Report of the Task Force on Assessment of Readiness for Practice

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A Joint Task Force of:
American Dental Association, American Dental Education Association
and American Student Dental Association

Overview: A Call for Change

Each year nearly 6,000 students graduate from dental schools across the United States. To practice dentistry, they must first obtain a dental license, the purpose of which is to ensure public safety by showing that new dentists can provide safe and quality dental care on day one of their careers. Similarly, out of over 196,000 active licensed dentists in the United States, more than 10,000 moved across state lines from 2011 to 2016.[1] To continue practicing dentistry, each must obtain a new state license.

Ensuring patient safety and that each dentist meets professional standards for practice are the critical underpinnings of the dental licensure process. It is the responsibility of state boards of dentistry to establish the qualifications for licensure and subsequently issue licenses to qualified individuals.

The Task Force on Assessment of Readiness for Practice ["Task Force"] observes two challenges and priority concerns with the existing licensure process in place in most states:

- The use of single encounter, procedure-based examinations on patients[2] as part of the licensure examination.
- Mobility challenges that are unduly burdensome and unnecessary for ensuring patient safety.

First, the Task Force opposes single encounter, procedure-based examinations on patients, which virtually all states currently use to fulfill the clinical examination requirement. This approach has been demonstrated to be subject to random error; does not have strong validity evidence; is not reflective of the broad set of skills and knowledge expected of a dentist; and poses ethical challenges for test-takers, dental schools and the dental profession.

While not by design, the single encounter, procedure-based examination may not be in the best interest of the patients who participate in the examination process. In particular, these exams are administered in such a way that the focus is on a single quadrant, lesion and tooth that both best meets the exam criteria for acceptance (and will not be rejected resulting in failure of the exam) and is perceived by the candidate (test-taker) to provide the highest likelihood of success. This single focus is typically in lieu of the patient's comprehensive and most severe or urgent needs, resulting in a standard of care that may well be below today's acceptable level. Patients in the exam are often not patients of record or they have been solicited and registered at the school solely for the purpose of sitting for the exam. These patients may experience great difficulty in follow-up care, along with potentially significant liability issues regarding who is responsible for the patient's treatment, if the outcome is below the standard of care. The search for the "minimally acceptable cavity" as a path to exam success has led to the rise in patient brokering services, further compromising ethical treatment of patients. Identical challenges exist for clinical exams taken by senior dental students away from their school sites, and also for experienced dentists who must take second or third clinical exams to apply for licensure in a new state. The American Dental Association's Council on Ethics, Bylaws, and Judicial Affairs (CEBJA) published a white paper examining these ethical issues[3] and concluded that certain safeguards are necessary to protect the patient during the exam process. The patient protection protocols outlined by CEBJA mirror those used by research and academic institutions that utilize patients in medical clinical studies, serving as a nationally recognized standard by which patient rights are protected in the examination process. Unfortunately, the majority of clinical exams proceed without these recommended safeguards.

After careful study, the Task Force calls upon state dental boards to eliminate the single encounter, procedure-based patient exams, replacing these with clinical assessments that have stronger validity and reliability evidence.

Second, licensure portability also presents a significant issue for the dental profession in both expected and unexpected ways. The majority of students at over half of the country's dental schools do not practice in the same state where they were educated. For students in states with restrictive licensure policies, the cost of licensure in another state is often extremely expensive and unnecessarily burdensome. A similar burden exists for the over 10,000 active licensed dentists who moved across state lines between 2011 and 2016.

Restrictions on portability of dental licensure also have some unexpected impacts on society:

- Although dentists serving in the military and federal services are afforded a level of professional mobility, their spouses are not. When following a spouse or partner to a new military posting, the civilian spouses who are practicing dentists may be forced to spend significant financial resources and time submitting extensive documentation required for licensure by credentials; some are also required

to re-take a procedure-based patient clinical exam. Others simply stop practicing, which impacts their professional identities and their family's economic stability and further reduces access to care.

- Academia is a highly mobile profession. Dental school faculty who move across state lines for employment must go through a similar process as described above. While it may be possible for faculty members to get a "restricted license" to teach in the dental school clinic, they are typically not allowed to participate in either faculty practice or private practice. Most clinical faculty members see patients in the school's faculty practice or private practice one or more days per week in order to remain current and supplement their income. As a result, this type of limited license, which diminishes the individual's earning power and practice opportunities, creates a challenge for schools when recruiting new faculty members.
- Restrictions on mobility also impact dentists' ability to participate in volunteer outreach efforts to increase access to care, such as Missions of Mercy, Remote Area Medical or emergency response such as the response to Hurricanes Harvey, Irma and Maria in 2017. While some states allow for volunteer licensure, particularly for the provision of free dental care, most do not.

