Dental Examination Committee shall have the following duties with respect to the National Uniform Examination for Dentists developed by the Corporation, and such other duties as may from time to time be delegated to it by the Board of Directors:

1. Prepare the National Uniform Examination for Dentists, including content, procedures for administration, and scoring;

2. Review and prepare a critical analysis of content, breadth, depth and scope of the National Uniform Examination for Dentists;

3. Aid in preparing the content and format of the National Uniform Examination for Dentists;

4. Make recommendations to the Board of Directors for improving the National Uniform Examination for Dentists;

5. Serve in any other capacity as determined by the Board of Directors; and

6. Prepare and present regular reports to the Board of Directors containing its recommendations, suggestions and actions with respect to the National Uniform Examination for Dentists. Among these reports shall be an annual report with respect to proposed changes to the National Uniform Examination for Dentists, which shall be presented to the Board of Directors prior to the Annual Meeting. The Board of Directors shall receive the annual report of the Dental Examination Committee and either accept the report, or reject the report and direct the Dental Examination Committee to reconvene and submit a revised report.

SECTION 11. Dental Hygiene Examination Committee

A. Chair. The Chair of the Dental Hygiene Examination Committee shall be appointed by the President and approved by the Board of Directors. Any person appointed to serve as the Chair of the Dental Hygiene Examination Committee must be a licensed dental hygienist who is, at the time of appointment, licensed to practice by one or more Member Board. The Chair shall serve a term of three (3) years, and thereafter continuing until a successor has been duly elected and qualified. No person who has any affiliation with any agency that develops and/or administers clinical licensure examinations for dentists or dental hygienists; and is not authorized to administer any of the National Uniform Examinations, shall be eligible to serve as Chair of the Dental Examination Committee. shall be eligible to serve as Chair of the Dental Examination Committee.

B. Composition. Except as otherwise set forth herein, each member of the Dental Hygiene Examination Committee shall have the right to cast one (1) vote on all matters coming before the committee, except the Chair who shall only vote in the event of a tie. The Dental Hygiene Examination Committee shall be comprised of:

i) the District Dental Hygiene Representative for each District;

ii) (1) Dentist appointed by the President;

iii) One of the two Consumer Directors (the other of whom shall serve on the Dental Hygiene Examination Committee) who shall rotate annually, immediately following the Annual Meeting, onto the Dental Examination Committee;

iv) (1) Dental Hygiene Educator appointed by the President;

v) The Chair of the Dental Hygiene Examination Committee;

vi) The Corporation's psychometrician (non-voting).

C. Subcommittees. The Dental Hygiene Examination Committee may from time to time appoint such subcommittees, as it deems necessary to conduct its work. The members of each subcommittee shall be appointed from among the voting members of this Committee.

D. General Provisions.

1. Appointments and Term. Appointments to the Dental Hygiene Examination Committee shall be made at the Annual Meeting, and shall be effective as of the first day of the month following the Annual Meeting at which such appointment was made.

2. Qualifications. The dental hygiene educator on the Dental Hygiene Examination Committee must be a licensed dental hygienist serving on the faculty of a dental or dental hygiene school located in a Jurisdiction whose Dental Hygiene Board is a Member Board.

3. Each member of the Dental Hygiene Examination Committee who is appointed by the President shall serve a term of three years, but may be removed with or without cause by the President at any time.

E. Consultants. The Dental Hygiene Examination Committee may secure the assistance of such consultants as the committee or its Chair may deem necessary from time to time. Consultants are not members of this Committee and shall not vote.

F. Duties. The Dental Hygiene Examination Committee shall have the following duties and such other duties as may from time to time be delegated to it by the Board of Directors:

1. Develop the National Uniform Examination for Dental Hygiene;

2. Review and prepare a critical analysis of results of the National Uniform Examination for Dental Hygiene, particularly as it determines the performance of candidates;

3. Aid in revising the content and format of the National Uniform Examination for Dental Hygiene;

4. Make recommendations to the Board of Directors for improving the National Uniform Examination for Dental Hygiene;

5. Serve in any other capacity as determined by the Board of Directors; and

6. Prepare and present regular reports to the Board of Directors containing its recommendations, suggestions and actions with respect to the National Uniform Examination for Dental Hygienists. Among these reports shall be an annual report with respect to proposed changes to the National Uniform Examination for Dental Hygienists, which shall be presented to the Board of Directors prior to the Annual Meeting. The Board of Directors shall receive the annual report of the Dental Hygiene Examination Committee and either accept the report, or reject the report and direct the Dental Hygiene Examination Committee to reconvene and submit a revised report.

ARTICLE EIGHT. RULES OF ORDER

The Standard Code of Parliamentary Procedure shall govern any meeting of the Corporation, including the House of Representatives, Member Boards, Board of Directors, and all committees. In the event of conflict between the Standard Code and these Bylaws, these Bylaws shall control. The President or presiding Officer may appoint a parliamentarian.

ARTICLE NINE. INDEMNIFICATION OF DIRECTORS AND OFFICERS

The Corporation shall indemnify any person who is serving or has served the Corporation as a Director, Officer, employee, committee chair or member, or examiner, pursuant to and to the maximum extent authorized by K.S.A. 17-6305, as amended.

ARTICLE TEN. AMENDMENTS

Amendments to the Bylaws may be proposed by a Member Board or by the Board of Directors. Any amendment to these Bylaws must be approved by at least a 2/3 vote of the Member Boards present at any meeting of the House of Representatives, provided that the proposed amendment is sent to the Member Boards

at least ninety (90) days prior to the meeting. These Bylaws may be amended, without notice, by the vote of seventy-five (75) percent of all Member Boards present at a duly called Annual Meeting.

ARTICLE ELEVEN. ELECTRONIC MEETINGS

Any meeting of the House of Representatives, Member Boards, Board of Directors, or any committee may be held, in whole or part, via internet, or other communication technology. Any meeting held via internet or other communication technology, shall at a minimum, permit participants who participate electronically to hear or read proceedings substantially concurrent with their occurrence, vote on matters to all participants for a vote, pose questions, and make comments.

ARTICLE TWELVE. DEFINITIONS

"Jurisdiction" shall mean a country, or the state, province, or other political subdivision thereof, which grants licenses for the practice of dentistry and/or dental hygiene.

The term "Board of Dental Examiners" shall be construed to mean the body in each Jurisdiction granted the authority to examine candidates for, or advise with respect to, licensure of dentists, dental hygienists, or other dental health care providers under the law of such Jurisdiction in effect at the time the determination is made.

Adopted 05.10.05
Revised 05.11.06
Revised 06.17.07
Revised 06.15.08
Revised 06.13.09
Revised 06.27.10
Revised 11.07.10
Revised 11.10.13
Revised 10.09.14
Revised 11.15.15
Revised 04.26.17

Exhibit A

ADEX Districts

District 1
- California

District 2
- Alaska
- Arizona
- Colorado
- Hawaii
- Idaho
- Montana
- Nevada
- New Mexico
- Oregon
- Utah
- Washington
- Wyoming

District 3
- Kansas
- Missouri
- Nebraska
- Oklahoma
- Texas

District 4
- Iowa
- Minnesota
- North Dakota
- South Dakota
- Wisconsin

District 5
- Illinois
- Indiana
- Michigan
- Ohio

District 6
- Arkansas
- Georgia
- Kentucky
- South Carolina
- Tennessee
- Virginia
- West Virginia

District 7
- Maryland
- Pennsylvania

District 8
- Connecticut
- Delaware
- Virgin Islands
- Washington, DC

District 9
- New Hampshire
- New Jersey
- New York
- Rhode Island

District 10
- Maine
- Massachusetts
- Vermont

District 11
- Alabama
- Louisiana
- Mississippi
- North Carolina
- Puerto Rico

District 12
- Florida

District 13
- International District

Updated 11.07.10

Appendix B

Highlights of the 13th Annual American Board of Dental Examiners, Inc.

ADEX

AMERICAN BOARD OF DENTAL EXAMINERS, INC.

Highlights of the 13th Annual American Board of Dental Examiners, Inc. (ADEX)
House of Representatives
August 13, 2017
Rosemont, IL

The following are highlights of the 13th Annual ADEX House of Representatives:

The ADEX House of Representatives consists of Member States and Jurisdictions, District Hygiene and District Consumer Representatives which total 60 representatives, 48 representatives were present.

