

**VIRGINIA BOARD OF DENTISTRY**

**AGENDAS**

September 6 and 7, 2012

Department of Health Professions

Perimeter Center - 9960 Mayland Drive, 2nd Floor Conference Center - Henrico, Virginia 23233

PAGE

September 6, 2012

9:00 a.m. Reserved for New Member Orientation

1:00 p.m. Formal Hearing

September 7, 2012

Board Business

8:45 a.m. Nominating Committee

9:00 a.m. Call to Order – Dr. Petticolas, Vice-President

Evacuation Announcement – Ms. Reen

Public Comment

Election of Officers

Approval of Minutes

- June 8, 2012 Board Business Meeting
- June 14, 2012 Telephone Conference Call
- July 23, 2012 Telephone Conference Call
- August 22, 2012 Telephone Conference Call

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- Adoption of Exempt Regulations on Dental Hygiene Practice in Department of Health

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- Surveys of Renewing Dentists and Dental Hygienists
- AADB Survey on Opioids
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- Update on Dental Laboratory Work Group/Forms
- Sanction Reference Points Working Paper
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**Election of Officers**

**VIRGINIA BOARD OF DENTISTRY**  
**MINUTES**  
**JUNE 8, 2012**

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**TIME AND PLACE:** The meeting of the Board of Dentistry was called to order at 9:10 a.m. on June 8, 2012 in Board Room 4, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

**PRESIDING:** Robert B. Hall, Jr. D.D.S., President

**BOARD MEMBERS PRESENT:**

Augustus A. Petticolos, Jr., D.D.S., Vice President  
Herbert R. Boyd, III, D.D.S., Secretary-Treasurer  
Martha C. Cutright, D.D.S.  
Surya P. Dhakar, D.D.S.  
Meera A. Gokli, D.D.S.  
Jeffrey Levin, D.D.S.  
Jacqueline G. Pace, R.D.H.

**BOARD MEMBERS ABSENT:**

Misty Mesimer, R.D.H.  
Myra Howard, Citizen Member

**STAFF PRESENT:**

Sandra K. Reen, Executive Director for the Board  
Elaine J. Yeatts, DHP Senior Policy Analyst  
Alan Heaberlin, Deputy Executive Director for the Board  
Huong Vu, Operations Manager for the Board

**OTHERS PRESENT:**

Howard M. Casway, Senior Assistant Attorney General

**ESTABLISHMENT OF A QUORUM:**

With eight members of the Board present, a quorum was established.

**PUBLIC COMMENT:**

Lynn Pooley, of the Virginia Dental Assistants Association, referenced the petition for rulemaking to permit DAsII to use high speed hand-pieces in the mouth and said the Board is responsible for addressing the skills needed for quality dental care. She also said that dental assistants are committed members of the dental team.

Carrie Simpson stated that the Virginia Dental Hygienists Association does not support allowing DAsII to use high speed hand-pieces in a patient's mouth.

**APPROVAL OF  
MINUTES:**

Dr. Hall asked if the Board members had reviewed the March 9, 2012 minutes. Dr. Petticolas moved to accept the minutes. The motion was seconded and carried.

**DHP DIRECTOR'S  
REPORT:**

Dr. Hall noted that Dr. Cane was unable to attend today.

**REPORT ON  
SANCTION REFERECE  
POINTS (SRP):**

Mr. Kauder reported the Board of Health Professions has engaged his company, VisualResearch, to study implementation of the SRP program to determine its effectiveness and to identify potential improvements the boards might consider. He said that, based on Dentistry's consistently high agreement rate and the information gathered through interviews with Board members and staff, there is no need to make significant changes to the worksheets. He then reviewed the following recommendations that were identified:

