Dental Assisting National Board, Inc. (DANB)
American Dental Assistants Association (ADAA)

Executive Summary

Position Paper of the
ADAA/DANB Alliance

Addressing A Uniform National Model For The Dental Assisting Profession

September 2005

Dental Assisting National Board, Inc., Chicago, Illinois

A. Introduction

In November 2000, a joint committee of the American Dental Assistants Association (ADAA), the national membership association for dental assistants, and the Dental Assisting National Board, Inc. (DANB), the nationally recognized and accredited dental assisting testing and credentialing organization, initiated a four-phase study of dental assisting core competencies. The goal of the study was to rank dental assisting tasks from most basic to most complex and to classify these tasks into clearly delineated categories or task groupings, each associated with a pre-defined level of education, training, and experience. In classifying these tasks, the joint committee, known as the ADAA/DANB Alliance, sought to create a unified set of definitions related to dental assisting tasks, career levels, and educational/training/credentialing requirements and to lay the foundation for nationwide acceptance and recognition of a uniform national model for the dental assisting profession.

The ADAA/DANB Alliance discusses the findings of this study and the implications of those findings in the *Position Paper of the ADAA/DANB Alliance Addressing a Uniform National Model for the Dental Assisting Profession*.[1] This Executive Summary will outline the issues addressed in the ADAA/DANB Alliance's position paper, including the factors affecting current dental assisting practice, the findings of the DANB/ADAA Study to Define and Rank Core Competencies for Dental Assistants, and the implications of the study's findings as they relate to the profession of dental assisting, the delivery of oral healthcare services, and the health and welfare of the public. (See Appendix A for the Table of Contents of the complete *Position Paper of the ADAA/DANB Alliance Addressing a Uniform National Model for the Dental Assisting Profession.*)

B. The Current State of Dental Assisting Education, Credentialing, and Regulation

Regulation of the Practice of Dental Assisting

Currently, there is no national set of guidelines that governs the practice of dental assisting in the United States. Each of the 50 states has a dental practice act governing the practice of dentistry, and the 50 dental practice acts define the allowable activities of dental assistants to varying degrees: Some state practice acts permit dental assistants to perform any reversible procedure, while others specifically enumerate the tasks that dental assistants are permitted to perform. Many states require registration, licensure, permits, or national certification before dental assistants can perform certain advanced or "expanded" functions, while others permit dentists to delegate tasks to any assistant whom a dentist deems competent. In states where dental assistants are allowed to perform expanded functions, various levels of supervision by the dentist may be required. A few states/districts do not address the practice of dental assisting at all. The spectrum of variation among the 50 states is very broad, and the lack of uniformity makes a state-by-state comparison of the dental assisting profession a time-consuming and labor-intensive proposition.

However, despite the lack of uniformity among the 50 states, certain generalizations about the dental assisting profession can be made, and certain trends can be identified. Dental assistants are explicitly or implicitly recognized in the dental practice acts or administrative rules of 49 states. The dental practice acts and/or administrative rules of a majority of states (31) explicitly or implicitly recognize *more than one level* of dental assistant and restrict the performance of certain advanced functions to dental assistants who complete certain educational or clinical experience requirements or who hold

[1] ADAA/DANB Alliance. *Position Paper of the ADAA/DANB Alliance Addressing a Uniform National Model for the Dental Assisting Profession.* (Chicago: DANB, 2005).

certain credentials. This number has more than doubled since 1993, when only 14 states recognized more than one category of dental assistant (excluding four additional states that had separate requirements for radiography).[2]

Since 2000, at least 11 states have passed new legislation or adopted new administrative rules governing the practice of dental assisting. In each case, the new law or rule permitted or more clearly defined delegation of expanded functions to dental assistants, or established or more clearly defined credentialing requirements for dental assistants. Additional regulatory revisions pertaining to delegation of expanded functions or education and credentialing requirements are currently under consideration in 10 other states.[3] The trend since 2000 toward enactment of new rules related to the delegation of expanded functions to dental assistants, combined with the increase since 1993 in the number of states recognizing two or more levels of dental assisting, reflects the oral healthcare community's increasing interest in allowing the delegation of expanded functions to dental assistants. These trends also indicate that the oral healthcare and regulatory communities recognize that dental assistants who perform expanded functions should be competent and qualified to perform them and that it is necessary to establish and implement a means of measuring competency and/or verifying qualifications of these dental assistants.

Dental Assisting Education

Prospective dental assistants may obtain dental assisting education from a number of different types of education sources, including

- Dental assisting education programs accredited by the American Dental Association's Commission on Dental Accreditation (also referred to as "ADA-accredited dental assisting programs")
- Dental assisting education programs that are not accredited by the ADA, but are offered by post-secondary institutions accredited by U.S. Department of Education–recognized accrediting agencies (also referred to as "non-ADA-accredited dental assisting programs")
- Dental assisting programs based in high schools
- Expanded functions courses approved by state dental boards
- In-office training courses offered by dentist-employers
- On-the-job training
- Continuing dental education programs

It is estimated that college-level dental assisting education programs, both ADA-accredited programs and non-ADA-accredited programs, enroll about 15,000 students per year, though the number of graduates is typically at least 25% lower.[4] In most states, formal education for dental assistants is not required by law, although many do require specific coursework for performing expanded functions. It is estimated that about half of all dental assistants receive most or all of their training on the job.[5]

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[2] ADAA, "Position Paper of the ADAA Task Force to Investigate Mandatory Education and Credentialing for Dental Assistants" (Chicago: ADAA, 1994).

[3] DANB, "DANB RHS in Ohio," *Certified Press* 1, no. 35 (2000): 1; "DANB Executive Director at the Illinois Board of Dentistry," *Certified Press* 1, no. 35 (2000): 5; State of the States, *Certified Press* 3, no. 38 (2002): 6; 4, no. 43 (2003): 7; 22, no. 1 (2004): 6; 22, no. 3 (2004): 6; 22, no. 4 (2004): 7; 23, no. 1 (2005): 7; 23, no. 2 (2005): 7; 23, no. 3 (2005): 5.

[4] American Dental Association. *2002-2003 Survey of Allied Dental Education* (Chicago: ADA, 2004).

[5] Estimate based on the average number of graduates from ADA-accredited dental assisting programs and non-ADA-accredited dental assisting programs, multiplied by an average 11.4 years of working as a dental assistant, reflecting the average career span of a dental assistant employed

A National Credential

Currently, the only measure of dental assisting competency that draws nationwide recognition and participation is the Certified Dental Assistant (CDA) credential that is conferred to dental assistants who pass the CDA Examination administered by DANB. The CDA Exam is made up of three components: Radiation Health and Safety (RHS), Infection Control (ICE), and General Chairside Assisting (GC). These components may be taken all at once, or each component may be taken individually. A candidate must pass all three components within five years to earn the CDA credential.

