

DATE: January 20, 2016

TO: ADEA Council of Deans
ADEA Council of Allied Dental Program Directors

FROM: ADEA Task Force on Licensure
Steven W. Friedrichsen, D.D.S., Chair, ADEA Task Force on Licensure
Evelyn Lucas-Perry, D.D.S., M.P.H., ADEA Director of Public Policy Research

CC: Richard W. Valachovic, D.M.D., M.P.H., ADEA President and CEO

RE: Update on ADEA Task Force on Licensure’s Recommendations Toward
Elimination of the Human Subject/Patient Component of the Clinical Licensure
Exam

ADEA Task Force on Resolution 5H-2014

In March 2014, the American Dental Education Association (ADEA) House of Delegates passed Resolution 5H-2014, *Recommendation for a Task Force and Report Toward Elimination of the Human Subject/Patient Component of the Clinical Licensure Exam*. Resolution 5H-2014 was introduced by the ADEA Council of Deans and the ADEA Council of Allied Dental Program Directors. The ADEA Task Force on Resolution 5H-2014 (Task Force) provided a First Report to the ADEA Board of Directors in January 2015 and to the ADEA House of Delegates at the 2015 ADEA Annual Session & Exhibition (Appendix 1—First Report of the ADEA Task Force on Resolution 5H-2014).

With the ADEA Board of Directors’ approval, the Task Force was continued beyond the 2015 House of Delegates sessions to complete the development of an action plan that would meet the intent of Resolution 5H-2014. The culmination of the Task Force’s work included a working session on September 30, 2015, and sponsorship of the *ADEA Symposium on the Future of the Clinical Licensure Examination* (ADEA Symposium) on October 1, 2015. The ADEA Symposium included representatives from various stakeholder communities (Appendix 2—Symposium Attendee List) and was designed to elicit engagement of the various groups in a productive dialog (Appendix 3—Symposium Agenda, Breakout Groups and Discussion Guide) related to all current clinical licensure pathways (Appendix 4—Symposium Summary of Breakout Group Reports).

2016 Report from the Task Force on Resolution 5H-2014

The clinical licensure examination process has evolved significantly and continues to change at an increasing pace. Currently, there are three alternative clinical licensure pathways¹ accepted by states: the Post-Graduate Year Residency (PGY-1), the Minnesota Objective Structure Clinical Examination (Minnesota OSCE), and the Hybrid Portfolio. The number of graduating dental

¹ The Task Force distinguishes licensure *pathways* from licensure *models*. A licensure pathway is an existing approach to satisfy a state’s clinical licensure requirement, while a licensing model is a future approach under development, being piloted or not yet existing, that has the potential to satisfy a state’s clinical licensure requirement.

students who can achieve initial licensure from alternatives to the "traditional" patient-based clinical licensure examination has grown: seven states accept² PGY-1, Minnesota accepts the Minnesota OSCE, and the Hybrid Portfolio is accepted in California. Nearly one out of every four dental school seniors who graduated in 2015 took or plan to take an alternative clinical licensure pathway. Additionally, the patient-based components of the regional examinations constitute a smaller fraction of the traditional clinical patient-based licensure examination than in the past, with the inclusion of computer-based clinical and diagnostic exams. The acceptance of various examinations and pathways has expanded tremendously over the last decade. Of the 53 different licensing agencies,³ 24 (45%) accept all regional examinations and now seven (13%) will only accept their regional exams. Nine (17%) accept at least one alternative licensing pathway (PGY-1, Minnesota OSCE, or Hybrid Portfolio).

Task Force Recommendations

The Task Force recognizes that the current alternative pathways reflect the autonomy of each state board, and foresees that universal acceptance of one single model is unlikely at this point in time. As such, the Task Force does not endorse one single pathway or model, but strongly supports professional mobility through licensure portability and increasing acceptance of multiple pathways to initial licensure.⁴ Furthermore, the Task Force agrees that the greatest success in the development, implementation and assessment of multiple pathways to dental and dental hygiene licensure has been and will continue to be achieved by a high level of communication, collaboration and trust among the testing agencies, state boards, professional societies, dental schools and dental hygiene programs.

Therefore, the Task Force recommends the following strategies to increase communication, collaboration and trust among the involved parties of the dental and dental hygiene licensure process. These strategies provide a foundation for the Task Force's continuing efforts to expand the availability of alternative pathways and emerging models to licensure, which do not have a human subject/patient component.

Increase awareness and understanding of emerging licensure models

Based on its work and deliberations, the Task Force recommends that ADEA implement the following activities:

- Work with the examining and licensing community, the American Dental Association (ADA), the American Student Dental Association (ASDA), the American Dental Hygienists' Association (ADHA), the American Association of Dental Boards (AADB) and other key stakeholders to increase awareness and understanding among state examiners, board members, dental providers and students of the development and realities of the alternative formats.
 - Develop high-quality, accurate and meaningful materials (i.e., briefing papers, white papers, *JDE* or *JADA* articles) to inform stakeholder communities of the licensure pathways.

² PGY-1 is mandated in New York and Delaware (DE requires a patient-based clinical exam as well) and accepted in CA, CT, OH, and WA (in WA, must be completed at an FQHC-type institution).

³ Includes all 50 states, the District of Columbia, Puerto Rico and the U.S. Virgin Islands.

⁴ The Task Force differentiates between acceptance of initial licensure and portability, which was defined as the ability to go from one jurisdiction to another once licensed.

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- Develop, with willing stakeholders, “attributes and models” for clinical licensure that assesses the knowledge, skills and competencies expected of a 21st century dentist and dental hygienist. The assessments should demonstrate reliability, validity and take into consideration effective use of resources.
- Engage dental education leadership (i.e., deans, allied program directors) to communicate with students, faculty and alumni about the necessity of change and the validity of emerging licensure models and alternative pathways.
- Develop a legislative toolkit/briefing document to be used for outreach with state boards/legislators to ask for interim studies [explain the political nuisances behind this strategy at the January 2016 ADEA Joint Council Administrative Boards (JCAB) meeting—a study for the legislators, not the dental community]. Dental school administrators, dental hygiene program directors, faculty and students should have companion briefing documents and responses to commonly asked questions that can support legislative understanding.
- Convene involved parties in educational forums and discussions (i.e., webinars, presentations, conferences) about the alternative licensure models.
- Work with the ADA, ADHA, ASDA, AADB or directly with state boards and others to establish a central location, such as an online database, of resources and updates on licensure progress.
 - The online database should be accessible to the public, and funding should be allocated by ADEA and/or the organization housing the database for maintenance, updates and dissemination to stakeholders, including state board members, students, faculty, alumni and prospective students.

