

BOARD OF HEALTH PROFESSIONS

REVIEW OF DENTAL HYGIENIST SCOPE OF PRACTICE REGULATIONS PUBLIC HEARING SUMMARY

DR. MICHAEL LINK

Representing: The Virginia Dental Association

Options Supported:

Options Opposed:

Notes: Dr. Link stated that the committee had exceeded its scope by including access issues. Suggested that the Board collect complaint data going back 20 years. Suggested that other providers, such as a proposed Community Dental Health Coordinator, should also be examined. Mr. Link provided statements that suggest VDA believes independent practice for dental hygienists (option 2) would be ineffective, costly and exacerbate workforce issues.

BRUCE WYMAN

Periodontist

Assistant Clinical Professor at the University of Maryland in Baltimore

Member of the Board of Dentistry (Not speaking as a member).

Options Supported:

Options Opposed:

Notes: Mr. Wyman states Options 1 & 2 “are okay”, Option 4 is impractical, that a combination of Option 3, 5 and 6 “could work”. He believes dental hygienists in a remote location need five years experience. He notes exceptions to the scope could create confusion. He thinks that dental hygiene patients should see a dentist within nine months.

MICHELLE MCGREGOR

Representing: VCU Dental Hygiene Program (Program Director)

Ms. McGregor is also the president of the Virginia Dental Hygienists Association

Options Supported: Option 3 & 4

Options Opposed:

Notes: Notes that the Board “will have to do option six if [the Board does] option three or four”. Asks to include all of the stakeholders. Urges the Board consider educalt requirements for dental hygienists in a remote capacity.

JOYCE FLORES

Representing: Virginia Dental Hygienists Association
Ms. Flores is also an educator from Old Dominion University

Options Supported:

Options Opposed:

Notes: Ms. Flores read a position statement from the Virginia Dental Hygienists Association, which was also provided as written comment. Details on this statement are available in the written comment summary for organizations.

COPY

REGULATORY RESEARCH COMMITTEE
VIRGINIA BOARD OF HEALTH PROFESSIONS
VIRGINIA DEPARTMENT OF HEALTH PROFESSIONS
9960 Mayland Drive
Richmond, Virginia

PUBLIC HEARING

IN RE: DENTAL HYGIENIST SCOPE OF PRACTICE

JANUARY 22, 2015

10:30 A.M.

COMMITTEE MEMBERS:

Virginia Van de Water, Ed.D., Chair, Board of Psychology
Elizabeth Carter, Ph.D., Executive Director, DHP
Michelle Chesser, Ph.D., Health Policy Administrator, JCHC
Josh Crew, MPA, Deputy Executive Director, BHP
Frazier Frantz, M.D., Board of Medicine
Yvonne Haynes, LCSW, Board of Social Work
Laura Jackson, Operations Manager, BHP
Jaime Hoyle, JD, Chief Deputy Director, DHP
James Watkins, DDS, Board of Dentistry
James Well, RPh, Citizen Member

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1 NOTE: The Public Hearing held by the
2 Regulatory Research Committee of the Department of Health
3 Professions commences at 10:45 a.m., with the aforementioned
4 Committee Members present, as follows:

5
6 DR. VAN DE WATER: Thank you for your
7 attendance. Let me read you an announcement about our safety
8 measures. We are in Boardroom 2. In case of an emergency,
9 when an alarm sounds you are to leave the room immediately
10 and follow any instructions given by security staff. For
11 this room we are to exit the room using one of the two doors
12 in the back of the room. Upon exiting the room, turn right
13 and follow the corridor to the emergency exit at the end of
14 the hall. Upon exiting the building, proceed straight ahead
15 through the parking lot to the fence at the end of the lot.
16 Wait there for further instructions.

17 You may also exit the room using the side door,
18 which is over there. When I am inside a building, I lose my
19 orientation. Turn to the right and make an immediate left,
20 follow the corridor to the emergency exit at the end of that
21 hall. Upon exiting the building, proceed straight ahead
22 through the parking lot to the fence at the end of the lot
23 and wait there for further instructions.