DANB is recognized by the American Dental Association as the national credentialing agency for dental assistants. Its national certification programs—including the Certified Dental Assistant (CDA), Certified Orthodontic Assistant (COA), and Certified Dental Practice Management Administrator (CDPMA) Examinations, and the RHS, ICE, GC, and Orthodontic Assisting (OA) component examinations—are accredited by the National Commission for Certifying Agencies (NCCA), the accrediting body of the National Organization for Competency Assurance (NOCA). Of the estimated 266,000[6] dental assistants currently practicing nationwide, approximately 31,000 are DANB-Certified, while an additional 100,000+ have passed one or both of the RHS and ICE components of the CDA Exam since 1997, when DANB first began keeping records pertaining to candidate volumes for individual component exams.

DANB requires that Certification be renewed annually—CDAs, COAs, CDPMAs, and COMSAs[7] must complete, each year, 12 hours of continuing dental education (CDE) meeting the CDE guidelines established by DANB for recertification and must maintain current CPR certification.

Currently, 34 states and the Veterans Health Administration recognize or require successful performance on a DANB dental assisting exam (CDA, COA, or one or more DANB component exams) for dental assistants to meet state or agency regulations or as a prerequisite to performing expanded functions.

C. The Need for a Uniform National Dental Assisting Model

In 2000, the U.S. Surgeon General published a comprehensive report[8] that sought to provide an account of the state of oral health of the U.S. population and to identify areas for further improvement, especially among underserved segments of the population. Subsequently, a coalition of public and private organizations responding to the Surgeon General's report identified a number of broad categories within which communities of interest could take action to effect the necessary changes: the coalition recommended, among other actions, taking steps to increase the oral health workforce's diversity, capacity, and flexibility.[9]

by a private practitioner, as determined by the ADA in its 2003 Survey of Dental Practice (Chicago: ADA, 2005). This number is then subtracted from the Bureau of Labor Statistics estimate of the number of individuals employed as dental assistants (266,000) and the result is divided by the same number to yield the estimated percentage of dental assistants who are trained primarily or solely on the job.

[6] U.S. Department of Labor, Bureau of Labor Statistics. *Occupational Outlook Handbook, 2004-2005 Edition,* online version (Washington, D.C.: U.S. Department of Labor, 2005).

[7] For more information about the currently discontinued Certified Oral and Maxillofacial Surgery Assistant (COMSA) credential, see page 3 of the full *Position Paper of the ADAA/DANB Alliance Addressing a Uniform National Model for the Dental Assisting Profession.*

[8] U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.

[9] U.S. Department of Health and Human Services. *A National Call to Action to Promote Oral Health.* Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, and the National Institutes of Health, National Institute of Dental and Craniofacial Research. NIH Publication No. 03-5303, May 2003.

In concert with such efforts at the national level to mobilize the oral healthcare community for action in the service of improving the nation's oral and general health, the ADAA/DANB Alliance recommends that the communities of interest—dentists, dental hygienists, dental assistants, state and federal regulators, public health organizations, and consumers of oral healthcare services—give serious consideration to the adoption or support of a uniform national model for the dental assisting profession.

The acceptance of a uniform national dental assisting model has the potential to provide a number of benefits to the public, to dental assistants, and to the oral healthcare community.

First, a uniform national model for dental assisting may help to mitigate disparities in quality of care among various segments of the U.S. population by standardizing education, training, and competency testing requirements for dental assistants. In addition, acceptance of a standardized national model for dental assisting can help to enhance the overall capacity of the oral healthcare services infrastructure through the cumulative effect of improvements in productivity and cost-efficiency resulting from the safe and expedient delegation of expanded functions to qualified and competent dental assistants.

Adherence to a uniform national model for dental assistants can also increase the capacity of the oral healthcare services infrastructure by enhancing dental assistant recruitment and retention. Specifically, an established uniform national model for dental assisting can

- Minimize unproductive time that dental assistants spend obtaining new credentials when they change their state of residence, and reduce losses from the dental assisting workforce of experienced dental assistants who choose not to obtain new credentials when they change their state of residence;
- Mitigate shortages in the dental assisting workforce by enhancing the ability of dental offices within commuting distance of neighboring states to hire dental assistants living in those states;
- Expedite the transition of military dental specialists into the civilian dental assisting workforce; and
- Facilitate the participation of civilian spouses of frequently relocated military personnel in the dental assisting workforce.

In addition, public health initiatives designed to benefit underserved segments of the population can more effectively recruit qualified dental assisting personnel with the help of nationally standardized credentials. Similarly, national recognition of a standardized set of credentials for dental assistants could greatly facilitate the call-up of dental assisting volunteers in response to a mass casualty event, such as a natural disaster or a terrorist attack.

D. The DANB/ADAA Study to Define and Rank Core Competencies for Dental Assistants

The ADAA/DANB Alliance has undertaken the DANB/ADAA Study to Define and Rank Core Comptencies for Dental Assistants (the "DANB/ADAA Core Competencies Study") with the intention that the definitions and recommendations emerging from the study will serve a number of purposes, including:

- To protect the public by identifying standards in quality of care that may be deployed across all states and socio-economic environments
- To help state regulators understand current trends, opinions, and practices prevalent among oral healthcare professionals as they consider the enactment of new legislation, regulations, or

administrative rules related to dental assisting, including reciprocal recognition of dental assisting credentials among states, in furtherance of their public protection obligations

- To assist in efforts to maximize the capacity of the oral healthcare services infrastructure and, thereby, maximize access to care for all U.S. residents by effecting improvements in dental team productivity and cost-efficiency
- To reinforce the idea of a viable career ladder for dental assistants, for the purpose of aiding in recruitment and retention of a qualified dental assisting workforce through enhancements in career mobility and job satisfaction
- To assist public health agencies in identifying qualified dental assistants to assist dentists participating in volunteer programs and other public health initiatives designed to address shortfalls in capacity and disparities in access to care among various segments of the population

Core Competencies Survey Content and Distribution

The ADAA/DANB Alliance distributed a survey listing 70 dental assisting tasks and asked the participants to rate each task in terms of training, education, and/or experience they believed *should be* required to perform the task (rather than what currently *is required* in their state). The study began in 2000 and was conducted in several phases; an analysis of the results of the final two phases—Phases III and IV—is included herein.

In Phase III of the study, in which the survey was distributed to dentists, respondents were asked to assign each task in a list of 70 dental assisting tasks to one of four defined skill categories, which were labeled with generic identifiers (Category A, Category B, Category C, and Category D). In Phase IV, the same survey was distributed to CDAs, Program Directors of ADA-accredited dental assisting programs, and dental assistants who are not CDAs. Because the response rate of non-Certified dental assistants was very low, the responses of this group have not been included in the final analysis.