Promote further development and piloting of alternative licensure models

Based on its work and deliberations, the Task Force recommends that ADEA implement the following activities:

- Partner with state dental boards, regional testing agencies and the ADA, ASDA, ADHA and others in the development and pilot testing of the existing alternative pathways and subcomponents of existing exams, as a precursor to the envisioned expansion of these alternative models to initial licensure.
- Promote dental schools and dental hygiene programs to lead in clinical assessment practices by modeling best practices (i.e., adopt Minnesota OSCE and Hybrid Portfolio elements) in dental and dental hygiene school curricula. Dental schools and dental hygiene programs should consider replacing existing high-stakes, patient-based examinations and “competencies” with multi-faceted competency evaluations. This can be achieved through various platforms, including developing teaching resources, hosting virtual informational webinars and leading discussions at meetings and conferences.
- Partner with AADB, directly with state boards or with other key stakeholders to commission a survey of members of state boards to assess awareness of and attitudes toward the existing model to initial licensure.
 - This approach could identify which states or regions are most amenable to alternative clinical pathways to initial licensure.

Increase understanding of the accreditation process

Based on its work and deliberations the Task Force recommends that ADEA implement the following activities:

- Work with the Commission on Dental Accreditation (CODA) and with AADB to increase understanding among state examiners and board members of the role of the accreditation process in ensuring *the quality and continuous improvement of dental and dental-related education and reflect the evolving practice of dentistry* (CODA, 2012).
- Work with CODA and AADB to facilitate state examiners and board members to observe during accreditation site visits.
- Work with dental schools and dental hygiene programs to provide additional opportunities (i.e., "open house days," committee membership, increased involvement) for state boards and licensure agencies to increase communication, trust and transparency related to student evaluation processes.

Promote research and distribution of findings from alternative licensure models

Based on its work and deliberations the Task Force recommends that ADEA implement the following activities:

- Work with the ADA to longitudinally track professionals using the DENTPIN® to determine if there are differences in outcomes based on the different models to licensure.
- Develop opportunities for dental schools, dental hygiene programs and partners engaged in developing, implementing and accessing alternative licensure models to share and distribute data, findings and best practices.
- Collaborate with the ADA to with the regional testing agencies and state boards to determine national "never pass" and or "never practice" rates for dental school graduates.
- Partner with ADHA to identify the dental hygiene community's attitudes, awareness and knowledge of developing and promoting non-patient-based clinical examinations.

Publicly recognize and collaborate with others engaged in alternative licensure models

Based on its work and deliberations the Task Force recommends that ADEA implement the following activities:

- Affirm and support the efforts of the ADA, ASDA and ADHA and others to increase portability and acceptance of multiple pathways to initial licensure.
- Affirm why it does not support the Clinical Integrated Format (CIF), or identify potential transitions from the CIF model to alternatives that do not use patients as test subjects.
- Work in concert with the leadership of the ADA, ADHA, ASDA, AADB and others to align its strategies and efforts to provide more uniform messaging, prevent unnecessary duplication of efforts and build a stronger strategic partnership in support of non-patient-based clinical licensure.

Next Steps

To advance these recommendations, the Task Force recommends that the ADEA Board of Directors allocate appropriate funding to advance the activities outlined in this report.

Appendices

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Appendix 1—First Report of the ADEA Task Force on Resolution 5H-2014

First Report of the ADEA Task Force on Resolution 5H-2014

Background and Overview of Next Steps

Introduction

In March 2014, the American Dental Education Association (ADEA) House of Delegates passed *Resolution 5H-2014—ADEA Council of Deans and ADEA Council of Allied Dental Program Directors Recommendation for a Task Force and Report Toward Elimination of the Human Subject/ Patient Component of the Clinical Licensure Examination*.

Resolution 5H-2014 reads: **Resolved, that the American Dental Education Association recommends the elimination of the human subject/patient-based components of clinical licensure examinations and the adoption of an alternative and validated process for the clinical assessment of candidates for licensure, such as the Objective Structured Clinical Examination (OSCE), and to that end we recommend creation of a Task Force comprised of representatives of ADEA, assessment experts, and representatives of the licensing examination community and other communities of interest, which will develop an action plan to transition to this new exam. A report of the Task Force should be made to the ADEA Board of Directors in January 2015 and subsequently to the ADEA House of Delegates at the 2015 ADEA Annual Session & Exhibition.**

Following the 2014 ADEA House of Delegates a Task Force was approved by the ADEA Board of Directors in June 2014. The Task Force includes the following persons:

Dr. Steven Friedrichsen, Dean, Western University of Health Sciences College of Dental Medicine (Chair)

Dr. Leon Assael, Dean, University of Minnesota School of Dentistry

Dr. William Calnon, Past President, American Dental Association

Prof. Joyce Hudson, Program Director of Dental Hygiene—East Central Campus, Ivy Tech Community College

Mr. Timothy Treat, Dental Student, Indiana University School of Dentistry

Dr. Bruce Horn, Private Practice Dentist, Dental Examiner & former head of Oklahoma State Dental Board

Dr. Jack Gerrow, Executive Director and Registrar, National Dental Examining Board of Canada

Update on ADEA Task Force on Licensure's Recommendations Toward Elimination of the Human Subject/Patient Component of the Clinical Licensure Exam

The Task Force worked closely with ADEA staff to clarify key language in the resolution, which included the overarching goal for the Task Force to develop a plan that would support transition away from the current "human subject/patient" exam. It was determined that, given the state by state authority for licensure of dental professionals (dentists and dental hygienists) the most productive plan would involve developing strategies that could be used to support the transition at the state and regional levels.

Beginning in August 2014, the Task Force conducted three group conference calls, four calls between the Chair and individual Task Force members, one partial Task Force in-person meeting at the American Dental Association (ADA) Annual Session, and one all-day in-person meeting of the Task Force and special guests from the American Student Dental Association (ASDA), ADA, Western Regional Examining Board (WREB), and New York Dental Board.

