

Ohio State Dental Board

Board Meeting

December 5, 2012

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Ohio State Dental Board

Board Meeting

December 5, 2012

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 December 5, 2012, beginning at 1:00 p.m. Board members present were:

Lawrence Kaye, D.D.S., President
Douglas W. Wallace, D.D.S., Vice President
Mary Ellen Wynn, D.D.S., the Board Secretary
Marybeth Shaffer, D.D.S., Vice Secretary
Jacinto W. Beard, D.D.S.
Constance F. Clark, R.D.H.
Ashok Das, D.D.S.
W. Chris Hanners, D.D.S.
Clifford Jones, R.D.H.
James Lawrence
William G. Leffler, D.D.S.
Gregory A. McDonald, D.D.S.
Linda R. Staley, R.D.H.

The following guests were also in attendance: Katherine Bockbrader, Esq. of the Ohio Attorney General's Office; Keith Kerns, Esq. and Henry Fields, D.D.S. of the Ohio Dental Association (ODA); Mark S. Wenzel, D.D.S. of the ODA Dentists Concerned for Dentists; Michele Carr, R.D.H., M.A. of the Ohio State University College of Dentistry, Division of Dental Hygiene; David D. Goldberg, D.O. and Mark Lutz, M.A., L.C.D.C. II of the Ohio Physicians Health Program (OPHP); Quentin Holmes, Enforcement Supervisor, Mike Flugge and Gail Noble, Dental Board Enforcement Officers, Jayne Smith, Licensing Coordinator and Malynda Franks of the Ohio State Dental Board; and other guests.

Call to Order

Dr. Kaye extended greetings to everyone and noting that there was a quorum present called the meeting to order at approximately 1:17 p.m.

Introduction of Board Members

Dr. Kaye introduced himself as the Board President, a periodontist from Akron. He took a moment to introduce the rest of the Board members; Dr. Douglas Wallace, the Board Vice President, an oral and maxillofacial surgeon from Fairfield, Dr. Mary Ellen Wynn, the Board Secretary, a general dentist from Cincinnati, Dr. Marybeth Shaffer, the Board's Vice Secretary, a general dentist from Leetonia, Dr. Jacinto Beard, a general dentist from Gahanna, Dr. Ashok Das, a general dentists from Mason, Dr. Chris Hanners, a general dentist from Chillicothe, Dr. William Leffler, a general dentist from Akron, Dr. Gregory A. McDonald, a general dentist from Springfield, Ms. Constance Clark, a dental hygienist from Dublin, Mr. Clifford Jones, a dental hygienist from Cincinnati, Ms. Linda Staley, a dental hygienist from Lima, and Mr. James Lawrence, the Board's public member from Akron.

Review of Minutes

Motion by Dr. Leffler, second by Dr. Wynn, to approve the November 7, 2012 minutes as presented.

Motion carried unanimously.

Enforcement Report

Personal Appearance(s)

David J. Kozar, D.D.S.

Ms. Noble informed the Board members that Dr. David Kozar is appearing before the Board for his second appearance after completing inpatient treatment at Glenbeigh. She stated that subsequent to his last appearance with the Board, Dr. Kozar entered into and completed Glenbeigh's Intensive Outpatient Program on October 25, 2012 and is now in Glenbeigh's Aftercare program. Ms. Noble informed the members that Dr. Kozar has been in compliance with his Consent Agreement since the last meeting and that all urine screenings have been negative.

Upon questioning by the Board, Dr. Kozar stated that he has been doing well and that he keeps thinking that today is better than yesterday. He informed the members that he feels he is getting better and that he continues to attend his meetings. Dr. Kozar commented that he feels that things are progressing well with his physician in that mentally he is doing better than he has been in the past four (4) months.

Dr. Kozar informed the Board that he has accepted who he is in that there is nothing he can do to change his disease, that he has given up on trying to solve the problem by himself, and that he has surrendered, stopped fighting and now allowing others to help him fight this problem. Dr. Kozar stated that he does morning meditations, attends aftercare and caduceus meetings four (4) out of seven (7) days per week, and attends three (3) Alcoholics Anonymous (AA) meetings per week. He commented that these things are the center of his life.

When asked about his practice, Dr. Kozar informed the Board that he goes into his office to process paperwork only and that he follows the advice given by fellow AA members and complying with the terms of his Consent Agreement with the Board.

When asked how he felt about returning to practice, Dr. Kozar said that he feels he should continue as he has during the past four (4) months regarding attendance to meetings. However, he stated that he felt he needs to have interaction with patients and practicing twenty (20) hours per week would be a blessing. He commented that performing dentistry was not a stressor for him.

Board members inquired as to what he would do differently this time in regards to stressors and the problems that led to his relapse. Dr. Kozar informed the members that there were no specific triggers in his life that led to his relapse. He stated that he did not need to drink to get numb as his life was not necessarily bad or good. He commented that he had been so far along in the disease that anytime was good to take a drink until he got to a point where he just could not stop. Dr. Kozar recognizes now that he cannot control this disease and that he cannot drink alcohol again or else the same thing will happen.

Executive Session

Motion by Dr. Beard, second by Mr. Lawrence, to move the Board into executive session pursuant to Ohio Revised Code Section 121.22(G)(3) to confer with counsel on matters that are the subject of pending or imminent court action, pursuant to Ohio Revised Code Section 121.22 (G)(1) to consider the matter of David J. Kozar, D.D.S.

Roll call vote. Motion carried unanimously.

Dr. Kaye requested Mr. Holmes, Ms. Bockbrader and Mr. Wenzel to attend the Executive Session.

Open Session

The Board resumed open session at 1:48 p.m.

Decision In The Matter Of David J. Kozar, D.D.S.

Motion by Mr. Lawrence, second by Dr. Leffler, that the license of David J. Kozar, D.D.S. be reinstated up to eight (8) hours per week with no more than four (4) hours in any given day and pursuant to the terms of his consent agreement with the Board.

Motion carried unanimously.

Dr. Kaye indicated that the Board would like to invite Dr. Kozar to appear before them at their meeting in February 2013 in order to see how he is progressing, as they have a great deal of concern for Dr. Kozar's recovery.

Report and Recommendation in the Matter of Mark T. Shue, D.D.S.

Dr. Kaye turned the meeting over to Dr. Shaffer to conduct the Report and Recommendation. Dr. Shaffer then announced that the board would now consider the Attorney Hearing Examiner's Report

and Recommendation in the matter of Mark T. Shue, D.D.S. that was filed by Attorney Hearing Examiner, Lawrence D. Pratt, Esq., on October 18, 2012.

Dr. Shaffer then proceeded by asking whether each member of the board had read the Report and Recommendation in the matter of Mark T. Shue, D.D.S.?

- Roll call:
- Dr. Beard - Yes
 - Ms. Clark - Yes
 - Dr. Das - Yes
 - Dr. Hanners - Yes
 - Mr. Jones - Yes
 - Dr. Kaye - Yes
 - Mr. Lawrence - Absent
 - Dr. Leffler - Yes
 - Dr. McDonald - Yes
 - Dr. Shaffer - Yes
 - Ms. Staley - Yes
 - Dr. Wallace - Yes
 - Dr. Wynn - Yes

Dr. Shaffer then asked whether each member of the board had the record, including the transcript available to refer to when necessary when reviewing this matter?

- Roll call:
- Dr. Beard - Yes
 - Ms. Clark - Yes
 - Dr. Das - Yes
 - Dr. Hanners - Yes
 - Mr. Jones - Yes
 - Dr. Kaye - Yes
 - Mr. Lawrence - Absent
 - Dr. Leffler - Yes
 - Dr. McDonald - Yes
 - Dr. Shaffer - Yes
 - Ms. Staley - Yes
 - Dr. Wallace - Yes
 - Dr. Wynn - Yes

Dr. Shaffer proceeded by asking if each board member read any Objections to the Report and Recommendations filed in this case?

- Roll call:
- Dr. Beard - Yes
 - Ms. Clark - Yes
 - Dr. Das - Yes
 - Dr. Hanners - Yes
 - Mr. Jones - Yes
 - Dr. Kaye - Yes
 - Mr. Lawrence - Absent
 - Dr. Leffler - Yes

Dr. McDonald - Yes
Dr. Shaffer - Yes
Ms. Staley - Yes
Dr. Wallace - Yes
Dr. Wynn - Yes

Dr. Shaffer asked if either Dr. Shue and/or his attorney were present. Dr. Recker indicated that he was representing Dr. Shue in this matter and that both he and his client, Dr. Shue, were in attendance. Dr. Shaffer then stated that the Board's minutes would serve as the official record of the proceedings. She stated that Dr. Shue and his attorney, Dr. Recker, have requested the opportunity to address the Board and therefore, the Assistant Attorney General, Katherine Bockbrader, Esq., in this matter will be given the opportunity to respond. Dr. Shaffer informed Drs. Shue and Recker to limit their comments to the Attorney Hearing Examiner's Findings of Fact, Conclusions, and Proposed Order in this matter. She advised them that the Board will only consider the evidence presented in during the Administrative Hearing in this matter. Therefore, she stated that there would be no questions from the Board members.

Frank R. Recker, D.D.S., Esq.

Dr. Recker began by introducing himself and his client, Dr. Mark Shue. He then introduced the rest of his group: Mr. Terry Thomas, the attorney for the complainant in this matter; Sandy Recker, Dr. Reckers' Legal Assistant; and Todd Newkirk, Esq., Dr. Reckers' associate. Dr. Recker then queried as to why the Board would invest two (2) years in a matter which he, Dr. Recker, felt should have been considered for the Board's Quality Intervention Program (QUIP).

Dr. Recker informed the members that Dr. Shue had no choice in this matter in that, due to the economy, Dr. Shue had been forced to close his practice in late 2009/early 2010. He stated that Dr. Shue is currently employed by a large group practice and that any formal disciplinary action that is reported to the National Practitioners Databank by the Board would result in the ruining of Dr. Shue's reputation and subsequently he would be terminated by his employer. Dr. Recker informed the Board that he had approached the Board's legal representation repeatedly prior to the Hearing, requesting that Dr. Shue be required to enter into QUIP, take remediation/continuing education, anything that would preclude the Board from ultimately taking formal, reportable disciplinary action.

Continuing on, Dr. Recker directed the Board's attention to Terry Thomas, Esq., the attorney for the patient in this matter. He stated that Dr. Shue has made restitution satisfactory to the patient and that Mr. Thomas was in attendance to answer any questions that the Board members should have in that regard. Dr. Recker informed the members that to this point in time, no adverse reporting has been made to the National Practitioner's Databank regarding this matter. He stated that the Board's decision in this matter was the only remaining "hurdle" and as such, he was asking the Board to dismiss the charges. Dr. Recker stated that his client would be willing to sign any kind of a waiver, complete continuing education, or enter into the Board's Quality Intervention Program (QUIP). Dr. Recker said that he was respectfully requesting that the Board members consider

dismissing the case in order to avoid any formal disciplinary action so that Dr. Shue could retain his livelihood.

Concluding, Dr. Recker stated that this case has cost both parties a lot of money and that is unfortunate. However, he offered that members could ask the patients' attorney if the original complainant in this matter is satisfied with the ultimate outcome or ask questions of Dr. Shue.

Dr. Kaye informed Dr. Recker that the Board would not be posing any questions in this matter.