Dental Assisting Categories

The following dental assisting skill category definitions were provided to survey participants:

> Category A: These are the most basic dental assisting tasks: No minimum experience, training, or education should be required to perform the task (though the task may require a short orientation in order to perform it); that is, in order to perform a Category A task, the assistant needs only to be provided with short, one-time verbal instructions or read a short instruction sheet.
>
> Category B: These tasks are of low to moderate complexity, requiring less than 2 years full-time or up to 4 years part-time dental assisting work experience OR up to 12 months of formal education or training in order to perform this task. Tasks in Category B are appropriate for relatively new OJTs (on-the-job-trained dental assistants) and students currently enrolled in a formal dental assisting education program.
>
> Category C: These tasks are of moderate complexity, requiring 2+ years of full-time or 4+ years of part-time work experience (or some combination of full- and part-time experience) OR at least 12 months of formal education or training. (Tasks in Category C are appropriate for dental assistants who have completed a formal dental assisting education program or who are highly experienced OJTs.)

Category D: These tasks are most complex. In order to perform Category D tasks, the dental assistant would require specific, advanced education or training in addition to or beyond the level required for Category C tasks.

Survey Results

Using appropriate statistical methods and modeling,[10] the survey responses were analyzed and a number of significant results were observed:

- There was significant agreement among the three groups of respondents (dentists, CDAs, and program directors of ADA-accredited dental assisting programs) with regard to the skill level needed for the performance of tasks and the direction of difficulty of the tasks.
- Categorization of tasks was sufficiently consistent among the four categories (Categories A through D) to uphold the appropriateness of the category definitions.
- The analysis revealed that most dental assisting tasks fall into one of two categories—Categories B and C—which correspond roughly to the levels of dental assisting as they are most often defined in dental practice acts that recognize two levels of dental assistant.

The following graphs chart the Rasch Difficulty Measure assigned to each dental assisting task in the survey response analysis for each respondent group. The Rasch Difficulty Measure is a numeric value that corresponds to the survey respondents' perceptions of the level of skill required to perform a task competently, as determined by respondents' assignment of the task to a skill category in the survey. The results for the three respondent groups are plotted side-by-side. Note that eight of the original 70 tasks were removed from the final analysis because of statistical misfit. (Specific tasks measured in the DANB/ADAA Core Competencies Study can be found in Tables A–D later in this Executive Summary.)

[10] For a complete discussion of the statistical methods and models used, see ADAA/DANB Alliance, "Dental Assisting Core Competencies Study," June 15, 2005 (available at www.danb.org).

Figure 1.A: Task Ratings
Tasks 2 - 26

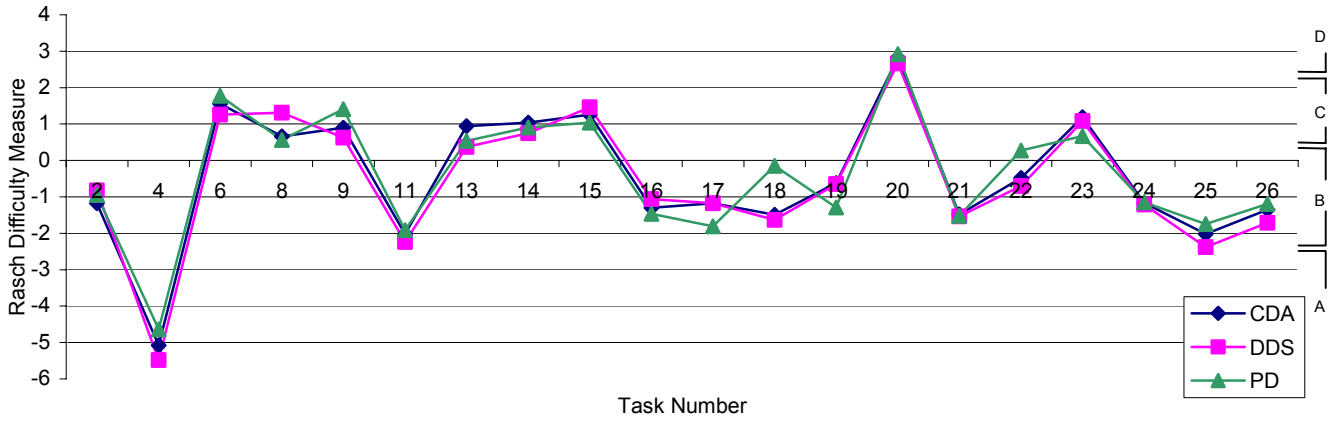


Figure 1.B: Task Ratings
Tasks 27 - 47

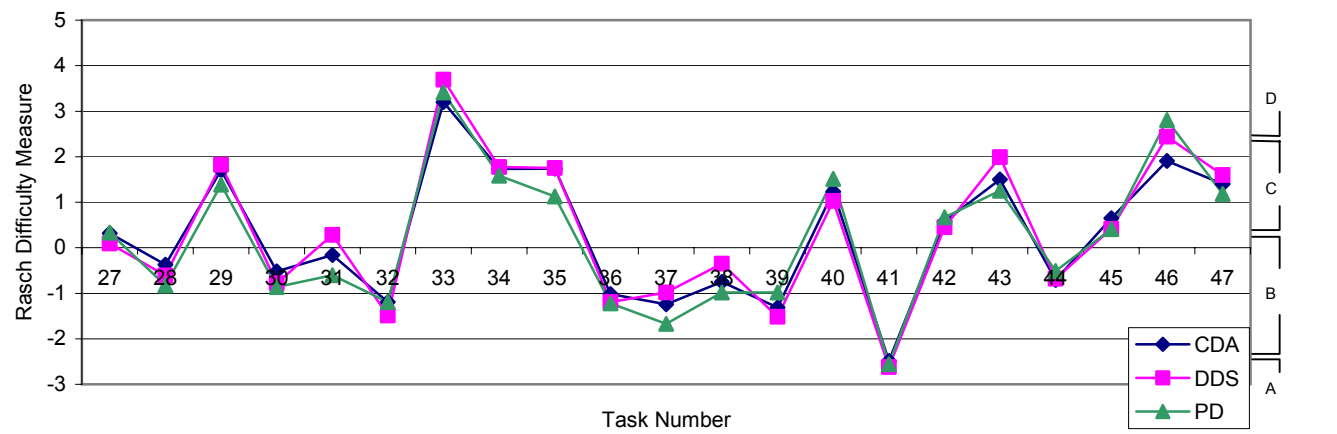
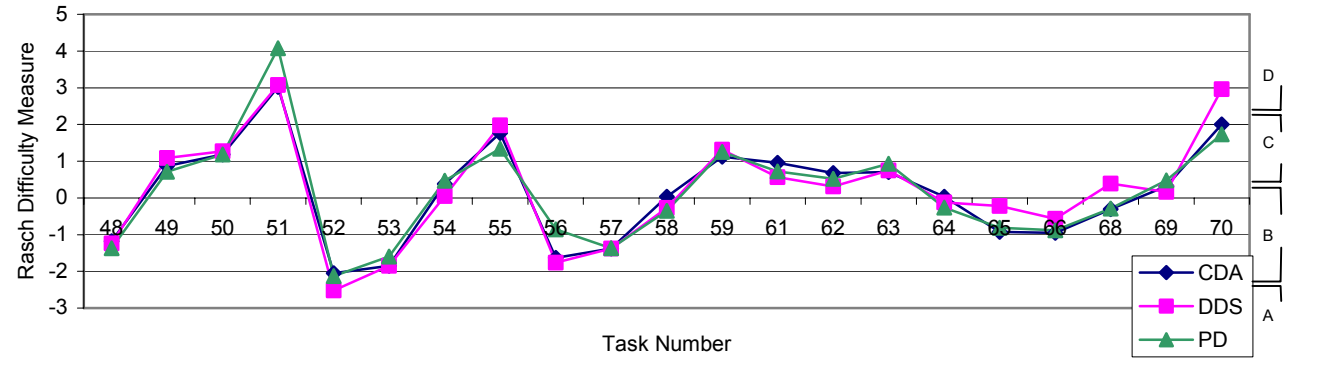


