

**Dental Exam Review Board  
October 12, 2018  
Tempe, Arizona**

**EXECUTIVE SUMMARY**

**Present:**

Dr. Leonard Aste, UT	Dr. Norman Magnuson, President
Dr. Byron Blasco, NV	Dr. Dennis Manning, IL
Dr. Bryce Castillon, WY	Dr. Scott Morrison, Assist. Dir. of Dental Exams
Dr. Nathan Catmull, ID	Dr. Mike Mulvehill, Educator Member
Dr. Mark Christensen, WREB Consultant	Dr. Rudy Ramos, Chair
Dr. Bill Dill, AR	Dr. Robert Shaw, WA
Dr. Greg Evanoff, ND	Dr. Roger Stevens, KS
Dr. Amy Fine, OR	Dr. Burrell Tucker, NM
Dr. Bruce Horn, Dir. of Dental Exams	Dr. Greg Waite, AZ
Dr. Michael Howl, OK	Beth Cole, Chief Executive Officer
Dr. George Johnston, MT	Sally Clifford, Chief Operating Officer
Dr. William Kane, MO	Sharon Osborn Popp, PhD, Testing Specialist
Dr. Thomas Kovaleski, AK	Denise Diaz, Director of Dental Operations
Dr. Huong Le, CA	

The meeting was brought to order at 8:30 am by the DERB Chair, Dr. Rudy Ramos. Dr. Ramos welcomed members and introductions were made.

**Committee Reports**

Drs. Bruce Horn and Scott Morrison presented the committee reports and included recommendations prepared by the Committee Chairs. Reports were presented for the Perio, Operative, CTP, and Endo committees.

**Psychometric Update**

Dr. Sharon Osborn Popp presented an overview of the 2018 exam statistics, including an update on examiner performance and 2018 dental exam results.

**Practice Analysis Results**

Dr. Sharon Osborn Popp reviewed the results of the 2018 practice analysis done in conjunction with CRDTS. The survey was sent to over 11,000 general practitioners in nine states.

**Role of the Exam Review Boards**

Beth Cole gave a brief summary of the evolution of the Dental and Hygiene Exam Review Boards (DERB and HERB). The Board of Directors responsibilities include strategic, legal, and financial. The Board of Directors makes final decisions, but the ERBs provide input to WREB from member state boards through their representatives. In return, WREB provides information back to state boards through ERB representatives. The expectation is that ERB members share the information with their state boards to help them stay abreast of developments to the WREB exam. The timing of the ERB meetings was modified to work better with the timing of committee workflow the implementation of changes. Two of the most critical roles of the ERBs are that they elect representatives to the Board of Directors and its

officers. The ERBs also ratify changes to the bylaws. The ERBs are a vehicle for two-way communication between member state boards and WREB, specifically related to clinical licensure topics such as exam content and administration. Any input received from DERB is submitted for committee consideration. If implemented, an 18-24 month turnaround can be expected. DERB members' roles includes bringing comments, feedback, and suggestions from their respective state boards, advocating for WREB in the examining community, and sharing information about what they hear about WREB, both negative and positive. Future meetings will be once a year, probably in the fall. At future meetings WREB will request that each member report meaningful information on *exam-related* topics.

### **Reports from States on Clinical Licensure Testing Topics**

Each representative briefly reported on behalf of their respective state boards.

### **WREB Update**

Beth Cole provided an update on internal changes. She reviewed the addition of new staff, including Sally Clifford, WREB COO, and the expansion of the IT department, which had several new positions added in the last six months. Beth Cole also noted that WREB is intent on keeping state board members involved so that they maintain an understanding of the exam. With the influx of new examiners, it is becoming increasingly difficult to give all examiners the minimum of two required exams. This is also challenging because WREB needs a newer demographic to build future leadership. As such, Beth informed the DERB that she would like to gather input from members on how to manage this dilemma.

### **Election Results**

Dr. Ramos reported the following election results:

- Dale Chamberlain, President
- Rob Lauf, President-elect
- Marshall Titus, Treasurer
- Mike Moriarty and Jonna Hongo, Members-at-large

### **New Business**

The floor was opened for members to request new business to be discussed at the next meeting. Dr. Roger Stevens stated that in the bylaws, ERB members are referred to as elected, but they are actually appointed by states. He also pointed out that the bylaws state the President-elect should be the chair of the nominations committee. He recommended this either be followed, or the language be updated to reflect what is actually done.

The meeting was adjourned.

Respectfully Submitted,  
Denise Diaz  
Director of Dental Operations

## **WREB Dental 2018 Examination Brief Psychometric Update Regarding Examination Changes**

**2018 Dental Exam Sections** (all are graded anonymously by three calibrated, independent examiners)

1. Comprehensive Treatment Planning (CTP) Section (constructed-response; graded by examiners)
2. Operative Section (patient-based)
3. Endodontics Section (manikin-based, universal precautions & patient position apply)
4. Periodontal Treatment Section (patient-based)
5. Prosthodontics Section (manikin-based, universal precautions & patient position apply)

### **WREB 2018 Dental Examination**

#### **Comprehensive Treatment Planning (CTP) Section**

No changes have been made to the CTP examination. The CTP examination committee continues to expand the number of patient cases that may be administered to candidates. CTP requires a candidate to review materials for three diverse patient cases (including one pediatric patient), construct treatment plans for each and answer open ended questions associated with each case. Test specifications include operative restoration, prosthodontics, periodontics, endodontics, surgery, oral pathology, pediatric dentistry, pharmacology and specialist referrals.