- Definition for "Patient Injury" – Mr. Kauder stated concern was expressed about limiting the scoring to injuries requiring medical care so the proposed definition would broaden this factor to impairing "normal daily functions." Ms. Reen said she was concerned that there are injuries that might not impair daily functions and the term itself would need to be defined in order for it to be applied consistently. She provided a reference sheet on the Board's current parameters and parameters recently adopted by other boards. She commented that other Boards' definitions move away from physical injury. Dr. Gokli suggested that the Board stay with physical injury. Ms. Pace said she would like to add mental abuse. Dr. Levin suggested narrowing down to oral and dental injuries. Ms. Reen asked for permission to revise the proposed language and bring a recommendation to the September meeting. All agreed.
- Automating SRP worksheets – Mr. Kauder said that the Board of Nursing (BON) is beginning to complete its worksheets in Microsoft Excel so that scoring is automatic. He offered to set up the worksheets, if Dentistry would like to implement this change. Ms. Reen suggested letting the BON work out any kinks before undertaking this change. All agreed.
- Reporting of quarterly SRP agreement rates – Mr. Kauder noted that he was withdrawing the recommendation for distribution of the quarterly reports. He complimented the Board for consistently achieving high agreement rates.

Dr. Hall thanked Mr. Kauder for his report.

**LIAISON/COMMITTEE  
REPORTS:**

**Board of Health Professions (BHP).** Dr. Levin stated that there is nothing new to report because the May 8 meeting was cancelled.

**AADB Mid-Year Meeting.** Dr. Levin said that he and Ms. Reen attended AADB Mid-Year meeting in Chicago in April 2012. He then reported that the following subjects were addressed:

- Prescription drug abuse and the Prescribers' Clinical Support System for Opioid Therapies to promote safe use for patients with pain.
- Dental Professional Review and Evaluation Program (D-PREP) is new service offered by AADB which state boards might use to detect and evaluate deficiencies in dental practitioners. The participating schools are University of Maryland, Marquette University and Louisiana State University.
- Expert Review Assessment (ERA) is another new service offered by AADB to dental boards in need of an independent expert witness in disciplinary cases.
- Mid-Level Providers such as Dental Therapists are being considered in seven or eight states and AADB will provide more information soon.
- ADA RFP for Portfolio-Style Examinations was presented as an effort by to provide dental boards with an additional option for making licensing decisions.

Dr. Levin thanked the Board for sending him to the meeting and Ms. Reen said she had nothing to add.

**SRTA.** Dr. Hall stated that he has nothing new to report. Ms. Pace reported that the SRTA Annual meeting will be held in early August in Bonita Springs, FL and she plans to attend.

**Dental Laboratory Workgroup.** Dr. Hall reported that he, Dr. Boyd, Ms. Yeatts, Ms. Reen and Virginia Dental Association (VDA) representatives met twice to review the need for registration of dental labs. The proposed bill and the Board's dental laboratory work order forms were discussed without closure. Ms. Reen added that she has been invited to address the VDA Board of Directors on June 16, 2012. Dr. Boyd indicated that he would also attend.

**LEGISLATION AND  
REGULATIONS:**

**Status Report on Regulatory Actions.** Ms. Yeatts noted that not much has changed since the last report. She stated particular concern with the delay in implementing the regulations for sedation and anesthesia permits which have been at the Governor's Office

for approval for 177 days. Ms. Reen asked what the Board can do as a body to advance the regulations. Dr. Hall expressed his frustration about the regulations not being approved yet and commented that the Board has worked hard on the regulations. Ms. Yeatts said that the Board might express its concern to Dr. Cane and added that the need for action on the regulations is reported weekly to the Secretary of Health and Human Resources. Dr. Boyd moved that the Board send a letter to Dr. Cane expressing its concern about the regulations. The motion was seconded and passed.

**Ms. Burnette's Petition for Rulemaking.** Ms. Yeatts stated that Ms. Burnette petitioned the Board to allow dental assistants II (DAs II) to use high speed rotary instruments and it is presented for Board action. She added that the comment period was from April 23, 2012 to May 18, 2012 and the majority of the comments opposed the proposed action and only two were in favor. She noted that the statute limits delegation to DAsII to reversible, intraoral procedures and questioned if the use of high speed rotary instruments could cause irreversible harm to patients. Dr. Hall commented that this matter was addressed when the Board worked on the DA II regulations and decided that the risk of harm was too great. Dr. Petticolas moved to deny the petition due to the potential for irreversible harm to patients. The motion was seconded and passed.