2017 – 2018 Officers were elected: Dr. Stanwood Kanna, HI, President; Dr. William Pappas, NV, Vice-President; Dr. Jeffery Hartsog, MS, Secretary; Dr. Conrad "Chip" McVea, III, LA, Treasurer. Dr. Bruce Barrette, WI, remains as Immediate Past President.

Because of a major revision to the ADEX Bylaws the election of the Board of Directors and the election of Dental Hygiene Members to the Dental Hygiene Examination Committee and the ADEX House of Representatives was delayed until the 2018 ADEX House of Representatives.

ADEX Board of Directors:

- Appointment of a new Dental Examination Committee Chair – Dr. Stephen DuLong of Massachusetts to replace Dr. John Dixon of West Virginia who completed his three-year term.

Changes to the ADEX Dental Examination:

RESTORATIVE

- ALL restoration criteria for marginal deficiencies redefined. New SUB criteria is less than or equal to .5 mm. New DEF criteria is greater than .5 mm.
- Change from the use of **ACC** for acceptable criteria to **ATC,** meaning Adheres To Criteria which better defines what the scoring reflects, adheres to a minimal acceptable standard.
- Separate criteria now to be used for lower anterior incisors vs. maxillary anterior teeth And lower cuspids.

PROSTHODONTICS

- The changes this year proposed and approved from the Prosthodontic Subcommittee Involved clarification of the use of Stents for grading. All failures will be determined by use of the custom candidate fabricated stent where appropriate. In addition, minor undercuts of less than 0.5 mm will not result in failure unless they compromise the margin when blocked out.

ENDODONTICS

- The endodontic subcommittee met and proposed minor changes to the posterior endodontic criteria which were necessary to work with the new more anatomically correct Acadental molar tooth. The changes were approved

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www.adexexams.org

PERIODONTICS

- No changes to periodontal scaling exercise for next year. The periodontal subcommittee met in conjunction with periodontal ad hoc committee. Moving forward the two committees will be combined as the periodontal exam subcommittee. The committee is continuing to work on a new periodontal OSCE examination and is awaiting the results of the new occupational analysis as they develop the new examination.

SCORING

- The Scoring subcommittee met and worked on clarification of the exam rules. Clarification To the **18 Month rule,** the **Timing out Guidelines**, and the **Three Sub rule** were reviewed, **finalized** and approved.

Changes to the ADEX Dental Hygiene Examination:

- Periodontal Probing Exercise will be conducted Post Treatment by both the examiners and candidates on two teeth assigned from within the Case Selection. Implementation in 2018.

- Retain the current criteria that 4 minor tissue trauma errors convert to a major tissue trauma violation and a 100-point penalty.

- Criteria to be utilized in determining the diagnostic quality of the radiographs submitted for the dental hygiene exam will be developed and published in the appropriate manuals, orientations, calibrations and presentations directed at examiners and candidates. Implementation in 2018.

- The 3 criteria included in the Initial Case Presentation Section must **all** be Acceptable to accrue the 3 points assigned to that section of the examination. (Scoring is 0 or 3) Implementation in 2018.

- After a thorough review of the 2016 and 2017 dental hygiene examination data relative to the 12 Selected Surfaces of qualifying calculus in the Calculus Removal Section, it was determined that ADEX will retain the current scoring model relative to Case Acceptance and not implement a Second Submission Policy for the Dental Hygiene Examination.

- The process of stopping the exam after Pre-Treatment Evaluation if the candidate has not accrued enough points to possibly pass the examination has been piloted and will be implemented in 2018.

ADEX House of Representatives:

- Bylaws

  A major revision to the ADEX Bylaws was reviewed and approved by the ADEX House of Representative including a minor amendment that delayed the election of Members of Board of Directors and the election of Dental Hygiene Members to the Dental Hygiene Examination Committee and the ADEX House of Representatives until the 2018 ADEX House of Representatives

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14th Annual ADEX House of Representatives Meeting is scheduled on Saturday, August 11, 2018, Doubletree Hotel, Rosemont, IL.

Appendix C

A Response to the American Dental Association's Proposed Use of an Objective Structured Clinical Exam

A Response to the American Dental Association's Proposed Use of an Objective Structured Clinical Exam

Jocelyn McFarlane, M.A.
Psychometric Consultant

Chad W. Buckendahl, Ph.D.
ACS Ventures, LLC

Susan Davis-Becker, Ph.D.
ACS Ventures, LLC

August 11, 2017

Paper presented at the annual meeting of the American Board of Dental Examiners, Inc.. Chicago, IL.

Abstract

There has been increased scrutiny as of late within the dental community about the use of the clinical examination component that is currently part of the licensure examination taken by eligible candidates in almost all U.S. jurisdictions. In particular, critics of existing clinical examinations have cited a number of issues ranging from ethical concerns of using live patients to assertions that unqualified candidates are not successfully being screened out by the clinical skills assessment portion. As one of those critics, the American Dental Association (ADA) has embarked on a process to create an Objective Structured Clinical Examination (OSCE) modeled after that of the National Dental Examining Board (NDEB) of Canada, which relies on testing candidates exclusively on their clinical judgment, but not their psychomotor (performance) skills. The purpose of this paper is to discuss an OSCE as proposed by the ADA, critique the evidence used to support this proposal, and to discuss validity evidence of cognitive and psychomotor skills that should be considered by state boards of dentistry evaluating this option.

Introduction

The high stakes nature of the examination components of dental licensure continues to be a source of discourse throughout the dental community. The clinical examination component, in particular, has been of interest as of late. Test administration agencies currently administer clinical examinations that include a combination of items and tasks designed to assess clinical judgment (i.e., cognitive) as well as clinical skills (i.e., psychomotor). However, critics of this design argue that the use of an Objective Structured Clinical Examination (OSCE) that solely tests clinical judgments are sufficient. The counter to this argument is that this approach would eliminate measurement of important, job-related psychomotor or performance-based assessment aspects from dental licensing requirements, creating a gap in—and threatening the validity evidence base of—the current examination process. This paper explores this argument by evaluating a proposal for developing and implementing this proposed alternative design.

The American Dental Association (ADA) intends to develop a Dental Licensure Objective Structured Clinical Examination (DLOSCE) that purports to eliminate the need for a separate clinical skills assessment and create a unifying, national licensure examination process. As outlined by the ADA, the DLOSCE would closely follow the National Dental Examining Board (NDEB) of Canada's OSCE. This proposed approach would yield an examination design that eliminates the current clinical examinations' assessment of clinical skills or the assessment of a candidate's practical ability to treat live patients. Rather, it would test a candidate's clinical abilities with simulated models or a multiple-choice written examination.

The ADA has offered several reasons as to why the DLOSCE would be advantageous to the current examination. First, the ADA indicates that its psychometric review of available validity and reliability evidence strongly suggests that clinical examinations fail to "screen out" licensure candidates with inadequate psychomotor skills. Second, the ADA suggests there is a lack of correlation between performance on the clinical examination and performance in dental school (student's GPA or class rank). Third, the ADA has cited ethical concerns with including

live patients in the examination process. Therefore, the ADA believes that the use of a DLOSCE, as the ADA has defined it, would produce stronger validity and reliability evidence and thus, be a better screener to identify qualified candidates for dental licensure.

Professionally accepted measurement practices dictate following specific steps to develop an OSCE that will collect and evaluate valid and reliable results for a licensure program. Specifically, the *Standards for Educational and Psychological Testing* defines validity as "the degree to which accumulated evidence and theory support specific interpretations of test scores entailed by proposed uses of a test" (p.184).[1] When a licensure or certification body proposes the development of a new exam, a vital element of gathering validity evidence begins with stating the newly proposed exam's test purpose and determining exam content. While details of the ADA's DLOSCE "remain in the works," the ADA has stated the purpose of the examination will be to discern "whether a candidate for dental licensure possesses the necessary level of clinical skills to safely practice entry-level dentistry."[2]

The purpose of this paper is to discuss OSCEs as proposed by the ADA, critique the assertions and evidence offered by the ADA with respect to current clinical examinations, and to discuss considerations for state boards of dentistry who are evaluating this approach.

Objective Structured Clinical Examinations

Present requirements for dental licensure by most jurisdictions in the United States include 1) graduation from an accredited dental education program, 2) satisfactory completion of the written National Board Dental Examinations (NBDE) Parts I and II, 3) satisfactory completion of a clinical examination; and in some states, 4) additional testing certification, and/or state-specific requirements. Each of these requirements provides unique information to the licensure decision. Specifically, the NBDE exams and the clinical licensure exams focus on different aspects of the dental profession as they relate to safe, entry-level practice. Parts I and II of the NBDE exams concentrate on the knowledge that is required for an entry-level dentist,

whereas the clinical exams are designed to measure the clinical judgments and psychomotor skills of an entry-level dentist.