Figure 1.C: Task Ratings
Tasks 48 - 70



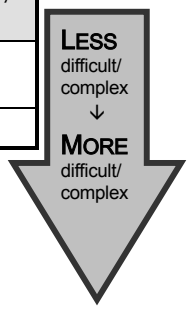
There was significant agreement among the three respondent groups with regard to the difficulty level of (or skill level needed to perform) each task and the direction of difficulty of the tasks as they relate to one another. The degree of consistency among the three respondent groups suggests the existence of a "de facto" model for dental assisting that is tacitly understood by a great number of oral healthcare professionals across the country who are directly involved in the performance and evaluation of the tasks under consideration. These results encourage the ADAA/DANB Alliance to believe that all members of the dental team will view a more formal national recognition of the definitions and guidelines emerging from this research as an organic outgrowth of current thought within the oral healthcare community.

(1) Category A

Category A corresponds to an entry-level dental assistant with very little training or experience. The survey results allowed for only two tasks to be assigned to the entry-level dental assistants represented by Category A.

Table A: Tasks Assigned to Category A (listed in ascending order, from most basic to most complex)

Survey Task Number	Task Name	Rasch Difficulty Measure*
4	Receive and prepare patients for treatment, including seating, positioning chair, and placing napkin	-5.14
41	Prepare procedural trays/armamentaria set-ups	-2.54



* The Rasch Difficulty Measure is a numeric value that corresponds to the survey respondents' perceptions of the level of skill required to perform a task competently, as determined by respondents' assignment of the task to a skill category in the survey.

Recommended **Education/Testing/Credentialing** Requirements for Category A

The respondents believe that no minimum experience, training, or education should be required to perform tasks in Category A; new dental assistants can perform these tasks after only a short orientation.

These results reveal that there is significant agreement among the dental professionals surveyed that some training and/or education should be required for all but the most elementary dental assisting tasks.

(2) Category B

Category B corresponds to relatively new on-the-job-trained dental assistants, or dental assisting students who have completed up to 12 months of formal education. Of the 62 dental assisting tasks categorized in the final survey analysis, 33 fall into Category B.

Table B: Tasks Assigned to Category B (listed in ascending order, from most basic to most complex)

Survey Task Number	Task Name	Rasch Difficulty Measure*
52	Process dental radiographs	-2.23
25	Perform sterilization and disinfection procedures	-2.12
11	Transfer dental instruments	-2.09
53	Mount and label dental radiographs	-1.83
56	Apply topical anesthetic to the injection site	-1.60
21	Mix dental materials	-1.50
26	Provide pre- and post-operative instructions	-1.46
18	Apply topical fluoride	-1.41
57	Demonstrate understanding of the Centers for Disease Control and Prevention Guidelines	-1.38
39	Clean and polish removable appliances and prostheses	-1.35
32	Demonstrate understanding of the OSHA Hazard Communication Standard	-1.30
17	Identify features of rotary instruments	-1.24
16	Demonstrate knowledge of ethics/jurisprudence/patient confidentiality	-1.22
48	Maintain field of operation during dental procedures through the use of retraction, suction, irrigation, drying, placing and removing cotton rolls, etc.	-1.22
24	Provide patient preventive education and oral hygiene instruction	-1.18
37	Take and record vital signs	-1.18
36	Demonstrate understanding of the OSHA Bloodborne Pathogens Standard	-1.10
2	Chart existing restorations or conditions	-1.03
66	Recognize basic dental emergencies	-0.80
19	Select and manipulate gypsums and waxes	-0.69
44	Take preliminary impressions	-0.68
65	Recognize basic medical emergencies	-0.65
30	Using the concepts of four-handed dentistry, assist with basic restorative procedures, including prosthodontics and restorative dentistry	-0.64
38	Monitor vital signs	-0.62
22	Expose radiographs	-0.50
28	Pour, trim, and evaluate the quality of diagnostic casts	-0.50
58	Using the concepts of four-handed dentistry, assist with basic intraoral surgical procedures, including extractions, periodontics, endodontics, and implants	-0.12
64	Fabricate custom trays, to include impression and bleaching trays, and athletic mouthguards	-0.05
68	Respond to basic dental emergencies	-0.04
31	Identify intraoral anatomy	-0.03
27	Place and remove dental dam	0.23
54	Remove temporary crowns and cements	0.26
69	Remove post-extraction dressings	0.27

LESS difficult/ complex

MORE difficult/ complex

* The Rasch Difficulty Measure is a numeric value that corresponds to the survey respondents' perceptions of the level of skill required to perform a task competently, as determined by respondents' assignment of the task to a skill category in the survey.

The survey results indicate that Category B dental assistants should be allowed to perform (and should be evaluated as competent to perform) tasks related to radiography and infection control, patient education and communications functions, preparation of dental instruments and materials, and all **extraoral** functions, with the exception of two extraoral tasks—*(23) Evaluate radiographs for diagnostic quality* and *(59) Monitor nitrous oxide/oxygen analgesia*—that were ranked by respondents as requiring a higher level of skill and can be found in Category C.

Category B dental assistants should be able to provide chairside assistance to the dentist as he or she performs a wide range of dental procedures. These dental assistants should also be fully conversant in the laws governing dental assisting activities in their state, and in infection control and hazardous material handling protocols. Finally, they should be able to recognize basic medical and dental emergencies and respond as appropriate.

Recommended **Education/Training** Requirements for Category B

Dental assisting programs accredited by the ADA's Commission on Dental Accreditation provide excellent preparation for dental assisting careers, and the ADAA/DANB Alliance supports and encourages participation in these programs among all prospective dental assistants for whom participation is geographically and financially feasible. However, due to the limited capacity and geographic availability of these programs, the ADAA/DANB Alliance also encourages the expansion of alternative education programs in ADA-accredited dental assisting programs, and applauds advancements in this area that have been made in recent years. Other options meriting consideration or further study include development and expansion of distance learning programs in other ADA-accredited dental assisting programs and the extension of accreditation by the ADA's Commission on Dental Accreditation to high school–level dental assisting programs, among others.