24 Good morning. I am Virginia Van de Water,
25 member of the Regulatory Research Committee. This is a

1 public hearing to receive public comment on the Board's study
2 of the scope of practice for dental hygienists. The Code of
3 Virginia authorizes the Board of Health Professions to advise
4 the Governor, the General Assembly and the Department
5 Directors on matters related to the regulation of healthcare
6 occupations and performance. Accordingly, the Board is
7 conducting this study and will provide recommendations on
8 whether there is a need for regulation.

9 At this time I will call on persons who have
10 signed up to comment. As I call your name, please come
11 forward and tell us your name, the profession you wish to
12 speak about and where you are from.

13 Good. This list was almost empty a few minutes
14 ago. The first person is Michael Link, VDA president.

15 DR. LINK: My name is Dr. Michael Link. I am
16 from Newport News, Virginia, and I am here to talk about the
17 report and some of the options that the Virginia Dental
18 Association is considering. We will be happy to e-mail the
19 report. I have a copy of it for you, so that you can have
20 it.

21 DR. VAN DE WATER: Thank you.

22 DR. LINK: First of all, the report that
23 charges from the Governor was to evaluate all health care
24 professions and occupations and whether each such profession
25 or occupation should be regulated and the degree of

1 regulation to be imposed. The approach is the unregulated
2 practice of the health occupation and the harm or endangering
3 the public. From our division, the Dental Association's
4 point of view, there were some gaps in the report that you
5 need to consider. This is not what we are recommending, but
6 this is what you need to consider.

7 The data from the Board of Dentistry should be
8 collected to determine the number of complaints and the Board
9 actions against dental hygienists dating over the last twenty
10 years, and the reason I say that is the report didn't
11 recognize that they need to be regulated at all, and if they
12 are under a direct-supervision model, this is what you are
13 going to receive as to how many complaints they receive. Any
14 changes in the supervision model must be taken into account
15 as far as the risk of the public.

16 Do the services restricted to the practice of
17 dental hygiene present a threat to the public and safety to
18 the degree that such a service could not be performed by a
19 person trained at a lower level, such a DAII, and could these
20 services be provided at a lower cost to the consumer with the
21 same level of risk if they are provided under the direct
22 supervision of a dentist. The other issue that were not
23 included in the report is the economics. Not included in the
24 study was employment statistics, in other words, hygiene
25 workforce shortage present now and will this shortage

1 dramatically increase if the output of dental hygienists are
2 not increased. The Bureau of Labor Market Statistics
3 projected that hygienists from 2012 to 2022 needs to be an
4 annual average of 316 that is needed in Virginia. Currently,
5 Virginia is putting out 177. That is a deficit of 139. We
6 are educating only 56% of the hygienists needed to meet the
7 U.S. Department of Labor Statistics, and this is an
8 occupational employment projection.

9 Hygiene study and demand economics create a
10 higher consumer cost to preventive services due to the high
11 salaries. Median cost of a hygienist is \$84,393. That is
12 also according to Labor Statistics. Do the services
13 restricted to the practice of dental hygiene present a threat
14 to the public health and safety to a degree that such a lower
15 service couldn't be performed by a person trained at a lower
16 level.

17 The report went into access care issues. That
18 really wasn't part of the charge. However, since we are
19 discussing this, the DAIIs, the regulation was implemented in
20 2010, and currently, according to the Board of Dentistry,
21 there are currently three registered DAIIs. DAIIs were not
22 even considered as far as being regulated or nonregulated in
23 this report as well. So any workforce changes that would
24 increase further demand on the supply of dental hygienists
25 must be met with significant expansion of dental hygienists.

1 Increasing access to dental care must be accompanied with the
2 addition of a more cost-effective team member. The Virginia
3 Dental Association is currently laying foundation to such a
4 member, and that member is called a CDHC, or Community Dental
5 Health Coordinator. The American Dental Association and the
6 Virginia Dental Association believe that the CDHC model will
7 be a much more cost-effective approach to improving access to
8 care.

9 Now, if you will look at the partial
10 occupational profile for dental hygienists, the entry level
11 of dental hygienists is basically \$30.12 an hour, for an
12 annual average wage of \$62,000. The median, somebody that
13 would be median-experienced, is \$40.57, which is \$84,000, and
14 then the experienced at \$45 per hour, which is \$94,000 a
15 year, and these are direct quotes from the Occupational
16 Information Network of the U.S. Department of
17 Labor/Employment and Training Statistics. Likewise, these
18 figures vary from different localities. In Washington, DC we
19 have a much higher rate of \$103,000 per year, to as low as
20 Lynchburg, which is \$68,000 a year.