For over three decades, OSCEs have been used to measure clinical competency skills within the medical field.[3] OSCEs may be cognitive, performance based, or a combination of these types of tests that typically consist of a series of questions and/or tasks, sometimes implemented as "stations," in which candidates are directly observed interviewing, examining, and treating patients in a simulated environment that is intended to approximate a job-related setting. Tasks can include a range of activities, such as interpreting laboratory results, taking a patient's medical history, reading radiographs, and delivering bad news to a patient. When patients are used in an OSCE, they are often referred to as standardized patients (SP) who have been trained to play the role of a real patient. Traditionally, candidates' communication skills as well as their clinical skills are assessed during an OSCE by a team of examiners trained to evaluate candidate performance on a range of pre-determined criteria generally including knowledge, performance, communication, and interaction. Examiners typically use a checklist or global rating scale, such as a Likert scale, to score candidate competency.

In the context of dentistry, the ADA suggested that its proposed DLOSCE will be modeled after Canada's dental licensure OSCE. To become a licensed dentist in Canada, three requirements must be met: 1) graduation from an accredited dental education program, 2) satisfactory completion of the NDEB written examination, and 3) satisfactory completion of the NDEB OSCE.

In 1995, the NDEB began administering an OSCE that consists of a series of stations that use simulated clinical scenarios as part of its licensure program. At each station, candidates consider the scenario, relevant stimuli, and answer multiple questions based on the case presented. Test items consist mostly of extended match questions, and some stations require candidates to review patient information and write a prescription for an acceptable medication commonly used by Canadian dentists. In the extended match questions, candidates are presented

with a case and asked to choose from up to 15 response options with one or more correct answers that may be scored dichotomously or differentially weighted. Candidates are given five minutes to answer the questions presented at each station. According to the NDEB, the exam is developed based on the *Competencies for a Beginning Dental Practitioner in Canada*, a document which contains approximately 50 statements about what a beginning dental practitioner must be able to know and demonstrate.

Traditionally, OSCEs are scored by human evaluators who use checklists or scales to assess a candidate's active knowledge and skills in a performance-based setting. For efficiency of scoring, the NDEB incorporated the extended match questions that assess clinical judgments, but do so in a passive manner by presenting candidates with the answer options. Therefore, these question types focus on cognitive abilities, but do not require that candidates produce information of their own accord or that they mimic any of the psychomotor actions they would need to perform as a practicing dentist.

Measurement of Psychomotor Skills Versus Clinical Judgments

The ADA has argued that an OSCE modeled after NDEB's exam would produce more valid and reliable scores than the current clinical examinations. However, the ADA's original proposal that was adopted by its Board of Trustees presents a key threat to validity: the loss of independent verification of entry-level psychomotor skills (i.e., content validity aligned with job-related practice). As an assessment of clinical judgment, the NDEB OSCE has proven validity evidence.[9] However, the most significant difference between the NDEB OSCE and a clinical skills examination is that the NDEB OSCE is strictly an assessment of clinical judgment. The NDEB exam does not assess beginning dentists' psychomotor or communication skills. In other words, the NDEB OSCE does not assess a beginning dentist's clinical skills using either simulated or live patients.

Content validity refers to how well a proposed exam accurately relates to the job-related knowledge, skills, and abilities required of a minimally competent candidate for licensure. From

the research on dental practice, there are commonly three areas of required expertise: domain-specific knowledge (e.g., pathology, pharmacology, histology), clinical judgments (e.g., diagnosis, treatment planning, aftercare plan), and clinical skills (e.g., surgical component, psychomotor abilities in multiple domains). The domain-specific knowledge components are typically measured in a written/computerized exam format. The clinical judgment components are often measured through either a written/computerized format or a skills-based exam with judgmental steps incorporated. Finally, the assessment of clinical skills is typically measured through a performance exam where examinees must complete tasks, procedures, or steps within a procedure. Without each of these components, the program may fail to provide a comprehensive measure of the set of knowledge, skills, and abilities that reflect what occurs in dental offices on a day-to-day basis. For the purpose of licensure, this gap can increase the risk to the public of an incompetent practitioner.

Because dental schools will inevitably vary in their admissions policies, retention policies, and more important, in the ways they design, define, (i.e., curriculum) and teach (i.e., instruction) clinical skills and the achievement or competency standards used to evaluate them, a common standard is required to ensure that all dentists are competent prior to being able to practice independently. The determination of clinical competence should be assessed through a combination of demonstrated knowledge and practical abilities. In addition to examinations that test knowledge and judgment, the licensure process must also test a candidate's ability to perform clinical skills in a setting that simulates job-related conditions.

Therefore, if the ADA contends that its proposed exam would serve as a replacement for current clinical skills testing, it would be appropriate for any dental licensing board responsible for protection of the public in its jurisdiction to ask the question of why this important psychomotor component is not included and distinctly evaluated.

Research on Clinical Skills Examinations

The ADA claims that its psychometric research indicates that patient-based, clinical exams fail to "screen out" or keep unqualified candidates from becoming licensed. This research appears to be largely based on a study of graduates of Canadian dental programs who at the time were required to take four exams in order to become eligible for licensure: 1) a written examination that tested the foundations of dental science, 2) a clinical I written examination of clinical judgments, 3) a clinical II skills examination that tested their ability to perform procedures on simulated patients or manikins, and finally, 4) a clinical III skills examination that tested the candidate's ability to perform procedures on live patients. The authors of the study concluded that because a high percentage of candidates passed the fourth and final patient-based, clinical skills examination, this component was ineffective in identifying qualified licensure candidates.[4]

However, this claim is flawed in that it does not consider the representation of the construct as the primary source of evidence, nor does it acknowledge a potential sequencing effect of the examination administration process outlined in the study. In other words, if there is a strong intercorrelation among the cognitive and skills components as suggested by these conclusions, then the order of the exams' administration influences the "screening out" process and may have contributed to the high passing score on the clinical III component of the examination process. For example, if candidates were required to take the clinical III examination first and the initial written examination last, the written examination would more than likely have produced a similarly high passing score. Reversing the order of the examination administration process for graduates of schools in Canada would likely have had a similar effect: the clinical skills (i.e., clinical II and clinical III) examinations would screen out a certain percentage of candidates and the written exam would more than likely have a higher passing score. Would the authors have been similarly comfortable concluding that the written examinations that measure knowledge of dental science and clinical judgments did not add value to the licensure decision? If

so, then in the U.S. context, the value of the NBDE Parts I and II should be questioned. However, as noted earlier, such a conclusion would be similarly short-sighted with respect to representation of the construct.

Moreover, this same statistical trend is commonly found in other high stakes medical credentialing examinations that have demonstrated valid and reliable evidence given the risk to the public. For example, Step II Clinical Skills (CS) of the United States Medical Licensing Examination (USMLE) is a standardized patient examination that measures a candidate's clinical skills. Exam pass rates for this exam from 2012–2016 ranged from 95%–97% with approximately 19,000 candidates tested each year.[5] Like the current comprehensive examination process used by existing clinical dental licensure examination programs like the American Board of Dental Examiners (ADEX), the Step II CS exam is also preceded by written assessments of knowledge and judgment in an effort to provide a comprehensive representation of the construct.

The NDEB chose to eliminate the skills or performance-based component of its licensure examinations for graduates of Canadian dental schools in part because the Canadian system has a much smaller population of candidates in addition to a consolidation of responsibilities with respect to training and assessing a dental candidate's clinical skills performance prior to licensure. The NDEB maintains that candidates learn and are assessed on performance-based skill set types during their time at accredited dental schools in Canada prior to taking their OSCE. Furthermore, the NDEB is responsible for multiple aspects of the training and licensure process from being responsible for defining competencies, overseeing accreditation, and maintaining the licensing examination program. Yet of critical importance in making comparisons to the Canadian system is that candidates who are not from accredited schools are still required to take a clinical skills examination as part of the licensure process.