Barriers to licensure can have adverse impact on state and local economies. The federal government and the Federal Trade Commission (FTC) are also interested in the requirements for obtaining occupational licensure at the state level. This interest includes licensure of the health professions, with dentistry featured predominantly in several papers. According to Kleiner in *Reforming Occupational Licensure Policies*:

> "…by making it more difficult to enter an occupation, licensing can affect employment in licensed occupations, wages of licensed workers, the prices for their services, and worker economic opportunity more broadly. Indeed, economic studies have demonstrated far more cases where occupational licensing has reduced employment and increased prices and wages of licensed workers than where it has improved the quality and safety of services.[4]"

Johnson and Kleiner pointed out in 2017[5] that occupational licensure, one of the most significant labor market regulations in the United States, may restrict the interstate movement of workers. They analyzed the interstate migration of 22 licensed occupations. Of note, the paper stated:

> "…three occupations stand out as showing substantially limited interstate migration, at a level comparable to lawyers: social workers, dental hygienists, and dentists."

As our nation becomes more mobile, these challenges will only grow worse over time. The Task Force calls upon state dental boards to enact changes that allow for increased licensure portability and to critically evaluate their licensure-by-credentials regulations and statutes, with the goal of accepting a common core of credentials that can serve as a basis for licensure compacts.

In summary, the Task Force calls upon state dental boards to amend their licensure requirements to (1) eliminate single encounter, procedure-based examinations on patients; (2) allow for increased initial licensure portability; and (3) work on the national level to establish a common core of dentist credentials for licensure that can serve as a basis for licensure compacts between states. This paper provides a summary of the existing licensure process and proposes new approaches to licensure.

Overview of Existing Licensure Processes

State boards of dentistry are entrusted with establishing the qualifications for licensure and for issuing licenses to qualified individuals as part of their responsibility to protect the public. This includes establishing rules of practice and conduct and taking disciplinary action against licensees who engage in misconduct. Though requirements vary by state, all dental licensure applicants must meet three basic requirements: an education requirement, a written examination requirement and a demonstration of clinical competence.[6]

1. The **educational requirement** in all states is a D.D.S. (doctor of dental surgery) or D.M.D. (doctor of dental medicine) degree from a university-based dental education program accredited by the Commission on Dental Accreditation (CODA). CODA is nationally recognized by the U.S. Department of Education as the sole agency to accredit dental, advanced dental and allied dental education programs conducted at the post-secondary level. CODA accreditation is evidence that the dental school meets predetermined quality assurance standards including requirements for documentation

of student competency (i.e., readiness for practice) throughout the D.D.S./D.M.D. curriculum.

2. All U.S. licensing jurisdictions require evidence that a candidate for licensure has passed a comprehensive **written examination**, called the National Board Dental Examination (NBDE). Currently this is a two-part exam. Part I covers biomedical sciences, dental anatomy and ethics. Part II covers clinical dentistry and case-based components, including diagnosis, ethics, critical thinking and patient management. In 2020, Parts I and II will be phased out and replaced by a single exam, the Integrated National Board Dental Examination (INBDE), which will combine and integrate the content areas of Parts I and II. The Joint Commission on National Dental Examinations (JCNDE), an independent agency, admnisters the NBDE and will administer the INBDE.
3. Currently, candidates for dental licensure in virtually all U.S. licensing jurisdictions must pass a single encounter, procedure-based **clinical examination** demonstrating a limited set of psychomotor skills (hand skills). Each state board of dentistry establishes its clinical examination requirement(s). Five regional testing agencies administer the four procedure-based clinical examinations; not all states accept all exam results even though the examinations are comparable. The result is limited licensure portability for dentists. Meanwhile, a growing number of states have adopted, or are in the process of adopting, pathways to licensure that do not include the single encounter performance of procedures on a patient.

The Task Force recognizes and supports the critical role that state dental boards perform in protecting the public through the licensure process. The Task Force remains committed to ensuring the highest levels of professionalism, ethical behavior and clinical competence through the licensure process and believes that third-party review, at key moments in the licensure process, is essential for ensuring trust and credibility in the process.

