ADEA AMERICAN DENTAL EDUCATION ASSOCIATION

Charting Progress

JULY 2011

A Monthly Newsletter from ADEA Executive Director Richard W. Valachovic, D.M.D., M.P.H.

The actions of individual state boards may ultimately reshape the overall licensure landscape, while also affecting advanced dental education and assessment of continuing competency.

In this month's letter, Dr. Rick Valachovic, Executive Director of the American Dental Education Association, appraises how recent state initiatives are reshaping the licensure landscape.

Making Waves, One State at a Time

In case the news hasn't reached you yet, let me start with a brief update.

• In July 2009, Minnesota became the first U.S. state to offer a licensure examination that does not include the use of patients when the state dental board adopted Canada's dental licensure exam, which includes the Objective Structured Clinical Examination (OSCE), as one pathway to initial licensure.
• Last fall, California became the first state in the nation to create a dental school-based portfolio examination as an alternative pathway to licensure.
• And just last month, Florida decided to recognize the American Board of Dental Examiners (ADEX) Dental Examination as the state's clinical exam for dental licensure, reducing to three the number of U.S. jurisdictions that continue to administer their own clinical licensure examinations.

Most exciting of all, these unrelated efforts have all come to fruition over the course of two short years. That's breathtaking speed in the world of licensure, and it comes on the heels of another recent innovation, the adoption by New York State of postdoctoral education as a path to licensure. This approach, known familiarly as "PGY1," has already been emulated by four other states: Minnesota, Connecticut, California, and Washington. Finally, change is also afoot at the Joint Commission on National Dental Examinations (JCNDE), which has committed to replacing Parts I and II of the National Board Dental Examinations (NBDE) with a single integrated exam that will assess entry-level competency in the basic, behavioral, and clinical sciences.

This may not constitute a tidal wave of innovation, but the actions of individual state boards are causing ripples that may ultimately play a significant role in reshaping the licensure landscape. At the very least, the emergence of these alternative pathways to licensure and the prospect of an integrated NBDE will be welcomed by most ADEA members. Our Association is on record supporting:

> freedom in geographic mobility; elimination of those licensure and regulatory barriers that restrict access to care; elimination of the use of patients in clinical examinations; and high reliability of any licensure examination process and content as well as predictive validity of information used by licensing authorities to make licensing decisions.
> (ADEA Policy Statement III. Licensure and Certification, A. Goals [See top of page 965])

These recent state initiatives represent a move away from the use of patients in licensure exams and, in the case of Florida, toward greater license portability. In addition, the ADEA Commission on Change and Innovation in Dental Education (ADEA CCI) can take some credit for inspiring the Joint Commission to explore the development of an integrated exam that would mirror the trend toward integration in the dental curriculum. Dr. Bruce Horn, Immediate Past Chair of the Joint Commission and a member of the ADEA CCI Oversight Committee, serves on JCNDE's Committee for an Integrated Exam (CIE). He is personally excited by the prospect of an integrated exam but knows it will pose some challenges.

"There's a cart and a horse here," he told me recently. "There will be some schools where the examination will be the cart because the school has already gone in that direction, but there will be many more schools where the exam will be the horse, and the schools will feel like they're being dragged along." To minimize the occurrence of

this second scenario, CIE is committed to communicating with all stakeholders early and often. Dr. Mark Christiansen, the committee's Chair and an officer with the American Association of Dental Boards (AADB), has issued several communiqués about the committee's work and will continue to do so.

Mark has been a key player in licensure issues for decades, so I was eager to get his thoughts on a related issue. Although health professions increasingly require demonstration of continuing competency, this is rarely required by state dental boards. Yet many in our community believe that boards should also ensure the competency of dentists after initial licensure.

According to Mark, the idea of assessing continuing competency has been discussed off and on for more than 25 years. "There's no disagreement that it's valuable," he told me, "but how do you do it in a cost-effective, positive way?"