Katherine Bockbrader, Esq., Assistant Attorney General

Ms. Bockbrader stated that in this case, the Hearing Examiner reviewed a very large amount of evidence, a lot of testimony and properly found that Dr. Shue violated the minimum standard of care by using an open palate in conjunction with a Locator attachment system. She stated that the implants were placed in a poor location and did not provide adequate retention to go with the support. Ms. Bockbrader stated that while it was true that the patient preferred to have an open palate, he had never demanded it. Furthermore and most importantly, she stated that the standard of care requires dentists to exercise their own professional judgment. She stated that sometimes you have to tell the patient "No" when you know that a specific treatment is not going to work for them.

Continuing on, Ms. Bockbrader stated that Dr. Shue's own expert, Dr. Rugh, testified that had the patient asked him for an open palate with Locator System attachments, he would have tried to persuade the patient to change his mind by explaining the problems with it. However, she informed the Board that Dr. Rue stated that if the patient would not agree to a proposed treatment plan, he would have dismissed the patient. She stated that Dr. Shue could have done that in this case. She stated that the patient testified that he would not have insisted on having an open palate and would have gone with the closed palate if Dr. Shue had told him it was not as good and that there was not a support for these implants. Ms. Bockbrader stated that what is important in this case is not the number of experts but the quality of the testimony. She informed the members that the Hearing Examiner found the testimony of the Board's experts to be more credible in that it was supported by the evidence, physics, and logic, whereas the Respondent's experts, while sometimes providing helpful testimony, often seemed to base their opinions on emotions and a desire to protect Dr. Shue. Ms. Bockbrader stated that the members should apply their own expertise to determine whether it was in the standard of care to provide the treatment that Dr. Shue had may be problematic in a patient, knowing that problems wouldn't occur in a patient that had Combination Syndrome. She directed the members to review the analysis beginning at page 83 of the Report and Recommendation, she indicated that the Hearing Examiner found that Dr. Shue knew that normally you should only use an open palate with the bar system, not with the locator system. She stated that Dr. Shue acknowledged during the testimony that you should cover the palate with the Locator system and that he knew the lack of stability and retention would be significant. Continuing, Ms. Bockbrader stated that Dr. Shue knew that there would not be the normal suction of a normal denture and that this would place a great burden on the implants. She stated that Dr. Shue testified that the patient had parafunctional habits and therefore, knew that would also have compromised

retention. Ms. Bockbrader informed the members that Dr. Shue knew the physiology of his patient, that his patient had significant Combination syndrome, and that he had a large, strong jaw that would place a lot of stress on the Locator system.

Further, Ms. Bockbrader continued, Dr. Shue admitted that the open palate compromised the result which resulted in tipping and movement of the denture for the patient. She stated that the degree of movement as described by the patient was not normal, nor acceptable, as the denture would flip out, drive up to his nose, and cause him insufferable embarrassment. Ms. Bockbrader stated that Dr. Shue's expert testified that the purpose of the denture is to restore the patient's ability to speak properly, to have a good smile, to have the ability to project one's self to the public with a positive attitude and to be able to eat and chew properly. She stated that this patient experiences none of these benefits, therefore, his denture was not functional and hence fell below the standard of care.

Concluding, Ms. Bockbrader indicated that Dr. Shue has asked you to dismiss this case and she would urge them not to consider that request. She stated that this concerns proper standard of care which was not met in this matter. Ms. Bockbrader reminded the Board members that QUIP is a confidential program and since this hearing is already a matter of public record, it is not appropriate to have Dr. Shue enter into QUIP. She stated that should the members determine that Dr. Shue did violate the standard of care, then they should determine that the Findings of Fact are true. Ms. Bockbrader suggested that if the members felt that Dr. Shue would benefit from remediation education such as he would have received in QUIP then they should stipulate to that as a part of the disciplinary order. Ms. Bockbrader concluded by informing the members that if they chose to modify any part of the hearing examiner's report and recommendation, then they state their rationale.

Quasi-judicial Deliberations in the Matter of Mark T. Shue, D.D.S.

Motion by Mr. Lawrence, second by Ms. Staley, to recess for the purpose conducting quasi-judicial deliberations in the disciplinary matter of Mark T. Shue, D.D.S. pursuant to Ohio Revised Code 119. and will reconvene in open session following deliberations.

Prior to entering into the deliberations, Dr. Shaffer asked Mr. Lawrence if he had read the Report and Recommendation in the matter of Mark T. Shue, D.D.S.?

Mr. Lawrence answered "Yes."

Dr. Shaffer then asked if Mr. Lawrence had the record, including the transcript available to refer to when necessary when reviewing this matter?

Mr. Lawrence answered "Yes."

Dr. Shaffer then asked if Mr. Lawrence had read any Objections to the Report and Recommendations filed in this case?

Mr. Lawrence answered "Yes."

Roll call vote. Motion carried unanimously.

Open Session

The Board resumed open session at 2:38 p.m.

Dr. Shaffer stated:

“Dr. William Leffler, Dr. Mary Ellen Wynn, and I, Dr. Marybeth Shaffer were involved as secretaries in this matter, and did not participate and were not present in quasi-judicial deliberation in this matter.”

Dr. Shaffer then asked if there was a motion concerning the Hearing Examiners’ Report and Recommendation in this matter?

Motion by Dr. Kaye, second by Dr. Beard to table the motion for the time being in order to and wait for a representative from the Attorney General’s Office to come in and answer some technical questions.

Motion carried with Drs. Leffler, Shaffer and Wynn abstaining.

Dr. Kaye explained to the audience that the Board was tabling this matter in order to obtain clarification from another assistant attorney general on a technical matter. He stated that it was inappropriate to request the assistance of the Boards’ Assistant Attorney General, Ms. Bockbrader, as she was privy to all testimony and evidence in this matter. Therefore, He stated that they would be returning to their deliberations once the Board had received assistance from another Assistant Attorney General.

Review of Proposed Voluntary Retirement(s)

The Board reviewed one (1) proposed voluntary retirement. The name of the individual/licensee was not included in the document reviewed by the Board. The name of the individual/licensee has been added to the minutes for public notice purposes.

John D. Beal, D.D.S.

Motion by Dr. McDonald, second by Ms. Staley, to approve the proposed voluntary retirement for John D. Beal, D.D.S., license number 30-011142, case number 12-50-0253.

Motion carried unanimously.

Review of Proposed Consent Agreement(s)

The Board reviewed two (2) 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.

Disciplinary

Melinda D. Berry, Dental Assistant

Motion by Dr. McDonald, second by Mr. Lawrence, to approve the proposed agreement for Melinda D. Berry, dental assistant, registration and certificate numbers; EFDA.01848, 51-010863, and CP.148, case number 12-19-0402.

Motion carried unanimously.

Mario M. Cook, Dental Assistant

Motion by Dr. McDonald, second by Ms. Staley, to approve the proposed agreement for Mario M. Cook, dental assistant, certificate number 51-023978, case number 12-57-0389.

Motion carried unanimously.

Enforcement Update

Deputy Director Quentin Holmes began his report by informing the Board that there are six (6) cases pending hearings, of which all have been assigned. He stated that there are four (4) cases listed that are pending the hearing officer's report and recommendation one of which was up for consideration today. Mr. Holmes indicated that there are currently forty-one (41) licensees under suspension. He informed the Board members that there are seventeen (17) active cases in QUIP. Additionally, Mr. Holmes stated that the Board currently has two hundred and thirty-eight (238) active cases and informed the Board that seven (7) cases have been investigated and reviewed by the Board Secretaries and are recommended to be closed. He informed the members that the Board Enforcement Officers and Investigator Assistant, Barb Palmucci, have performed forty-seven (47) infection control evaluations. Mr. Holmes stated that there are currently one hundred and nineteen (119) licensees on probation. He noted that probation will be completed on December 31, 2012 for forty-nine (49) of those licensees, leaving the Board with seventy (70) licensees on probation beginning in 2013.

Due to the requirement in Chapter 4715.03(D) of the Ohio Revised Code, that "The board shall not dismiss any complaint or terminate any investigation except by a majority vote of its members,..." Mr. Holmes reviewed the cases to be closed with the Board.

The following cases are to be closed:

11-50-0458	Impairment-Warning	12-40-0314	Standard Of Care
12-47-0180	Standard Of Care-Warning	12-25-0311	Standard Of Care
12-25-0268	Standard Of Care-Warning	12-73-0331	Standard Of Care
12-09-0255	Standard Of Care		

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

Roll call: Dr. Beard - No
Ms. Clark - No
Dr. Das - No
Dr. Hanners - No
Mr. Jones - No
Dr. Kaye - No
Mr. Lawrence - No
Dr. Leffler - No
Dr. McDonald - No
Dr. Shaffer - No
MS. Staley - No
Dr. Wallace - No
Dr. Wynn - No

Dr. Kaye then called for a motion to close the cases.

Motion by Ms. Staley, second by Mr. Lawrence, to close the above seven (7) cases.

Roll call vote: Dr. Beard - Yes
Ms. Clark - Yes
Dr. Das - Yes
Dr. Hanners - Yes
Mr. Jones - Yes
Dr. Kaye - Yes
Mr. Lawrence - Yes
Dr. Leffler - Yes
Dr. McDonald - Yes
Dr. Shaffer - Yes
MS. Staley - Yes
Dr. Wallace - Yes
Dr. Wynn - Yes

Motion carried unanimously.

Review of License/Certification/Registration/Permit Application(s)

License/Certification/Registration Report (Approved by the Executive Office)

Jayne Smith, Licensure Coordinator, had prepared a report of the licenses, certificates, and registrations issued since the previous Board meeting.

Dentist(s)

Motion by Dr. Shaffer, second by Mr. Lawrence, to approve the licensure report for the following dental licenses issued by a regional board examination:

Michael D. Couchot

Stephen D. Greiner

Gail L. Henry

Helen S. Nahouraii

Motion carried unanimously.

Dental Hygienist(s)

Motion by Dr. Beard, second by Dr. Wynn, to approve the licensure report for the following dental hygiene licenses issued by a regional board examination:

Jo Ellen Berry

Chassi M. Lecher

Kristin H. Cunningham

Melanie J. Marchbanks

Jasmine Girn

Sandra Sobhy

Ashley N. Hubbard

Motion carried unanimously.

Dental Assistant Radiographer(s)

Motion by Dr. Shaffer, second by Mr. Lawrence, to approve the licensure report for the following dental assistant radiographer certificates issued by: acceptable certification or licensure in another state, certification by the Dental Assisting National Board (DANB) or the Ohio Commission on Dental Assistant Certification (OCDAC), or successful completion of the Board-approved radiography course:

Heather Anderson

Ashley McGaughey

Nathaniel Cole

Amanda Ney

Mario Cook

Alicia Palone

Emily Hallett

Ana Santiago

Kar-Nita Hart

Laura Smith

Debra Kellner

Alexia Sykes

Meagan Larson

Aimee Wright

Susan Lehman

Motion carried unanimously.

Limited Continuing Education

Motion by Dr. Beard, second by Dr. Wynn, to approve the licensure report for the following limited continuing education license:

Justin M. Geller

Motion carried unanimously.