A centralized system like Canada's where one policy body is responsible for each of these aspects is not currently employed as part of the U.S. system. Rather, the different stakeholder groups responsible for training, accreditation of training programs, and independent

evaluation of minimum competence in the U.S. serve as a system of checks and balances to mitigate the effects of conflicts of interest. And, although performance or psychomotor skills should certainly form a large part of dental school teaching practices, "the question should not be about what a student accomplished in school with consultation and educational guidance, but should be about the quality of work a candidate can demonstrate independently at a time near the time that the candidate wishes to enter practice" (p.7).[6] Therefore, the current comprehensive nature of the U.S. licensure requirements serves as that standardized set of checks and balances on the education and program accreditation components of the system.

Comparisons with GPA or Class Rank

The ADA cites several reasons for what it believes is the inadequacy of current patient-based dental licensure examinations. One of these reasons is its belief that there is a lack of correlation between students' class rank and/or GPA at dental school and those same students' scores on clinical examinations. In psychometric terms, correlation is a statistical analysis that measures and describes the relationship between two variables. Correlations can provide us with information on the nature of the relationship (positive or negative), the form of the relationship (e.g., linear, quadratic) and the magnitude of the relationship (-1.0 to 1.0).

The ADA's assumption is that dental students with high GPAs and/or who are at the top of their class should also receive higher scores on their clinical exams. A lack of correlation between these two variables is used to call into question the validity and reliability of the test scores for the clinical skills components of the licensing examination process. The evidence presented by the ADA to demonstrate the lack of correlation is primarily based upon a relatively small number of studies conducted mostly in one dental school and on one clinical examination: the CDCA's.[7] Specifically, the authors of the study argue that 1) the CDCA examination is not a good measure of how faculty will grade students in dental school, 2) there is a high level of fluctuation each year in the clinical examination results (with the exception of the DSCE written component), and 3) different sections of the examinations are not able to validate each other.

It is a common, intuitive mistake to infer causality from an observed correlation or failing to consider alternate factors that may be responsible for an identified correlation or lack thereof. Grades in a classroom setting and performance on a clinical skills examination are not measures of the same construct. A candidate might be very capable on the cognitive aspects, but unable to perform the psychomotor skills needed to be an entry-level dentist. Content and grading practices are unique to the institution and instructor, and class rank is relative to the students' cohort. Grades may also be influenced by student effort, attendance, and attitude. Some studies have also suggested that faculty members often inadequately evaluate the skills vital to the determination of competent performance in the medical field.[8] In contrast, the content and grading practices for clinical skills examinations are based upon external and standardized verification of a candidate's knowledge, skills, and abilities. GPA metrics (often represented on a scale from 0.0–4.0), class rankings, and the pass/fail determination of licensure examinations are measures based on different constructs and for different purposes. Specifically, the variability sought in using GPA or class rank is not a goal of a licensure examination. Therefore, calculating correlations among these variables leads to misinterpretation and flawed conclusions.

To extend the discussion further, a lack of correlation between measures such as class rank, GPA, and cognitive measures relative to the clinical skills components of the examinations should be interpreted as a positive. A low correlation suggests that the performance on the clinical skills adds unique value to the comprehensive nature of the licensure examination process. In fact, a high correlation between measures like class rank and GPA relative to examinations like the NBDE's Part I and Part II exams, may suggest redundancy in the examinations that do not provide incremental validity to the licensure process.

Correlation is based on the ability of two measures of the same trait or construct to produce scores that are similarly rank ordered. Year-to-year fluctuation is somewhat misleading when the question is really about decision consistency. Rank order position is not the focal question, particularly when measures like GPA are heavily influenced by construct-irrelevant

variance as it relates to the clinical skills being measured. This becomes even more problematic when the measures are designed to represent different components of the domain, such as GPA and clinical skills examination scores. It is not surprising from a psychometric standpoint that two measurement systems with unique purposes would fail to demonstrate a strong relationship when using a statistical technique that is intended for rank ordering when one of the measures is not designed to produce rank ordered results.

The assertion that different sections of the clinical examination do not validate one another is also problematic from a measurement standpoint. This claim assumes that a one-dimensional relationship exists among the different components (e.g., operative/restorative, endodontic, prosthodontics) assessed through the clinical examination process. However, the assumption that a strong relationship should exist among the different exam components is "likely to be unsupported on dental clinical tests…because these disciplines represent different dimensions of dentistry that contain unique skill sets."[6] The curriculum and instruction for these different domains within the field are unique. If these were simply skills that generalized to any domain, there would not be a need for dental schools to have separate departments or faculty for each of these important aspects of the profession (e.g., operative, endodontics, prosthodontics). Further, the profession would not have recognized specialty level skills in these areas. Clinical licensure testing organizations have determined these as unique domains and, consequently, have separate examinations for each to illustrate that understanding.

Other Research on Psychomotor Skills

The importance of an independent assessment, separate from a training or preparation program, of the psychomotor skills of licensure candidates who are required to use their hands and communicate with patients as part of their everyday practice or job cannot be understated. While medical school graduates are required to attend residency programs that provide advanced clinical skills training, general dentists are considered potentially qualified to practice upon graduation from dental school. Despite the advanced training received during a residency

program, medical students from a variety of fields are still tested on their written knowledge and judgment abilities as well as their clinical performance skills prior to graduating and becoming a licensed doctor.

To illustrate, the USMLE consists of four exams that medical students must pass as part of the process to become a licensed physician. Of these exams, one component is the Step II Clinical Skills (CS) performance exam. The USMLE clinical skills exam is a hands-on exam that assesses an examinee's ability to gather necessary information from a patient, perform physical exams, communicate findings to the patient, and write patient notes. The clinical skills exam was added to the USMLE in 2004 because research by the National Board of Medical Examiners (NBME) suggested that it was essential to have an independent performance measure of students' ability to actively provide patient care.[10]

Graduates of osteopathic medicine are also required to take a clinical skills exam as part of their comprehensive licensure process. Similar to the USMLE's Step II CS exam, the osteopath's exam is a performance assessment of clinical skills in which students encounter 12 standardized patients and are required to demonstrate their ability to take patient history, perform physical exams, document findings, and express appropriate interpersonal skills and professionalism.

In addition to the clinical skills abilities measured by the USMLE and osteopathic exams, graduates seeking licensure in optometry must also demonstrate their ability to utilize ophthalmic equipment to perform refractions and retinoscopies, test pupils, and perform injections. A mixture of standardized and simulated patients is used throughout the assessment.

The clinical licensure exams discussed above utilize a conjunctive exam process that mirror current dental licensure requirements in the U.S., combining written examinations of knowledge and judgment with clinical skills or performance-based examinations. This means that candidates must pass each component to be deemed as passing overall. Being able to represent an

adequate combination of these skill sets has been deemed vital by the aforementioned organizations in determining whether or not a candidate is qualified for clinical licensure.

Implementing an OSCE: Considerations for State Boards of Dentistry

OSCEs that measure clinical abilities have been used in undergraduate medical assessment for many years. However, their implementation in the field of dentistry is relatively new using this particular labeling. As measures of clinical judgments examinations like the DSE, developed and utilized by ADEX is effectively a computerized OSCE with respect to the clinical judgments that are made on job-related scenarios. Before implementing a DLOSCE as proposed by the ADA, state boards of dentistry are encouraged to consider:

- What evidence from the ADA's practice analysis supports the use of a clinical judgment DLOSCE in lieu of comprehensive measurement of the entry-level knowledge, skills, abilities, and judgments needed to safely conduct independent practice?
- How will the ADA legally defend jurisdictions that would adopt a clinical judgment DLOSCE in lieu of comprehensive measures of clinical abilities?
- What additional assessments, if any, will be used with the ADA's proposed DLOSCE given the inherent limitations as comprehensive measurements of clinical skills[11]?
- What unique information would the ADA's proposed clinical judgment DLOSCE provide to the licensure process beyond what is currently available in the clinical licensure testing arena?

Conclusions

In the United States, there continues to be a need for independent verification of dental licensure candidates' clinical psychomotor skills as a critical requirement of the licensure process. An OSCE as envisioned and originally proposed by the ADA is not a replacement for current comprehensive clinical licensure examinations because it would not be representative of all the important knowledge, skills, and abilities required to be a minimally competent dentist.

Moreover, the claims made by the ADA regarding current clinical skills examinations are based on limited evidence and data in addition to misleading conclusions that, when considered in a broader context and alongside other variables, does not hold up to scrutiny.