Early in the work of the Task Force it was determined that the background principles provided in the Resolution varied considerably in strength as arguments in support of elimination of the current exam or as potential strategies for the transition plan. In addition, while the language of the Resolution and background is readily understood and accepted by some constituencies (dental education, students), that same language presented an automatic barrier to key constituencies (state boards, regional testing agencies). Attached to this report is an Appendix containing a preliminary Evaluation of the Background Statements from the Resolution as well as an initial draft of Guiding Principles. This section is not the final, but for discussion purposes and further review.

Although the Task Force clearly understands and supports the intent of the Resolution, as written, it precludes or hampers the development of a plan or strategies that are collaborative in nature. It was equally clear to the Task Force that development of an effective plan would require some level of collaboration with other stakeholders. The nature of the current clinical licensure exam has been a divisive issue within the dental profession for several decades and movement toward new licensure pathways is primarily a political process; one that may best be served by collaboration with key constituencies.

Next Steps:

1. The Task Force will complete the assigned charge of developing a plan and strategies to increase access to alternative approaches and formats that move away from the traditional licensure model support developing and adopting alternative pathways and examinations that are reflective of the professional identity and practice of dentistry and dental hygiene, in compliance with the goals of the Resolution, by completing the following:

- a. Developing a series of principles that will guide the formulation of recommended plan and strategies,
- b. Evaluating the strategic potential for each of the background statements and other areas that appear to be productive,
- c. Assembling the strategies into a plan and report to the ADEA Board of Directors at the September 2015 meeting.

Request to the ADEA Board of Directors:

1. The Task Force will need an expansion of membership and additional time to continue development and implementation of the plan and associated strategies.

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2. The Task Force would like to request support to convene a meeting to include all the major stakeholders around the clinical licensure issue. The purpose of the symposium would be to share research on traditional patient licensure examinations, new formats to the traditional model, such as the Curriculum Integrated Format (CIF), and new alternative pathways to licensure. The symposium would also allow for all groups to develop the licensure process that best strengthens the future of the profession.

Conclusion

The Task Force wants to thank the ADEA Board of Directors and membership for the opportunity to address this important aspect of the dental profession. This has been a divisive issue for decades. Developing a plan and strategies to effect change in the licensure process which will continue to assure that the public is served by competent dentists and dental hygienists will require additional time and effort by the Task Force on behalf of ADEA. The members of the Task Force are encouraged by the developments happening in the increasing number of states that accept an alternative pathway to licensure. Today one out of four dental students is enrolled in California, Minnesota and New York and has access to an alternative pathway to licensure. Other states are considering these pathways and the effort by ADEA can help support change across the country.

RESOLUTION 5H-2014

ADEA Council of Deans

Background:

In March 2014, the American Dental Education Association (ADEA) House of Delegates passed *Resolution 5H-2014 –ADEA Council of Deans and ADEA Council of Allied Dental Program Directors Recommendation for a Task Force and Report Toward Elimination of the Human Subject/Patient Component of the Clinical Licensure Examination.*

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During the first six months after the members of the task force were named the group conducted three group conference calls, four calls between the Chair and individual Task Force members, one partial Task Force in-person meeting at the American Dental Association (ADA) Annual Session, and one all-day in-person meeting of the Task Force and special guests from the American Student Dental Association (ASDA), ADA, Western Regional Examining Board (WREB), and New York Dental Board. The task force has made tremendous progress in better understanding the issues and perspectives of various stakeholders.

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More time is needed to complete the development and implementation of a strategy (action plan) to transition to a new clinical licensure examination.

The Task Force will need an expansion of membership and additional time to continue development and implementation of the plan and associated strategies.

The Task Force would also like to request support to convene a symposium to include all the major stakeholders around the clinical licensure issue. The purpose of the symposium would be to share research on traditional patient licensure examinations, new formats to the traditional model, such as the Curriculum Integrated Format (CIF), and new alternative pathways to licensure. The symposium would also allow for all groups to develop the licensure process that best strengthens the future of the profession.

Financial Impact Statement for the Task Force:

\$25,000 for the continuation of the work of the task force including the convening of a symposium of all stakeholders.

The ADEA Board of Directors asks the House to approve the following resolution:

5H-2014. Resolved, that the American Dental Education Association recommends the continued support of the ADEA Task Force on Clinical Licensure Examinations for the further development and implementation of a strategy and action plan to transition to a new clinical licensure examination. The activities of the task force will also include the convening of a symposium to include all the major stakeholders around the clinical licensure issue. A report of the Task Force to the ADEA Board of Directors should be made in January 2016, and subsequently to the ADEA House of Delegates at the March 2016 Annual Meeting.

And be it further resolved that a sum not to exceed \$25,000 be allocated for the work of the Task Force.

Appendix

Evaluation of Background Statements from the Resolution for Strategic Potential

The following statements are based on discussions and research of the Task Force since its inception and are still under review by Task Force members.

The Task Force started with the background statements identified as the key issues and concerns by deans and allied dental program directors and were included in the Resolution as justification for the elimination of the "human subject/patient" clinical licensure exam. The Task Force carefully examined each of these statements in order to clearly understand the issue from a variety of perspectives as well as determine the potential strength or viability of strategies that could be derived from each background theme for use in developing the action plan.

1. Psychometric Strength

- a. **Resolution 5H Background**—The current clinical examination protocol lacks the psychometric strength expected of an assessment of such importance and consequence. Specifically, the clinical examination component lacks sufficient validity and reliability, while alternative methods exist with such characteristics.
- b. **Strength/Viability**—The Task Force recognizes that each testing agency has worked to develop valid and reliable exams. There are differences of opinion around validity and reliability. The issue of psychometric strength will be a challenging focal point for strategies without agreement on definition of validity and reliability coupled with comparisons between examination methodologies.
- c. **Potential Opportunities/Strategies**—
 - i. Establish a common understanding of reliability and validity. Measure patient-based exams using common statistical measures.
 - ii. Review the fidelity of the entire patient exam based process through a national Never Pass/Never Practice rate vs. expenditure for an ROI calculation. Determine the number of graduates each year who do not obtain a license to practice or who are purposely not practicing. (i.e., went straight into a research, other academic or corporate career) and evaluate if the licensure process is worth the investment.
 - iii. Review the variance between dental school performance and pass rates on the patient based components of licensure exams.
 - iv. Evaluate changes to pass/never pass rates in states with alternate pathways to licensure.