In light of the rationale presented, the Task Force members are all on record in opposition to single encounter, procedure-based examinations on patients currently utilized by all states (with the exception of the state of New York, which requires completion of a PGY1 in lieu of a single encounter clinical exam) to fulfill the clinical examination requirement. As stated earlier, the single encounter, procedure-based clinical examination is subject to random error; does not have strong validity evidence; is not reflective of the broad set of skills and knowledge expected of the new dentist; and poses ethical challenges for the test-takers, the dental schools and the dental profession. For all these reasons, the random error inherent in the current clinical examinations that require single encounter, procedure-based examinations on patients cannot assure that the public is being protected at the highest levels from unsafe beginning dentists.

Federal Government Interest in Occupational Licensure

"States' legal authority to license professions is well-established. In 1889, the Supreme Court in *Dent v. West Virginia* established the rights of States to license professions. Under a line of cases starting with *Parker v. Brown*, State licensing boards have been assumed to be shielded from Federal antitrust liability, in the same manner as State courts and legislatures. However, in a recent decision, *North Carolina State Board of Dental Examiners v. Federal Trade Commission*, the Supreme Court held that state licensing boards are not automatically exempted from antitrust scrutiny. Under the standard articulated by the Court, if a controlling number of board members are themselves 'active market participants,' then the licensing board's conduct is only immune from antitrust scrutiny if it is (1) clearly articulated State policy, and (2) actively supervised by the State. The extent to which the Court's decision will in practice increase State licensing boards' exposure to antitrust actions and constrain occupational regulation is unclear" (from *Occupational Licensing: A Framework for Policymakers*[7]).

Two white papers released in 2015 on occupational licensure contain references to dental licensure: *Reforming Occupational Licensing Policies,*[4] which was prepared by the Hamilton Project and The Brookings Institution, and *Occupational Licensing: A Framework for Policymakers,*[7] a White House report prepared by the Department of the Treasury Office of Economic Policy, the Council of Economic Advisers and the Department of Labor. Both papers come to essentially the same conclusion:

> "When designed and implemented appropriately, licensing can benefit practitioners and consumers through improving quality and protecting public health and safety. This can be especially important in situations where it is costly or difficult for consumers to obtain information on service quality, or where low-quality practitioners can potentially inflict serious harm on consumers

> or the public at large…. Yet while licensing can bring benefits, current systems of licensure can also place burdens on workers, employers, and consumers, and too often are inconsistent, inefficient, and arbitrary. The evidence in this report suggests that licensing restricts mobility across States, increases the cost of goods and services to consumers, and reduces access to jobs in licensed occupations. The employment barriers created by licensing may raise wages for those who are successful in gaining entry to a licensed occupation, but they also raise prices for consumers and limit opportunity for other workers in terms of both wages and employment."

In the White House report, restrictive dental licensure is specifically referenced:

> "While older research suggests that more stringent entry requirements are associated with lower rates of untreated dental disease, more recent studies that control for potentially confounding factors find no evidence that tighter dentistry licensing requirements lead to better dental health, though they do lead to higher prices."

The FTC's Economic Liberty Task Force followed up on these papers with two webinars: one on July 27, 2017, examined ways to mitigate the effects of state-based occupational licensing requirements that make it difficult for license holders to obtain licenses in other states, and the other on November 7, 2017, examined empirical evidence on the effects of occupational licensure.

Finally, the National Conference of State Legislatures has selected 11 states for a public policy consortium that will familiarize participants with occupational licensing policy in their own states and occupational licensing best practices in other states. Each state will begin implementing actions to remove barriers to labor market entry and improve portability and reciprocity.

These initiatives highlight the need for the profession to become involved early in the process; otherwise, federal entities may impose solutions on dental boards and state legislatures.

A Contemporary Approach to Initial Dental Licensure

In the past, state dental boards understandably relied on the single encounter, procedure-based clinical examination, as there were few proven alternatives and varying points of view regarding the rigor of the CODA accreditation process and both the scope and rigor of school-based assessment processes. However, thanks to the adoption and evolution of competency-based education in accredited dental schools over the past 25 years, along with new effective pathways for dental clinical assessment, state dental boards no longer need to rely on this dated approach for the clinical assessment of candidates for licensure.

There is a critical need to modernize the dental licensure process that reflects current practices in pedagogy, assessment and licensure and that includes opportunities for third-party review and assurance throughout the process.