#### **Operative Section**

The Operative section is the same as it has been for many years with one exception. The key difference is that if a candidate demonstrates competence on one Class II procedure, he or she is exempt from performing a second procedure. An Operative procedure is a complex task that requires a high level of skill; successful completion cannot happen by accident. If a candidate completes one procedure successfully, there is a high probability that he or she will do so again. False positives are extremely rare. Years of Operative section data show that candidate performance is highly comparable on both procedures.

When two procedures are completed, the scores are averaged; that is, a candidate who did not score at the passing cut of 3.00 or higher on the first procedure cannot pass with a 3.00 on the second procedure. The second procedure score must *exceed* the passing score of 3.00 by at least the difference (e.g., if a candidate earned 2.80 on the first, he or she would need 3.20 or higher on the second to attain an average of at least 3.00). If a candidate who scored above 3.00 on the first procedure elects to complete a second procedure, he or she risks failing if the average of the two procedures does not meet or exceed 3.00.

About 11% of those that scored 3.00 or higher on their first procedure elected to perform a second procedure and of those, all but one of them passed the section after both procedures (i.e., one out of 222, less than half of one percent). After looking at this closely, that one candidate would have passed had it not been for an administrative penalty (and the candidate went on to pass upon retake at another exam site).

Of those that scored below 3.00 on their first procedure and were eligible to proceed to the second procedure (i.e., they did *not* incur a critical error), less than 60% pass. Those that do pass after the second procedure typically score close to 3.00 on their first procedure. In summary:

- Performance continues to be highly related on both Operative procedures
- Nearly all Candidates that would have passed after their first procedure pass after their second (all but one, charged with two unapproved Modification Requests)
- Candidates who score below 3.00 after their first procedure and pass after two procedures, are far more likely to have scored close to 3.00 on first
- Reliability and technical quality remain high
- 42% (1,907) fewer patient procedures were needed to attain the same outcomes regarding competence

### **Endodontics Section**

Prior to 2018, the Endodontics section required candidates to submit extracted teeth on which to perform the anterior and posterior endodontics procedures assessed in the section. After years of evaluating simulated teeth in search of a high-fidelity and standardized substitute for extracted human teeth, the WREB Endodontics Committee finally found and field-tested high quality, custom-manufactured teeth prior to 2018. The teeth have both an enamel-like substance and a dentin-like substance and hold up well to the heat and instrumentation characteristic of actual practice. The WREB custom-manufactured teeth are not available to candidates; however, candidates may obtain *similar* but not identical teeth from the manufacturer for practice and familiarization.

The teeth are evaluated by examiners radiographically on access, instrumentation and obturation for the anterior tooth and on access, with identification of all canals for the posterior tooth. Field-testing was extensive and forecasted that 2018 passing percentages would be comparable to previous years. Passing rates, after 32 of 33 exams are highly comparable to previous years (i.e., no statistically significant difference) and average raw exam points over the past five years are within 0.02 points of 2018 results.

### **Periodontal Section optional for states that do not require a patient-based Periodontal section.**

Most WREB member states, as well as most non-member states that accept the WREB examination in support of licensure, require a patient-based Periodontal section. The Periodontal section remains an included section on the WREB dental exam unless a candidate opts out. Only 4.2% of all dental exam attempts in 2018 (after 32 of 33 exams) did not include the Periodontal section. Periodontal content is also covered on the CTP section of the exam.

### **New Prosthodontics Section**

Some states continue to require a practical Prosthodontics section. To support portability for candidates, WREB developed an optional Prosthodontics clinical section. WREB does not require the Prosthodontics section because a) the treatment of ivory teeth has low fidelity to actual practice and b) prosthodontics (including diagnosis, planning, FPDs, RPDs, complete

dentures, implants, referrals, writing of laboratory prescriptions, etc.) is covered on the CTP section of the exam.

Almost one-third of candidates opted to include the Prosthodontics section in their WREB exam attempt in 2018. The exam is functioning very well psychometrically, with high reliability and technical quality. Passing percentages are highly comparable to Endodontics passing percentages, as expected from field-testing. The by-all-attempts pass rate is 93.4% after 32 of 33 exams (the by-all-attempts pass rate for Endodontics is 92.9%).

### **Onsite Retakes**

In 2018, many candidates who were unsuccessful on the Endodontics, Periodontal, or Prosthodontics sections could opt to retake the section during the same two and one half days of the exam. (Onsite retakes are not an option for the Operative section.) If a candidate has incurred a critical error or has failed the section a third time (which requires documentation of remediation prior to retake) he or she is not eligible for onsite retake. So far in 2018, after 32 of 33 exams, 7.4% of all exam attempts included an onsite retake.

The availability of onsite retakes led to a significant decrease in the number of candidates who failed the WREB Dental examination upon their initial attempt and then never returned for a retake. In 2016 and 2017, 2.5% and 2.3%, respectively, of unsuccessful initial Dental exam attempts remained failures without retake (i.e., over 50 candidates each year never returned after initial failure). In 2018, only 1% (i.e., fewer than 25 candidates) of unsuccessful initial exam attempts have not returned for retake.