## **BOARD**

### **DISCUSSION/ACTION:**

**Review of Public Comment Topics.** Dr. Hall noted that the comments received have already been addressed.

**AADB Membership.** Ms. Reen noted that the Board voted not to renew its AADB membership at its September 9, 2011 meeting. She added that she has notified AADB of the decision and AADB is requesting reconsideration. Discussion followed about the costs and benefits of membership. Dr. Levin moved that the Board not renew its membership but continue to appoint a Board member to attend AADB meetings. The motion was seconded and passed.

**State Board Letters on ADA Test RFP & ADA Responses.** Ms. Reen said the Board continues to receive letters from other states expressing their opposition to the ADA becoming involved in licensure examinations. She said the concern is that the ADA is encroaching on the responsibility of each state to decide its licensing process. No action was taken by the Board.

**Dental Lab Work Order Forms.** Ms. Reen stated that these forms were revised as requested by the Dental Laboratory Workgroup and that she recommended no action at this meeting because the

VDA representatives still have concerns. She asked Board members for suggestions on making them as workable as possible for possible action at the September meeting. Dr. Hall noted that these forms are templates only. Ms. Reen referred the Board to the Workgroup May 18, 2012 minutes on page 19 where Dr. Sarrett, Dean of VCU School of Dentistry, suggested that, instead of advancing the proposed bill, the VDA could consider developing a registry or clearinghouse so dental labs could voluntarily apply to be listed as doing business in the Commonwealth. She commented that this might be a good solution if the VDA decides to move in that direction.

**REPORT ON CASE  
ACTIVITY:**

Mr. Heaberlin reported that in the third quarter of FY2012 the Board received a total of 83 patient care cases and closed a total of 90 for a 108% clearance rate. He added that:

- the current caseload older than 250 days is 14%,
- 97% of all cases were closed within 250 business days,
- 235 cases are open, and
- 77 cases are in probable cause with 31 at Board member review.

He said that staff has begun reviewing cases before they are sent out for Probable Cause review and the Probable Cause review sheet has been revised and updated. He reminded members not to substitute the staff's review and notes for their own opinion. Dr. Hall stated his appreciation on staff work.

**BOARD COUNSEL  
REPORT:**

Mr. Casway reported that Dr. Jeffery R. Leidy tried to appeal the signed Consent Order entered June 9, 2008 to the Circuit Court and after many communications has finally decided to drop the suit.

**EXECUTIVE  
DIRECTOR'S  
REPORT/BUSINESS:**

Ms. Reen reported the following:

- The proposed calendar for 2013 is offered for adoption. She noted that all Board members had an opportunity to review and no changes were requested. Dr. Boyd asked to move the January 25, 2013 informal conference to February 1, 2013. Ms. Reen said that the change is noted. Dr. Petticolas moved to adopt the amended 2013 calendar. The motion was seconded and passed.
- Ms. Reen reported on staff's work on new member orientation and preparing for four to five new members. She asked for recommendations to make the revised Probable Cause Review form and the draft Guide to Case Review and Probable Cause Decisions easier to user. Discussion

followed about the improvements made and the concern that the staff review section on the Probable Cause Review form may cause reviewers to overlook the issues the staff reports already doing. Dr. Levin's suggestion to remove the references to staff's work so reviewers consider the content issues was agreed to by consensus. Ms. Reen noted that she is working on another reference sheet that highlights typical case complaints, violations and sanctions plus the resources and tools available for making probable cause decisions. She said she will circulate this document for feedback, too. She thanked Dr. Hall and Dr. Boyd for their guidance.

- The Commemorative Resolution is offered for adoption by the Board. Ms. Reen stated that Dr. Hall requested the Resolution to honor and recognize the outstanding professional career of Robert T. Edwards, DDS, who was a former Board Member in the 70's. Dr. Levin moved to adopt the Resolution. The motion was seconded and passed. Dr. Levin moved to send the resolution upon receiving notice of the death of a former member. The motion was seconded and passed.

#### **SCHOOL OF DENTISTRY UPDATE:**

**David C. Sarrett, D.M.D., M.S., Dean** – Dr. Sarrett provided a presentation addressing the:

- DDS program applications and enrollees,
- VCU RAMpS program and its statistics,
- Student breakdown, debt and cost of education,
- Focus on Ethics through Book Read Program,
- Recent faculty hires,
- FY11 Budget,
- Comparison of VCU tuition and fee rates with other schools, and
- Dean priorities and Dean's blog.