Coronal Polishing

Motion by Dr. Wynn, second by Dr. Beard, to approve the licensure report for the following coronal polishing certificates issued by: certification by the Dental Assisting National Board (DANB) or the Ohio Commission on Dental Assistant Certification (OCDAC) and completion of the requirements necessary to obtain certification:

Cheryl J. Brand	Tiffani L. Longworth
Natalie M. Bruser-Brown	Jamie L. Maxwell
Hope L. Ervin	Jerri L. Muckus
Julie L. Farr	Kayla D. Nolen
Kelly M. Goodin	Maureen A. Ryan
Bridget S. Jacob	Sandra D. Smeltzer
Amber L. Layman	Samantha D. Wilson
Rebecca Jo Locke	

Motion carried unanimously.

Expanded Function Dental Auxilliary

Motion by Ms. Staley, second by Dr. Wynn, to approve the licensure report for the following expanded function dental auxilliary registrations issued by: certification by the Dental Assisting National Board (DANB) or the Ohio Commission on Dental Assistant Certification (OCDAC) and completion of the requirements necessary to obtain registration:

Jessica Baker	Denise M Killin
Sharnise Beery	Amy L Kinnamon
Melanie L Board	Jennifer Koder
Nicole Brennan	Linda M Kott
Tiffany Brown	Jamie L Mckinnon
Natalie Bruser-Brown	Stepheni Monger
Stephanie C Cordonnier	Christy L Ocheltree
Rachel I Dunn	Michelle Pickens
Amy J Fahrer	Tiffany Poole
Dianne Fissel	Brenda Poynter
Patricia A Gandee	Kaitlyn Reilly
Breanna Garman	Jenna Sanders
Karen D Gwiner	Michele M Scott
Kimberly Hake	Emily D Smith
Renee E Harmon	Bhuvana Sundaram
Leslie M Hauenstein	Sarah E Thomas
Farrah B Hill	Nicole Trisler
Robin James	Ech'o E Wilson
Alicia L Jenkins	

Motion carried unanimously.

Oral Health Access Supervision Permit(s)

Motion by Dr. McDonald, second by Dr. Wynn, that the following applicants have met the requirements necessary to obtain permits to practice under the oral health access supervision program:

Dentist(s)

Leland McDonald, D.D.S.

Dental Hygienist(s)

Megan C. Bacome, R.D.H.

Ladeana Pierce, R.D.H.

Motion carried unanimously.

Reinstatement License Application(s) – No Interview

Motion by Dr. McDonald, second by Dr. Wynn, to approve the following reinstatement application for licensure in Ohio:

Dental Hygienist(s)

Sandra A. Minch, R.D.H.

Motion carried unanimously.

Anesthesia Committee Report

Provisional Conscious Sedation Privilege(s)

Dr. Wallace stated that the following individuals have applied for conscious sedation permits. He explained that the Anesthesia Committee has reviewed the applications and the applicants are recommended to receive provisional privileges:

Dr. Andre Paes Batista Da Silva – Cleveland, Ohio

– Intravenous

Dr. Thaddeus R. Carter – Cincinnati, Ohio

– Intravenous

Dr. Ricky L. Chapman – Worthington, Ohio

– Intravenous

Provisional Anesthesia Privilege(s)

Dr. Wallace stated that the following individuals have applied for anesthesia permits. He explained that the Anesthesia Committee has reviewed the applications and the applicants are recommended to receive provisional privileges:

Dr. Steven Specca – Boardman, Ohio

Dr. Wallace made the motion from the Anesthesia Committee to accept the report and approve the above applicants to receive privileges.

Motion carried unanimously.

Education Committee Report

Review of Required Course Application(s)

Dental Hygiene Medical Emergency Recognition

Ms. Staley stated that the following organization has submitted a request for approval of curriculum for the Dental Hygiene Medical Emergency Recognition course and has submitted all the appropriate documentation. She stated that the following course has been reviewed and is recommended for approval by the Education Committee:

Corydon Palmer Dental Society

- "The Prevention, Recognition and Treatment of Medical Emergencies That Commonly Occur in the Dental Office"

Dental Assistant Radiographer Initial Training

Ms. Staley stated that the following organization has submitted a request for approval of curriculum for the Dental Assistant Radiographer Initial Training course and has submitted all the appropriate documentation. She stated that the following course has been reviewed and is recommended for approval by the Education Committee:

Ross Medical Education Center

- "Dental Radiography and Clinical Procedures"

Ms. Staley made the motion from the Education Committee to accept the report and approve the above applications.

Motion carried unanimously.

Law and Rules Review Committee Report

Dr. McDonald informed the members that the Law and Rules Review Committee met earlier that day to continue their rule review. He stated that at this time the Committee would like to make the following recommendation:

Motion by Dr. McDonald, second by Dr. Wallace to initial file Ohio Administrative Code rules 4715-5-05 and 4715-5-07 as amended with the Joint Committee on Agency Rule Review (JCARR) , the Legislative Service Commission (LSC), the Secretary of State (SOS), and with the Ohio Department of Development (DOD) Office of Small Business.

Motion carried unanimously.

Continuing on, Dr. McDonald stated that former Board member and member of the ADEX Examining Committee, Eleanore Awadalla, D.D.S. provided a report on the American Board of Dental Examiners (ADEX) meeting to all the Board members at the end of the Law and Rules Review Committee meeting. He indicated that Dr. Beard had also attended the meeting as the Boards' Representative to ADEX.

Dr. McDonald informed the Board members that due to a scheduling conflict, Dr. Awadalla was unable to attend the Board meeting to present her report. He stated that she would be providing the Board with a copy of the draft minutes from the ADEX meeting (Attachment A).

Anything for the Good of the Board

American Board of Dental Examiners Meeting Report

Dr. Kaye asked if Dr. Beard would like to provide his report on the ADEX meeting to the Board at this time since they were discussing it, rather than at the end of the agenda/meeting. Dr. Beard agreed and then distributed copies of the following documents/reports (Attachment B):

- Report on the ADEX House of Representatives Meeting, November 11, 2012 – Jacinto Beard, D.D.S.
- 2013 Exam Committee Recommendations to the ADEX 2013 House of Representatives
- ADEX Dental Hygiene Committee Report – Nancy St. Pierre, R.D.H., Chairperson
- Statistical Analysis of the 2012 Dental Hygiene Exam – Stephen Klein, Ph.D. and Roger Bolus, Ph.D.
- Technical Analysis of ADEX Results: 2011-2012 - Stephen Klein, Ph.D. and Roger Bolus, Ph.D.
- Elections

Dr. Beard invited the Board members to read the individual reports and stated that most of the information was self-explanatory. He then indicated that there were just a few items he wished to point out, the first being a request from Janet Bolina, D.D.S., of The Ohio State University College of Dentistry, to be recommended as our District Dental Educator Representative to the ADEX Dental Exam Committee. He commented that if it was the consensus of the Board, he would proceed in making that recommendation at the next ADEX meeting.

Continuing, Dr. Beard pointed out that he had included the results of the elections in the documentation for their review. He noted that former President and Board member, Lynda Sabat, R.D.H., had been elected the House District Dental Hygiene Representative and the Ohio Dental Hygiene Examination Committee member for District 5. Additionally, Dr. Beard informed the members that Ms. Sabat had also been appointed to a subcommittee of the Dental Hygiene Examination Committee that will be revising the dental hygiene examination for 2014.

Dr. Beard stated that he felt it was a very good and positive meeting. He stated that David Johnson, Senior Vice President of Assessment Services for the Federation of State Medical Boards, gave an overview of how the FSMB came from three (3) examinations to one (1) medical licensure exam. Dr. Beard stated that Immediate Past President of ADEX, Guy Champaine, D.D.S., gave a presentation on the advantages of the ADEX examination and the benefits of having a single licensure examination that is accepted by all states. He

informed the members that Steven Klein, Ph.D. presented on the dental and dental hygiene examination technical reports, including the statistics on case acceptance, examiner agreement, pass/fail statistics, etc.

Dr. Kaye thanked Dr. Beard for his report and commented that it is very important to the Board, that those persons representing the Board at dental meetings return and provide a full report on the meetings.

A brief discussion followed regarding the licensure examinations and the Board's support of one (1) national dental licensure examination.

Motion by Mr. Lawrence, second by Dr. Hanners, to support the concept of a national dental examination as proposed by ADEX.

Motion carried unanimously.

Supervisory Investigative Panel Report

Dr. Wynn attested that, as Secretary, she had spent in excess of ten (10) hours per week attending to Board business. Dr. Shaffer, as Vice Secretary, attested that she had spent in excess of ten (10) hours per week attending to Board business.

Motion by Dr. Wallace, second by Mr. Lawrence, to approve the Supervisory Investigative Panel report.

Motion carried unanimously.

Office Expense Report

Motion by Dr. Wallace, second by Dr. Hanners, to approve the expense report and approve payment of the November, 2012 Board bills.

Motion carried unanimously.

Anything for the Good of the Board (Continued)

NERB Examination Report

Dr. Kaye informed the Board members that he has been on the North East Regional Board of Dental Examiners, Inc. (NERB) Constitution and Bylaws Committee for several months. He commented that he has had lengthy telephone conference conversations, some of which were three (3) hours in duration and included fifteen to twenty (15-20) people. He stated that it has been interesting and that there were a couple of items that he wished to bring to the Board that the Committee would be discussing at its next meeting in Orlando, Florida.

Dr. Kaye stated that one of the issues that would be voted on was making a change to the constitution concerning the jurisdiction in Washington, D.C. He stated that currently, NERB is listed as a member-governed organization, and as such, the Board cannot represent them at NERB, nor are the Boards represented at ADEX. Dr. Kaye explained that we are NERB members. He indicated that some of us are

active Board members and some of us are past Board members on NERB, however, he stated that we are not representing the Board. Dr. Kaye stated that since the members of NERB were not representing the Board, they were considering an amendment to the constitution that allows for any changes or issues be forwarded to the respective representative Boards at least 60 days in advance of any meeting in order that individual Boards may look at the issues being considered, in order to speak to NERB in support or opposition of the issues. He explained that participating Board members as individuals cannot caucus and even if they chose to do so, they would be outnumbered by the non-members in attendance.

Another amendment to the constitution, Dr. Kaye stated, was to clarify that the dental examination is to be developed by ADEX alone and not by NERB. He stated that the constitution will clearly state that NERB administrates the examination while ADEX develops the examination. He stated some committees, such as the Education Committee, would be dropped as a part of this change to the constitution.

Continuing, Dr. Kaye informed the members that another amendment for consideration regarded the participation of public members. He stated that both the Executive Committee and the Constitution Committee felt it important that any public members that are a part of NERB must know what the licensure process is and what the licensing examination is all about. He stated that it is felt that once the public member is no longer on the Board their input into NERB is very limited and somewhat limited as to what they do functionally at the exam. He stated that going forward, public members will be considered a part of NERB until such time as they are no longer Board members. Dr. Kaye stated that at that time they would no longer be considered a NERB member.

Enforcement Report (Continued)

Report and Recommendation in the Matter of Mark T. Shue, D.D.S.

Dr. Kaye received notice that Assistant Attorney General, Hilary R. Damaser, Esq. was in attendance to assist with the technical questions that the Board members had in regards to the matter of Mark T. Shue, D.D.S.