Currently, states generally handle the issue of continuing competency by requiring that dentists log a specified number of continuing education hours in order to retain licensure. These requirements vary considerably in length of time and specificity of content, but Mark believes this system is adequate to ensure that the vast majority of dentists are keeping up their knowledge and skills. "In many locations," he told me, "the competition is enough that dentists need to be pretty aggressive in learning new technology and new techniques in order to market themselves. You hate to put everybody through a burdensome hurdle for the few bad eggs."

Nevertheless, many people think the current system needs an upgrade. One of them is Dr. James Cole II, who has served on the dental board in New Mexico, as an officer of AADB and the Western Regional Examination Board (WREB) , and as Chair of the Commission on Dental Accreditation (CODA). "Fifty boards require some type of CE," Jim told me, "but you can ski in the morning and take a course in the afternoon. There's no outcome assessment. Perhaps CE is a way to *maintain* your competency, but it is not a way to *demonstrate* your competency."

As Jim reminded me, the current continuing education requirement began with a single state, Minnesota. He believes that once a critical mass of states takes action on continuing competency, it won't be long before other states follow suit. He is concerned that if dentistry does not come up with a way to assess continuing competency on its own, "consumer groups, state legislatures, or a federal mandate will do this for us. I'd like dentistry to stay ahead of the curve." So would I, which puts the onus on ADEA, the ADA, and the AADB to begin a more concerted discussion on how best to make this happen.

I am glad to see the state boards shifting more of their attention toward practicing professionals. There is tremendous variation in how states discipline their licensees. When I spoke with Jim, he expressed concern that some states close no cases, while others (like New Jersey and Arizona) close over 600 cases a year. On the positive side, we seem to have left the era when a practitioner who got into trouble in one state could just pack up and move to another. Many states now have reciprocal discipline, and the National Practitioner Data Bank makes it easier to track malpractice by health care providers. AADB has also created a Clearinghouse for Board Actions that is available to all states and, according to Mark, more and more states are choosing to participate.

This progress is heartening. Yet despite these advances—the widespread acceptance of regional exams and bold initiatives by individual states—alternatives to traditional licensure exams remain controversial. After my recent conversations with our colleagues in the licensure community, I am even more aware that it may take some time for them to be convinced of the merits of new approaches. They seem especially uncomfortable with pathways to licensure that reside in educational programs themselves.

"It's the proverbial fox guarding the henhouse," Jim says of California's legislation, noting that this is what prompted state legislatures to create licensing boards in the first place. Bruce Horn, as a past state board president, also expressed concerns about the process of faculty objectively assessing their students in a licensure examination format. In his view, "the anonymous and independent third-party assessment that has been the foundation of clinical licensure examinations is missing."

As California lays out specific guidelines for how the portfolio exam will be administered, I have no doubt their concerns will be taken seriously. Both Mark and Jim told me that they like the idea of a portfolio exam, but in Mark's view, third-party control must be firmly established. A little over a decade ago, the examining community (which Jim led at the time) invited ADEA to take part in a conversation about developing innovative testing methodologies. There was considerable support for developing a portfolio exam that would include third-party evaluation, but the time was not right at that moment for the adoption of this methodology. Perhaps California's latest move is a bellwether of things to come.

Meanwhile, in Minnesota procedures are in place to ensure that the new initial

licensure process it offers graduates of the University of Minnesota provides an accurate assessment of licensure candidates' readiness for practice. Canada's National Dental Examining Board (NDEB) exam, which the state offers as an alternative to a clinical exam, has two parts, a written test and an Objective Structured Clinical Examination (OSCE), which does not involve patients. I briefly described the OSCE in the July 2008 issue of *Charting Progress*. The University of Minnesota hosts both parts of the exam, but faculty have no opportunity to influence the outcome of the exam. NDEB procedures and training ensure that the exam is securely stored and properly administered, and all scoring and evaluation is performed centrally in Ottawa. During the two years it has been offered in Minnesota, a member of the state dental board has been on site as an observer, which should further reassure those who are concerned about the test's reliability.