21 So the employment of dental hygienists is
22 projected to grow 33 percent from 2012 to 2022, much faster
23 than the average for all other occupations. Ongoing research
24 linking oral health and general health will continue to spur
25 the demand for preventive services, which is often provided

1 by the dental hygienist. Hygienists perform routine dental
2 care and allow dentists to see more patients. In addition,
3 as the baby-boomer population ages, people are keeping more
4 of their original teeth, and therefore, the need to maintain
5 these teeth will continue to drive the increase for dental
6 care.

7 Federal insurance regulation is expected to
8 expand the number of patients who have access to health
9 insurance. So people with newer expanded dental insurance
10 coverage will be more likely to visit dentists than in the
11 past. As a result, the demand for dental services, including
12 those performed by hygienists, will increase.

13 As of January 16, 2015, the Virginia Employment
14 Website noted that there were 29 dental hygienists looking
15 for jobs and an opening for dental hygienists of 32, for an
16 employment-per-candidate job opening of .9 percent. So there
17 are more openings than there are hygienists. The ADA also
18 did a study that proves that unsupervised practice of dental
19 hygienists does not increase access to care, and this study
20 was done out in Colorado. Unsupervised dental practice has
21 not had a noble effect on access to care in Colorado, and
22 this study was done by Jackson Brown, House and Nash, and you
23 will have access to this report as well.

24 The impact of those practices is limited in two
25 important ways. There are very few practices. They are

1 located in areas also served by dental offices with
2 traditional dental hygienists. The economic viability of the
3 unsupervised hygienist business model is questionable,
4 because their prophylaxis fees, on an average, are not
5 different from traditional dental practices, which have the
6 advantage of providing full dental services. This may
7 explain why independent practices have not expanded
8 substantially in states where they are permitted.

9 As I mentioned earlier, the Virginia Dental
10 Association is looking at the CDHC focus, and its primary
11 goal is prevention. The CDHC is focused on reducing the oral
12 health disparity by targeting the social determinants of oral
13 disease and improving access to dental care. In the vision,
14 you have patient navigation, prevention of dental/oral
15 disease, health promotion, community engagement and
16 palliative care.

17 In the winter of 2010, the Journal of Public
18 Health Dentistry had an article, A Proven Access to Care
19 Approach, and we will provide you with this article as well.
20 In this article by Brinkley, Garrett and Johnson, children
21 and caregivers in the intervention group received education
22 assistance in finding a dentist. The children did not have
23 assistance and support in scheduling to keep dental
24 appointments through the use of a dental care coordinator.
25 The dental care coordinator intervention significantly

1 increased dental utilization compared with similar children
2 who received routine Medicaid member services. Public health
3 programs in communities and endeavors to reduce oral health
4 disparities may want to consider incorporating a dental care
5 coordinator along with initiatives to increase dental
6 utilization by disadvantaged children.

7 As the model described by the author, CDHC will
8 be focused on education, prevention and patient advocacy.
9 It is the hope that the graduation of CDHC will work
10 primarily in public health and communities, settings such as
11 federal-qualified health centers, schools, churches,
12 head-start programs, in coordination with other varieties of
13 dental providers, including clinics, community health
14 centers, as well as private practice dentists. As Dr.
15 Chesterford (phonetic) stated, Michelle Chesterford stated,
16 the waitlist as described will be alleviated or help to be
17 alleviated by navigating these patients into dental homes
18 that do not currently have the current population that they
19 need to maintain a practice, the and coordination is the key.

20 So in the economics of the CDHC, you have a
21 basic CDHC which is currently at about \$34,000 a year. These
22 community healthcare workers are already in place, but they
23 are in medicine mainly right now. So they would take several
24 months of education and come out making about \$34,000 a year,
25 and as I described earlier, a hygienist makes a median wage

1 of about \$84,000, all the way up to dentists making between
2 \$165,000 to \$195,000. So the report, we believe, exceeded
3 its charge by giving access to fair discussion. However, as
4 such discussions of workforce come into play, it is now clear
5 that there is not an overabundance of dental hygienists to
6 fill any new positions, and if there is a desire to expand
7 workforce, it must begin with meeting the projected need of
8 the dental hygienist before even considering creating a new
9 position that is very expensive at \$84,000 a year, and thus
10 not cost-effective to providing a solution to the access of
11 care. Our approach from the Virginia Dental Association, the
12 CDHC model could be that most important part, or missing
13 part, into being more a cost-effective approach to helping
14 the access to care.