2. Ethical Concerns

- a. **Resolution 5H Background**—Myriad ethical concerns exist concerning the primary construct and secondary effects of this examination component.
- b. **Strength/Viability**—There is nothing inherently unethical about the concept of observing the completion of clinical procedures under conditions that test the independent skill of the students—it is an everyday occurrence in dental education. All of the regional testing agencies consider the design of their exams to be ethical and they discourage unprofessional and unethical activity by candidates. Statements or arguments that the exam itself is unethical lead to solid resistance from the examining bodies, including the state dental boards. Basing strategies on the argument that the exam is inherently unethical will be counterproductive to any strategy or tactics that involve collaboration or cooperation. Further, it would require dental schools also eliminate similar approaches from their assessment processes.

There may be some strategic potential in the fact that the high-stakes design and nature of the exam forces candidates into difficult choices in order to successfully complete these examinations. The changing demographics and patterns of oral disease as well as contemporary treatment modalities reduce the number of suitable patients for the narrow requirements required or perceived to contribute to success

on the exam. This reality leads to the screening large numbers of patients specifically for the exam and creates a market for patient procurement services. Patients who present with appropriate clinical needs quickly recognize their value in this process and can command high “payments” to sit for the exam.

The majority of state dental practice acts prohibit fee-splitting or providing incentives for patients to obtain treatment with a dentist or hygienist. The widespread understanding and acceptance of the payment of patients to participate in the clinical licensure exam appears to turn a blind eye to the laws of most states.

Even though the examination may not be unethical by design, in implementation it creates the strong incentive to bring our students into the practice of the profession by compromising their ethics and/or professionalism. The dental profession has a proud reputation and a strong history of supporting ethics and professionalism. Surely there is a better alternative that birth's the newest members of the profession in a manner that does not compel them to compromise either in order to achieve licensure.

c. Potential Opportunities/Strategies

- i. Collect data on the actual screening processes, payments by students, ethical compromises, etc. To be used for developing key talking points with groups.
- ii. Review the potential legal implications of the payment of patients using the various state dental practice acts.
- iii. Engaging a consumer member on the taskforce (or as a consultant) to gain their perspective and potential audience for the message.
- iv. Develop a public message related to the processes used in dental licensure.

3. Standard of Care

- a. **Resolution 5H Background**—Educational institutions that provide the facilities for the clinical examination are most probably, in certain cases, permitting or acknowledging care that would not comply with those institutions' own standard of care. The foremost concern is that individuals receiving treatment in the examination are, by definition, human subjects in a formal protocol and are not patients since essential elements of the doctor-patient relationship are absent. This primary concern seeds several secondary concerns including the following: Institutional Review Board (IRB) approval should be required for human subject participation; Proper informed consent is lacking; Methods to recruit individuals as subjects are, in some cases, inappropriate and unethical. Such violations may include the planning of treatment that would normally be considered not advisable; the provision of unnecessary treatment (e.g., provision of an irreversible operative procedure rather than observation and non-surgical care); an inappropriate delay in the provision of needed, timely care to match the scheduling of the clinical examination; and an absence of a defined protocol to assess patient response to and clinical outcomes of the therapy provided.

- b. **Strength/Viability**—There was tremendous debate in crafting the Resolution about whether the persons treated during these clinical examinations are human subjects rather than patients. This is a very important consideration. If the persons treated are “human subjects” and the exams are subject to IRB approval, it would be of considerable concern. Unfortunately, there is almost no strategic potential to this argument.

The Department of Health and Human Services (DHHS) regulations under 45CFR46.102(f) define a human subject as a living individual about whom an investigator conducting research obtains (1) data through intervention or interaction with the individual; or (2) identifiable private information. Intervention includes both physical procedures by which data are gathered (e.g., venipuncture) and manipulations of the subject or the subject's environment that are performed for research purposes.

While the Task Force understands the concerns of those who view persons treated during clinical licensure examinations as human subjects the Task Force does not believe that the examination and the examination environment meet the federal definition of a human subject because the patient-based clinical examination does not meet the definition of research. The clinical examination is intended to evaluate the ability of the student to deliver appropriate patient care. It is closer to a quality assurance or quality improvement (QA/QI) process than research.

The following definition of research is taken from the Code of Federal Regulations, Title 45, Part 46, which essentially governs human subjects research in the United States:

Research means a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge.

Quality improvement and quality assurance activities conducted solely for the intent of maintaining or improving quality of services provided by an institution, likewise, are not considered research activities. However, if the data collected are **generalizable** and are to be shared outside of the institution through discussion, presentation, or publication, the activity qualifies as research. Sometimes, data from a quality improvement or quality assurance activity becomes of interest to the external community after they have been analyzed. In these cases, the research use of the data collected for another purpose must be reviewed.

There may be some potential in the pursuit of a strategy related to the treatment of patients, especially as it relates to changes in the therapeutic intervention for minimal caries. The use of remineralization as the first therapeutic intervention for early carious lesions and use of minimally invasive techniques continues to garner additional evidence of efficacy and effectiveness. In addition, timing of care and

delays to meet the needs of the examination could be considered as potential strategies.

It should be noted however that there are elements of the dental education process that may exhibit some of the same characteristics as the clinical licensure examination. The philosophy related to treatment of the early carious lesion varies considerably among schools and can be affected by the need to demonstrate technical proficiency of restoration. Timing of treatment can be affected by class cohort transitions, academic calendars, etc. There is likely some, but limited potential for this to serve as an effective strategy.

c. Potential Opportunities/Strategies—

- i. Review data/information on “withholding treatment to save lesions” for the messaging and key talking points
- ii. Compare carious lesion acceptance criteria with contemporary criteria for treatment versus remineralization.

4. Patient Safety and Well-Being

- a. **Background Statements**—The safety and well-being of patients are at risk by receiving care within an examination protocol that, by design, requires that an unlicensed, novice provider deliver care independently and under very limited supervision.
- b. **Strength/Validity**—The strength of this argument is diluted significantly by the requirement that the dental schools approve students for the examination process. The approval process is designed to indicate that the educational institution has deemed that the student is prepared for the examination.