The ADAA/DANB Alliance believes that dental assisting programs at non-ADA-accredited institutions that are accredited by other U.S. Department of Education–recognized bodies may be effective in preparing dental assistants to perform tasks in Category B and that further study to evaluate their effectiveness is warranted. In addition, because almost half of all dental assistants receive most or all of their training on the job, the ADAA/DANB Alliance encourages the development of standardized in-office training protocols to be used by dentists for on-the-job training of dental assistants until such time as formal education for dental assistants becomes mandatory.

Recommended **Testing/Credentialing** Requirements for Category B

The ADAA/DANB Alliance recommends that the oral healthcare community make use of **ALL** of the following tools for measuring the competency of Category B assistants:

- *Passing score on DANB's **RHS** and **ICE** Exams*. These two exams test a dental assistant's knowledge in the areas of Radiation Health and Safety and Infection Control; they are components of the full Certified Dental Assistant (CDA) Examination and may be taken by any dental assistant, as there are no eligibility prerequisites.
- *State-specific jurisprudence exam (where available).* Awareness of the duties that are allowed or prohibited by law is an important part of dental assisting practice. The ADAA/DANB Alliance recommends that dental assistants be required to pass a jurisprudence examination that will test their knowledge in this area. (Note that development of a uniform national model for dental assisting may give rise to the need for a national jurisprudence exam that would replace the state-

specific exams.) Currently, as reflected in state dental practice acts, only four states (Iowa, Minnesota, New Mexico, and Texas) require or administer a separate jurisprudence examination for dental assistants.[11]

- *CPR certification*. Category B dental assistants should know how to take a patient's vital signs and be competent to recognize and/or respond to medical emergencies, at least at the basic level.
- *Basic chairside skills exam (where available).* Currently, as reflected in state dental practice acts, two states, Missouri and Oregon, require basic dental assisting examinations (which are developed and administered by DANB) that measure a dental assistant's competency to perform basic functions (many of which are found in Category B). The ADAA/DANB Alliance endorses the requirement of these exams in those states where they are available. The ADAA/DANB Alliance also believes the development of a national basic skills examination that would be less comprehensive than the DANB CDA Exam should be given serious consideration and investigated further.

(3) Category C

Category C corresponds to experienced on-the-job-trained dental assistants or dental assistants who have graduated from formal dental assisting education programs, such as those accredited by the ADA's Commission on Dental Accreditation. Of the 62 tasks categorized in the final survey analysis, 23 fall into Category C, which are shown in Table C on the following page.

The survey analysis indicates that Category C dental assistants should be allowed to perform (and should be evaluated as competent to perform) advanced intraoral procedures (often referred to as "expanded functions" or "expanded duties") under appropriate levels of dentist supervision. Only four tasks were deemed by survey respondents to be of a complexity beyond the competency level of Category C assistants (these tasks can be found in Category D). Therefore, all but the most complex intraoral dental assisting procedures should be within the scope of practice and the competency of Category C assistants.

Recommended **Education/Training** Requirements for Category C

The ADAA/DANB Alliance believes that the two primary pathways by which a dental assistant can become eligible to sit for the full CDA Exam (consisting of RHS, ICE and GC component exams) or the General Chairside (GC) component of the CDA Exam are also excellent models to use in establishing training and education requirements for assistants performing tasks in Category C.

Pathway I centers on graduation from a dental assisting program accredited by the ADA's Commission on Dental Accreditation. As previously noted, the ADAA/DANB Alliance urges expansion of access to these programs through alternative education offerings or other means.

Pathway II is for on-the-job-trained dental assistants; in addition to a high school diploma, 3,500 hours of full- or part-time work experience accumulated over a period of 24 to 48 months is required.

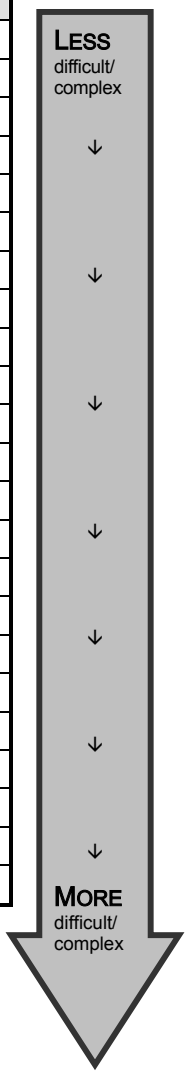
Studies conducted by DANB have shown that candidates using each of these two pathways (Pathways I and II) to qualify to take the CDA Exam (or the GC component of the CDA Exam) pass the exam at rates that are statistically equivalent to candidates using the other pathway; therefore, the

[11] DANB. *DANB's State Fact Booklet, Volume 2* (Chicago: DANB, 2004).

ADAA/DANB Alliance believes that education and training obtained through either of these pathways is appropriate to prepare dental assistants to perform the tasks in Category C. (A 2002–2003 DANB research study revealed that the average pass rate of CDA or GC examinees who were graduates of non-ADA-accredited dental assisting education programs was *not* statistically equivalent to the average pass rate of graduates of ADA-accredited programs.)[12]

Table C: Tasks Assigned to Category C (listed in ascending order, from most basic to most complex)

Survey Task Number	Task Name	Rasch Difficulty Measure*
62	Remove periodontal dressings	0.52
42	Place orthodontic separators	0.54
45	Place and remove matrix bands	0.54
13	Remove sutures	0.69
63	Place post-extraction dressings	0.73
61	Remove permanent cement from supragingival surfaces	0.78
9	Perform coronal polishing procedures	0.84
8	Monitor and respond to post-surgical bleeding	0.90
14	Dry canals	0.92
49	Perform vitality tests	0.94
23	Evaluate radiographs for diagnostic quality	1.10
40	Apply pit and fissure sealants	1.17
59	Monitor nitrous oxide/oxygen analgesia	1.20
50	Place temporary fillings	1.21
15	Tie in archwires	1.31
6	Place and remove retraction cord	1.45
47	Fabricate and place temporary crowns	1.46
43	Size and fit stainless steel crowns	1.66
35	Place periodontal dressings	1.69
29	Size and place orthodontic bands and brackets	1.72
34	Place liners and bases	1.73
55	Remove temporary fillings	1.81
46	Take final impressions	2.18



* The Rasch Difficulty Measure is a numeric value that corresponds to the survey respondents' perceptions of the level of skill required to perform a task competently, as determined by respondents' assignment of the task to a skill category in the survey.

[12] "CDA/GC Pilot Pathway IV Study Reviewed and Evaluated," *Certified Press* 22, no. 2 (2004): 6.