The Task Force proposes a modernized process for initial licensure that includes the following three components:

1. Completion of a D.D.S. or D.M.D. degree from a university-based dental education program accredited by the Commission on Dental Accreditation, which requires documentation of clinical competence and the assessment of psychomotor skills ("hand-skills");
2. Passage of the National Board Dental Examination, a valid and reliable written test of applied knowledge; and
3. Successful passage of a valid and reliable clinical assessment that does not require single encounter, procedure-based examinations on patients. Examples include: an Objective Structured Clinical Examination (OSCE); or graduation from CODA-accredited PGY-1 program; or completion of a standardized compilation of clinical competency assessments designed to demonstrate psychomotor skills and practice relevant patient care knowledge, skills and abilities (e.g., California Hybrid Portfolio or Compendium of [Clinical] Competency Assessments).

Overview of the Proposed Licensure Process

The table below describes a proposed licensure process and demonstration of skills as well as the role of third-party review.

Component 1 of the Licensure Process

Completion of a D.D.S. or D.M.D. degree from a university-based dental education program accredited by the Commission on Dental Accreditation (CODA), which includes documentation of clinical competence and the assessment of psychomotor skills ("hand-skills").

What This Demonstrates	Third-Party Review
The awarding of a D.D.S. or D.M.D. degree demonstrates that the student has fulfilled all the requirements of the educational program leading to that degree, including a comprehensive assessment of the graduate's ability to be a safe, beginning practitioner. CODA accreditation ensures that the dental schools' processes meet the quality standards in six areas established for dental education programs, including the requirement that graduates demonstrate specified competencies. Throughout the dental school experience, students must demonstrate competence by challenging hundreds of school-based competency examinations. Over time, students and their institutions develop a compendium of competency assessments that demonstrates the acquisition of relevant knowledge and ability across all competencies that meets pre-specified criteria for success.[8] School-based competency examinations go far beyond the current single encounter clinical examination and include multiple measures of competencies across a wide range of clinical and non-clinical competencies.	The dental schools are accredited by the Commission on Dental Accreditation (CODA). CODA has the authority to make independent accreditation decisions. Reaccreditation for dental programs occurs every seven years, and CODA monitors dental programs for continued compliance with all quality standards between the formal accreditation reviews. The CODA Board of Commissioners has a fiduciary responsibility to the Commission, not to the agency that appoints them. CODA is recognized by the U.S. Department of Education as the sole agency for accrediting dental education programs. This recognition assures the public that the CODA meets quality standards for accreditation of educational programs. CODA must renew its recognition every five years. The Commission must demonstrate to the U.S. Department of Education that conflicts of interest are appropriately handled and cannot affect accreditation decisions. To build trust and credibility in the independence and objectivity of school-based competency exams, the Task Force recommends that state dental boards work in partnership with the dental schools in their state to develop methods for the calibration, quality assurance and third-party auditing of these exams. Potential examples include engagement of state dental board members on key dental school committees; "auditing" of data, images and other documentation from the competency exams; utilizing faculty as examiners; and creating opportunities for observation by state board members of these challenge exams.

Component 2 of the Licensure Process

Passage of the National Board Dental Examination, a valid and reliable written test of didactic knowledge.

What This Demonstrates	Third-Party Review
The National Board Dental Examination is a standardized, comprehensive set of examinations covering the basic biomedical sciences, dental anatomy, ethics and clinical dental subjects, including patient management. Note: Currently, the exam is divided into Part I and Part II, but as the dental school curriculum has moved to a more integrated format, the Joint Commission on National Dental Examinations (JCNDE) will transition to the Integrated National Board Dental Examination in 2020.	The National Board Dental Examination is administered by the Joint Commission on National Dental Examinations (JCNDE). The Joint Commission has authority to make independent decisions regarding exam content and administration. Members of the JCNDE Board of Commissioners have a fiduciary responsibility to the Joint Commission, not to the agency that appoints them. The Joint Commission's examination program meets the quality standards for high stakes testing as outlined in the *Standards for Educational and Psychological Testing*. Accordingly, the JCNDE publishes and makes publicly available its annual *Technical Report* documenting the reliability and validity evidence for each examination.