A variation of this background statement does appear to offer some strategic potential. Society is seeking increased accountability of many long-standing processes. Under public scrutiny, patient-based clinical licensure exams may be considered to offer limited protection of the public while consuming significant resources. It is important to note the following:

- i. narrow focus on a minimal number of readily observed procedures,
- ii. one-time nature of the exam,
- iii. primary focus on procedures,
- iv. the majority of practitioner complaints are not based on procedural skills, and
- v. rate of practitioner complaints is static or climbing, not decreasing.

Each of the above contribute to a need to re-examine the process to determine if it produces the desired outcomes. There should be increased concern for the impact of the learning environment and the investment into this one element of student preparation. The educational institutions devote inordinate curriculum time and resources to assisting students with patient selection, coordinating the curriculum to provide students with preparation that is specific to the exam that could be

devoted to other aspects of learning to provide patient care. The resources devoted to preparation of students is often imbedded in the curriculum and patient care experience and likely underestimated by all parties.

c. Potential Opportunities/Strategies

- i. Review the skillset desired for practitioners that go beyond technical skills, synthesize those into a message regarding the goals and aspirations for assessment of the future practitioner.
- ii. Conduct an analysis of the curriculum time, commitment and resources directed toward the completion of the patient-based clinical exam.
- iii. Review state databases on practitioner complaints and remediation to determine source and rate
- iv. Review changes to rates and sources of complaints in New York and Minnesota to determine changes resulting from alternate licensure pathways.

5. Institutional Liability

- a. **Resolution 5H Background**—Excessive liability is assumed by the educational institutions providing the clinical site for delivery of the examination. There is significant concern that educational institutions are being placed at significant liability risk due to a) lack of IRB approval for the protocol, b) lack of proper informed consent, and c) the consequences of treatment provided by unlicensed providers under limited supervision of an external party not affiliated with the educational institution.
- b. **Strength/Validity**—The strategic potential related to institutional liability is likely very limited by the lack of significant strength of previous statements related to Standard of Care as well as Patient Safety and Well Being. The consent process for the licensure exams appears to be appropriate for a limited treatment event and is paralleled by dental school and dental practice consents for limited care. Without strong strategies related to these two areas, the concept of excessive institutional liability does not hold significant potential as a successful strategy.
- c. **Potential Opportunities/Strategies**
 - i. Instead of institutional liability, the greater question relates to ROI and the “true value” obtained by the current licensure process.
 - ii. Develop talking points based upon aspirational goals for the process.

Guiding Principles for Further Discussion:

The following statements are based on discussion at the December 15, 2014 Task Force meeting and still under review by Task Force members.

Principle 1

All parties involved share an interest in and responsibility for ensuring that qualified and competent individuals are licensed to practice dentistry and dental hygiene.

- The parties involved in dental and dental hygiene licensure include the dental education community (ADEA, ASDA, ASDHA), organized dentistry and dental hygiene (ADA, ADHA, NDA, HDA), the state

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dental boards and the regional testing agencies (Council of Interstate Testing Agencies—CITA; the Central Regional Dental Testing Service, Inc.-CRDTS; the Northeast Regional Board-NERB; the Southern Regional Testing Agency-SRTA; and the Western Regional Examining Board-WREB).

- All parties should have a vested interest in protecting the public to uphold the public's trust and support the autonomy of the profession. As a self-governing profession, the onus is on all parties to critically analyze and ensure its practice and processes, including the pathway to licensure, meet the intended needs.
- The educational community bears primary responsibility for ensuring that students are prepared with the knowledge, clinical skills and competencies needed for the practice of general dentistry, dental hygiene and/or entry into residency or specialty training.
- Independent, external assessments of the educational process provide value in ensuring quality assurance and adequacy of candidates' educational experiences and qualifications for licensure. These assessments include, National Dental Board Examinations, CODA Accreditation and evaluation of readiness for licensure to practice dentistry/dental hygiene.

Principle 2

Licensure pathways should assess the knowledge, clinical skills and competencies expected of a dentist or dental hygienist in the 21st century. Assessment and examination methodologies should demonstrate reliability and validity and take into consideration effective use of resources.

- The pathways to licensure should be designed to ensure the health, safety, and welfare of the public by identifying candidates that possess the competencies necessary to safely practice dentistry and dental hygiene. Each state mandates the requirements for dental and dental hygiene licensure and practice by state statutes and laws.
- Examinations and assessments for licensure should be consistent with established competencies necessary for practice in the dental profession as a general dentist or dental hygienist. Licensed oral health professionals should possess the knowledge, attitudes, abilities, and skills (including procedural and technical, critical thinking and reasoning, ethical decision making, and communication) to provide safe, appropriate, patient-centered care.
- The evaluation process should recognize the changing role of the dentist and dental hygienist in healthcare and emphasize skills beyond procedural and technical competence to include other areas such as communication and safety of patient care that are relevant for leadership of the oral health care team.
- Examination and assessment for licensure should work in cooperation with the dental education community and other external assessments (CODA, NDBE) to reduce the impact on curriculum time and resources needed to support the current licensure pathways.

Principle 3

There are a variety of pathways to licensure that can be demonstrated as valid and reliable alternatives to the current patient-based components of the examination process.

- Third party evaluation can take place in a variety of settings and assessments, such as OSCE, Portfolios, and in residency programs.
- Alternative pathways should be valid, or accurately measure what they intend to measure, and be reliable, or demonstrate stable and consistent results. Currently, there are two alternative clinical

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pathways for dental licensure that have demonstrated to be valid and reliable; the Post-Graduate Year Residency (PGY-1) which is accepted in California, Connecticut, New York (mandated), and Washington, and the Non- Patient Based Objective Structured Clinical Exam (OSCE) which is accepted in Minnesota. California's Hybrid Portfolio is being validated. There is not an alternative clinical pathway for dental hygiene licensure.

- The pathway to licensure in combination with the pre-doctoral or dental hygiene curricula should be used to evaluate readiness for licensure.
- The pathways to licensure that involve patient care should include patients of record and be integrated into the normal sequence of care.

Principle 4

Greater license portability, including efforts to increase the number of states recognizing all licensure pathways, is an important ancillary endeavor to the adoption of multiple pathways to licensure.

- At this time, no testing agency or examination is universally recognized by each state. The portability of licensure is considered a significant barrier and needed to have mobility.
- Increased portability of various licensure pathways will support and facilitate state adoption of alternative licensure pathways.