Examinations representing the development, validation, and construct representation of clinical judgments and psychomotor skills as comprehensive measures of entry-level practice in dentistry already exist within the current licensure examination process, calling into question the need for a new examination.[12,13] The ADA's development and potential use of an OSCE modeled on Canada's requirement would most likely be redundant when considering that examinations that measure a dental candidate's clinical judgment have already been developed with established validity evidence by some organizations. If the ADA plans to offer its OSCE as an option that would be used in combination with clinical judgments or in lieu of a unique clinical skills examination, then it should include a component that tests dental candidates' ability to perform the important psychomotor skills needed in a dental setting. However, as proposed and purported, there does not appear to be sound theoretical or psychometric evidence that having good clinical judgment abilities are a sufficient proxy for demonstrated clinical skills in the important, job-related domains of the profession.

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Appendix D

American Association of Oral and Maxillofacial Surgeons Correspondence

Oral and maxillofacial surgeons:
The experts in face, mouth and jaw surgery®

American Association of Oral and Maxillofacial Surgeons

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aaoms.org

Douglas W. Fain, DDS, MD, FACS
President

Scott Farrell, MBA, CPA
Executive Director

SENT VIA EMAIL

August 15, 2017

Dear Colleagues:

The American Association of Oral and Maxillofacial Surgeons (AAOMS) and its fellows and members are dedicated to provide safe and accessible anesthesia services for our adult and pediatric patients. We have provided cost-effective anesthesia in the outpatient setting with an unparalleled safety record for more than 60 years.

AAOMS and its Board of Trustees have embraced a multifaceted approach to support our strong and long-held beliefs in a culture of safety and, especially, anesthesia patient safety. These efforts include a wide scope of initiatives that exemplify our level of ongoing commitment to a culture of anesthesia safety in the practice of oral and maxillofacial surgery, including:

- Stewardship of OMS residency education standards that require a five-month rotation on the medical anesthesia service as well as a continuous outpatient experience, whereby OMS residents participate in the delivery of all levels of anesthesia through their four to six years of training.
- A self-imposed mandatory Office Anesthesia Evaluation program, in place for more than 25 years.
- Development of the Dental Anesthesia Assistant National Certification Examination (DAANCE), which strengthens our anesthesia team model and augments our multiple educational programs for anesthesia assistants.
- Our recently developed anesthesia emergency management simulation training modules in cooperation with the Medical University of South Carolina Simulation Center. These courses will maintain critical skills as well as further enhance and promote patient safety and excellence for the OMS anesthesia team.
- AAOMS being the first dental specialty to embrace the mandatory requirement of end-tidal carbon dioxide monitoring in the delivery of outpatient anesthesia.
- Active support of the recent revisions of the American Dental Association's Council on Dental Education and Licensure's anesthesia guidelines.

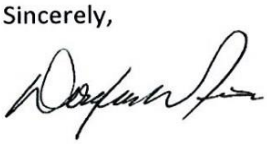
Oral and maxillofacial surgeons perform millions of outpatient anesthetic procedures throughout the United States every year. Despite the highest levels of quality care and a continuous focus on patient safety, a small number of adverse events still occur – not unlike

any specialty that delivers anesthesia. These rare events create negative publicity, which can have devastating consequences to all dentists who deliver anesthesia and the overall profession of dentistry. Recently, pediatric sedation/anesthesia has become a particular focus of the news media. Adverse events in this age group are understandably disturbing. With the intense media focus, emotions – instead of science and evidence-based medicine – are being used to enact changes to state anesthesia rules.

Responses to these unfortunate events have promulgated communications from various groups (e.g., AGD) that, in many cases, are less familiar with sedation and anesthesia in general. More significantly, these groups appear to be unaware of the unparalleled safety record of the oral and maxillofacial surgeon and our team model of anesthesia delivery. These same groups also suggest or demand changes without having scientific or evidence-based studies to support such actions. An example of this is the fallout from Caleb's Law in California. The related legislation that followed – had it passed without modification – would have done significant harm by reducing access to care and limiting resources available to the most at-risk populations, with no evidence there would be improved outcomes.

All stakeholders, including state dental boards, should recognize the long-standing commitment that AAOMS and its fellows and members have made to ensure the continued safe delivery of office-based anesthesia. AAOMS strives to achieve visionary education and training for our members and future members. It is our hope that our dental colleagues would embrace rather than challenge this commitment. Sending out unfounded critical communiqués is not productive nor collaborative. Instead, we welcome all areas of dentistry to join us in our pursuit to improve the safety record for all patients.

Sincerely,



Douglas W. Fain, DDS, MD, FACS
President
American Association of Oral and Maxillofacial Surgeons

Appendix E

Ohio Society of Oral and Maxillofacial Surgeons Correspondence

Ohio Society of Oral and Maxillofacial Surgeons

OSOMS

RECEIVED
AUG 17 2017
OHIO DENTAL BOARD

August 16, 2017

Mr. Kamdar and Members of the Ohio State Dental Board,

The Ohio Society of Oral and Maxillofacial Surgeons, a component society of the American Association of Oral and Maxillofacial Surgeons (AAOMS), is dedicated to providing safe and accessible anesthesia services for our adult and pediatric patients. Members of the AAOMS have provided cost-effective anesthesia in the outpatient setting for over 60 years with an unparalleled safety record. The AAOMS has embraced a multifaceted approach to support its members' strong and long held belief in a Culture of Safety and especially Anesthesia Patient Safety. Efforts toward this goal include:

- Stewardship of OMS residency education standards requiring a five-month resident rotation on the medical anesthesia service as well as an ongoing outpatient experience in all forms of anesthesia through their four to six years of training.
- Maintenance of a self-imposed, mandatory Office Anesthesia Evaluation Program the AAOMS and its component state societies which is now in its 25th year.
- Provision of the Dental Anesthesia Assistant National Certification Examination (DAANCE) developed by the AAOMS with intent to strengthen our anesthesia team model.
- Embracing the mandatory requirement of end-tidal carbon dioxide monitoring in the delivery of outpatient anesthesia. The AAOMS was the first dental specialty association to do so.
- Recent development of an anesthesia emergency management simulation training program in cooperation with the Medical University of South Carolina Simulation Center. Participation in this simulation program will maintain critical technical and problem-solving skills for the OMS anesthesia team. This will further enhance and promote safety and excellence in the anesthesia team delivery model.
- Active support of the recent revisions of the American Dental Association's Council on Dental Education and Licensure anesthesia guidelines.

Oral and Maxillofacial Surgeons perform millions of outpatient anesthetic procedures throughout the United States every year. Despite the highest levels of quality care and a continuous focus on safety, a small number of adverse events still occur. These rare events are obviously extremely unfortunate. They create negative publicity, which can have devastating consequences to all parties involved. Recently, pediatric sedation and anesthesia have become a particular focus of the news media. Adverse events in this age group are understandably disturbing. With the intense media focus, emotions, instead of science and evidence based medicine, are being used to enact changes to state anesthesia rules. This response to these unfortunate events has promulgated communications from various groups, the Academy of General Dentistry most recently, who in many cases are unfamiliar with sedation and anesthesia in general nor training requirements for OMSs. More significantly, these groups are apparently unaware of our unparalleled OMS safety record and our team model of anesthesia delivery. These same groups then suggest or demand changes without having scientific or

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evidence based medicine to support such actions. An example of this is the fallout from Caleb's Law in California. The related legislation which followed, had it passed without modification, would have done significant harm by reducing access to care and limiting resources available to the most at-risk populations with no evidence that there would be improved outcomes.

State dental boards and all stakeholders in the delivery of office-based anesthesia should be reminded of the OMS history as well as the AAOMS commitment and vision for future anesthesia delivery. It is our hope that other groups in dentistry would embrace and not challenge this commitment. Rather than sending out counterproductive and unfounded critical communiqués, they should join us in our pursuit to improve the safety record for all of our patients.

Sincerely,

Kelly S. Kennedy

Kelly S. Kennedy, DDS
President, *Ohio Society of Oral and Maxillofacial Surgeons*
Diplomate, *American Board of Oral and Maxillofacial Surgery*
Associate Professor, Oral and Maxillofacial Surgery, *The Ohio State University College of Dentistry*

Appendix F

American Dental Association DLOSCE Talking Points

RESPONSE
TO THE
ADA DLOSCE TALKING POINTS

Background: Within the past 2 years, the ADA has openly encouraged State Boards and Associations to accept all Regional Exams, asserting that they were all comparable. This effort included 2-3 Licensure Task Force meetings that initially included many of the stakeholders involved in processes associated with licensure and clinical evaluation. More recently, the ADA renewed and strengthened its campaign to eliminate patient-based exams, ultimately, in favor of their forthcoming ADA DLOSCE. Unfortunately, for the later Task Force meetings, the entire licensing community was uninvited to attend any subsequent meetings. The ADA continues to determine who will be invited to the table, who may represent the testing agencies and State Boards, and they control the scope and agenda of any meetings or discussions. Seemingly, the script for these items was written long before any meetings were held and those who did not concur with the agenda were not invited back. Additionally, concern exists that the ADA BOT was not given complete or accurate documentation in order to make an informed decision.