15 Thank you very much for allowing me to talk,
16 even though I lost my voice.

17 THE COURT: We have the right to ask questions
18 at this point. Thank you for your comments.

19 Any questions?

20 Thank you very much for your presentation.

21 Is there a Wyman here? That is Bruce Wyman?

22 Thank you.

23 DR. WYMAN: Good morning. My name is Bruce
24 Wyman. I am a periodontist. I am retired, leaving a
25 part-time practice in Fairfax, Virginia, having practiced

1 there for more than forty years. I am also an assistant
2 clinical professor in periodontics at the University of
3 Maryland in Baltimore, where I teach clinically
4 post-graduate, post-doctoral periodontists and dentists, as
5 well as post-doctoral fellows, and as part of my periodontal
6 training, I have been also extensively involved with
7 hygienists over four decades.

8 I am a member of the Board of Dentistry, but I
9 am not here in that capacity in any way officially. I have
10 not discussed any of this presentation or my ideas with any
11 other Board members. I am also the founder and the past
12 president, or I should say the co-founder and past president,
13 of the Northern Virginia Indigent Dental Clinic, which today,
14 I believe, is the largest or one of the largest clinics of
15 its kind in the country. It is sponsored by the Northern
16 Virginia Dental Society, a component of the VDA. It has been
17 established about twenty years, and we have a model in
18 Northern Virginia based upon mostly volunteers, but also some
19 part-time paid dentists. We get numerous foundation monies,
20 and, in fact, the Virginia Healthcare Foundation was the
21 initial supporter of us. Without their help we probably
22 would not have existed, although we are not relying upon them
23 anymore because we have grown from that.

24 I just want to share a few things. In your
25 proposal I think options one and two are okay. Option four

1 predicates the Commonwealth to constantly reevaluate, which
2 constitutes special areas or settings, and is quite
3 impractical and requires constant supervision, because these
4 settings might change quite a bit. I believe the combination
5 of options three, five and six could work, and I will address
6 the matrix concept in option six first.

7 I strongly believe that hygienists in a remote
8 location, without occasional face-to-face supervision, need
9 at least five years of full-time improvement by the practice
10 experience. Many hygienists work part-time, especially when
11 they first get out of school. In fact, many of the
12 hygienists in the Commonwealth are trained in community
13 colleges, and they go on to get four-year degrees after that.
14 So for the first two or three years after their hygiene
15 degree, many of them are working part-time or maybe not at
16 all, but they are technically registered hygienists in
17 places.

18 These hygienists might have three to five years
19 of experience, but they don't equilibrate to somebody who has
20 worked full-time, and I am saying full-time by the minimum of
21 thirty hours a week for at least five years. I have been
22 interacting with hygienists for over forty years as a
23 periodontist, and I must say that a periodontist deals with
24 gums and implants. Within the dental school and hygiene
25 school departments, periodontics is the specialty which

1 supervises hygienists more than any other specialty, so I am
2 very familiar with what they are doing and their education,
3 as well as the experts here from the other schools.

4 I would not give exceptions to the scope that
5 would allow procedures for dental hygiene, because this would
6 be subject to misinterpretation because of ideation from
7 known regulation. Hygiene practice in customary routine
8 settings now is occasionally misinterpreted and must be
9 currently subject to disciplinary actions by the Board, and
10 this option of allowing them other regulations will further
11 exacerbate that situation and make it more confusing than
12 help. I think if we can get beyond the economic situation
13 that was just presented, we also need to look at interaction
14 with dentists.

15 To allow hygienists being unsupervised
16 completely, I think, is completely crazy. Certainly
17 tele-dentistry will help, but I think that a patient who does
18 not have an existing dentist must see a dentist within nine
19 months. If not, they should not be seen again by a
20 remote-access hygienist until they do so. A dentist must
21 conventionally examine that patient, using pathology to
22 eliminate cancer, which would not be done without physically
23 being present to examine soft tissues.