Component 3 of the Licensure Process

Successful passage of a valid and reliable clinical assessment that does not require single encounter, procedure-based examinations on patients. Three examples are provided:

What This Demonstrates	Third-Party Review
EXAMPLE 1. Objective Structured Clinical Examination (OSCE). An OSCE is a high-stakes examination consisting of multiple, standardized stations, each of which require candidates to use their clinical knowledge and skills to successfully complete one or more dental problem-solving tasks. The OSCE provides information to dental boards about whether a candidate for dental licensure possesses the necessary level of clinical knowledge and skills to safely practice entry-level dentistry thought the use of a valid and reliable examination. The OSCE can protect public health more effectively than current clinical licensure exams. Traditionally, an OSCE format used in health professions training and testing may include physical materials, such as radiographs, photographs, models and order/prescription writing. Advances in computer-based testing, simulated patient and haptic technologies suggest that these modalities may be incorporated into the OSCE format in the future. OSCEs are widely used across the health sciences, including the United States Medical Licensing Examinations, and are used by the National Dental Examining Board of Canada for dental licensure in that country.[9] Note: The Dental Licensure Objective Structured Clinical Examination (DLOSCE) is currently being developed by the ADA's Department of Testing Services, which is staffed by testing professionals with advanced degrees in psychological measurement and related fields. The Department of Testing Services has significant experience in the development of standardized tests for the dental and dental hygiene communities.	The OSCE is utilized by state dental boards — in conjunction with the school-based competency assessments — to fulfill the clinical examination requirement. The OSCE is administered by an independent, third-party testing agency, similar to the process used for the National Dental Board Examination.

Component 3 of the Licensure Process (continued)	
What This Demonstrates	**Third-Party Review**
EXAMPLE 2. Graduation from CODA-accredited PGY-1 program. PGY-1 is completion of a residency program at least one year in length at a CODA-accredited clinically based advanced general dentistry and/or specialty residency program. PGY-1 programs are designed to provide education beyond the level of D.D.S./ D.M.D. programs in oral health care, using applied basic and behavioral sciences. The programs are designed to expand the scope and depth of the graduates' knowledge and skills to enable them to provide comprehensive oral health care to a wide range of populations.	PGY-1 programs are CODA-accredited and competency-based.
EXAMPLE 3. Completion of a standardized compilation of clinical competency assessments designed to demonstrate psychomotor skills and practice relevant patient care knowledge, skills and abilities that is accepted by licensing jurisdictions (e.g., California Hybrid Portfolio or Compendium of [Clinical] Competency Assessments). The compilation of clinical competency assessments is a standardized approach to assessing psychomotor skills and practice relevant patient care knowledge, skills and abilities for licensure that is accepted by licensing jurisdictions. The compilation of clinical assessments uses the evaluation mechanisms currently applied by the dental schools to assess student competence. The compilation of clinical assessments can evaluate candidate performance in a broader range and complexity of common dental procedures, in addition to newer clinical procedures and technologies, than single encounter, procedure-based examinations on patients. An approved compilation will consist of competencies assembled using selected measures of assessment, will be collected over the course of time and will support provision of comprehensive patient care. Examples include the California Hybrid Portfolio and Compendium of (Clinical) Competency Assessments. Note: The Compendium of (Clinical) Competency Assessments, a standardized set of clinical competency assessment, is currently being developed by a working group of members of the American Dental Education Association. The working group contains representation of dental and allied dental educators and experts in competency assessment.	Performance is assessed by calibrated examiners who are members of the dental school faculty. The dental board routinely audits the examinations to ensure reliability and objectively.

Increasing Dental Licensure Portability

The more contemporary approach to the clinical licensure process outlined in the preceding section is focused on the *initial* licensure process. Initial licensure is the process through which a first-time candidate, who does not hold a dental license in another jurisdiction at the time of application, applies for and receives a dental license.

While pursuing the goal of a modernized process for dental licensure that does not contain single encounter, procedure-based examinations on patients, in the near term, the Task Force is seeking to enhance the professional mobility and success of the nearly 200,000 active licensed dentists in the United States by two primary means:

1. Through increased portability of licensure, and
2. By enabling new graduates to use any of the available examination modalities to obtain a license.

To this end, while acknowledging that there are subtle differences among the traditional single encounter, procedure-based examinations on patients administered by the five clinical testing agencies, an analysis conducted by the ADA found that these clinical examinations "adhere to a common set of core design and content requirements that renders them *conceptually comparable*."

What makes these clinical examinations conceptually comparable?

- All reported additional reliance on subject matter experts to inform test specifications (for exams with information available).
- All include both patient-based and manikin-based test sections.
- All require candidates to pass each examination section in order to pass the examination.
- All rely on subject matter expert ratings of candidate performance (typically three subject matter experts).
- All have procedures for selecting, training and evaluating subject matter experts (for exams with information available).
- All use established scoring rubrics that share many common characteristics, but also present some differences.
- All employ criterion-referenced performance standards (cut scores) to facilitate use of examination results by state boards.
- Most examinations use compensatory scoring within test sections, as well as the concept of "critical errors." Some examinations also include penalty points in scoring.
- The five clinical testing agencies differ significantly with respect to the amount of validity and reliability evidence made publicly available.