Recommended **Testing/Credentialing** Requirements for Category C

The ADAA/DANB Alliance recommends that the oral healthcare community make use of **ALL** of the following tools for measuring the competency of Category C assistants:

- *Certified Dental Assistant (CDA) credential.* Passing of DANB's CDA Exam and maintenance of a current DANB CDA credential. (Note that maintenance of the CDA credential requires 12 hours of continuing dental education per year and current CPR certification.)

  It is important to note that, within the context of these recommendations, those dental assistants who are qualified to perform Category B tasks would already have demonstrated appropriate knowledge levels by passing DANB's RHS and ICE Exams, and would need only to pass DANB's GC Exam to earn the CDA credential (as long as the RHS, ICE, and GC components have all been passed within a five-year period).

  The ADAA/DANB Alliance believes that some state-specific registered dental assistant (RDA) examinations and credentials may be valid measures of competency and does not oppose their continued use in states where they are currently available during a transition to a uniform national model. However, the ADAA/DANB Alliance believes that, ultimately, uniform national credentials, such as the CDA credential, will more effectively simplify interstate mobility of dental assistants, enhancing recruitment and retention.

- *CPR certification.* CPR certification prepares dental assistants to recognize and/or respond to medical emergencies, at least at the basic level; it is a prerequisite to sit for the CDA Exam and for annual renewal of the CDA credential.

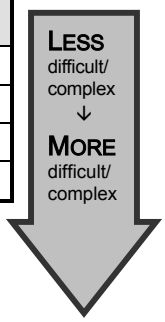
(4) Category D

Category D corresponds to highly skilled dental assistants who have received specialized training and education in the performance of specific advanced functions. Of the 62 tasks categorized in the final survey analysis, only four fall into Category D.

Table D: Tasks Assigned to Category D (listed in ascending order, from most basic to most complex)

Survey Task Number	Task Name	Rasch Difficulty Measure*
70	Place stainless steel crowns	2.33
20	Perform supragingival scaling	2.76
51	Carve amalgams	3.09
33	Place, cure and finish composite resin restorations	3.40

* The Rasch Difficulty Measure is a numeric value that corresponds to the survey respondents' perceptions of the level of skill required to perform a task competently, as determined by respondents' assignment of the task to a skill category in the survey.



The tasks that are found in Category D are complex intraoral tasks that involve a high degree of skill, precision, and manual dexterity. While a few states allow dental assistants to perform one or more of these functions, each of these tasks is currently restricted from delegation to dental assistants in some states.

If dental assistants are allowed by law to perform these tasks and the dentist-employer wants to delegate these tasks to dental assistants, the ADAA/DANB Alliance recommends that only dental assistants who have earned the CDA credential and have significant experience performing tasks in Category C should be allowed to receive prescribed on-the-job training in these Category D tasks or to enroll in formal education covering the performance of these tasks. The ADAA/DANB Alliance recommends that dental assistants be allowed to perform these tasks only if they have received specific advanced clinical training in the performance of these tasks and have successfully demonstrated competency in a hands-on clinical examination, developed by a nationally accredited testing agency in accordance with nationally accepted psychometric standards.

E. Dental Assisting Tasks Not Included in the DANB/ADAA Core Competencies Study

In selecting a finite set of tasks to study (62 tasks, net of eight additional tasks that were omitted from the final analysis because of statistical misfit), it has not been the intention of the ADAA/DANB Alliance to suggest that dental assistants' activities should be limited to the performance of only these tasks; rather, the tasks selected for the study were determined to be representative of a broad range of dental assisting core competencies.

Some state dental practice acts attempt to define a dental assistant's scope of practice by specifically enumerating the tasks that dentists may delegate to dental assistants, while others define dental assisting practice in broad terms and allow the dentist to delegate any task that is not expressly forbidden. Both of these approaches to defining the scope of practice of dental assistants present certain challenges, and can be more restrictive or more permissive than intended if the respective lists of allowable or prohibited tasks are not developed with the utmost care. In addition, even when dental assisting scope of practice is defined effectively for current dental office conditions, changes in the science of oral healthcare over time may give rise to the need to permit or prohibit additional tasks and functions.

The uniform national dental assisting model proposed by the ADAA/DANB Alliance can be a useful tool in resolving the difficulties inherent in defining the scope of practice for dental assistants. The proposed model describes each category of dental assisting tasks and defines the education, experience, and credentials that a dental assistant should have to perform the tasks in each category, thereby providing a framework within which to evaluate the appropriateness of any new or previously omitted task for delegation to dental assistants. Further research can be conducted to determine the category (Category A, B, C, or D) to which additional dental assisting tasks not previously studied should be assigned.

F. Supervision of Dental Assistants by Licensed Dentists

An important consideration in the discussion of the delegation of tasks to dental assistants is that of supervision of dental assistants by their dentist-employers. The ADA has identified four levels of supervision for dental auxiliaries, including dental assistants, which it defines in its "Comprehensive Policy Statement on Allied Dental Personnel" (2002:400), which is part of its *Current Policies*;[13] however, these definitions have not been uniformly adopted by the dental boards of every U.S. state or district. In furtherance of the establishment of a uniform national model for dental assisting, the ADAA/DANB Alliance encourages the uniform adoption of the ADA's definitions for the various levels of supervision and recommends that the level of supervision required to perform each dental assisting task be given careful consideration by communities of interest.

[13] ADA. *Current Policies: Adopted 1954-2003,* online version (Chicago: ADA, 2003), 33-34.

G. Proposed Uniform National Model for the Dental Assisting Profession

The following table summarizes the ADAA/DANB Alliance's proposed uniform national model for the dental assisting profession, as determined by the responses of survey participants, and the recommended requirements for each level, progressing from the entry-level at the bottom to the most advanced level at the top.

Table G: Proposed Uniform National Model for the Dental Assisting Profession

Suggested Title	Recommended Education/Training	Recommended Experience	Recommended Credentials	Summary of Allowable Tasks
Expanded Functions Dental Assistant (Category D in this paper)	Specialized formal training within an ADA-accredited program or state board–approved course	Several years' experience working as a CDA and performing intraoral tasks AND Prescribed on-the-job training by licensed dentist in the specific functions to be performed Education and experience required.	CPR Certification Clinical examination (to be developed by a nationally accredited testing agency in accordance with nationally accepted psychometric standards)	Four tasks (See Table D): Complex intraoral tasks involving a high degree of skill, precision, and manual dexterity
Certified Dental Assistant OR ***Registered Dental Assistant**** **(Category C in this paper)**	Graduation from an ADA-accredited dental assisting program	Two or more years' full-time or four or more years' part-time experience, including on-the-job training by licensed dentist Either education or experience required.	CPR Certification Current DANB CDA credential **(or state-specific RDA credential, it it measures knowledge of these Category C tasks and is developed according to generally accepted psychometric principles and standards)*	23 tasks (See Table C): All but the most difficult and complex intraoral procedures, as allowed by law
Dental Assistant (Category B in this paper)	Enrollment in and partial completion of an ADA-accredited dental assisting program OR Graduation from a dental assisting program (non-ADA-accredited)	Up to two years' full-time experience or up to four years' part-time experience, which includes on-the-job training by licensed dentist Either education or experience required.	CPR Certification DANB RHS Exam DANB ICE Exam Jurisprudence Exam (where available) Basic Dental Assisting Skills Exam (where available) Future national basic dental assisting skills and jurisprudence exams, to be developed (if deemed appropriate)	33 tasks (See Table B): All extraoral tasks, except those requiring specialized knowledge or skill Chairside assistance during dental procedures Radiography Infection control procedures Emergency response Limited intraoral procedures
Entry Level Dental Assistant (Category A in this paper)	High school diploma	In-office orientation, or verbal/written instructions of licensed dentist	None	Two tasks (See Table A): The most elementary dental assisting tasks