1. **Portability:** The ADA alleges that the development of the OSCE will not only eliminate patients from the licensure examinations, but also improve licensure portability. The ADA is combining the initial licensure process with portability for currently licensed dentists. Most states DO have policies for currently licensed dentists to be licensed in another state by credentials, if they chose to relocate. This is a states right issue and not in the purview of the ADA. Most likely, the vast majority of the 160,000 ADA members already have a license. While portability to move to another state after licensure may be an issue for some of these members, initial licensure is not. The ADA continues to combine the issue of portability AFTER initial licensure with the granting of an initial license, which is really not the same issue. An initial license is granted only after a jurisdiction is satisfied that the applicant has met the competency standards for their state. Issuing a license to an already licensed, competent dentist is a different issue for most states and they have statutes to deal with this.
   The ADA readily admits that it would probably take 5 to 10 years for all states to accept the OSCE in lieu of patient-based examinations. When the vast majority of states currently accept all regional exams and the portability of licensure is greater than ever before in the history of the profession, the divisiveness of trying to eliminate patient-based exams and replace them with the ADA's OSCE will have a very deleterious effect on licensure portability.

2. **Ethical Considerations:** The "Talking Points" also address the ethical issues of the patient based examination. The ADA and ADEA continue to attack the present patient based examinations on ethical grounds. However, they have no issue with the CODA competency exams that are required of every dental student. If one examines the process for a CODA competency, the process is very similar to what occurs during a patient based examination. The major difference is that 3 anonymous graders who have no prior personal knowledge or relationship with the candidate grade the candidate's work independently. The decision of pass or fail is solely on the quality of the work presented to the graders. Regional clinical examinations also have mechanisms for follow-up care in instances of substandard treatment. It can be argued that the exam process is more valid and reliable because there can be NO bias from the examiners compared to faculty grading their own students during a competency. Why is the use of patients in the educational process with beginning, unlicensed practitioners, any more ethical than patient-based examinations of candidates who have completed their professional education?

3. **Regulation:** Clinical licensure examinations in dentistry are intended to support licensure decisions by identifying, independently and anonymously, candidates who are not able to demonstrate, in an authentic (patient-based) or highly realistic simulated situation, performance that reflects at least the level of

minimal competency expected of entry-level professionals. Features of performance critical to success on the examination, as in the profession, include content knowledge, clinical ability, critical thinking and diagnostic judgment. Only one aspect of performance is "hand-skills."

By law, the regulation of health professions is a ***governmental function***, and dentistry is entrusted with self-regulation through State Boards of Dentistry, whose sole purpose is protection of the public. The ADA is attempting to regulate the profession and the regulating Boards of Dentistry by controlling entry into dental school, educational accreditation of institutions and now redefining the nature of clinical competency assessments and setting themselves up as the appropriate provider of psychometrically qualified examinations of clinical competence.

4. **Roles:** The ADA is a professional association whose role is to promote the profession, as well as provide services and representation to its membership. Therefore, the membership of new young dentists, with its concomitant dues revenue, is a primary goal. The profession's trade association should not be its gatekeeper as well, setting itself up with a monopoly for all exams and as the sole arbiter of professional standards in control of the profession from the entry point of determining initial dental aptitude to final competence:

    a. Educational accreditation via CODA
    b. Competency assessments ranging from aptitude and admissions testing to licensure qualifying exams:
        i. DAT
        ii. NBDE – Parts I and II
        iii. Clinical Examinations

    The ADA states that "the ADA Department of Testing Services has a long-track record of developing and implementing highly valid and reliable high-stakes examinations in both the licensure and admissions areas", (the DAT and NBDE examinations). However, there is a big difference in constructing a didactic examination and a performance based examination. The patient based examinations have been developed to reflect the procedures for entry level practitioners, based on an occupational analysis and as required by the 51 jurisdictions' statutes. It has been noted that most professional associations, such as the American Medical Association or the Physical Therapists Association, do NOT engage in competency assessment. Their Board examinations are administered by a testing agency separate from their associations.

5. **Self-regulation:** ADA has put the profession's own self-regulating Boards in an embarrassing position by providing talking points for state associations to use with their membership in lobbying state legislatures which openly challenge the validity and reliability of the competency assessments that Boards have historically used for protection of the public. The ADA is denigrating the profession's regulatory Boards, as well as the Regional Coalitions of Boards that have spent many years developing and administering psychometrically sound clinical examinations.

    There are a number of federal agencies that would like to see health professions controlled at the federal level. In particular, the FTC has challenged the appropriateness of dentistry being a self-regulating profession and more than once in the public arena it has been suggested that Boards of Dentistry should be populated by a majority of public members. An intra-professional conflict will not promote the best interests of the profession nor the public it serves.

6. **Documentation:** The so-called "psychometric analysis" that ADA claims to have conducted is seriously flawed, and based on unsound psychometric practices. At best, their "study" can only claim to be a literature review of 10 selected journal articles and/or editorials, one dated from 1975, two in 2003, two in 2004, one in 2005, one in 2006, one in 2011 and an editorial in 2016. Although a few of the cited articles could be technically called "peer reviewed", Richard Ranney's and Jack Gerrow's, the remainder are

editorial pieces. The design of the "analysis" done by Ranney et al, and one of Jack Gerrow's articles is misconceived. Both sets of articles are written by faculty who make the foundational assumption that class rankings are the gold standard of validity and reliability by which the patient-based exams should be measured. Class rank is a multifactorial process and is based on a completely different set of criteria than performance based licensure exams. A careful reading of Ranney's article merely confirms what many other articles have already demonstrated; that is, individuals who do well on cognitive exams, do well on other cognitive exams thus the high correlation with the Dental School exams. It is precisely because there is not necessarily a correlation with class rank that performance licensure exams are necessary. Anonymous examiners evaluating clinical surgical care is not accomplished by any OSCE and variability in patient care cannot be evaluated by a manikin. Some of the cited articles criticized licensure examinations because the scores on multi-sectioned examinations did not correlate with one another. There appears to be no understanding that the separate conjunctive sections of licensure examinations are purposeful. Regional Boards have conducted their own correlation studies and realize that one cannot safely ***generalize*** that a practitioner who is competent in endodontics or periodontics will also demonstrate competence in restorative dentistry. Thus, our multi-sectioned examinations. OSCEs evaluate only the cognitive understanding of dentistry, important to be sure, but cannot identify a candidate that cannot translate that knowledge into acceptable clinical care.

The dates of the ADA's selected articles are also important. ADA's Testing Department has failed to take into consideration the work that most Regional Boards did throughout 2004-05 developing a criterion-based examination in which the actual ***measurable performance criteria are the scorable items,*** and continue to be used by most testing agencies today. These developmental efforts were aided and guided by multiple measurement specialists. So, comparing pass-fail data from one testing agency to the class ranking or GPA from one school cannot meet the standard of psychometric analysis. It should be noted that from 2006 forward, there is far more comparability between the performance criteria of Regional Testing Agencies, than exists for the clinical evaluation systems among the nation's dental schools. In addition, school faculty are not routinely calibrated as examiners are and clinical evaluations in schools are neither anonymous nor objective.

By their own admission at the 2017 JCNDE Advisory Forum, the ADA did not have raw data to perform a true psychometric analysis of any of the current licensure examinations administered. After the testing agencies were asked to provide technical reports, which the majority did in the interest of transparency and collaboration, none of the agencies received any feedback from the ADA indicating that any evidence of validity provided was inadequate or missing from the technical reports. The ADA has an obligation to present the data and the facts honestly when they are making these kinds of allegations. The ADA component societies that have received these talking points, the ADA members, the state dental boards and the public expect and deserve the truth, not opinion cited as proof.