Ms. Bockbrader interjected that she wanted it noted for the record that during the earlier private session she and Dr. Recker came in and clarified for the Board that she was not taking the position that The Board was not allowed to dismiss the case. She stated that if it was the Boards wishes to do so, they could dismiss the case. She stated that she had been urging them not to dismiss the case. Dr. Recker confirmed that Ms. Bockbrader had made a correct statement.

Quasi-judicial Deliberations in the Matter of Mark T. Shue, D.D.S.

Motion by Mr. Lawrence, second by Dr. Beard, to recess for the purpose conducting quasi-judicial deliberations in the disciplinary matter of Mark T. Shue, D.D.S. pursuant to Ohio Revised Code 119. and will reconvene in open session following deliberations.

Roll call vote. Motion carried unanimously.

Dr. Kaye requested Assistant Attorney General, Hilary R. Damaser, Esq., to attend the deliberations.

Open Session

The Board resumed open session at 3:06 p.m.

Decision In The Matter Of Mark T. Shue, D.D.S.

Dr. Shaffer stated:

"Dr. William Leffler, Dr. Mary Ellen Wynn, and I, Dr. Marybeth Shaffer were involved as secretaries in this matter, and did not participate and were not present in either of the quasi-judicial deliberations in this matter."

Dr. Shaffer then asked if there was a motion concerning the Hearing Examiners' Report and Recommendation in this matter?

Motion by Mr. Lawrence, second by Dr. McDonald, to table the discussions and any motion regarding the matter of Mark T. Shue, D.D.S. until the February Board meeting.

Motion carried with Drs. Leffler, Shaffer and Wynn abstaining.

Anything for the Good of the Board (Continued)**Election of Officers**

Dr. Kaye received nominations for Board officers for 2013.

Motion by Dr. Hanners, second by Ms. Staley, to appoint the following persons as Board officers for 2013:

President – Dr. Lawrence Kaye
Vice President – Dr. Gregory McDonald
Secretary – Dr. Mary Ellen Wynn
Vice Secretary – Dr. Marybeth Shaffer
Alternate Secretary – Dr. Ashok Das
QUIP Coordinator – Dr. Jacinto Beard

Motion carried unanimously.

Board members offered congratulations to the appointees. Dr. Kaye thanked Dr. Wallace for his service as the Vice President for 2012.

Adjourn

Dr. Kaye adjourned the meeting at 3:48 p.m. He wished everyone healthy, happy holidays and then reminded the Board members that their next meeting would not be until February 6, 2013.



Lawrence Kaye, D.D.S.
President



Mary Ellen Wynn, D.D.S.
Secretary

DRAFT

ADEX Examination Committee MINUTES

November 9, 2012

Rosemont, IL

1:30 pm to 5:00 pm

ADEX Exam Committee – 11/9/12 – Scot Houfek, Chair

Call to Order: The meeting was called to order by Dr. Scott Houfek, Chair, ADEX Dental Examination Committee, at 1:35 p.m., November 9, 2012, The Signature Ballroom, Doubletree Hotel, Rosemont, IL.

Those Members present were:

Dr. Scott Houfek, Dental Examination Committee Chair; Dr. Bruce Barrette, WI President of ADEX; Dr. Stan Kanna, HI, Vice-President of ADEX; Dr. William Pappas, NV, Secretary of ADEX; Guy Champagne, MD, Immediate Past President of ADEX; Dr. Peter Carlesimo, CO; Dr. Robert Gheradi, NM; Dr. Jonna Hongo, OR; Dr. Rick Thiriot, NV; Dr. Keith Clemence, WI; Dr. Leo Huck, WI; Dr. Dennis Manning, IL; Dr. Matthew Miller, IN; Dr. Eleanore Adwadalla, OH; Dr. Peter Yaman, MI; Dr. Robert Zena, KY; Dr. David Jones, SC; Dr. John Dixon, WV; Dr. John M. Douglass, Jr, TN; Dr. George Martin, AR; Dr. James Watkins, VA; Dr. Ron Archer, VA; Dr. Susan Calderbank, PA; Dr. Uri Hangorsky, PA; Dr. David Perkins, CT; Dr. John Bailey, DC; Dr. Barbara Rich, NJ; Dr. Arthur McKibbin, Jr, NH; Dr. Henry Levin, RI; Dr. Marc Rosenblum, NJ; Dr. Robert DeFrancisco, MA; Dr. LeeAnn Podruch, VT; Dr. Rockwell Davis, ME; Dr. Stephen DuLong, MA; Dr. A Roddy Scarbrough, MS; Dr. Larry C. Breeding, MS; Dr. William Kochenour, FL; Dr. Boyd Robinson, FL; Mr. Alan Horwitz, Esq., PA; Dr. Stephen Klein, CA; Dr. Ronald Chenette, NERB, MD; Kathleen, White, SRTA, VA; and Mr. Patrick D. Braatz, ADEX Volunteer Administrator.

Guests: Dr. Patricia Parker, OR, Dr. Martha Cutright, VA, Dr. Michelle Bedell, SC, Dr. H. R. Marshall, WV, Dr. Carl Boykin, MS, Dr. James Haddix, FL, Dr. Wade Winker, FL, Dr. Jacinto Beard, OH, Dr. Robert Sherman, HI, Dr. J. Gordon Kinnard, NV, Dr. Richard Dickinson, VT, Dr. Jeffrey Hartsog, E.W. Looney, Brightlink, GA, and Ms. Leah Diane Howell, MS.

Approval of Minutes November 4-5, 2011

Dr. Rick Thiriot moved and seconded by Dr. John Bailey to adopt the minutes of November 4-5, 2011 Dental Examination Committee Meeting minutes as amended. **Approved.**

Approval of Agenda

Dr. Barbara Rich moved and seconded by Dr. Stephen DuLong to adopt the agenda with the Chair's ability to change as he determines. **Approved.**

1-Report form Dr. Klein, Testing Specialist

Dr. Dennis Manning moved to accept the report of the Dental Examination Technical Report, seconded by Dr. Kochenour. **Approved.**

2-Pros Criteria from the group that reviewed this information

Nothing reported

3-Criteria for margin on gold crown appears in different areas of the criteria

Nothing reported.

4-Endo Criteria

Nothing reported

5- Restorative Criteria

Dr. A Roddy Scarbrough moved to recommend to the ADEX Board of Directors to change the proximal in the box to no more than 1mm to the buccal or lingual from contact for all posterior preps and to change the subs from 1 to 2.5 mm and change the def to above 2.5, seconded Dr. Rick Thiriot. **Approved.**

Dr. William Pappas moved that a subcommittee be appointed to review criteria, seconded by Dr. Stanwood Kanna.

6-Calibration Committee Update

Dr. Pappas reported on the current status of the Calibration Committees work and that the new Calibration process should be ready by February of 2013.

7-Perio Committee Update

Dr. Wade Winker made a presentation on a proposed perio exam proposal

Dr, George Martin moved to recommend to the Board of Directors to continue to pursue the seconded by Dr. Rick Thiriot. **Approved.**

Dr. Houfek moved to item 26.

26-Recommendations from the Quality Assurance Committee

Dr. Haering reported on the recommendations from the Quality Assurance Committee Meeting from this morning.

Dr. Shampaine moved to accept the report of the Quality Assurance Committee, seconded by Dr. Rick Thiriot. **Approved.**

8-Proposal to combine the SAT and ACC categories – NERB

As part of the QA Committee Recommendations that the SAT and ACC scoring combine the satisfactory and acceptable scoring criteria into one category.criteri category. **Approved.**

9-Proposal to report scores as 75 or above as passing – NERB

As a part of the QA Committee Recommendation that examination scores of 75 or above reported as a Pass and below is to fail. **Approved.**

10-Proposal to have CFE's do modification requests on the floor up to the point of where there is a question of the request being appropriate. Then send it to express Chair. Only the Captain and designated CFE's would do medication requests – Dr. Guillen.

There was no motion to make a change

11-Proposal that there must be occlusion on the restored material for a posterior restoration – Dr. Gullien

There was no motion to make a change.

12-Proposal to score anterior and posterior restoration conjunctively – SRTA

Dr. Shampaine moved to recommend to the Board of Directors to score and report separately the anterior and posterior restorations and that retakes would only be required for the second restorative procedure if the candidate passed the first restoration and that a three hour time limit on the retake, seconded by Dr. Stanwood Kanna. **Approved.**

Dr. Keith Clemence moved to recommend to the Board of Directors that for the patient based examination that candidates be allowed three hours for each part of the examination within and open format, with a maximum of nine hours, seconded by Dr. Kochenour. **Approved.**

13-Proposal to use the Acidental anterior endo tooth and have pre and post-op radiographs for the endo evaluation of the anterior endo procedure – SRTA

Dr. John Douglass moved to recommend to the Board of Directors to use the Acidental anterior endo tooth and have pre and post-op radiographs for the endo evaluation of the anterior endo procedure and seconded by A. Roddy Scarbough.

Dr. Douglass withdrew his motion, Dr. A. Roddy Scarbough agreed.

Dr. John Dixon moved to recommend to the Board of Directors that a radiographable anterior endo tooth to be utilized and implemented in 2015 pending response by the schools, seconded Dr. A. Roddy Scarborough. **Approved.**

Dr. John Douglass moved to recommend to the Board of Directors that a radiographable posterior endo tooth to be utilized and implemented in 2015 pending response by the schools, seconded by Dr. Rick Thiriot. **Defeated.**

14-Review the radiograph requirements for restorative procedures. Currently if there are 2 lesions on a tooth and one has been restored previously, a new radiograph is required. Proposal to change this to “new radiographs are not required unless there is a clinical justification.”

Dr. John Douglass moved to recommend to the Board of Directors that new radiographs are not required unless there is a clinical justification, seconded by Dr. Shampaine. **Approved.**

Dr. Houfek Adjourned the meeting at 5:00 p.m. until Saturday, November 10, 2012 at 8:30 a.m.

The Meeting resumed Saturday, November 10, 2012 with Dr. Scot Houfek calling the meeting to order at 8:30 am In Signature 3.

Those Members present were:

Dr. Scott Houfek, Dental Examination Committee Chair; Dr. Bruce Barrette, WI President of ADEX; Dr. Stan Kanna, HI, Vice-President of ADEX; Dr. William Pappas, NV, Secretary of ADEX; Guy Shampaine, MD, Immediate Past President of ADEX; Dr. Peter Carlesimo, CO; Dr. Robert Gheradi, NM; Dr. Jonna Hongo, OR; Dr. Rick Thiriot, NV; Dr. Keith Clemence, WI; Dr. Leo Huck, WI; Dr. Dennis Manning, IL; Dr. Matthew Miller, IN; Dr. Eleanore Adwadalla, OH; Dr. Peter Yaman, MI; Dr. Robert Zena, KY; Dr. David Jones, SC; Dr. John Dixon, WV; Dr. John M. Douglas, Jr, TN; Dr. George Martin, AR; Dr. James Watkins, VA; Dr. Ron Archer, VA; Dr. Susan Calderbank, PA; Dr. Uri Hangorsky, PA; Dr. David Perkins, CT; Dr. John Bailey, DC; Dr. Barbara Rich, NJ; Dr. Arthur McKibbin, Jr, NH; Dr. Henry Levin, RI; Dr. Marc Rosenblum, NJ; Dr. Robert DeFrancisco, MA; Dr. LeeAnn Podruch, VT; Dr. Rockwell Davis, ME; Dr. Stephen DuLong, MA; Dr. A Roddy Scarbough, MS; Dr. Larry C. Breeding, MS; Dr. William Kochenour, FL; Dr. Boyd Robinson, FL; Mr. Alan Horwitz, Esq., PA; Dr.