Appendix 2—Symposium Attendee List

ADEA Symposium on the Future of Clinical Licensure Examination October 1, 2015
American Dental Education Association, Washington, DC

Guests

Dr. Melissa G. Efurd

American Dental Hygiene Association (ADHA)/University of Arkansas for Medical Sciences, Chair,
Department of Dental Hygiene

Dr. Guy Shampaine

Commission on Dental Competency Assessment (CDCA)

Dr. Robert A. Hersh

Joint Commission on National Dental Examinations (JCNDE), Chair

Dr. Steven Holm

ADA Council of Dental Education and Licensure

Ms. Nancy Honeycutt

American Student Dental Association (ASDA), Executive Director

Dr. Gary E. Jeffers

American Dental Association (ADA)/Interim Director of Admissions, University of Detroit Mercy School
of Dentistry

Dr. Mina Paul

American Association of Dental Boards (AADB), President

Dr. David Perkins

Commission on Dental Competency Assessment (CDCA), President

Dr. Joan Sheppard

Central Regional Dental Testing Service (CRDTS), Inc.

Ms. Pamela J. Steinbach

American Dental Hygiene Association (ADHA), Director, Education & Research

Dr. Carol Gomez Summerhays

American Dental Association (ADA), President-elect

Dr. Anthony J. Ziebert

American Dental Association (ADA), Vice President, Education and Professional Affairs

Dr. Nathaniel Tippit, Jr.

Western Regional Examining Board (WREB), President Elect

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Dr. Michael Glick
University at Buffalo School of Dental Medicine

Dr. Paul Leary
Chair of the New York State Dental Association Task Force on PGY-1

ADEA Task Force on Clinical Licensure Members

Dr. Leon A. Assael
University of Minnesota School of Dentistry, Dean

Dr. William R. Calnon
University of Rochester Medical Center School of Medicine and Dentistry, Professor

Dr. Steven W. Friedrichsen
Western University of Health Sciences College of Dental Medical, Dean

Dr. Jack D. Gerrow
National Dental Examining Board of Canada, Executive Director and Registrar

Dr. Bruce D. Horn
Former State Dental Board and The Joint Commission on National Dental Examinations Member

Ms. Joyce Hudson
East Central Campus, Ivy Tech Community College, Program Director of Dental Hygiene

Ms. Adrien Lewis
American Student Dental Association (ASDA), Vice President

Mr. Tim Treat
Indiana University School of Dentistry

ADEA Board of Directors

Dr. Huw F. Thomas
Chair of the ADEA Board of Directors
Tufts University School of Dental Medicine, Dean

Dr. Cecile A. Feldman
Chair-elect of the ADEA Board of Directors
Rutgers, The State University of New Jersey, School of Dental Medicine, Dean

Dr. T. Lily Garcia
Immediate Past Chair of the ADEA Board of Directors
The University of Iowa College of Dentistry & Dental Clinics, Associate Dean for Education

Dr. Kim T. Isringhausen
ADEA Board Director for Allied Dental Program Directors
Virginia Commonwealth University School of Dentistry, Dir., Division of Dental Hygiene and Preceptorship Program

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Dr. R. Lamont MacNeil
ADEA Board Director for Deans
University of Connecticut School of Dental Medicine, Dean

ADEA Staff and Consultant

Dr. Richard W. Valachovic
ADEA President and CEO

Dr. Eugene L. Anderson
ADEA Chief Policy Officer and Managing Vice President

Ms. Tami Grzesikowski
ADEA Senior Director for Allied Dental Education

Ms. Sonja Harrison
ADEA Director of Program Services

Dr. Evelyn Lucas-Perry
ADEA Director of Public Policy Research

Mr. Josh Mintz
Cavanaugh Hagan Pierson & Mintz, President

Appendix 3—Symposium Agenda, Breakout Groups and Discussion Guide

ADEA Symposium on the Future of Clinical Examination Licensure

October 1, 2015

ADEA Office (655 K Street NW, Washington, DC)

GOALS FOR THE SYMPOSIUM

To increase understanding of the multiple approaches for assessing readiness for practice and identify opportunities for collaboration among the dental education and dental licensure communities to increase acceptance and utilization of these multiple pathways to clinical licensure.

AGENDA

- 8:00 a.m. Breakfast Available
- 8:30 a.m. Open and Welcome
- Opening Remarks (Thomas and Valachovic)
 - Introductions (All)
 - Background and Context (Friedrichsen)
- 9:00 a.m. The Environment for Clinical Examination Licensure: *What's Driving Change?*
- Brief remarks on “what’s driving change” from various stakeholder groups followed by full group discussion of the changing environment
- 10:00 a.m. Break
- 10:15 a.m. Overview of Models for Assessing Readiness for Practice
- Brief overview of the five primary pathways for initial licensure
 - Traditional exam: Bruce Horn
 - PGY-1: Dr. Paul Leary, Chair of the NYSDA Task Force on PGY-1
 - Portfolio: Dr. Friedrichsen
 - OSCE in Minnesota: Dr. Leon Assael
 - CIF/Buffalo: Dr. Michael Glick
 - time for Q&A for understanding
- 11:15 a.m. Break Out Groups: The Pros and Cons of the Various Pathways
- Small group discussions (1 group per pathway) to discuss the (1) pros/cons of the model, (2) opportunities to improve the model, (3) what information we need to obtain in order to increase acceptance and utilization of the model, (4) the potential role of the licensing agencies in advancing this model and (5) the two most important actions we could take to move this pathway forward.
- 12:15 p.m. Lunch
- 1:00 p.m. Full Group Debrief and Discussion

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- 2:00 p.m. Next Steps: Opportunities for Collaboration
- Identification and prioritization of potential next steps for individual groups or collective action to advance awareness, acceptance and utilization of the multiple pathways to licensure
- 2:45 p.m. Closing Comments
- 3:00 p.m. Adjourn