7. **References to the Canadian OSCE:** "Psychometric analyses of the Canadian OSCE "strongly" suggest there is more evidence that the Canadian OSCE is more reliable and valid than the present patient based exams." Again, a statement by the ADA without data to back it up. Another opinion article written by a biased author with no proof. Dr. Popp, the WREB psychometrician cited data from WREB's psychometric analysis of their recent examination and compared it to the data on the Canadian OSCE web site and showed that in fact the WREB exam outperformed the Canadian OSCE's data. There appears to be no evidence that the reviewers of the ADA or the personnel responsible for collecting validity evidence of Canada's Assessment of Clinical Skills have the appropriate level of understanding or expertise in the evaluation of technical quality for performance-based tests to conduct a review of the testing agencies that conduct clinical examinations in support of dental licensure.

Appendix G

American Dental Association OSCE Proposal Rebuttal Talking Points

ADA OSCE PROPOSAL REBUTTAL
TALKING POINTS

1. Within the past 2 years, the ADA has openly encouraged State Boards and Associations to accept all Regional Exams, asserting that they were all comparable. This effort included 2-3 Licensure Task Force meetings that initially included many of the stakeholders involved in processes associated with licensure and clinical evaluation. More recently, the ADA renewed and strengthened its campaign to eliminate patient-based exams, ultimately, in favor of their forthcoming ADA DLOSCE. Unfortunately, for the later Task Force meetings, the entire licensing community was uninvited to attend the subsequent meetings of the Licensure Task Force. The ADA continues to determine who will be invited to the table, who may represent the testing agencies and State Boards, and they control the scope and agenda of any meetings or discussions. Seemingly, the script for these items was written long before any meetings were held and those who did not concur with the agenda were not invited back. Additionally, concern exists that the ADA BOT was not given complete or accurate documentation in order to make an informed decision.
2. The ADA alleges that the development of the OSCE will not only eliminate patients from the licensure examinations, but also improve licensure portability. The ADA is combining the initial licensure process with portability for currently licensed dentists. Most states DO have policies for currently licensed dentists to be licensed in another state by credentials, if they chose to relocate. This is a states right issue and not in the purview of the ADA. Most likely, the vast majority of the 160,000 ADA members already have a license. While portability to move to another state after licensure may be an issue for some of these members, initial licensure is not. The ADA continues to combine the issue of portability AFTER initial licensure with the granting of an initial license, which is really not the same issue. An initial license is granted only after a jurisdiction is satisfied that the applicant has met the competency standards for their state. Issuing a license to an already licensed, competent dentist is a different issue for most states and they have statutes to deal with this.
3. Conflict of interest: The ADA is a professional association whose role is to represent its membership and promote the profession. Therefore, the membership and therefore, the revenue, of new young dentists is a primary goal. The profession's trade association should not be its gatekeeper as well and therefore in charge of:
    a. educational accreditation via CODA
    b. competency assessments ranging from aptitude and admissions testing to licensure qualifying exams:
        i. DAT
        ii. NBDE – Parts I and II
        iii. Clinical Examinations

    The ADA states that "the ADA Department of Testing Services has a long-track record of developing and implementing highly valid and reliable high-stakes examinations in both the licensure and admissions areas", (the DAT and NBDE examinations). However, there is a big difference in constructing a didactic examination and a performance based examination. The patient based examinations have been developed to reflect the procedures for entry level practitioners, based on an occupational analysis and as required by the 51 jurisdictions' statutes. Presently, not 1 state statute accepts a non-patient based examination.
4. The "Talking Points" also address the ethical issues of the patient based examination. Dr. Ziebert, the ADA and ADEA continue to attack the present patient based examinations on ethical grounds. However, they

have no issue with the CODA competency exams that are required of every dental student. If one examines the process for a CODA competency, the process is very similar to what occurs during a patient based examination. The major difference is that 3 anonymous graders who have no prior relationship with the candidate and in fact have never seen the candidate grade the candidate's work independently. The decision of pass or fail is solely on the quality of the work presented to the graders. I would argue the exam process is more valid and reliable because their can be NO bias from the examiners compared to faculty grading their own students during a competency.

5. Clinical licensure examinations in dentistry are intended to support licensure decisions by identifying, independently and anonymously, candidates who are not able to demonstrate, in an authentic (patient-based) or highly realistic simulated situation, performance that reflects at least the level of minimal competency expected of entry-level professionals. Features of performance critical to success on the examination, as in the profession, include content knowledge, clinical ability, critical thinking and diagnostic judgment. Only one aspect of performance is "hand-skills."

   By law, the regulation of health professions is a governmental function, and dentistry is entrusted with self-regulation through State Boards of Dentistry, all of which have a majority of dentists on the Board. The ADA is attempting to regulate the profession and the regulating Boards of Dentistry by controlling entry into dental school, educational accreditation of institutions and now redefining the nature of clinical competency assessments and setting themselves up as the appropriate provider of psychometrically qualified examinations of clinical competence.

6. ADA has put the profession's own self-regulating Boards in an embarrassing position by providing talking points for state associations to use with their membership in lobbying state legislatures which openly challenge the validity and reliability of the competency assessments that Boards have historically used for protection of the public. The ADA is denigrating the profession's regulatory Boards, as well as the Regional Coalitions of Boards that have spent many years developing and administering psychometrically sound clinical examinations.

7. There are a number of federal agencies that would like to see health professions controlled at the federal level. In particular, the FTC has challenged the appropriateness of dentistry being a self-regulating profession and more than once in the public arena it has been suggested that Boards of Dentistry should be populated by a majority of public members. An intra-professional conflict will not promote the best interests of the profession nor the public it serves.

8. The so-called "psychometric studies" that ADA claims to have conducted are seriously flawed. (no data; comparing exam results to class rankings in schools; no standardization of evaluation systems from school to school; school faculty are not routinely calibrated as examiners are; clinical evaluations in schools are neither anonymous nor objective and their purpose is to teach rather than assess; most of the statistical applications for the analysis of written exams, such as National Boards, are not relevant to the analysis of clinical exams;) Although a few of the cited articles could be technically called "peer reviewed", Ranney's and Jack Gerrow's, the remainder are editorial pieces. The design of the "analysis" done by Ranney et al, and one of Jack Gerrow's article is fatally flawed. Both sets of articles are written by faculty who make the foundational assumption that the class rankings are the gold standard by which the licensure exams should be measured.

   In reality this whole comparison is flawed. Class rank is a multifactorial process. A careful reading of Ranney's article merely confirms what many others articles have already demonstrated, that is, individuals who do well on cognitive exams, do well on other cognitive exams thus the high correlation with the DSE exams. It is precisely because there is not necessarily a correlation with class rank that makes performance licensure exams necessary. Anonymous examiners evaluating clinical surgical care is not accomplished by any OSCE and variability in patient care cannot be evaluated by a manikin. Thus our muti-sectioned

examinations. OSEs evaluate only the cognitive understanding of dentistry, important to be sure, but cannot identify a candidate that cannot translate that knowledge into acceptable clinical care.

The ADA by their own admission (Dr. Waldschmidt at the AADB cited a list of 10-12 year old articles that the ADA used to draw their conclusions, he admitted they did NOT have raw data from any testing agency), did not have raw technical data to perform a true psychometric analysis of any of the current licensure examinations administered. After the testing agencies were asked to provide technical reports, which the majority did in the interest of transparency and collaboration, none of the agencies received any feedback from the ADA indicating that any evidence of validity provided was inadequate or missing from the technical reports. Dr. Ziebert and the ADA have an obligation to present the data and the facts honestly when they are making these kinds of allegations. The ADA component societies that have received these talking points, the ADA members, the state dental boards and the public expect and deserve the truth, not opinion cited as proof.

9. References to the Canadian OSCE: "Psychometric analyses of the Canadian OSCE "strongly" suggest there is more evidence that the Canadian OSCE is more reliable and valid than the present patient based exams." Again, a statement by the ADA without data to back it up. Another opinion article written by a biased author with no proof. Dr. Popp, the WREB psychometrician cited data from WREB's psychometric analysis of their recent examination and compared it to the data on the Canadian OSCE web site and showed that in fact the WREB exam outperformed the Canadian OSCE's data. There appears to be no evidence that the reviewers of the ADA or the personnel responsible for collecting validity evidence of Canada's Assessment of Clinical Skills have the appropriate level of understanding or expertise in the evaluation of technical quality for performance-based tests to conduct a review of the testing agencies that conduct clinical examinations in support of dental licensure.
10. The ADA readily admits that it would probably take 5 to 10 years for all states to accept the OSCE in lieu of patient-based examinations. When the vast majority of states currently accept all regional exams and the portability of licensure is greater than ever before in the history of the profession, the divisiveness of trying to eliminate patient-based exams and replace them with the ADA's OSCE will have a very deleterious effect on licensure portability.

