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MEMORANDUM

DATE	February 12, 2020
TO	Members of the Dental Board of California and the Dental Assisting Council
FROM	Gabriel Nevin, Legislative and Regulatory Analyst Dental Board of California
SUBJECT	**Agenda Item 2:** Discussion and Possible Action to Initiate the Dental Assisting Comprehensive Rulemaking Proposal

During the November 14, 2019 meeting, the Dental Assisting Council (Council) considered the draft language of the dental assisting comprehensive rulemaking proposal. After review and discussion, the Council voted to direct staff to prepare the proposed language in the final format and include all forms to be incorporated by reference, delegate authority to the Executive Officer to make any technical or non-substantive changes to the proposed language, and recommended the proposal be forwarded to the Board to consider initiation of the rulemaking at its February Board meeting.

Since the November 14th meeting, staff has received feedback from the California Association of Dental Assisting Teachers (CADAT), the California Dental Association (CDA), the Foundation for Allied Dental Education (FADE), the California Dental Assisting Association (CDAA), DAGGERS, and individual licensees regarding the proposed language. Staff's recommendations based on a review of the proposed language and stakeholder feedback follows:

1. 1070(d)(3)(B) requires that faculty in RDAEF programs possess 2 years of experience in clinical chairside dental assisting involving 4 handed dentistry. Stakeholders have pointed out, and similar sections have been reconfigured to reflect that the point of the experience requirements is that faculty have experience working in the capacity which they will be teaching students in. Therefore staff recommends changing this requirement to: "2 years of experience working as an RDAEF in a clinical setting."

2. 1070(h)(1) provides for health and safety standards and requires written protocols for emergencies be provided to students. In addition to these written materials, stakeholders have requested the addition of the following language related to standard Safety Data Sheets, which staff agrees would be a valuable addition: "All students and faculty shall have access to a resource notebook to include the Safety Data Sheets for all materials and chemicals used in the program or course."

3. 1070(l)(3) Was modified to require faculty calibration meetings be held every instructional period, instead of annually. This would prevent a faculty member being hired in the middle of the year and not attending a calibration meeting until the beginning of the next year.

However 1070(d)(1)(E), (2)(E), (3)(E), (e)(2)(E), (f)(2)(E), all still reference the annually calibration frequency. Staff recommends updating these sections to ensure all faculty are calibrated every instructional period.

4. Subsection 1070(j)(1) refers to “qualified faculty” which could be confuse people into believing that there is a difference between “faculty” and “qualified faculty” The qualifications for faculty are enumerated elsewhere, and all faculty must be qualified, or they may not serve as faculty. Therefore to remove confusion, staff recommends changing “qualified faculty” to “faculty”.

5. Proposed section 1070.2(h)(5)(D) Requires program curriculum to provide, “[i]nstruction in basic life support (BLS) for healthcare professionals to include use of AED as required by 16 CCR 1016(b)(1)(C) prior to the beginning of the pre-clinical or clinical experiences, wherein recertification intervals may not exceed two years.”

However Stakeholders (MR) have pointed out that programs are currently allowed to accept a student’s certification in BLS from another education provider. Therefore this will require that many programs add new certifications to their curricula, and additionally could affect course sequencing.

The current language at Section 1070.2(d)(9)(D) adds to the requirement for BLS certification: “The program may require that the student complete this course as a prerequisite to program enrollment, or that the student provide evidence of having completed the course from another provider.” Staff Recommends that this caveat be added back to the proposed language to allow programs flexibility in course offerings and sequencing, unless the Council’s intention is to require programs to offer BLS courses.

6. 1070.2(h)(6) States that programs “shall provide students with instruction in the California Division of Occupational Safety and Health (Cal/OSHA) Regulations (8 CCR 330-344.85) and the Board’s Minimum Standards for Infection Control (16 CCR 1005). Students shall be enrolled in or have a program-approved plan to enroll in courses culminating in a comprehensive written final examination prior to the student's performance of procedures on patients.” Stakeholders have pointed out that many linear dental assisting programs enroll students in IC/OSHA courses simultaneously with other chairside, x-ray, and patient assessment type courses and therefore Requiring those programs to ensure that students have completed a comprehensive written final IC/OSHA exam prior to performance of procedures on patients will require dramatic and expensive revisions to their program sequencing and curriculum design, and does not yield substantial safety increases, because students are overseen by faculty who ensure that all IC protocols and OSHA regulations are observed.

Staff recommends a reversion to the current language of 1070.2(d)(8)(B) which requires that programs provide instruction in IC and OSHA but does not require the completion of a written exam prior to performing procedures on patients, and add language

requiring that faculty maintain all IC protocols and OSHA regulations. Staff suggests the new (6) read:

“All programs shall provide students with instruction in the California Division of Occupational Safety and Health (Cal/OSHA) Regulations (8 CCR 330-344.85) and the Board’s Minimum Standards for Infection Control (16 CCR 1005) prior to the student's performance of procedures on patients. Faculty will be responsible for ensuring that all proper Infection Control and Cal/OSHA regulations and requirements are maintained whenever students perform procedures on patients.”