Stephen Klein, CA; Dr. Ronald Chenette, NERB, MD; Kathleen, White, SRTA, VA; and Mr. Patrick D. Braatz, ADEX Volunteer Administrator.

Guests: Dr. Patricia Parker, OR, Dr. Martha Cutright, VA, Dr. Michelle Bedell, SC, Dr. H. R. Marshall, WV, Dr. Carl Boykin, MS, Dr. James Haddix, FL, Dr. Wade Winker, FL, Dr. Jacinto Beard, OH, Dr. Robert Sherman, HI, Dr. J. Gordon Kinnard, NV, Dr. Richard Dickinson, VT, Dr. Jeffrey Hartsog, E.W. Looney, Brightlink, GA, Dr. Robert Jolly, AR, , Dr. Carl Boykin, MS, Dr. Jacinto Bear, OH, Dr. Warren Whitis, AR, Dr. Ngoc Chu, MD, Mr. Michael Curtis, FL and Ms. Leah Diane Howell, MS.

15-Update on typodonts

Dr. Scott Houfek announced that by 2015 only the Acidental typodonts will be used.

16-Update on Computerized Examinations

Dr. Guy Champagne and Dr. Ronald Chenette reported that DSCE has been shortened from 280 to 150 questions with 15 pilot questions. 30 items for patient evaluation, 60 items for treatment planning and 60 items for perio, pros and medical conditions relating to the dental examination. It will now be a scaled score vs. raw score. The CSCE (Hygiene) revision is not yet complete but is expect to be ready for implementation by the end of March.

30 items on patient evaluation, 60 items on comprehensive treatment planning, 60 items on periodontics, prosthodontics and medical considerations.

17-Review unable to floss criteria

Dr. Guy Champagne moved to recommend to the Board of Directors that on the unable to floss criteria that if two examiners on an interproximal contact cannot pass floss it is a sub and if three examiners cannot pass floss it is a critical deficiency, seconded by Dr. Barbara Rich. **Approved.**

Dr. Keith Clemence moved to revise his previous motion and recommend to the Board of Directors that for the patient based examination that candidates be allowed four hours for one procedure, seven hours for two procedures and nine hours for three procedures for the examination within an open format, with a maximum of nine hours, seconded by Dr. Rockwell Davis **Approved.**

18-Review the flash criterion composite restoration

No Change

19-Review the slot prep and existing sealant criteria

Approved last year

20-Proposal to have CFE's review restorative medical histories

Dr. Guy Champagne moved , to have all CFE's check medical histories on the floor, seconded by Dr. Rick Thiriot. **Approved.**

21-Review protocol when captains change to an examiner. Should they disqualify themselves if they did a modification request for the patient?

No Change

22-Review penalties for modification request denial when prep is not prepared to a Sat or Acc

Dr. Guy Champagne moved that we have a Captain's Calibration tool be developed, seconded by Dr. Stanwood Kanna, **Approved.**

23-Proposal to grad without rubber dam

No Change

24-Review criteria on endo under fill

Dr. Scott Houfek announced that he would appoint a subcommittee to look at this and bring back next year.

25-Proposal for treating occlusal decay when preparation is a slot preparation

Dr. William Pappas moved to recommend to the Board of Directors that if occlusal caries exist on a Class II proximal box a separate restoration is allowed if 1mm or more tooth structure exists if less that 1 mm exists then a conventional Class II composite must be done. seconded by Dr. Rockwell Davis. **Approved.**

27-PA or NP for medical hx clearance

No change

28-Sterilization of instruments for examiners – sterile packet to be opened by 1st examiner

Dr. Scott Houfek determined this was an administrative issue.

29-Lingual margin width criteria on PFM

Dr. Scott Houfek will appoint a subcommittee and have it come back next year.

30-Failure to break contact on posterior composite slot prep – No penalty.
There is a penalty on traditional posterior composite

Dr. Guy Champagne, moved to recommend to the Board of Directors that a penalty be included for failure to break contact on posterior composite slot prep, seconded by Dr. Rick Thiriot. **Approved.**

Dr. William Pappas that this be a 2013 Examination Change, seconded by Dr. Stanwood Kanna. **Approved.**

31-Confirmed DEF on Perio in hard or soft tissue management 100 points is appropriate.

No Change

32-Eliminate line/base placement from exam

No Change

33-Madate a rubber dam for restoring a posterior composite

Already done

34-Clean typodonts before turning them in. Penalty?

Dr. Scott Houfek determined this should be a Calibration issue.

35-CFE signing off on anesthesia record before tx approved

No Change

36-Recontouring of adjacent teeth

No Change

37-Finish time of first restoration

Dr. Susan Calderbank, moved to recommend to the Board of Directors that if a candidate is doing two restorations, the first restoration has to be done and graded by 3:00 pm in order for the candidate to start that the second restoration, seconded Dr. John Dixon. **Defeated.**

38-Radiology

Dr. Scott Houfek will appoint a committee to review all radiology protocols

39-Evaualte how many Subs to fail and Examination

Dr. Scott Houfek will appoint a subcommittee to review and report back next year.

40-Review critical deficiencies to see what criteria's are not being utilized.

Dr. Scott Houfek will appoint a subcommittee to review and report back next year.

41-CIF Issues

A discussion was held and questions answered regarding the CIF Examination.

42-CFE monitoring of Blood Pressure issue

Dr. Guy Champaine moved to recommend to the Board of Directors to go back to not having the CFE have to monitor the taking of blood pressure and go back to asking the patient if their blood pressure was taken, seconded Dr. Leo Huck. **Approved.**

43-CFE check #9 for endo access

Dr. William Pappas, to recommend to the Board of Directors that the CFE needs to check #9 for endo access prior to the start of the ceramic crown preparation, seconded Dr. Guy Champaine. **Approved.**

There being no further business of the ADEX Dental Examination Committee meeting the Meeting was adjourned at 11:30 am.

Dental Exam Committee Meeting 11.09-10.12 ADEX MTG. (1)

The ADEX House of Representatives met in Chicago on Sun. Nov.11, 2012.

The program speaker was David Johnson, Vice President of assessment services, Federation of State Medical Boards. He gave an overview of the time line on how physicians navigated licensure in various states and 3 different testing agencies, to a single testing agency and a united licensure process among all the states for MD's, DO's and International MD's. Through cooperation from a few influential persons in each of the 3 testing agencies they were able to establish a national licensing examination accepted by all the states.

Dr. Guy Champaine, immediate past president of ADEX gave a presentation entitled, ADEX structure and Examination- if you could see what we see. Dr. Champaine presented a power point presentation on the advantages of the ADEX exam, the statistical information it provides, and the benefits of having an exam that is accepted by all the states. He intends to take this power point presentation personally to each state board that will hear him.

Dr. Stephen Klein presented the Dental/ Dental Hygiene examination technical report (attached). The report analyzed the examination components, administration, format, case acceptance, examiner agreement, and pass/fail statistics. The use of this type of psychometric testing and analysis to improve the exam is what makes the ADEX exam the premiere exam for dental testing, and is acceptance in 47 states for licensure.

The Dental/Dental hygiene examination committee reports and motions were submitted and passed by the House of Representatives and a copy of the motions that were passed is attached to this report.

Elections were held and the results are attached. Positions elected to or are currently being held by Ohio members:

Dr. Jacinto Beard, ADEX House of Representatives member

Dr. Eleanore Awadalla, Dental Examination Committee member

Ms. Linda Sabat, RDH, House District RDH Representative

Ms. Linda Sabot, RDH, RDH Examination Committee member

(Linda has been appointed to a sub committee to revise the 2014 hygiene manual)

Dr. Janet Bolina expressed a desire to be recommended as District Dental Educator Representative to the ADEX Dental Exam Committee. There were no significant bylaws changes and the meeting was adjourned.

Respectfully submitted,
Jacinto W. Beard

2013 Exam Committee Recommendations

to the

ADEX

2013 House of Representatives

1. Change the SAT & ACC criteria to no more than 1mm for the Buccal and Lingual proximal box clearance. Substandard more than 1mm to 2.5 mm, Crit Def – More than 2.5mm
2. Recommendation – Combine the SAT & ACC categories.
3. Recommends – Report passing scores as 75 or higher.
- 4 Recommends – Score anterior & posterior procedures separately. If candidate passes the first procedure and fails second – retake second and if fails the first has to retake both restorative procedures.
5. Recommend – Utilize a radiopaque radiographable tooth in 2015 for anterior endo procedure pending feedback from the schools on implementation. The root portion on the endo procedure will be graded on the radiographs.
6. 2013 – Recommend if the examiner is unable to floss criteria be changed. If 2 examiners rate crit def cannot pass floss it is scored as a sub, and if all 3 examiners score a crit def it will be a crit def.
7. Recommend – CFE's evaluate all medical histories.
8. Separate restorations be allowed for occlusal decay and a slot prep if 1 mm or more tooth structure exists between the slot prep and the occlusal prep.
9. Recommend – The criteria for the posterior slot prep & the posterior conventional composite for breaking gingival contact be the same. i.e. gig. Contact does not have to broken for SAT.
10. Timelines
 - 4 –Hours – 1 procedure
 - 7 – Hours – 2 procedures
 - 9 – Hours – 3 procedures
11. Recommend – CFE's ask the patient if Blood Pressure was taken – no longer observe procedure.

ADEX DH Committee Report
Nov. 10.2012
Nancy St Pierre RDH Chairperson

Members Include:

Jill Mason RDH/OR	District 2
Nan Kosydar Dreves RDH/WI	District 4
Lynda Sabat RDH/OH	District 5
Dina Vaughan RDH/WV	District 6
Mariellen Brickley-Raab RDH/PA	District 7
Judith Neeley RDH/DC	District 8
Shirley Bierenz RDH/NJ	District 9
Karen Dunn RDH/MA	District 10
Irene Stravros RDH/FL	District 12
Maxine Feinberg DDS	Dentist Member
Donna Homenko RDH,PhD	Educator
Zeno St.Cyril	Consumer Representative
Stephen Klein,PhD	Testing Specialist

Guests:

Bruce Barrette/ ADEX Pres.	EW/Brightlink
Jennifer Lamb RDH/AR	Tuko RDH/NV
Jan Jolly RDH/AR	Cheryl Bruce RDH/MD
Marlene Fulilove RDH/TE	Michael Zeder Director of Technology/NERB
Sherie Barbare RDH/SC	Ellis Hall Director of Examinations/NERB
Mary Ann Birch/KT	Kathleen White/SRTA
Mary Davidson/WREB	Mo/Colorado Exc. Director

Motion: To accept the agenda and change order as needed. passed unanimously.

Motion: To accept minutes of the 2011 ADEX-DH meeting. M. Rickley-Raab, RDH abstained.