Currently more than half of the states accept passing results from all five regional testing agencies, while 10 states accept two or three of the available exams and four states accept only one of the available exams. Recognizing that the transition to a more contemporary approach for dental licensure that eliminates the use of single encounter, procedure-based examinations on patients will take time to implement across the 53 licensing jurisdictions and in light of the fact that more than half of the states currently accept results from all five testing agencies, the Task Force calls upon state dental boards to accept all clinical examinations and pathways to licensure until this transition is complete.

Once a dentist passes a clinical examination, receives a license and has been actively practicing for several years, a process exists for obtaining licensure by credentials in the majority of states (exceptions are Delaware, Florida, Hawaii, Nevada and the Virgin Islands). However, licensed dentists who relocate to another state (or whose practice crosses state lines) in many cases are forced to expend significant financial resources and time submitting extensive documentation required for licensure by credentials; some are required to re-take a procedure-based patient clinical exam.

No consensus exists among state dental boards of what constitutes a credential for licensure; therefore, licensure by credentials varies significantly among the states. A credential is defined as "diplomas, degrees, certificates, and certifications, in order to attest to the completion of specific training or education programs by students, to attest to their successful completion of tests and exams, and to provide independent validation of an individual's possession of the knowledge, skills, and ability necessary to practice a particular occupation competently."[10] Based on this definition, many of the most common requirements for "licensure by credentials" are, in fact, not credentials and do not provide dental boards with a reliable or valid measurement of whether an individual already licensed in one or more states will provide competent dental care in another state:

Credential

Dental school diploma from accredited program
Specialty certificate/master's degree from accredited program
Specialty Board certification
GPR/AEGD certificate from accredited program
Current license in good standing
Criminal background check
Passing grade on an initial clinical licensure exam
Documentation of completion of continuing education

Not a Credential

Interview
Oral examination
Hours/years of practice
Affidavits from colleagues/letters of recommendation
Physician statement of good health
Case presentation
Retake of a clinical licensure exam, or a portion thereof
Dental school transcripts

The Task Force calls for state dental boards across the country to allow for increased mobility for new and practicing dentists by (1) accepting all clinical examinations and pathways to licensure for the purpose of licensure portability in the short-term, (2) accepting a common core of requirements for licensure by credentials in the mid-term, and (3) investigating the establishment of licensure compacts among states in the longer-term.

An Environment of Trust: A Necessary Precursor to Change

There is a common attribute among a handful of states in which new and additional pathways to licensure have been adopted. That is, a high degree of trust exists among the state dental board, the state dental association and the dental schools located within the state.

For this contemporary approach to licensure to be successful, there must be a strong partnership among these entities based on transparency, communication, collaboration and mutual understanding. State dental boards should have trust and confidence that a combination of a graduate's D.D.S./D.M.D. degree from a university-based CODA-accredited program including the assessment of psychomotor skills (hand skills), passage of the NBDE and successful completion of a reliable and valid OSCE examination or a PGY1 program or a standardized compilation of clinical competency assessments assures the public of a competent practitioner.

The Task Force believes that for this to occur, there needs to be increased understanding of the:

- CODA accreditation process and confidence that CODA accreditation is a credible marker of the quality standards for dental schools and advanced dental education programs; and
- Rigor of the competency-based challenge examinations performed in dental schools and advanced dental education programs, the independence and objectivity of the assessment process, and the development of appropriate methods of third-party oversight of this process to ensure credibility; and
- Purpose and methodology of the OSCE, including the Dental Licensure Objective Structured Clinical Examination being developed by the ADA's Department of Testing Services, and the validity and reliability of this clinical exam that does not utilize performance of procedures on patients for licensure decisions; and
- Challenges to professional mobility and access to care created by current licensure portability restrictions.

The members of the Task Force believe that collectively, we can achieve our long-term goals of creating a valid and reliable process for dental licensure that does not include single encounter, procedure-based examinations on patients and increasing the portability of dental licensure among all states for the benefit of both the public and the profession.

Endnotes

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2 Single encounter, procedure-based examinations on patients are administered by five dental clinical testing agencies in the United States. The candidate is required to preselect usually up to three patients who have met predetermined criteria and to ensure the patients are present on the day of the test. The test takes place on one day. During this single encounter the candidate must perform the following treatment on the patient(s): periodontal scaling/root planing, an anterior restoration, and a posterior restoration. Patients receive only these specific, limited procedures.

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