24 I believe a referral to a dentist by a
25 remote-practicing hygienist must be made initially to a local

1 component office of the VDA. These are my own personal
2 recommendations. That referral to the local component office
3 can in turn refer patients to dentists who elect to treat
4 such a population under these circumstances. Some dentists
5 do not want to accept Medicaid. Some might do screens in
6 their office pro bono. Also, by going through the office of
7 the local components, dentists who want to participate may do
8 it in relatively equal numbers. In other words, one
9 hygienist may not be sending the bulk of their patients to
10 one or two dentists, as opposed to having a screening process
11 within the component.

12 I think a dentist must be involved with
13 examining the medical history and any dental findings of
14 patients. While most of those who go to the dentist can have
15 very few, if any, problems, medically there are many patients
16 who have other problems besides just needing a cleaning or an
17 exam or a couple fillings, and I think that to not have some
18 regulation that this population needs to see a dentist at
19 some time is being extremely risky. I don't want to see two
20 sets of relations, those of need and those without need. I
21 think everybody should be done by the same regulations.

22 I would like to briefly describe the primary
23 reason why I am here and interested, is because in our
24 experience with the Northern Virginia Dental Clinic, which
25 was not addressed at all, it is the most sophisticated one in

1 the Commonwealth, and it may be one of the most sophisticated
2 ones in the country. It did receive a Golden Apple award
3 from the ADA when we initially brought it up, and this day it
4 is officially sponsored by the Dental Society. We do almost
5 two million dollars of dentistry a year in two different
6 offices, one is Bailey's Crossroads and one in Sterling. We
7 have a contractual agreement with five local governments,
8 including Arlington, Fairfax City, Fairfax County, Loudoun
9 County and Alexandria. All the patients who go to these
10 facilities are screened by local social service agencies
11 appointed by the local governments. In other words, patients
12 cannot come in off the street. They have to be economically
13 qualified. Most of the work is done by dentist and hygienist
14 volunteers. We do have some foundation money, as I mentioned
15 before, to support some part-time dentists, who are usually
16 younger dentists or retiring dentists that just want to work
17 a day or two in the clinic.

18 I can't emphasize enough that anything less, in
19 my mind, than five years of hygiene experience and being put
20 in a remote setting without direct supervision would be
21 absolutely terrible. When a hygienist gets out of school, in
22 my opinion, they need a certain amount of oversight, and with
23 the current socioeconomic system where many hygienists do not
24 go into full-time practice for some time after that, I think
25 if they could claim to the Board that they have five years

1 experience, but three or four years of that might have been
2 still in school and working a day a week, or they couldn't
3 find jobs, jobs in the Commonwealth for hygienist vary
4 tremendously in terms of not only, as you heard, income, but
5 availability, and the availability also changes with time.
6 Ten years ago it was almost impossible to find a hygienist,
7 and droves of hygienists are coming from other areas of the
8 country to get licensed and work in Northern Virginia,
9 because nobody could find them. With the economy changing in
10 the last six or seven years, that has changed tremendously as
11 well.

12 That is the end of my presentation.

13 THE COURT: Thank you very much.

14 Any questions?

15 Thank you.

16 Michelle McGregor.

17 MS. MCGREGOR: Good morning. My name is
18 Michelle McGregor. I am the president of the Virginia Dental
19 Hygienists' Association, but I am actually here as the
20 program director for the dental hygiene program at Virginia
21 Commonwealth University. I would like to thank everyone for
22 this opportunity to provide comment, and I also applaud you
23 on the work you have been doing. I feel like in the past two
24 or three years I have been constantly going to stakeholder
25 meetings with many of the groups you have met with, and these

1 same conversations seem to keep taking place. I feel like we
2 are making forward momentum, but I feel like there is still
3 to be a lot of conversations and we are still not addressing
4 any of these issues.

5 I would like to say that the dental hygiene
6 program at Virginia Commonwealth recommends option three and
7 option four. We do have some concern with the language that
8 is in options four and five, and we would urge you to
9 consider the wording expanded scope of practice, because I
10 think there is a lot of misconception with using that
11 verbiage, that people think you want to put dental hygienists
12 out there, expanding what they do, and I don't think that is
13 what you are trying to achieve. I think we are looking at
14 expanded supervision requirements with hygienists working
15 under their current scope of practice and not changing that.
16 I have been on a lot of conference calls discussing this
17 policy, and people seem to get very confused on that issue,
18 and I think they are thinking that hygienists are looking for
19 an independent practice or an expanded scope, and I think we
20 are looking to work within our scope, just with some
21 expanding settings, to help meet some of these needs.