**ADEA Symposium on the Future of Clinical Licensure Examination
American Dental Education Association**

**October 1, 2015
Washington, DC**

Breakout Groups

1. Traditional patient-based exam
 - a. Dr. Bruce D. Horn
 - b. Dr. Anthony J. Ziebert, American Dental Association (ADA), Vice President, Education and Professional Affairs
 - c. Dr. Mina Paul, American Association of Dental Boards (AADB), President
 - d. Ms. Nancy Honeycutt, American Student Dental Association (ASDA), Executive Director
2. PGY-1
 - a. Dr. Paul R. Leary, Chair of the New York State Dental Association (NYSDA) Task Force on PGY-1
 - b. Dr. Nathaniel Tippit, Jr., Western Regional Examining Board (WREB), President Elect
 - c. Dr. Steven Holm, ADA Council of Dental Education and Licensure
 - d. Dr. Carol Gomez Summerhays, American Dental Association (ADA), President-elect
3. Portfolio in California
 - a. Dr. Steven W. Friedrichsen
 - b. Dr. David Perkins, Commission on Dental Competency Assessment (CDCA), President
 - c. Dr. Gary E. Jeffers, American Dental Association (ADA)/Interim Director of Admissions, University of Detroit Mercy School of Dentistry
 - d. Mr. Tim Treat, Indiana University School of Dentistry
 - e. Ms. Pamela J. Steinbach, American Dental Hygiene Association (ADHA), Director, Education & Research
4. Objective Structured Clinical Examination (OSCE) in Minnesota
 - a. Dr. Leon A. Assael, Dean, University of Minnesota School of Dentistry
 - b. Dr. Guy Champagne, (ADEX)
 - c. Dr. William R. Calnon, University of Rochester Medical Center School of Medicine and Dentistry, Professor
 - d. Dr. Melissa G. Efurd, American Dental Hygiene Association (ADHA)/University of Arkansas for Medical Sciences, Chair, Department of Dental Hygiene,
5. Curriculum Integrated Format (CIF)/Buffalo:
 - a. Dr. Michael Glick, Professor, Oral Diagnostic Sciences, University at Buffalo School of Dental Medicine

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- b. Dr. Joan Sheppard, Central Regional Dental Testing Service (CRDTS), Inc.
- c. Dr. Robert A. Hersh, Joint Commission on National Dental Examinations (JCNDE), Chair
- d. Ms. Adrien Lewis, American Student Dental Association (ASDA), Vice President
- e. Ms. Joyce Hudson, East Central Campus, Ivy Tech Community College, Program Director of Dental Hygiene

**ADEA Symposium on the Future of Clinical Examination Licensure
Small Group Discussion Guide**

You have an hour to discuss the following questions, so please allow enough time to discuss each question (approximately, 10 minutes each). ADEA staff will serve as a recorder and group leader will report to the group.

Name of the model		
What are the key pros and cons of this model?	<i>Advantages/Benefits</i>	<i>Disadvantages/Challenges</i>
What opportunities exist to improve this model?		
What information do we need to better understand this model?		
What is the potential role of the testing and licensing agencies in advancing this model?		
What are the two most important actions that would help move this model forward?		
What didn’t you know about this model prior to today’s discussion?		

Appendix 4—Symposium Summary of Breakout Group Reports

ADEA Symposium on the Future of Clinical Licensure Examination Small Group Summary Reports

Disclaimer: The following is a draft summary of the five breakout group discussions. This document does not necessarily reflect the position of ADEA or any of the other organizations participating in the Symposium and is not intended for circulation or attribution.

Name of the model	CIF/UB	
What are the key pros and cons of this model?	<i>Advantages/Benefits</i>	<i>Disadvantages/Challenges</i>
	<ul style="list-style-type: none"> • Could fit into competency assessments that every school has. • Takes the testing agency out of the business of determining when the patient is treated. • Removes the “harvesting” of patients just for the exam and then discard them. • Levels the playing field (current model requires students to seek out patients with the same conditions, which becomes difficult and leads to brokering). • Improves trust and relationship between dental schools and examiners. • Not penalized for no-shows. 	<ul style="list-style-type: none"> • Logistical challenge, scheduling. • Increased faculty time and cost. • Not all schools could integrate seamlessly. • Not available to non-students.
What opportunities exist to improve this model?	<ul style="list-style-type: none"> • Looking at a DH version. • Opportunities for non-students to take the exam. • Continued evaluation and improvement. 	
What information do we need to better understand this model?	<ul style="list-style-type: none"> • Logistical details around test sites, # of students and examiners. • Complete cost analysis. Is it really no added cost (building on top of existing model)? 	
What is the potential role of the testing and licensing agencies in advancing this model?	<ul style="list-style-type: none"> • Requires the testing agency to be flexible and creative in their approach to working with schools. 	
What are the two most important actions that would help move this model forward?	<ul style="list-style-type: none"> • Schools interested in partnering. Implementing in different ways. • Advancing model to morph into more of a hybrid exam that relies more on just faculty assessment. • Evidence to support faculty as impartial evaluators. 	
What didn’t you know about this model prior to today’s discussion?	<ul style="list-style-type: none"> • No increase in cost to candidates (even after pilot). • It’s sustainable. 	

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Name of the model	Traditional Patient-Based	
What are the key pros and cons of this model?	<i>Advantages/Benefits</i>	<i>Disadvantages/Challenges</i>
	<ul style="list-style-type: none"> • Independent third party assessment • Anonymous • Known entity • Cost to candidate known in advance • Years of data available • Criteria available to candidates well in advance 	<ul style="list-style-type: none"> • Ethical issues (live patients use and all the ramifications that accompany) • Lack of dental school buy in • Doesn’t align with what a practitioner will do or what the students are taught • Remediation isn’t required in all states
What opportunities exist to improve this model?	<ul style="list-style-type: none"> • A Buffalo Model type of examination (integration) • Something without a live patient • Something similar to Medicine 	
What information do we need to better understand this model?	<ul style="list-style-type: none"> • More transparency from each testing organization (what is contributing to failure, pass rates, and published data) 	
What is the potential role of the testing and licensing agencies in advancing this model?	<ul style="list-style-type: none"> • This model is used nearly everywhere; maybe at its peak. Testing Agencies and Licensing Boards should take a leadership role and work collaboratively to promote this model. 	
What are the two most important actions that would help move this model forward?	<ul style="list-style-type: none"> • Not applicable as our model is already in place 	
What didn’t you know about this model prior to today’s discussion?	<ul style="list-style-type: none"> • Not much 	

Additional discussion: remediation and retesting varies from place (some places offer the exam only once a year so retake requires the candidate to travel with a patient to a different location. Collaboration between school and state board should be happening more.