7. 1070.3(f) Describes the hours required for pit and fissure courses. The proposed language currently requires, “no less than 16 clockhours in length consisting of a combination of didactic, laboratory, simulated clinical, and clinical instruction designed for the student to develop minimum competency in all aspects of the subject area, including at least four hours of didactic training, at least four hours of laboratory training, and at least eight hours of clinical training.”

This formulation does not include a specific requirement of hours for simulated clinical training, and a course could under this formulation include only nominal simulated clinical training. However simulated clinical training is now included on the examination requirements at 1070.3(g)(5). Therefore staff requests that the Council establish a required number of hours of simulated clinical training. Staff suggests dividing the required laboratory training in half and using the following formulation:

“no less than 16 clockhours in length consisting of a combination of didactic, laboratory, simulated clinical, and clinical instruction designed for the student to develop minimum competency in all aspects of the subject area, including at least four hours of didactic training, at least two hours of laboratory training, two hours simulated clinical training, and at least eight hours of clinical training.”

8. The Board has received substantial feedback regarding the changes to 1070.3(g)(5) which were made during the November 2019 DAC meeting. Staff recommends a further change to the section which is based on stakeholder comments and will bring it in line with the CODA standards:

(i) no less than 16 teeth total;

(ii) no less than four (4) laboratory applications;

(iii) no less than four (4) applications on simulation devices;

(iv) no less than eight (8) clinical applications on live patients;

(v) no less than two live patients;

(vi) no more than four applications on any of the required live patients

9. Section 1070.3(i)(3)(B) details the clinical experiences that students in pit and fissure sealant courses must be evaluated on after completing their didactic instruction. The requirements listed here have been the same as the examination requirements listed at

subsection (g)(5), however they are listed in one sentence instead of broken out across multiple sections. As a result subsection (i)(3)(B) is confusingly worded and difficult to decipher. Staff recommends changing subsection (1)(3)(B) to reference subsection (g)(5) rather that repeating the formulation provided by that subsection:

“(B) Sufficient time shall be available for students to demonstrate competency in performing the applications required under Section 1070.3(g)(5).”

10. There are some inconsistencies in the proposed language for ultrasonic course at 16 CCR 1070.5 - the course is described as consisting of didactic and laboratory instruction in subsection (f) but paragraph (i) refers “laboratory, pre-clinical and clinical” instruction

The existing and proposed language does not appear to require clinical instruction or examination. The existing 16 CCR 1070.5 does not replicate proposed subsection (f), and it does only require that courses provide didactic and laboratory instruction and examination. The existing section spells out requirements for optional extramural (clinical) instruction. It is optional because the current requirements for examination do not require extramural evaluation. The existing language merely provides guidance for courses that choose to offer extramural training.

The proposed language does not mention extramural instruction or facilities. It is possible “Clinical instruction” was added by mistake, since it is not otherwise addressed. The same construction of a subsection header reading “Laboratory, Simulated-Clinical and Clinical Instruction:” appears in other parts of the document so this could be unintentional reproduction of that language.

The draft section appears incomplete because it does not fully lay out the requirements for lab or clinical instruction, and the subsections which do reference laboratory and clinical instruction are not specific to this section or laboratory oratory and clinical instruction. The existing 1070.5 language has limited rules for the laboratory component of instruction other than requiring 2 hours of it (a requirement that is missing from the proposed language).

Staff recommends adding the language from existing 1070.5(h) in to replace the proposed 1070.5(i), and that the requirement for two hours of laboratory instruction be added back to proposed subsection 1070.5(f) course duration. This will maintain the existing regulatory structure, without requiring a more substantial re-writing of the proposed language. In the alternative subsection (i) could be removed entirely as it currently duplicates other language found in the section.

11. 1070.9(d)(2) was restructured to allow students who are taking courses as part of a dental assisting program to enroll in classes which they have not completed the prerequisite instruction if the course plans to provide that instruction concurrently. This exception to the prerequisites should have extended to IC and BLS certification required by this section. Therefore staff recommends changing this section from

(2) When instruction is incorporated in a registered dental assisting program, students shall have completed, enrolled in, or have a program program-approved plan to be enrolled in, instruction in, basic chairside skills, anatomy, tooth morphology, infection

control and basic life support, as defined herein, prior to the start of instruction in radiation safety.

12. 1070.9(l) states that, “Extramural dental facilities may be utilized by a course for the purposes of radiographic clinical experiences, but may not be used for final clinical competency.”