As for PGY1, critics have expressed concern that the variation between advanced education programs may not ensure consistent quality in a candidate's skills. While I agree that it would be almost impossible to control for variations among postdoctoral programs, I question the notion that one of our graduates who spends a supervised year in practice will emerge less qualified for licensure than one who does not. It will be interesting to follow the first New York dentists who achieve licensure through PGY1 to see how their practice performance compares with their peers who achieve licensure through clinical examination.

To my mind, the biggest obstacle that may prevent PGY1 and other state initiatives from gaining traction is their lack of recognition by other states. With regional exams in place, licenses have become more portable than ever. Despite variations, the regional exams are substantially comparable, and more and more states are accepting exams from outside their regions as a basis for licensure. In a world where economic uncertainty and family demands often force people to relocate, these realities may prompt most students to choose traditional clinical licensure exams in the short term simply to ensure the portability of their licenses.

Our community has long taken exception to these exams because of their use of patients in the process of determining competency to practice independently. In fact, the 2011 ADEA House of Delegates passed a resolution submitted by the ADEA Council of Deans stating that "by the year 2015, the live patient exam for dental licensure should be eliminated and all states should offer methods of licensure in dentistry that include advanced education of at least one year, portfolio assessment, and/or other non-live patient based methods" [Resolution 10H-2011, ADEA Policy Statement on Elimination of Live Patient Exam by 2015]. The ADA has also called for the elimination of patients from licensure exams.

While I personally agree with this stance, I think the views of our colleagues in the licensure community who take issue with our position are worth sharing. Mark put it bluntly: "In dental school we also use patients to train students, and the candidates who are taking the exam have completed the training process and been deemed adequately trained. It should be safer to work on a patient as the candidate in an exam than as a student in a school," he insists, pointing out that medical students also interact with patients in teaching hospitals because some things are best learned in this way.

Similarly, in his view, testing candidates with patients is currently the best way to verify some learning. All that said, Mark would not be averse to replacing the live patient clinical exam with simulation once simulation can fully replicate the conditions under which dentistry is practiced. "Simulation is ideal," he says, "and it would allow us to standardize things much better if we could eliminate the variability of patients."

Jim Cole holds similar views. "Until there's some type of a format that allows a student to drive a hand piece on a computer with saliva and tongues and other things that get in the way, there will always be a requirement that students do a procedure on a patient, but it doesn't have to be multiple procedures."

Jim points out that the regional exams use fewer patients than the state exams did, citing the incorporation of computer simulation and OSCE-like components in the CSW exams currently being used by both the Southern Regional Testing Agency (SRTA) and the Western Regional Examining Board (WREB). CSW is a not-for-profit that creates and administers computer-simulated dental exams.

As we consider recent changes to initial licensure and those that lie ahead, it is important to remember that we have come a long way since the days when prisoners in some states were brought to the county courthouse basement to allow candidates for licensure to demonstrate their clinical competency, or when the governor's nephew could be assured of passing the exam because everyone knew he was taking the test. Although the timetable is uncertain, we can say with confidence that we are headed in the right direction.

"These alternative pathways to initial licensure are currently the outliers, but they may become the top of the bell curve," Bruce conjectures. "I think the activity associated with the licensure process for expanded-duty, mid-level providers will probably also drive some changes in dental licensure."

It well may. Either way, the pace of change is accelerating, and the ripples we are feeling today may become waves over the next decade. As Mark pointed out, "Now more than ever before, states are aware of what's going on in other states, and good ideas are readily implemented across the country." Let’s hope that word continues to spread about the promising developments occurring in licensure, and that more state dental boards feel called upon to further reshape the licensure landscape. And, of course, these issues also apply to the licensure of dental hygienists. I will address their situation in the near future.

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