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Name of the model	PGY-1	
What are the key pros and cons of this model?	<i>Advantages/Benefits</i>	<i>Disadvantages/Challenges</i>
	<ul style="list-style-type: none"> • Works in NY. Year of training instead of test, another year of education. Not a one-shot deal as opposed to exam. • A way to calibrate what has been learned from multiple school experiences. • Exposure to more medically-compromised patients. The four-year program is densely packed and cannot provide all the breadth of clinical experience that they will see in GPR. • From a financial standpoint, students make between 50-70K regardless of production, you take production for pay out of the equation during a formative time in their professional career. They get to defer loan. They are ready to begin practicing when they can produce more because of the GPR experience. 	<ul style="list-style-type: none"> • Millennial generation doesn’t want another year. They want license now. • Punitive to students who are ready (and fully prepared) to practice after 4 years. • Not enough programs to accommodate all graduates in other states if this option were adopted elsewhere. • Conflict of interest. Program and the individual are being enumerated by GME—money involved. If program isn’t filled, program loses money.
What opportunities exist to improve this model?	<ul style="list-style-type: none"> • More than five states recognize it. • Add CIF, improvement based on portability. Third party metric is critical to guard against bias. • Law—completion of program necessary for licensure. Modify the law making it more palatable—A single year of all advanced dental education programs would qualify as acceptance for licensure. 	
What information do we need to better understand this model?	<ul style="list-style-type: none"> • Psychometrics (that are verifiable). What’s the failure rate? Benchmark about the common practice (traditional licensing exam). 	
What is the potential role of the testing and licensing agencies in advancing this model?	<ul style="list-style-type: none"> • Take back to state boards to ask that they look at it again based on evidence. • Testing agencies should be making critical decisions about the best licensing methods based on the evidence (assessment theory not money) and sharing info with the State Boards. 	
What are the two most important actions that would help move this model forward?	<ul style="list-style-type: none"> • Psychometrics (that are verifiable). What’s the failure rate? • Finding out why other states are reluctant to accept PGY-1 in order to advocate for reciprocity. • Get more states to accept. • Advocating for GME funding through a CODA or regionally accredited institution. 	
What didn’t you know about this model prior to today’s discussion?	<ul style="list-style-type: none"> • Didn’t know that under the law, first year doesn’t apply to all advanced education programs. 	

Name of the model	Portfolio in California	
<p>What are the key pros and cons of this model?</p>	<i>Advantages/Benefits</i>	<i>Disadvantages/Challenges</i>
	<ul style="list-style-type: none"> • Implementation of portfolio for student education and reflection • Can start in 3rd year. • Exam is done on an actual patient • An all-inclusive model 	<ul style="list-style-type: none"> • Portfolio/reflection not built in • Does not have self-assessment element • What happens when the two evaluators don't agree? • Don't know all the ramifications because they've only done the alpha group • Procedures are more complex. Procedures can take more than one visit. • What happens to students that don't complete by graduation? • Cost is a big factor. • No portability • No third party oversight. • Law is proscriptive about what they want.
<p>What opportunities exist to improve this model?</p>	<ul style="list-style-type: none"> • Having examiners from other states could help with portability. 	
<p>What information do we need to better understand this model?</p>	<ul style="list-style-type: none"> • Financial implications • Can third parties be involved (testing agencies) • Liability issue 	
<p>What is the potential role of the testing and licensing agencies in advancing this model?</p>	<ul style="list-style-type: none"> • Serve as the one of the examiners, or a third examiner, along with the faculty. • Build trust with testing agencies. • CDCA has built trust by taking back what they learned during the examination to their testing agencies. • Examiners being faculty 	
<p>What are the two most important actions that would help move this model forward?</p>	<ul style="list-style-type: none"> • Doing something to help with portability. • Volume of applicants 	
<p>What didn't you know about this model prior to today's discussion?</p>	<ul style="list-style-type: none"> • How comprehensive the model is (areas tested, rubrics). • Self-assessment and how portfolio exam is not a part of the requirements. • If you fail a section there is an opportunity to re-do it and pass. 	

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Name of the model		Minnesota Model: OSCE	
		<i>Advantages/Benefits</i>	<i>Disadvantages/Challenges</i>
What are the key pros and cons of this model?		<ul style="list-style-type: none"> • Improvement made at the dental school as a result of input from the dental board; • Calibration; • Trust by all parties involved; • Model is part of a process that is overseen by a third party but doesn’t disrupt the academic process; • Correlation between OSCE performance and academic performance; • Testing for clinical performance/”thought process” and not psychomotor performance; • Redirects professional identity from “fixing teeth” and being a trade; • Cultivating a new culture at the dental school and developing confidence of graduates; and • Model has a low rate of legal challenges compared to the traditional patient-based exam 	<ul style="list-style-type: none"> • Getting buy-in; • Poor portability; • Scalability to states with more than one school; • Structure of State Boards and their willingness/ ability to be involved; and • Current disconnect between State Boards, testing agencies and dental schools.
What opportunities exist to improve this model?		<ul style="list-style-type: none"> • Improve the understanding of the comprehensiveness of the model and the history behind the drivers to implement the model and the timeline. 	
What information do we need to better understand this model?		<ul style="list-style-type: none"> • First, improving the knowledge about the model itself- the questions asked and their structure and what type of information that the questions aiming to assess. • Secondly, the results, i.e. how many students passed/failed. • Lastly, a better understanding about the contextual factors which the model operates; primarily, the structure of the State Board and their authority (decision making ability or advisory power). How was support/trust garnered from the State Board? 	
What is the potential role of the testing and licensing agencies in advancing this model?		<ul style="list-style-type: none"> • There is fatigue on the State Board so potential opportunity for the examining agencies. Use a sampling method for direct oversight of students. • Recognizing that the skills of a Board Member and different from an examiner. 	
What are the two most important actions that would help move this model forward?		<ul style="list-style-type: none"> • Education about the model, the dental school curriculum and education proves. 	
What didn’t you know about this model prior to today’s discussion?		<ul style="list-style-type: none"> • Didn’t understand the comprehensiveness of the model- beyond administering the OSCE but inclusive of engagement from the State Board in the curriculum and educational activities. • Fourth year is spent on getting ready for the traditional patient-based exam and how this falls short of value to the student (the fourth year is lost to the exam) 	

Side point: FTC ruling what will state board look like in the near future- implementing this model would need to have a flexible approach.