#### **NATIONAL BOARD EXAMINATIONS:**

**B. Ellen Byrne, D.D.S., PhD, Senior Associate Dean,  
Professor of Endodontics, VCU School of Dentistry -**

Dr. Byrne gave a presentation addressing:

- JCNDE Mission Statement,
- Committee for an Integrated Examination (CIE),
- Brief History of Integrated National Board Dental Exam,
- CIE members and affiliations,
- CIE progress – 12 steps for test development, and
- INBDE project phases & method of communication

Dr. Hall asked if the VCU School of Dentistry will need to align course content to the INBDE and Dr. Byrne said yes.

Dr. Hall thanked Dr. Sarrett and Dr. Byrne for their presentations.

**CALIFORNIA'S  
PORTFOLIO  
EXAMINATIONS:**

Ms. Reen stated that the Board asked for presentations on the alternatives to live patient clinical examinations. She noted that the Board heard about some exam models at its December 2011 and March 2012 meeting. Then she introduced Dental Board of CA representatives, Richard DeCuir, Board Executive Officer, and Stephen Casagrande, DDS, Board member, who joined the meeting by conference call to address the CA Portfolio Examination.

Mr. DeCuir reported that the first step the CA Board took to explore the feasibility of using alternative pathways to initial licensure was to contract with Comira to do a feasibility study. Following the feasibility study, Comira was hired to define the competencies to be tested and to provide background research that might affect implementation. He confirmed that VA had received both Comira reports. He then said development and implementation was a coordinated effort between the Board and the five CA dental schools. Then Dr. Casagrande discussed the characteristics of the exam which assesses the skills required in commonly encountered clinical situations with patients of record at the respective schools within the student's program of dental education.

Mr. DeCuir and Dr. Casagrande then responded to the questions which the VA Board had sent them as follows:

- The projected cost to develop and administer the portfolio was about \$300,000 and it is part of the Dental Board of CA budget. It took about 2 years to be developed.
- The features of the portfolio model are:
  - a. Oversight is maintained by the Board .
  - b. Built-in system for auditing the process.
  - c. No additional resources are required from students, schools, or the Board.
  - d. Must be instituted within the current systems of student evaluation.
  - e. Must meet all professional testing standards.
  - f. Meets psychometric standards for examinations set forth by the Standards for Educational and Psychological Testing (1999).
  - g. Designed to cover the full continuum of competence by assessing competencies throughout the course of treatment including oral diagnosis and treatment planning, follow-up and ongoing care, restorative,

endodontics, periodontics, radiography, and removable prosthodontics.

- h. Evaluation of competence is within the course of treatment plan for patients of record.
  - i. Evaluators are regularly calibrated for consistent implementation of the alternative examination. There are six (6) different calibrations in the process of being developing. Examiners are dental school faculty trained to use a standardized evaluation system. If any examiner is unable to be re-calibrated, the Board will dismiss them.
  - j. Has policies and procedures that treat licensure candidates fairly and professionally, with timely and complete communication of examination logistics and results.
- The portfolio exam is supported by content-related validity evidence from a job analysis and addresses six competency domains: comprehensive oral diagnosis and treatment planning, direct and indirect restoration, removable prosthodontics, periodontics, and endodontics.
  - Deans, associate deans, and key faculty at the five Board-approved dental schools were involved in establishing and/or completing the portfolio evaluation process.
  - There is a separate Law and Ethics examination.
  - Each testing site is a CA licensed dental school which has to be CODA accredited.
  - Students pay \$350 to take the exam and decide when to challenge a competency so they are graded over time in a top down qualifying process.
  - The portfolio exam is not accepted by other states yet. Students can take WREB if they want to apply for license in other states.
  - The Dental Board of CA is looking at the feasibility of a similar examination for dental hygiene candidates.