Motion passed

The following motions 1-7 are to change the 2013 ADEX-Dental Hygiene examination process, as requested by NERB:

Motion (1): To have CFE select 2 teeth for probing after patient acceptance and before pre-treatment evaluation. Motion passed

Motion (2): To have all six surfaces per tooth graded for the probing exercise. Motion passed

Motion (3): To have the candidate probe the 2 CFE selected teeth before sending patient to the evaluation station for pre-treatment evaluation. Motion passed

Motion (4): To change the time for candidate treatment from two hours to 90 minutes.
Motion passed

Motion (5): For the calculus detection exercise, to have the CFE select the 3 teeth 'outside' of the candidate treatment selection. Motion passed

Motion (6): In the calculus detection exercise, to have the CFE select the 3 teeth and to have the candidate perform the task after patient acceptance and before pre-treatment evaluation.
Motion passed

Motion (7): To change the calculus detection exercise to 3 teeth documenting four surfaces (M,D, L, B) instead of six surfaces (MB, D, DB, ML, L, DL). Motion passed unanimously as amended.

Motion (8): For the calculus detection exercise, the calculus be defined as 'detectable' calculus.
NOTE: Refer to SRTA Manual (page 25) & add to the ADEX 2013 Draft Manual (page 19). For the 2013 examination. Motion passed

Motion: Due to the concern of the ADEX-Dental Hygiene Committee for electronic scoring that the NERB IT representatives to observe a SRTA Dental Hygiene examination. Motion Rescinded

Motion: The ADEX-Dental Hygiene committee continues to encourage the agencies to investigate the resources to move electronic scoring forward. Motion passed

The following motions for the 2014 ADEX DH Examination

Motion: To notify the candidate of the ADEX-Dental Hygiene examination of their success or failure with a score of 75 or higher as passing and a score of less than 75 as a failure with a description that criteria where they were unsuccessful be identified.

Motion passed: 7 Yes; 5 No

11/9/12: Meeting Adjourned 5:20 pm

11/10/12: Meeting Continuation at 8:30 am

Motion: To combine the SAT and ACC grading competency levels, where appropriate.
Motion rescinded by the initiator.

Motion: To maintain the grading competency levels for the 2014 ADEX-Dental Hygiene examination. Motion passed: 3 Yes; 4 No Motion failed

Motion: To accept the 2013 SRTA point rubric for the 2014 ADEX-Dental Hygiene examination. Motion amended to: We accept the jointly decided upon scoring point rubric for the 2014 ADEX-Dental Hygiene examination. Motion passed

Motion: On the scoring rubric, to change the penalty points if examiner verifies 4 (four) or more surfaces of remaining calculus. Motion passed

2014 Manual Revision Committee: Mariellen Brickley-Raab, Lynda Sabat, Irene Starvos, Karen Dunn and Jan Jolly (SRTA Consultant).

Motion: The ADEX-Dental Hygiene examination accepts a qualified local anesthesia practitioner for the 2014 examination. Motion passed

Motion: For the 2014 ADEX-Dental Hygiene examination, Motion to allow the candidate to choose 12 surfaces with qualifying calculus that must be verified by 2 examiners. If any surfaces are disputed, the substitute surfaces are chosen systematically by the examiner within the primary quadrant or additional selection and verified by two examiners. Passed with one abstention

Adjourned 11:45

Respectfully Submitted,
Nancy St Pierre RDH
ADEX DH Committee Chairperson

V. POINTS SYSTEM

Candidates may receive a maximum of 100 points for the clinical examination, as described below.

Criteria	Point System	Points Possible
Initial case presentation	<ul style="list-style-type: none"> At least two molars in the full selection (quadrant plus additional teeth), with at least one of the molars located in the quadrant At least six teeth in the quadrant At least one molar with a proximal contact (may be located in either the quadrant or on additional teeth) Patient free of excessive soft debris 	4
Calculus requirements	<ul style="list-style-type: none"> Calculus requirements met: (12-8-5-3) <ul style="list-style-type: none"> 12 surfaces of qualifying, moderate to heavy calculus (easily felt with explorer) Eight of those 12 on posterior teeth <ul style="list-style-type: none"> Five of those eight on proximal surfaces of posterior teeth Three of those five on proximal surfaces of molars 	5
Radiographs	Radiographs of the selected quadrant and any additional teeth are of diagnostic quality	8
Calculus detection	12 surfaces worth 1.5 points each, evaluated for the presence or absence of any type of calculus	18
Calculus removal	<ul style="list-style-type: none"> 12 surfaces of qualifying calculus worth 4.5 points each If examiners verify five or more surfaces with remaining calculus, an additional 15 points will be deducted. <p>If two examiners are unable to find 12 surfaces of qualifying calculus in the entire selection, points can be earned for removal only on the number of surfaces with qualifying calculus identified by examiners.*</p>	54
Periodontal assessment	Six measurements worth one point each	6
Minor tissue trauma	<ul style="list-style-type: none"> Three points awarded if no minor tissue trauma is present One point deducted for each site of minor tissue trauma, up to three sites The presence of four or more sites qualifies as major tissue trauma and automatic failure. 	3
Final case presentation	Treated selection is presented free of visible plaque, extrinsic stains, prophy paste, and any other visible debris.	2
Total		100
Major tissue trauma or major infection control violation**	100-point deduction = automatic failure	-100

*For example, if, after thorough examination of both the quadrant and any additional teeth selected by the candidate, two examiners independently identify only 10 surfaces with qualifying calculus, the candidate can earn points for removal **only** on those 10 surfaces, for a maximum total of 45 points for removal. If only eight surfaces of qualifying calculus are found, points for removal will be awarded only on those eight surfaces. **Only when 12 surfaces of qualifying calculus are identified by at least two examiners can the maximum of 54 points be earned for calculus removal.**

**Examples of major infection control violations include, but are not limited to, forms, patient bibs, gauze, and/or barriers visibly contaminated with blood; use of non-sterile instruments; uncapped needles; and other violations that put the patient, candidate, examiner, or staff members at risk for injury or exposure.

SRTA assigns points in accordance with the nationwide task analysis conducted every five years. Results from this survey of practicing dental hygienists allows SRTA to determine which clinical skills are performed most frequently and which clinical skills are considered most important to protect the public. Skills that rate highest are weighted more heavily than skills that rate lower.

STATISTICAL ANALYSIS OF THE 2012 DENTAL HYGIENE EXAM

Stephen Klein, Ph.D. and Roger Bolus, Ph.D.
October 24, 2012

This report provides summary results on ADEX's Clinical Hygiene Examination and on its Computer Simulated Clinical Examination (CSCE) for dental hygienists. Results are for the 2,124 candidates who took both tests for the first time between April and August 2012.

A total score of 75 or higher is needed for passing each test. The percent passing the clinical exam, the CSCE, and both tests on the first try were: 93.5, 93.1 and 87.2 percent, respectively.

Clinical Exam Scoring Rules

Table 1 shows the number of points candidates could receive on each part of the clinical exam. A candidate's score on a part is the median of the scores assigned by three independent examiners. The first two scores are for the "Pre-treatment" portion of the exam and the last three are for the "Post-treatment" portion. The total score is the sum of the five part scores minus any penalty points. Appendix A describes the point deductions that could be assigned.

Table 1
Possible Points In Each Section

Section	Number of judgments	Points per judgment	Total Points
Pocket Depth Measurement	12	1.5	18
Calculus Detection	12	3.0	36
Calculus Removal	12	3.0	36
Plaque/Stain Removal	6	1.0	6
Hard/Soft Tissue	2	2.0	4
Total			100

Table 2 shows the mean score and standard deviation on each part. A comparison of these means with the corresponding maximum possible scores indicates that most candidates had perfect or near perfect scores on each part. Nevertheless, the reliability (coefficient alpha) of the total score was 0.80, which is high given that (a) candidates may have had different examiners for the pre- and post-treatment sections and (b) there was a significant restriction in the range of scores assigned.

Table 2
Summary Test Statistics by Performance Test Section

Exam Section	Maximum Score	Mean Score	Standard Deviation	Score Reliability
Pocket Depth Measurement	18	17.54	1.15	.54
Calculus Detection	36	34.77	3.46	.77
Calculus Removal	36	32.94	4.75	.68
Plaque/Stain Removal	6	5.98	0.17	.26
Hard/Soft Tissue	4	3.89	0.31	.01
Total Score	100	93.90	10.50	.80

Penalty points were not included in these calculations. A candidate's final score on an item corresponded to the score that at least two of the three examiners assigned.

Effect of Penalties

Table 3 shows the number and percentage of candidates that lost points for the reasons noted in Appendix A, such as making a pocket depth qualification error. It also shows the number and percent that failed the exam because of these errors; i.e., these candidates would have passed were it not for the penalties they received. The policy of imposing only the largest applicable penalty (rather than the sum of all the separate ones assigned to the candidate) had no effect on the passing rate. No candidate received a deficient (def) score for hard or soft tissue and there were no pocket depth *measurement* penalties. The mean total clinical score before and after penalty points were awarded were 95.1 and 94.0, respectively.

Table 3
Percentage of Candidates Receiving Penalty Points

Received penalty for:	All candidates		Candidates failing because of penalty	
	N	Percent	N	Percent
Case Acceptance	54	2.5	1	0.0
Pocket Depth Qualification	16	0.8	1	0.0
Calculus Detection	59	2.8	8	0.4
Calculus Removal	76	3.6	72	3.4
Any section	205	9.7	82	3.9

Inter-Examiner Agreement

Each candidate's work on the Clinical Examination was evaluated by three independent examiners (i.e., the examiners made their judgments without consultation with each other or knowing the scores assigned by other examiners). Table 4 shows that despite the extreme restriction in range noted in Table 2, there was still an adequate overall correlation between examiners in the scores they assigned.¹

Table 4
Mean Correlation Between Two Examiners on Each Clinical Examination Section and Overall

Exam Section	Correlation
Pocket Depth Measurement	0.415
Calculus Detection	0.391
Calculus Removal	0.311
Plaque/Stain Removal	0.082
Hard/Soft Tissue	0.100
Total	0.330

Another way to look at examiner agreement is to see how often different examiners would make the same pass/fail decision about an applicant. This analysis (which did not consider penalty points) found that 86.3% of the applicants received a passing grade from all three examiners and 0.6% percent received a failing grade from all three. The total perfect agreement rate was therefore 86.9% (see Table 5). However, an 86.9% agreement rate is only 3.3 percentage points higher than the rate that would occur by chance alone.²

¹ Correlation coefficients can range from -1.00 to 1.00. The stronger the relationship between the two variables (such as the scores assigned by examiner #1 and examiner #2), the higher the coefficient (regardless of its algebraic sign). For example, a high positive correlation between two examiners indicates that they generally agreed with each other in how they would rank order the candidates.

² The chance rate is the product of the average of the three examiners' individual passing rates. Specifically, the first, second, and third examiners had passing rates of 93.8%, 94.4%, and 94.6%,

Table 5
Percent Agreement in Overall Pass/Fail Decisions Among
the First, Second, and Third Examiners

3/3 Agree Pass	2/3 Agree Pass	3/3 Agree Fail	2/3 Agree Fail	% All agree	% All Agree by Chance
86.3	10.6	0.6	2.5	86.9	83.6

Comparison of Clinical and CSCE Statistics

Table 6 shows that 87.2% of the candidates passed both tests and 0.6% failed both for an overall agreement rate of 87.8%. However, given the marginal totals, this is very close to the agreement rate that would occur by chance.³

Table 6
Correspondence in the Percentage of Pass/Fail Decisions
Between the Clinical and CSCE Exams

	Fail Clinical	Pass Clinical	Total
Fail CSCE	0.6	6.3	6.9
Pass CSCE	5.9	87.2	93.1
Total	6.5	93.5	100.0

There was a very low correlation between CSCE and Clinical Examination scores ($r = 0.104$). If this correlation is corrected for the less than perfect reliability of the measures, it would still be only 0.133. In short, the degree of agreement in pass/fail decisions and scores between these two tests was not much higher than what would occur by chance alone.