Appendix H

Western Regional Examining Board Summary of 2018 Dental Exam Format Changes

WREB
A National Dental and Dental Hygiene Testing Agency

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Summary of 2018 Dental Exam Format Changes

Overview

The Dental exam will consist of the following required sections: Operative, Endodontics, and Comprehensive Treatment Planning (CTP). The Periodontal section remains part of the exam and is included in the full exam fee, but the Candidate may opt out during registration if the state to which they are applying for initial licensure does not require this procedure. An optional Prosthodontic section will be offered for an additional fee, if the state to which a Candidate is applying for initial licensure requires it. The Prosthodontic section is not a required section of the WREB exam.

The CTP exam is a written exam that will be taken in the fall at a Prometric Testing Center. Windows to take the exam at Prometric are approximately six weeks long and are pre-assigned based on the site where the Candidate will take the clinical exam.

Exam Sections

Operative: This is a required section. The Candidate may complete up to two procedures to demonstrate competence on the Operative section. The procedures may be any of the following, in any combination:

- Direct Posterior Class II Composite
- Direct Posterior Class II Amalgam
- Indirect (cast gold inlay/onlay up to ¾ Crown)

If the Candidate is successful, (3.00 or higher), on the first procedure, the section is Passed, with no need to complete another procedure. If the first procedure scores below a 3.00, the Candidate may proceed with a second procedure, which will be averaged with the first procedure. The average of the two procedures must be 3.00 or higher to pass the section. If a second procedure is completed and the average scores below 3.00, the attempt is completed and reported as failing. In this instance, the Candidate must pay to retake the full Operative exam at a different site. No onsite retakes are available for Operative.

If needed, the second procedure may be completed on Clinic Days Two or Three.

Endodontics: This is a required section and will be completed on simulated teeth. Teeth mounted in sextants and preoperative radiographs will be provided to Candidates by WREB upon arrival in the simulation lab. Candidates are required to place and maintain the manikin in correct patient treatment position and remain articulated in correct vertical dimension. Universal precautions and a rubber dam are required for all endodontic treatment. Candidates are allotted three (3) hours to complete their treatment and postoperative radiographs. The sextants and radiographs are then submitted for calibrated examiner scoring to published criteria. Candidates are allotted a thirty (30) minute set up period prior to the start of the exam. Required Endodontic procedures:

- Anterior– Graded on Access and Condensation
- Posterior– Graded on Access only

Candidates with a failing result in Endodontics will have the opportunity to retake the section at the same exam site on the third clinic day. Onsite retakes for Endodontics are not available on Clinic Days 1 or 2.

6/8/17

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Three hours will be allotted for the retake on Clinic Day 3 if the schools are willing to provide the simulation lab space. There is no additional fee for an onsite retake. If, for any reason, the section is not retaken onsite, the Candidate must pay to retake the section at a different site.

Periodontal Treatment: Initial Phase Treatment, S/RP subject to acceptance criteria. Candidates will have the choice to opt out of the periodontal section during registration if the state to which they are applying for initial licensure does not require this procedure. It remains part of the WREB exam and candidate results are reported to state dental boards unless the candidate removes it at application.

A retake of the Periodontal section may be taken onsite on Clinic Days Two or Three, if applicable. There is no additional fee for an onsite retake. If, for any reason, the section is not retaken onsite, the Candidate must pay to retake the section at a different site.

Prosthodontics: Simulated preparation of two abutments to support a posterior three-unit fixed partial denture prosthesis and preparation of an anterior tooth for a full-coverage ceramic crown. The preparations are performed on simulated teeth set in arches with simulated gingival tissue mounted in an articulator or manikin. Candidates will prepare a maxillary central incisor for an All Ceramic Crown (ACC) restoration. The posterior three-unit fixed partial denture prosthesis will replace a missing tooth in an upper quadrant. For example, if the missing tooth is #4; the tooth to be prepared as the anterior abutment for the fixed partial denture will be #5, and the tooth to be prepared as the posterior abutment for the fixed partial denture will be #3. Candidates are monitored to ensure they work independently, observe universal precautions, and work in a manner that simulates performing procedures on a patient, including that they maintain proper patient head position and normal vertical dimension. The prosthodontic preparations are completed in a single day during a time slot assigned for this purpose. Candidates are allotted three (3) hours to complete their prosthodontic preparations, and are given thirty (30) minutes prior to start of the exam to set up their unit, mount their arches and prepare to begin. Candidates can to opt into the prosthodontic section during registration if the state to which they are applying for initial licensure requires this procedure. The Prosthodontic section is not part of the WREB Dental Examination unless the candidate adds it at the time of application.

Candidates with a failing result in Prosthodontics will have the opportunity to retake the section at the same exam site on the third clinic day. Onsite retakes for Prosthodontics are not available on Clinic Days 1 or 2. Three hours will be allotted for the retake on Clinic Day 3 if the schools are willing to provide the simulation lab space. There is no additional fee for an onsite retake. If, for any reason, the section is not retaken onsite, the Candidate must pay to retake the Prosthodontic section at a different site.

Comprehensive Treatment Planning (CTP): This is a required section. The Comprehensive Treatment Planning (CTP) examination is a computer-based examination administered at Prometric test centers. The exam consists of three (3) patient cases of varying complexity, one of which is a pediatric patient. For each case, Candidates assess patient history, photographs, radiographs, and clinical information in order to create and submit a treatment plan. Candidates are required to answer questions with constructed responses and perform tasks related to each case such as appropriate pharmacy prescriptions and case specific dental laboratory work authorizations, when required. Candidates are allowed three (3) hours to complete the CTP exam. A 15-minute tutorial is provided prior to the beginning of the examination. Candidate scoring is completed by calibrated examiners utilizing published scoring criteria rating scales.

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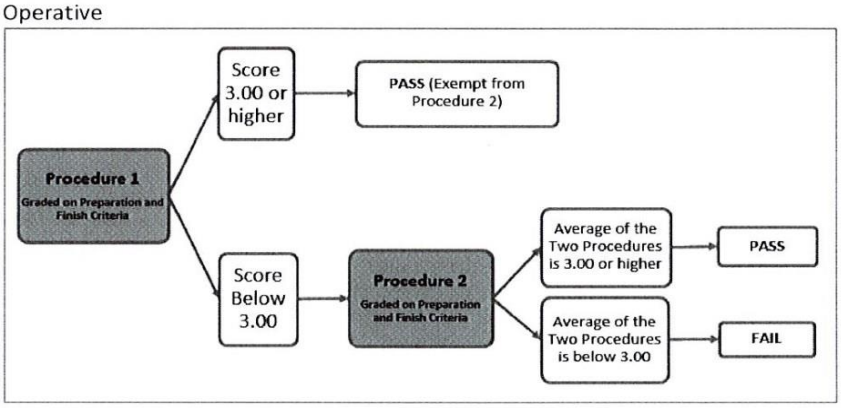
Clinical Exam Schedule

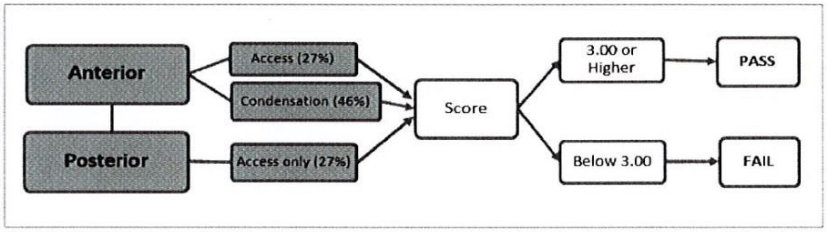
The clinical exam will consist of one Orientation Day and two clinical days starting at 8:00 am and ending at 4:00 pm, plus a third half day starting at 8:00 am and ending at 11:00 am. Provisional results will be posted at the end of each clinic day. The initial Operative and Periodontal procedures must be started on Clinic Days 1 or 2. Endodontics, (and Prosthodontics if taken), are scheduled sections and will be scheduled on Clinic Days 1 or 2. The third half day will be reserved for onsite retakes or operative second procedures only.

Passing Requirements

Operative



Endodontics



6/8/17

Appendix I

Ohio State Dental Board Strategic Map For Calendar Years 2017-2018