Dr. Casagrande closed the presentation by offering assistance if VA is interested in establishing a portfolio exam. Dr. Hall thanked Mr. DeCuir and Dr. Casagrande for their assistance and asked for comments and questions. Discussion followed about the need to assure continuity of work on alternatives to the current clinical exams. Dr. Byrne suggested establishing an advisory committee. Dr. Sarrett suggested that the Board and the school work together to establish an exam similar to CA's. Dr. Hall stated that the Board should pursue a portfolio exam and continue to work with SRTA for a non-patient exam. Ms. Pace added that the Board should explore a model for Virginia with partnership with the school. Dr. Boyd moved that the Board establish a regulatory advisory committee to work with the Exam Committee to recommend actions the Board

should consider. The motion was seconded and passed. Ms. Reen asked if the Board would like to include others, like the VDA and VDHA, on the committee. The consensus was yes.

**CASE**

**RECOMMENDATIONS:** Case# 136273, Case# 136278, Case# 135072, Case# 135478, and Case# 136456

**Closed Meeting:** Dr. Boyd moved that the Board convene a closed meeting pursuant to Section 2.2-3711(A)(27) of the *Code of Virginia* for the purpose of deliberation to reach decisions in the matters of case # 136273, # 135072, # 135478, # 136456, and # 136278. Additionally, Dr. Boyd moved that Board staff, Ms. Reen and Ms. Vu attend the closed meeting because their presence in the closed meeting is deemed necessary, and will aid the Board in its deliberations.

**Reconvene:** Dr. Boyd moved that the Board certify that it heard, discussed or considered only public business matters lawfully exempted from open meeting requirements under the Virginia Freedom of Information Act and only such public business matters as were identified in the motion by which the closed meeting was convened. The motion was seconded and passed.

Dr. Gokli moved to accept the Consent Order for Case # 136273. The motion was seconded and passed.

Dr. Petticolas moved to accept the recommended Order of the Credentials Committee for Case # 136278. The motion was seconded and passed.

Dr. Gokli moved to accept the Consent Order for Case # 135072, Case # 135478, and Case # 136456. The motion was seconded and passed.

**ADJOURNMENT:** With all business concluded, the meeting was adjourned at 3:32 p.m.

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Robert B. Hall, Jr., D.D.S., President

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Sandra K. Reen, Executive Director

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

**UNAPPROVED**

**VIRGINIA BOARD OF DENTISTRY**

**MINUTES**

**SPECIAL SESSION - TELEPHONE CONFERENCE CALL**

- CALL TO ORDER:** The meeting of the Board of Dentistry was called to order at 5:10 p.m., on June 14, 2012, at the Department of Health Professions, Perimeter Center, 2<sup>nd</sup> Floor Conference Center, 9960 Mayland Drive, Henrico, Virginia 23233.
- PRESIDING:** Robert B. Hall, Jr., D.D.S.
- MEMBERS PRESENT:** Herbert R. Boyd, III, D.D.S.  
Martha C. Cutright, D.D.S.  
Meera A. Gokli, D.D.S.  
Jeffrey Levin, D.D.S.  
Augustus A. Petticolas, Jr., D.D.S.  
Jacqueline G. Pace, R.D.H.
- MEMBERS ABSENT:** Surya P. Dhakar, D.D.S.  
Myra Howard  
Misty Mesimer, R.D.H.
- QUORUM:** With seven members present, a quorum was established.
- STAFF PRESENT:** Sandra K. Reen, Executive Director  
Alan Heaberlin, Deputy Executive Director  
Lorraine McGehee, Deputy Director, Administrative Proceedings Division  
Indy Toliver, Adjudication Specialist  
Donna Lee, Discipline Case Manager
- OTHERS PRESENT:** Howard M. Casway, Senior Assistant Attorney General  
Cori Wolf, Assistant Attorney General
- Gregory Hughes,  
D.D.S.  
Case No.: 143638** The Board received information from Ms. Wolf in order to determine if Dr. Hughes' impairment from mental illness constitutes a substantial danger to public health and safety. Ms. Wolf reviewed the case and responded to questions.
- Closed Meeting:** Dr. Petticolas moved that the Committee convene a closed meeting pursuant to § 2.2-3711(A)(27) of the Code of Virginia for the purpose of deliberation to reach a decision in the matter of Gregory Hughes. Additionally, Dr. Petticolas moved that Ms. Reen, Mr. Heaberlin, Ms. Lee, Ms. Wolf, Ms. McGehee and Ms. Toliver attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Committee in its deliberations. The motion was seconded and passed.