Table 7 shows that the very low correlation between the Clinical and CSCE was **not** the result of their scores being unreliable. They both had adequate reliabilities (coefficient alphas) for making pass/fail decisions, especially given their high passing rates. Taken together, these findings support ADEX's use of a "conjunctive" rule (i.e., a rule that requires candidates to pass both tests in order to pass overall) rather than a "compensatory" rule (that would allow candidates to offset a low score on one test with a high score on the other).

respectively. The product of these three rates was 83.6%. Analyses were not conducted of the degree to which different examiners and Hygiene Coordinators would make the same decisions regarding case acceptance, the assignment of penalty points, or tooth selection for pocket depth measurements.

³ Data on repeaters were not analyzed for this report.

Table 7
Summary Test Statistics for the Clinical and CSCE Exams

Test	Mean	Median	Standard Deviation	Reliability
Clinical	93.9	97.0	10.5	.80
CSCE	85.4	86.0	6.8	.77

Clinical scores are after penalty points were imposed.

Appendix A Clinical Exam Penalty Point And Disqualification Rules

Case Acceptance

There are five case acceptance criteria, the first four of which are initially evaluated by a single examiner and have 2 to 4 scoring levels. The fifth criterion, Pocket Depth Qualification, is evaluated by three examiners. The five criteria are:

- Required Forms (SAT, ACC, SUB, or DEF)
- Blood Pressure (SAT, ACC, or DEF)
- Radiographs (SAT, ACC, SUB, or DEF)
- Teeth Deposit Requirements (SAT or ACC)
- Pocket Depth Qualification

No penalty points are deducted if the first examiner assigns a SAT to all of the first four of these criteria. However, if the examiner assigns a non-SAT score to one or more of them, then a second examiner is called in to evaluate all four criteria. If the two examiners agree on a non-SAT call, then that call stands. The point deductions for a corroborated ACC, SUB, and DEF call are 5, 15, and 30, respectively.

If the two examiners disagree as to the seriousness of a problem, then the penalty for the *least* serious call is used. For instance, if the first and second examiners made calls of DEF and ACC for Blood Pressure, then the 5-point penalty for the ACC call stands.

Pocket Depth Qualification is evaluated by three independent examiners. Candidates select 3 teeth they believe satisfy the requirements. Three examiners independently make their calls as to whether these teeth are satisfactory. There is a 10-point deduction off the candidate's total score if two or three examiners agree that the teeth the candidate nominated do not satisfy the

requirements; and 20 points are deducted if two or three examiners agree that two or three of the nominated teeth do not satisfy the requirements.

Penalty points do not accumulate across the five case acceptance criteria. Only the *largest* deduction for any of the five criteria is applied. For example, there is a total deduction of 20 points even if a candidate would otherwise lose 10 points for Blood Pressure, 5 points for Radiographs, and 20 points for Pocket Depth Qualification.

Other Point Deductions and Disqualifications

Candidates lose 3 points for each corroborated calculation detection or removal error, such as by saying a surface is calculus free when two or three examiners say it is not free of calculus. Candidates fail the exam if they make: (a) 4 or more corroborated calculus detection errors, (b) 4 or more corroborated calculus removal errors, or (c) a corroborated hard or soft tissue critical error. Candidates lose 1.5 points for each corroborated pocket depth measurement error and 1 point for each plaque and stain removal error.

TECHNICAL ANALYSIS OF ADEX RESULTS: 2011-2012

Prepared by Stephen Klein, Ph.D. and Roger Bolus, Ph.D.

I. Examination Structure and Rules

Passing the ADEX test battery in 2012 was accepted by 47 states as evidence that a candidate seeking licensure to practice dentistry had acquired the knowledge, skills, and abilities that are necessary for providing safe and appropriate care. Candidates also must satisfy specific state educational and other requirements to be licensed.

Examination Components, Administration, and Format. The ADEX test battery consists of five separate tests: Diagnostic Skills Examination (DSE), Endodontics, Fixed Prosthodontics, Periodontics, and Restorative.

The DSE is a computer based enhanced multiple choice test. Many of its items require candidates to make judgments about clinical conditions based on radiographs, photographs, laboratory data, and working models that are displayed on the candidate's computer screen. This one-day test is administered at professional test centers across the country.

The other four measures are performance tests that are administered using standardized dental instruments and performed at work stations at accredited dental schools. These work stations correspond to ones typically used in practice. The Endodontics and Fixed Prosthodontics tests involve candidates working on manikins that are specially constructed and standardized for the ADEX. A candidate typically takes one of the four performance tests in the morning and another in the afternoon. The Restorative and Periodontics tests are given on one day and the other two performance tests on another day.

Case Acceptance. The Periodontics and Restorative care tests involve live patients who are recruited by the candidates. On the restorative test, two examiners independently review each patient to determine the patient's suitability for treatment, that is, that the patient has the necessary oral conditions to be treated, the appropriate diagnosis and treatment plan is in place, and the medical history does not contain any counter indications for treatment. If the first two examiners do not agree about the patient's suitability, a third examiner is called to break the tie. The ADEX Technical Manual (which is available on the web) describes each test's operational procedures, specifications, and scoring and decision rules.¹

¹ Case acceptance on the Periodontics exam is discussed later in this report.

Dental Examiners. The quality of a candidate's work on each of the four performance tests is evaluated by three specially trained dentists. They record their judgments on an electronic tablet that is programmed for this purpose. The examiners work independently (e.g., they do not discuss the quality of a candidate's performance with the other examiners or the patient). To preserve anonymity and independence, examiners do not see or interact with the candidates and they do not watch the candidate perform the work.

Pass/Fail Rules. Candidates must pass all five tests to receive ADEX certification and they must repeat all the parts and sections of any test they fail. A high score on one performance test or test section cannot offset a low score or failing status on another test. Candidates are allowed to retake the exams they failed during the August through May testing window, but they cannot carry a passing status on a test across windows. They must pass all five tests within a window to pass overall.

If in the judgment of at least two examiners the candidate made a critical error or deficiency on a live patient, the candidate is excused from continuing the test and receives a failing grade on it. If that happens, the condition of the candidate's patient is temporized and where appropriate, patients are counseled to have any problems with their oral condition addressed by a licensed professional.

Analysis Sample and Testing Window. Except as noted otherwise, results are based on the roughly 1,548 candidates who took all five tests with the Curriculum Integrated Format (CIF) for the first time between August 1, 2011 and May 31, 2012.² Results are based on examinations administered by NERB and the Nevada State Board of Dental Examiners.

II. Pass/Fail Decisions

This report focuses mainly on pass/fail decisions (rather than scores) because (1) all the tests were designed to make that type of decision and (2) candidates had to pass each exam to pass overall.

Table 1-A shows the percentage of candidates passing each test on their first attempt and by their last attempt (i.e., if they failed initially and took the exam again). For example, 96.8% passed the DSE on their first try and 98.8% passed after taking this test at least one more time. Most but not all of those failing an exam elected to repeat it.

² N's vary slightly across analyses as a result of merging of diverse data sets.

Table 1-A
Number of Candidates Taking Each Test and Percent Passing

Test	% Pass on 1st Attempt	% Pass by last Attempt	% Did Not Repeat after Initial Fail
DSE	96.8	98.8	1.0
Endodontics	96.8	99.9	0.1
Fixed Prosthodontics	94.1	99.9	0.0
Periodontics	96.9	99.6	0.2
Restorative Dentistry	86.8	97.7	0.5
Mean	94.3	99.2	0.4

On the Restorative exam, all candidates had to perform an anterior composite restoration and a posterior restoration. However, for the posterior restoration, they could choose to do an amalgam, a box composite, or a conventional restoration. Candidates were classified as having chosen an option if they had a non-zero score or a critical error or deficiency associated with that option. The 27 candidates (1.8% of the total) who did not perform any type of posterior restoration were assumed to have taken and failed the anterior composite and therefore were not allowed to continue (see Table 1-B).

Table 1-B
Number of Candidates Taking and Percent Passing Each Restorative Option

Restorative Test Options	Number of Candidates	% Pass
Anterior Test Only	27	0.0
Anterior w. Amalgam	922	88.1
Anterior w. Box Composite	251	90.8
Anterior w. Conventional Composite	340	88.8

The small differences in passing rates among the three restorative options may stem from inherent differences in the difficulty of these procedures, differences in grading standards among the options, differences in the skills of the applicants who select one option over another, chance, or some combination of these and other factors.

The restorative exam had the most influence on a candidate's overall pass/fail status because for most applicants, it was the most difficult one to pass. This was true regardless of which option they selected. Slightly over 75% of the candidates passed the entire exam (all five tests) on their first attempt and 96% passed after repeating one or more tests. Thus, 4% did not pass despite having the option of retaking the exam.

Table 2 shows the median (50th percentile) score on each test. Medians (rather than means) are reported because the zero's assigned to critical errors and deficiencies skew the score distributions.

Table 2
Median Scores by Exam for First Timers

Test	Median
DSE	86.0
Endodontics	98.0
Fixed Prosthodontics	95.0
Periodontics	100.0
Restorative	96.0

Examiners may classify a portion of a procedure within a section (such as "proper placement of the access opening") as critically deficient (DEF) or they may indicate a critical error for the section as a whole, such as saying the candidate treated the wrong tooth or tooth surface. If two or more examiners agree the candidate made a particular type of critical error or DEF, then such corroboration results in the candidate failing the exam.

Table 3 shows that with the exception of the Periodontics exam, only a very small percentage of first timers failed a test without having a critical deficiency or committing at least one corroborated critical error (i.e., few failed because of a low point total). And, no one with even an uncorroborated DEF or critical error passed the Endodontics or fixed Prosthodontics exam.

Table 3
Role of Critical Errors and Deficiencies in Pass/Fail Decisions

Test	Fail with Critical Error		Fail without Critical Error	
	N	%	N	%
Endodontics	46	3.0	3	0.2
Fixed Prosthodontics	90	5.8	1	0.1
Periodontics	13	0.8	35	2.3
Restorative	179	11.6	19	1.2

Table 4 shows that because of the very high passing rates on all the tests, there was little or no correspondence in their pass/fail decisions other than what would occur by chance. For example, the chance agreement rate was usually less than one percentage point lower than the actual agreement rate.³ This finding supports the policy of requiring that applicants pass all five tests in the ADEX battery in order to pass overall.