The ADAA/DANB Alliance would like to state unequivocally that dental assistants are members of an oral healthcare team who work under the supervision of dentists (or under the supervision of dental hygienists, in states where supervision of dental assistants by dental hygienists is permitted by law) and that no future is envisioned in which the role of the dental assistant will evolve into that of an independent provider of dental services. Indeed, the very term "dental assistant" denotes a person who gives aid to another person in the performance of dental tasks and is inconsistent with the notion of practicing independently. The interest of the ADAA/DANB Alliance in defining and standardizing delegable functions has always been predicated on the assumption that these functions would be performed under appropriate levels of supervision, as determined by competent authorities within the oral healthcare community.

H. Alliance Research Distribution

The ADAA/DANB Alliance will serve the public interest by disseminating information on the results of its research as follows:

1. Proactively, to federal-level health agencies (such as the Office of the Surgeon General and the U.S. Department of Health and Human Services), state boards of dentistry, state dental associations, organized dentistry (i.e. professional membership organizations representing various groups of dental professionals), oral health advocacy groups (such as Oral Health America), dental-related corporations, dental schools and dental assisting programs accredited by the ADA's Commission on Dental Accreditation, other dental assisting programs (not ADA-accredited), high school vocational education coordinators, and other groups (policymakers, public health organizations) as appropriate.
2. On request, to members of the oral healthcare team (and to dentists in particular), high school career counselors, consumers, and others not already listed.

I. Recommendations and Next Steps

The dental assisting community, as represented by the ADAA and DANB, has taken the first step in the process of establishing a uniform national model for the dental assisting profession by developing and proposing a reasonable set of dental assisting guidelines, based on empirical, statistically analyzed data derived from survey responses of those most qualified to determine the appropriateness of such guidelines: dentists, dental assistants, and dental assisting educators.

The next step will involve receiving input from other communities of interest, pursuing further areas of research that might provide additional useful data, and synthesizing such input and data into a final proposal that will be submitted to the appropriate communities of interest with the authority to enact change.

In considering the roles of the various communities of interest in the proposed endeavor, the ADAA/DANB Alliance has developed a set of recommendations for each group. Summaries of each of these recommendations are set forth below.

1. For Dental Practitioners and Dental Organizations

The ADAA/DANB Alliance recommends that dentists continue to take an active interest in the issue of a uniform national model for the dental assisting profession and that they voice their support for the establishment of such a model in their local, state, and national dental associations. The ADAA/DANB

Alliance also encourages national dental associations to sponsor further research into the role of dental assistant education and credentialing in improving the delivery of oral healthcare services, including research into the development a formal training protocol and standardized educational materials for use by dentists who conduct on-the-job training of dental assistants, with the goal of elevating and standardizing such training.

2. For Dental Assisting Educators

The ADAA/DANB Alliance recommends that sponsors and directors of ADA-accredited dental assisting programs continue their efforts to expand access to these programs through alternative education programs, including distance-learning programs. The ADAA/DANB Alliance also recommends that those dental assisting programs that are not currently accredited by the ADA's Commission on Dental Accreditation pursue this accreditation.

3. For Legislators, State Boards of Dentistry, and Other Policymakers

The ADAA/DANB Alliance recommends that policymakers and regulators take the proposed uniform national dental assisting model set forth in this paper under advisement as they periodically evaluate dental assisting scopes of practice and that they open the floor for discussion of this matter in their respective spheres of influence. The ADAA/DANB Alliance also recommends that, in those states that allow individuals who have not completed ADA-accredited dental assisting programs to work as dental assistants, state dental boards work with dental educators to develop a formal in-office training protocol and standardized educational materials to be used for on-the-job training of these dental assistants.

4. For Federal Health Agencies and Oral Health Advocacy Groups

The ADAA/DANB Alliance recommends that federal health agencies and independent oral health advocacy groups endorse the uniform national model for dental assisting proposed by the ADAA/DANB Alliance and, to the extent possible, provide funding for further research.

5. For Dental Assistants

The ADAA/DANB Alliance recommends that dental assistants support efforts to elevate their profession by becoming DANB-Certified and by contributing to the discussion of a uniform national dental assisting model through involvement in local, state, and national dental assisting associations.

6. For DANB and the ADAA

The members of the ADAA/DANB Alliance recommend that their parent organizations, DANB and the ADAA, continue their work in support of the establishment of a uniform, nationally recognized model for the dental assisting profession that can also serve as a national career ladder for dental assistants. Specifically, the ADAA/DANB Alliance recommends that each organization (1) disseminate this paper to the appropriate authorities and other communities of interest, (2) provide additional information to communities of interest upon request, (3) pursue further research as recommended by the *Position Paper of the ADAA/DANB Alliance Addressing a Uniform National Model for the Dental Assisting Profession*, where feasible and appropriate, and (4) publicize future developments in the establishment of a uniform national dental assisting model to the oral healthcare community and the general public.

J. Conclusion

The ADAA/DANB Alliance believes that a uniform national dental assisting model has the potential to effect the following positive changes: (1) enhance patient safety and improve public attitudes about dental treatment, (2) mitigate the risk of errors in the dental office and the associated costs, (3) enhance efficiency of the dental team, (4) enhance recruitment and retention of qualified dental assistants, (5) through increased efficiency and reduced turnover of dental assistants, augment the capacity of the oral healthcare services infrastructure, and (6) promote and simplify participation in public health volunteer programs designed to reach underserved segments of the population. It is the position of the ADAA/DANB Alliance that the acceptance of a uniform national model for dental assistants will help to maximize access to oral healthcare services for all segments of the U.S. population.

K. For More Information

For more information about any topic covered in this Executive Summary, please contact:

DANB
Cynthia C. Durley, MEd, MBA
Executive Director
Dental Assisting National Board, Inc.
676 N. St. Clair, Suite 1880
Chicago, IL 60611
1-800-FOR-DANB
cdurley@danb.org
www.danb.org

ADAA
Anna Nelson, CDA, RDA
ADAA/DANB Alliance Co-Chair
American Dental Assistants Association
35 E. Wacker, Suite 1730
Chicago, IL 60601
1-312-541-1550
adaa1@aol.com
www.dentalassistant.org

To order a copy of the entire *Position Paper of the ADAA/DANB Alliance Addressing a Uniform National Model for the Dental Assisting Profession*, please contact DANB.