22 Just to speak on what some people have brought
23 up as far as the education and not having enough schools or
24 not having enough students and not having enough dental
25 hygienists in the area, I can tell you every school in the

1 Commonwealth can expand their student output. VCU, a couple
2 of years ago, doubled their class size, based on input from
3 the Virginia Dental Association, the Board of Dentistry and
4 other stakeholders. We reduced that because hygienists were
5 struggling to find jobs, because there weren't enough jobs,
6 but we have the capacity to double our class size, and I know
7 ODU can do the same.

8 Speaking on education, I think this is a good
9 opportunity. Listening to Dr. Wyman speaking of a minimum of
10 five years of education or something like that, as you look
11 at option six, which you will have to do option six if you do
12 option three or four, I would implore you to involve all the
13 stakeholders, and I think that perhaps this is the time to
14 really look at the requirements if you are considering having
15 a dental hygienist working in remote supervision, which we
16 already have, by the way. You already have hygienists
17 working for the Department of Health, and they are not under
18 direct supervision of a dentist. They can be a
19 two-year-educated dental hygienist or a four-year-educated
20 dental hygienist. There are no requirements. The only
21 requirement is two years of education.

22 I think the Department of Health has done a
23 fantastic job, and you can look at the report. It has lots
24 of statistics on the achievements that they have made, and it
25 is a successful model, but having two years of education, as

1 others have said already this morning, does not ensure that I
2 am ready to go out and work in these settings. It doesn't
3 ensure that I have any more knowledge on cultural diversity
4 or understanding the populations that I am serving or
5 understanding Medicaid or how to work the system and
6 insurance and things like that.

7 In your report you even state that a dental
8 hygienist with a baccalaureate or a master's degree does not
9 get any more clinical knowledge, which is true. I have been
10 in education in both types of programs, so that is true.
11 Clinically they are exactly the same. What happens in a
12 baccalaureate or master's program is students get a lot more
13 experience in public health and community service. They work
14 in rural settings. They work in underserved communities.
15 They get more experience in research. They have more
16 education. They are better at critical thought. So I would
17 urge you, as you look at option six, to consider not only a
18 time frame of clinical practice, which is necessary to have
19 more critical-thinking skills, but also the educational
20 requirements of somebody working in a remote capacity.

21 I think that is really all I have to say.

22 DR. VAN DE WATER: Any questions?

23 Thank you very much.

24 MS. MCGREGOR: Thank you.

25 DR. VAN DE WATER: Our last speaker on the list

1 is Joyce Flores of ODU.

2 MS. FLORES: Hello, and thank you for this
3 opportunity. I am here as a representative, mainly from the
4 Virginia Dental Hygienists' Association, but I do speak as an
5 educator from Old Dominion University. I have our position
6 from the Virginia Dental Hygienists' Association, but I would
7 like to go ahead and start and tell you a little bit about
8 me, as you requested.

9 I am a graduate of Old Dominion University and
10 have practiced as a dental hygienist for over twenty-two
11 years. In order to get into the program at Old Dominion
12 University, which I pursued the bachelor's option for a
13 baccalaureate degree, I had to pursue the same entry-level
14 requirements as the associate levels and certificate programs
15 for dental hygienists. So when I heard comment about
16 two-year education programs, I want to say that even with an
17 associate program there are about two years worth of
18 prerequisites, as established by CODA, the accrediting board,
19 which require basic sciences such as anatomy, physiology,
20 microbiology, chemistry, nutrition, all the basic sciences.
21 So when you do hear talk about two-year degrees for dental
22 hygienists at the associate and certificate level, that is
23 much more than two years of dental hygiene education, because
24 the prerequisites to get into those programs take about one
25 to two years.