Stakeholders have pointed out that this prohibition is inconsistent with the coronal polish and pit and fissure course requirements. Furthermore, clinical competency must be evaluated by faculty, and it should not matter where this is done. Therefore staff recommends removing this burden on courses.

In addition 1070.9(l) states that, “Didactic and laboratory instruction shall be provided only by course faculty or instructional staff prior to clinical performances and shall not be provided in an extramural dental facility.” Staff recommends that the prohibition against providing didactic instruction in an extramural dental facility be removed so that the section reads: “Didactic and laboratory instruction shall be provided only by course faculty or instructional staff prior to clinical performances.
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Instruction must be given by course faculty and therefore it should not make a difference where the instruction is provided. If students require instruction in an extramural facility, faculty should be able to provide that instruction on the spot.

13. Staff have received extensive feedback regarding the new requirement that patients of students complete a health history and consent acknowledging that a student is performing procedures on the students and requiring that the health history and consents be transferred back to the course or program (1070(k)(5) and 1070.9(d)(2)). Commenters have argued that these requirements are unnecessarily burdensome, and that transferring records to the courses or programs could violate patient recordkeeping laws.

Staff agree that directing clinical facilities to violate recordkeeping laws is problematic and recommend that the second sentence in subsection (5) be changed from “Such documentation shall be maintained by the clinical facility and copies of the consent acknowledging the procedure is being performed by a student of the course or program shall be transferred to the educational program upon completion of the student’s clinical instruction to be maintained in the student’s records”, to “Such documentation shall be maintained by the clinical facility.”

Staff recommend not removing the requirement to receive written consent and acknowledgment from patients before allowing students to perform clinical duties. This is basic informed consent, and it is an issue of liability and ethics. Receiving consent will protect schools, doctors and students from liability and lawsuits by patients. Informed consent is also basic medical ethics and is found in Section 1 of the American Dental Association Principles of Ethics and Code of Professional Conduct. This does not need to be derailing to operations of dental clinics though. Dental facilities already ask all new patients to provide health histories and sign forms consenting to treatment. To comply with this subsection, facilities will merely have to add language to their consent forms informing patients that students work in the facility and may perform procedures on patients under proper supervision.

14. At 1070(d)(1)(B); 1070(d)(2)(C); and 1070(d)(3)(C) there is a requirement that faculty “demonstrate expertise” in subjects they are teaching. However no criteria for demonstrating expertise are provided This was modified from “possessing experience”. Staff recommends reverting to “possessing experience” or make a change tracking the CODA language.

CODA 3-5 requires that “[d]ental assisting faculty must have background in and current knowledge of dental assisting, the specific subjects they are teaching and educational theory and methodology consistent with teaching assignment, e.g., curriculum development, educational psychology, test construction, measurement and evaluation.” Therefore staff recommend changing, “shall be able to demonstrate expertise in each subject area for which they are teaching”, to “have a background in and current knowledge of the subjects they are teaching and the educational theory and methodology consistent with their teaching assignment.”

15. The requirements for program and course facilities have been updated to require either lecture classrooms or equipment for broadcasting lectures online. Stakeholders have pointed out the terms “broadcasting” and “online” are unnecessarily prescriptive.

Staff recommends terminology that is less technology specific and more directed at the desired outcome of providing students the ability to receive instruction in a different place and or time than the instructor. Therefore staff recommends that these various sections be updated to read: “lecture classrooms or the capability to facilitate distance learning modalities.”

16. The proposed language related to courses reference the requirement that a “single standard of care” is maintained by courses. The term “single standard of care” is not defined. Furthermore the sections which reference this language are detailed requirements for how courses should operate and the standards they must maintain. Because this term does not have a definition and does not clarify any other requirement staff recommends removing this term and the language around it. However if the Board/Council decides to keep the term, staff requests that the Board/Council provide staff with a definition or guidance in defining the term.

17. The proposed language references “patient selection criteria” without providing criteria or further guidance. It appears that patient selection is a reference to determining when a particular treatment is appropriate and when it is not for a particular patient. However this is adequately covered by “indications and contraindications”. Staff recommend removing references to patient selection criteria.

Action Requested:
Consider and possibly approve the proposed regulatory language relative to the dental assisting comprehensive rulemaking, and direct staff to take all steps necessary to initiate the formal rulemaking process, including noticing the proposed language for 45-day public comment, setting the proposed language for a public hearing, and delegating authority to the Executive Officer to make any technical or non-substantive changes to the rulemaking package. If after the close of the 45-day public comment period and public regulatory hearing, no adverse comments are received, delegate authority to the Executive Officer to make any technical or non-substantive changes to the proposed

regulations before completing the rulemaking process and adopt the proposed amendments to the California Code of Regulations, Title 16, Division 10, Chapter 3 as noticed in the proposed text.