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Appendix A

Position Paper
of the ADAA/DANB Alliance
Addressing Dental Assisting Core Competencies

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Position Paper of the ADAA/DANB Alliance Addressing a Uniform National Model for the Dental Assisting Profession

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For Dental Assistants

For DANB and the ADAA

Contact Information

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Appendix 1: DANB/ADAA Dental Assisting Core Competencies Study

Appendix 2: A National Call to Action to Promote Oral Health, List of Partnership Network Members

Appendix 3: Excerpts from DANB's Task Analysis, 9th Edition

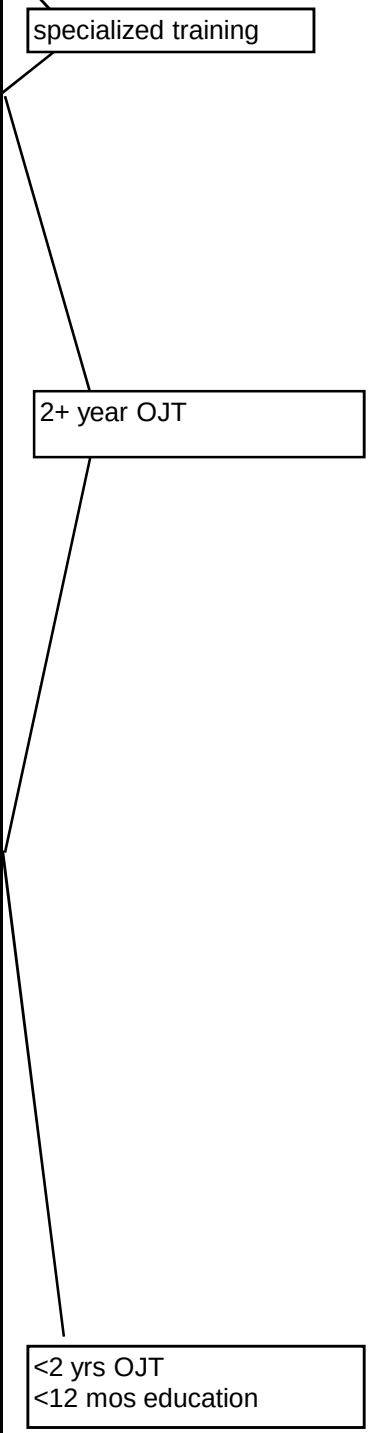
Content outlines for components of the Certified Dental Assistant (CDA) Exam:

- Radiation Health and Safety (RHS) Exam
- Infection Control Exam (ICE)
- General Chairside Assisting (GC) Exam

Appendix B

Final Task List

Survey Task #	Task Name	Difficulty Measure	Category
33	Place, cure and finish composite resin restorations	3.40	D
51	Carve amalgams	3.09	D
20	Perform supragingival scaling	2.76	D
70	Place stainless steel crowns	2.33	D
46	Take final impressions	2.18	C
55	Remove temporary fillings	1.81	C
34	Place liners and bases	1.73	C
29	Size and place orthodontic bands and brackets	1.72	C
35	Place periodontal dressings	1.69	C
43	Size and fit stainless steel crowns	1.66	C
47	Fabricate and place temporary crowns	1.46	C
6	Place and remove retraction cord	1.45	C
15	Tie in archwires	1.31	C
50	Place temporary fillings	1.21	C
59	Monitor nitrous oxide/oxygen analgesia	1.20	C
40	Apply pit and fissure sealants	1.17	C
23	Evaluate radiographs for diagnostic quality	1.10	C
49	Perform vitality tests	0.94	C
14	Dry canals	0.92	C
8	Monitor and respond to post-surgical bleeding	0.90	C
9	Perform coronal polishing procedures	0.84	C
61	Remove permanent cement from supragingival surfaces	0.78	C
63	Place post-extraction dressings	0.73	C
13	Remove sutures	0.69	C
42	Place orthodontic separators	0.54	C
45	Place and remove matrix bands	0.54	C
62	Remove periodontal dressings	0.52	C
69	Remove post-extraction dressings	0.27	B
54	Remove temporary crowns and cements	0.26	B
27	Place and remove dental dam	0.23	B
31	Identify intraoral anatomy	-0.03	B
68	Respond to basic dental emergencies	-0.04	B
64	Fabricate custom trays, to include impression and bleaching trays, and athletic mouthguards	-0.05	B
58	Using the concepts of four-handed dentistry, assist with basic intraoral surgical procedures, including extractions, periodontics, endodontics, and implants	-0.12	B
22	Expose radiographs	-0.50	B
28	Pour, trim, and evaluate the quality of diagnostic casts	-0.50	B
38	Monitor vital signs	-0.62	B
30	Using the concepts of four-handed dentistry, assist with basic restorative procedures, including prosthodontics and restorative dentistry	-0.64	B
65	Recognize basic medical emergencies	-0.65	B
44	Take preliminary impressions	-0.68	B
19	Select and manipulate gypsums and waxes	-0.69	B
66	Recognize basic dental emergencies	-0.80	B
2	Chart existing restorations or conditions	-1.03	B
36	Demonstrate understanding of the OSHA Bloodborne Pathogens Standard	-1.10	B



Appendix B

Final Task List

Survey Task #	Task Name	Difficulty Measure	Category
24	Provide patient preventive education and oral hygiene instruction	-1.18	B
37	Take and record vital signs	-1.18	B
16	Demonstrate knowledge of ethics/jurisprudence/patient confidentiality	-1.22	B
48	Maintain field of operation during dental procedures through the use of retraction, suction, irrigation, drying, placing and removing cotton rolls, etc.	-1.22	B
17	Identify features of rotary instruments	-1.24	B
32	Demonstrate understanding of the OSHA Hazard Communication Standard	-1.30	B
39	Clean and polish removable appliances and prostheses	-1.35	B
57	Demonstrate understanding of the Centers for Disease Control and Prevention Guidelines	-1.38	B
18	Apply topical fluoride	-1.41	B
26	Provide pre- and post-operative instructions	-1.46	B
21	Mix dental materials	-1.50	B
56	Apply topical anesthetic to the injection site	-1.60	B
53	Mount and label dental radiographs	-1.83	B
11	Transfer dental instruments	-2.09	B
25	Perform sterilization and disinfection procedures	-2.12	B
52	Process dental radiographs	-2.23	B
41	Prepare procedural trays/armamentaria set-ups	-2.54	A
4	Receive and prepare patients for treatment, including seating, positioning chair, and placing napkin	-5.14	A

<2 yrs OJT
<12 mos education

no experience