Table 4
Actual and Chance Agreement in Pass/Fail Decisions Between Examinations

Test Combination	Actual Agreement Rate	Chance Agreement Rate	Difference in Agreement Rates
DSE & Endodontics	94.0	93.8	0.2
DSE & Prosthodontics	92.1	91.3	0.8
DSE & Periodontics	94.2	93.9	0.3
DSE & Restorative	85.7	84.4	1.3
Endodontics & Prosthodontics	91.9	91.3	0.6
Endodontics & Periodontics	94.1	93.9	0.2
Endodontics & Restorative	85.0	84.4	0.6
Prosthodontics & Periodontics	91.4	91.4	0.0
Prosthodontics & Restorative	82.3	82.5	-0.2
Periodontics & Restorative	85.2	84.5	0.7
Average	89.6	89.1	0.5

Table 5 shows the reliability (coefficient alpha) of the scores on each test. These values indicate that the very low correlations between tests were not due to score reliability problems. In addition, as a result of the combination of very high pass rates and adequate score reliabilities, an applicant's pass/fail status is unlikely to change simply by chance (i.e., as distinct from being better prepared).⁴ This is referred to as "decision consistency" in the psychometric literature. Analyses were based on the candidates who took all four performance tests and the DSE.

³ The chance agreement rate between two tests is the product of their passing rates plus the product of their failure rates. For example, if the passing rates on the Endodontics and Prosthodontics exams were 95.5 and 94.5%; then their chance agreement rate would be $[(.955 \times .945) + (.045 \times .055)] = 90.5\%$.

⁴ Klein, S., Buckendahl, C., Mehrens, W., & Sackett, P. (2009). Evaluating clinical licensing exams for dentists and dental hygienists. American Board of Dental Examiners. Chicago, IL.

Table 5
Number of Items per Test and Internal Consistency Reliability

Test	Number Of Items	Number of Candidates	Reliability
Endodontics	24	1,522	0.505
Periodontics	37	1,536	0.627
Prosthodontics	43	1,527	0.826
Restorative w. amalgam	54	833	0.655
Restorative w. box	54	234	0.653
Restorative w. conventional	56	308	0.690

III. Inter-Examiner Agreement

Endodontic, Prosthodontic, and Restorative exams. As noted in Table 3, failing one of these tests was driven mainly by whether or not the candidate committed a "critical" error or deficiency. Almost no one failed without committing a corroborated critical error or deficiency; and no one passed who did. A candidate also can fail a test by not earning enough points (the so-called "paper grade") but that almost never occurred except on the Periodontics test where it was usually the sole determiner of a candidate's pass/fail status.

The foregoing considerations led us to look at inter-examiner agreement in two ways on the Endodontic, Prosthodontic, and Restorative exams. The first method involved constructing four ratios that focused on the extent to which the examiners agreed the candidate did or did not commit any of the test's possible critical errors or DEFs. For example, there were 21 different types of DEF or critical errors that could be called on the Endodontics test. All four ratios had the same denominator, namely: the number of candidates times the number of possible DEF or critical errors that could be called. The numerator for the first ratio was the total number of patients where all three examiners said there were no DEF or a critical error calls times the number of opportunities for such a call. The numerator for the second ratio was the number of patients where only two of the examiners said there were no DEF or critical error calls times the number of opportunities for making such a call, and so on.

Table 6 shows the examiners achieved consensus 98 to 99 percent of the time. This extremely high rate of decision consistency was due in part to the examiners rarely encountering work that they felt deserved being classified as a critical error or DEF (which is not surprising since almost all the candidates completed dental school). The rates also were inflated due to counting all the DEF and critical error calls that theoretically could be called but were hardly ever made.

Table 6
Percent Agreeing Critical Errors Were or Were Not Present

Test	No Critical Error		With Critical Error	
	% 3/3	% 2/3	% 3/3	% 2/3
Endodontics	99.5	0.4	0.1	0.1
Fixed Prosthodontics	98.6	1.2	0.0	0.2
Restorative w. amalgam	97.8	1.7	0.1	0.3
Restorative w. box	98.7	1.1	0.0	0.2
Restorative w. conventional	97.8	1.9	0.0	0.3

Note: The percentages in a row may not sum to 100.0% due to rounding.

The other way we measured examiner agreement involved calculating how often the three examiners made the same overall decision about a candidate's pass/fail status based on that candidate's "paper grade" which is a function of the number of points the candidate receives and where a score of 75% or higher of the possible maximum score is needed for passing (see Tables 7-A and 7-B). For example, the last row of Table 7-B shows that all three examiners agreed that of the candidates they saw who did a posterior conventional box prep restoration, 58.3% should pass and 8.2% should fail, for an overall perfect agreement rate of 66.5%. In contrast, the perfect agreement rate that was expected to occur by chance was only 48.4%.

Table 7-A
Inter-Examiner Agreement Rates on Endodontics and Prosthodontics

Test	Agree Pass		Agree Fail		Total % Agree	Chance % Agree
	% 3/3	% 2/3	% 3/3	% 2/3		
Endodontics	91.3	5.6	2.0	1.0	93.4	87.6
Prosthodontics	72.9	19.1	2.6	5.3	75.5	77.2

*Diff. method
Used to calculate
Than table 6*

Table 7-B
Inter-Examiner Agreement Rates on Restorative Test Options

Restorative Test with Posterior	Agree Pass		Agree Fail		Total % Agree	Chance % Agree
	% 3/3	% 2/3	% 3/3	% 2/3		
Amalgam	58.2	26.3	9.2	6.3	67.4	47.3
Box	65.9	23.3	6.4	4.4	72.3	56.8
Conventional	58.3	27.2	8.2	6.3	66.5	48.4

It is not clear why the actual degree of agreement between two Prosthodontic examiners (75.5%) was slightly (but not statistically significantly) lower than the chance rate (77.2%). This result came as a surprise since manikins rather than live patients are used for this test. Thus, the lower than expected agreement rate cannot be attributable to variation in patient characteristics. This finding suggests a more in-depth investigation is warranted for this test.

Periodontics. Case acceptance decisions on this test were done sequentially. In stage 1, the floor examiner classified a patient as "acceptable" (i.e., satisfied the case qualification criteria) or not. If "acceptable" the candidate could begin the calculus detection and removal portions of the exam. If the floor examiner determined the patient was not acceptable, then a second examiner evaluated the patient and classified that patient as acceptable or not. If the second examiner said the patient was acceptable, the candidate was cleared for the next portion of the exam. If the second examiner said the patient was not acceptable, the candidate could offer another patient or repeat the exam on another occasion.

There were 17 candidates who were flagged for possible penalty point deductions related to Periodontics case acceptance. The floor examiner flagged two candidates for 30-point deductions, but neither deduction was corroborated by another examiner. The first examiner gave two candidates a 20-point penalty, but only one of those cases was corroborated by a second examiner. The first examiner flagged 13 cases for 5-point penalties, but only 9 of them were corroborated by a second examiner. Thus, all told, only 10 of the 17 candidates that were flagged (59%) actually received penalty point deductions.

On the Periodontics exam itself, two examiners arrived at the same overall pass/fail decision (based on the "paper grade") for about 89% of the candidates. However, because this exam's overall pass rate was so high, the 89% figure is only 2 percentage points greater than what would be expected to occur by chance (such as by simply passing 9 out of every 10 of the candidates they evaluated).

IV. Psychometric Properties of the DSE

The DSE has the following three sections: DOR (Diagnosis, Oral Medicine, and Radiology), CTP (Comprehensive Treatment Planning), and PPMC (Periodontics, Prosthodontics, and Medical Considerations). Responses to the DSE are scored by computer. Examiner judgment is not required.

Table 8 provides summary data on each part of the DSE and the total score. The internal consistency (score reliability) estimates for the DSE were probably dampened by the restricted score range as indicated by the high mean and median scores. Ideally, reliability coefficients should be about 0.90 for this type of test.

Table 8
DSE Statistical Characteristics

Subtest	Number of Items	Mean percent correct	Standard Deviation	Internal Consistency
CTP	80	85.3	5.3	.511
DOR	100	85.5	6.4	.735
PPMC	100	85.7	5.4	.624
Total	280	85.5	4.8	.828

The moderate observed correlations among the three sections (see Table 9) support the policy of having a pass/fail rule for the DSE that allows for some but not total compensatory scoring; i.e., it is appropriate to assign penalty points if the score on one or two of its sections is especially low. The last column of Table 9 shows what the correlations among the sections are likely to be if they were all perfectly reliable (this is called a “correction for attenuation”).

Table 9
Observed and Corrected Correlations Between DSE Subtests

Subtests	Observed Correlation	Corrected Correlation
CTP with DOR	.589	.961
CTP with PPMC	.524	.928
DOR with PPMC	.494	.729

We continue to recommend that ADEX monitor whether p-values (percent correct) on repeated items are climbing (which could occur if there was a breach in test security) and explore whether pass/fail decisions can be based on equated rather than raw scores.

ELECTIONS

Dr. H Warren Whitis, AR moved and Mary Ann Burch, RDH, MD seconded a motion to nominate Dr. Robert Jolly, AR as Treasurer of ADEX for 2012-2013 term. There were no other nominations. The motion passed by general consent.

Dr. Shampaine, MD moved and Dr. Peter DeSciscio, NJ seconded a motion to nominate Dr. William Pappas as Secretary of ADEX for 2012-2013 term. There were no other nominations. The motion passed by general consent

Dr. Mina Pau, MA moved and Ms. Lynn Josyln, NH seconded a motion to nominate Dr. Stanwood Kanna, HI as Vice-President of ADEX for 2012-2013 term. There were no other nominations. The motion passed by general consent.

Dr. Scott Houfek, WY moved and Ms. Judith Ficks, WI seconded a motion to nominate Dr. Bruce Barrette, WI as President of ADEX for 2012 - 2013 term. There were no other nominations. The motion passed by general consent.

Election of Board of Director Dental Hygiene Member

Dr. Barrette noted since there was no additional nominations that the Secretary would cast a unanimous ballot for Ms. Mary Johnston of Michigan to be the Dental Hygiene Member of the Board of Directors.

Election of Board of Directors Consumer Member

Dr. Barrette noted since there was no additional nominations that the Secretary would cast a unanimous ballot for Ms. Clance Turner of Indiana to be the Consumer Member of the Board of Directors.

District 5: Linda Sabat, RDH, OH, House District RDH Representative
Linda Sabat, RDH, OH RDH Examination Committee member
Ms. Clance LaTurner, IN, Consumer Representative
Dr. Peter Yaman, MI, Educator Dental Exam Committee

Board of Directors

Dr. Bruce Barrette*	Dr. Stanwood Kanna*
President	Vice-President
Dr. William Pappas*	Dr. Robert Jolly*
Secretary	Treasurer
Dr. Guy Shampaine*	Dr. Patricia Parker
Immediate Past-President	District 2 Director
Dr. Keith Clemence	Dr. M. H. VanderVeen
District 4 Director	District 5 Director
Dr. Michelle Bedell	Dr. John Reitz
District 6 Director	District 7 Director
Dr. Robert Ray	Dr. Peter DeSciscio
District 8 Director	District 9 Director
Dr. Richard Dickinson	Dr. Jeffery Hartsog
District 10 Director	District 11 Director
Dr. Wade Winker	Ms. Judith Ficks
District 12 Director	Consumer Member
Ms. Clance LaTurner	Mr. James "Tuko" McKernan
Consumer Member	Dental Hygiene Member
Ms. Mary Johnston, RDH	Dr. Scott Houfek*
Dental Hygiene Member	Chair - Dental Exam Committee
Ms. Nan Kosydar Dreves, RDH, MBA*	
Chair - Dental Hygiene Exam Committee	

*Non-Voting Member