1 So after I met my prerequisites to get into Old
2 Dominion University, I knew I wanted to pursue a bachelor's
3 degree, because I did feel like I wanted to at some point in
4 my life go on beyond the clinical setting. I knew I wanted
5 to, perhaps at one point in life, take on a leadership role,
6 pursue education, as I have, or perhaps pursue my master's
7 and doctorate. I knew I aspired for further degrees, but I
8 knew dental hygiene would be a way that I could start caring
9 for people, and I thought it would be important for me to
10 start and then go on and use dental hygiene as a platform,
11 and that is what I have done. I acquired my bachelor's
12 degree, practiced in several states, North Carolina, Texas,
13 and I have always come back to Virginia, or my family on the
14 East Coast, and in doing so I knew I wanted to pursue my
15 master's, and now at this point I am inches away from my
16 dissertation for my Ph.D.

17 I live in Sandston, Virginia, but I actually
18 commute to Norfolk, so I have lots of meditation time on the
19 road, at which I can think about often the lectures that I
20 provide my students. I provide lectures to our undergraduate
21 and master's degree dental hygiene students, our
22 degree-completion baccalaureate students, where students,
23 again, have acquired their associates or certificate program
24 and come to Old Dominion to pursue their bachelor's degree.
25 I also teach master's and Ph.D. students. I teach research

1 methods in health sciences, where we review evidence-based
2 research and practice, and I also in the spring teach
3 administrative leadership on professional development for
4 dental hygienists.

5 Currently, I have 64 students in my class, and
6 38 are pursuing the undergraduate bachelor's degree. They
7 have not yet practiced dental hygiene, but will be after
8 passing their boards. Twenty-two of those students are a
9 combination between bachelor's degree, degree-completion
10 students, master's degree students as well, and many of them
11 are out of state, but most of them, with the exception of
12 about three, are actually pursuant of a bachelor's degree in
13 the Commonwealth.

14 Old Dominion has a fabulous distance program,
15 where the students, as in the report, can pursue online
16 education for the degree-completion program, and we have a
17 program where they are actually able to get onto the computer
18 and be live with me or watch an archived version. It is much
19 more advanced than the online traditional education. It goes
20 beyond that. We now refer to our online students as distance
21 students. They have a much more integrated active learning
22 style, at which, again, leadership is emphasized in the
23 degree-completion program. Many of our graduates do stay in
24 the Tidewater area and surrounding Virginia areas, and
25 reflective of a previous comment, we do often get phone calls

1 reflective of our graduates that do have issues in looking
2 for jobs. So I would ask, reflective of previous comment,
3 that you do look at the evidence and the unbiased, most
4 up-to-date evidence.

5 Previously, my active settings have included
6 general and periodontal settings. Currently, I do believe
7 that we still in our clinics see a lot of uncontrolled
8 disease, causing pain, malnutrition, lost work and lost
9 school for our patients. We see these patients in the dental
10 hygiene clinic, but oftentimes they travel very far across
11 the Commonwealth to come to our clinic to see our students at
12 a very reduced rate. We have a very low fee that we charge
13 our patients, but again, these are patients that are
14 sometimes already Medicaid dependent, are unable to get into
15 their already enrolled dental practices, or just overall
16 cannot afford care. Possibly, again, contributed to the
17 restrictive scope of dental hygienists in the Commonwealth.

18 I hold a position in the Virginia Dental
19 Hygienists' Association as the liaison to the Virginia Board
20 of People with Disabilities. I now will report the position
21 paper from the Virginia Dental Hygienists' Association. On
22 behalf of the Virginia Dental Hygienists' Association, we
23 would like to thank the Board of Health Professions for the
24 opportunity to provide comment on the draft report, Dental
25 Hygienist Scope of Practice.

1 Access to oral health care is a national issue,
2 and Virginia is no exception. Stakeholders have been meeting
3 to discuss how Virginia tackles improving oral health care
4 and examining how to divert patients from emergency
5 departments and ways providers can practice in settings to
6 access additional patient populations that are not being
7 reached. In 2009 the General Assembly enacted legislation
8 that reduces dentist oversight requirements for dental
9 hygienists employed by the Virginia Department of Health in
10 selected dentally underserved areas. The program has
11 documented success, and here is direct language from the
12 October 2014 VDH technical report on Remote Supervision
13 Hygienists.

14 "As this and previous reports indicate, the
15 remote supervision model offers an effective alternative
16 method of delivery for safety-net dental program services
17 with increased access for underserved populations."

18 "This effort has improved access to preventive
19 dental services for those at highest risk of dental disease,
20 as well as reducing barriers and costs for dental care for
21 low-income individuals."

22 "This expanded access model for preventive
23 services presents a potential opportunity to have impact on
24 the oral health of more Virginians than has been possible
25 with other comprehensive clinical models in place in the

1 past."

2 "Across the state, remote supervision
3 hygienists are making a significant contribution to the oral
4 health of their communities, not only through direct services
5 but through education, raising awareness of local dental
6 challenges, capturing oral health status data, partnering
7 with providers and linking children to the services they
8 need."

9 The Virginia Department of Health has already
10 documented improved oral health care outcomes using the
11 remote supervision model for dental hygienists. The VDHA
12 supports expansion of this program to include the utilization
13 of licensed dental hygienists across the Commonwealth in
14 safety-net facilities and all other health-oriented settings.
15 Implementing this model will enable dental hygienists to
16 fully utilize their education and training in supporting
17 solutions that improve the quality of life for all
18 Virginians.

19 As the draft report states, most likely due to
20 regulatory supervision restrictions, over 92% of dental
21 hygienists work primarily in solo or group practices.
22 Knowing that dental hygienists are educated and licensed to
23 provide oral disease management and educational/preventive
24 services, utilizing registered dental hygienists to their
25 full capacity will better meet access to care issues and the

1 needs of our underserved communities.

2 The VDHA policy associated with access to care
3 effort includes:

4 R 7-97 PREVENTIVE PROGRAMS

5 The Virginia Dental Hygienists' Association
6 advocates increased funding for preventive programs designed
7 to provide oral health services to underserved sectors of the
8 population.

9 R 6-98 COMMUNITY PROJECTS

10 The Virginia Dental Hygienists' Association
11 supports community health education programs and multiple
12 approaches to the prevention of oral diseases.

13 R 11-10 COMMUNITY PROJECTS

14 The Virginia Dental Hygienists' Association
15 affirms its support for optimal oral health for all people
16 and is committed to collaborative relationships, partnerships
17 and coalitions that improve access to oral health services.

18 R 13-10 AT-RISK POPULATIONS

19 A specific individual, group or subgroup that
20 is more likely to be exposed or is more sensitive to a
21 disease or condition than the general population, whether it
22 is due to health status, socioeconomic status, ethnicity or
23 other factors.

24 The VDHA supports the Board of Health
25 Professions policy options three and four, to include

1 evaluating options five and six in support of options three
2 and four. Due to a shortage of dentists in the underserved
3 communities, we recommend option three be amended to include
4 collaborative care supervision by physicians. Option four
5 may be the most advantageous and timely option to address the
6 immediate needs of access to care in the Commonwealth.

7 As the Board evaluates options five and six, we
8 request the Board to include the expertise of educators
9 administering the three degree levels of study in dental
10 hygiene, associate, baccalaureate and master's, among the
11 stakeholders in developing protocols for training, experience
12 and educational requirements. The VDHA cautions the DHP
13 using the language expanded scope of practice used for
14 options four and five, as this could be misleading if the
15 intent is to address supervision requirements, not scope of
16 practice.

17 If you have further questions, they can be
18 addressed to president@vdha.net.

19 Thank you.

20 DR. VAN DE WATER: Thank you.

21 Any questions?

22 That concludes the list that we have of
23 speakers. We want to thank all of you who took the time to
24 come today and offer comments on the study. We will consider
25 all comments prior to development of our recommendations

1 concerning further study. Written comment will be accepted
2 until 5:00 p.m. on February 10, 2015, so you have one more
3 option. Again, thank you for taking the time to participate,
4 and this concludes our hearing.

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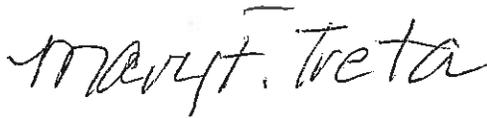
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CERTIFICATE OF COURT REPORTER

I, Mary F. Treta, certify that I was the court reporter for the Public Hearing at the Department of Health Services on January 22, 2015.

I further certify that the foregoing transcript is a true and accurate record of the comments rendered and reported during the hearing herein, to the best of my ability.

Given under my hand this 29th day of January, 2015.



Mary F. Treta