**Reconvene:**

Dr. Petticolas moved that the Committee certify that it heard, discussed or considered only public business matters lawfully exempted from open meeting requirements under the Virginia Freedom of Information Act and only such public business matters as were identified in the motion by which the closed meeting was convened. The motion was seconded and passed.

**DECISION:**

Dr. Levin moved that the Board summarily suspend Dr. Hughes' license to practice dentistry in that he is unable to practice dentistry safely due to impairment resulting from mental illness, and schedule him for a formal hearing. Following a second and discussion, a roll call vote was taken. The motion passed 6 to 1.

Dr. Levin moved that the Board offer a consent order to Dr. Hughes that would continue his license on indefinite suspension, with said suspension stayed upon proof of entry into a Participation Contract with the Virginia Health Practitioners' Monitoring Program and remaining compliant with the terms of the contract; failure to comply would result in the immediate rescission of the stay of indefinite suspension of Dr. Hughes' license to practice dentistry. Following a second and discussion, a roll call vote was taken. The motion passed unanimously.

**ADJOURNMENT:**

With all business concluded, the Board adjourned at 6:10 p.m.

\_\_\_\_\_  
Robert B. Hall, Jr., D.D.S., President

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Sandra K. Reen, Executive Director

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

**UNAPPROVED**

**VIRGINIA BOARD OF DENTISTRY**

**MINUTES**

**SPECIAL SESSION - TELEPHONE CONFERENCE CALL**

- CALL TO ORDER:** The meeting of the Board of Dentistry was called to order at 5:05 p.m., on July 23, 2012, at the Department of Health Professions, Perimeter Center, 2<sup>nd</sup> Floor Conference Center, 9960 Mayland Drive, Henrico, Virginia 23233.
- PRESIDING:** Robert B. Hall, Jr., D.D.S.
- MEMBERS PRESENT:** Herbert R. Boyd, III, D.D.S.  
Martha C. Cutright, D.D.S.  
Meera A. Gokli, D.D.S.  
Jeffrey Levin, D.D.S.  
Misty Mesimer, R.D.H.  
Jacqueline G. Pace, R.D.H.  
Augustus A. Petticolas, Jr., D.D.S.
- MEMBERS ABSENT:** Surya P. Dhakar, D.D.S.  
Myra Howard, Citizen Member
- QUORUM:** With eight members present, a quorum was established.
- STAFF PRESENT:** Sandra K. Reen, Executive Director  
Lorraine McGehee, Deputy Director, Administrative Proceedings Division  
Fielding Yelverton, Adjudication Specialist  
Donna Lee, Discipline Case Manager
- OTHERS PRESENT:** Howard M. Casway, Senior Assistant Attorney General  
Wayne Halbleib, Senior Assistant Attorney General
- Richard A. Smith, D.D.S.**  
**Case Nos.: 144697,**  
**145216, and 145223**
- The Board received information from Mr. Halbleib in order to determine if Dr. Smith's practice of dentistry constitutes a substantial danger to public health and safety. Mr. Halbleib reviewed the case and responded to questions.
- DECISION:** Dr. Levin moved that the Board Summarily Suspend Dr. Smith's license to practice dentistry in that his practice of dentistry constitutes a substantial danger to public health and safety, and schedule him for a formal hearing. Following a second and discussion, a roll call vote was taken. The motion passed unanimously.

**ADJOURNMENT:**

With all business concluded, the Board adjourned at 5:30 p.m.

\_\_\_\_\_  
Robert B. Hall, Jr., D.D.S., President

\_\_\_\_\_  
Sandra K. Reen, Executive Director

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

**UNAPPROVED**

**BOARD OF DENTISTRY**

**MINUTES**

**TELEPHONE CONFERENCE CALL**

**CALL TO ORDER:** The meeting of the Board of Dentistry was called to order at 5:05 p.m., on August 22, 2012, at the Department of Health Professions, Perimeter Center, 2<sup>nd</sup> Floor Conference Center, 9960 Mayland Drive, Henrico, VA 23233.

**PRESIDING:** Augustus A. Petticolos, Jr., D.D.S., Vice-President

**MEMBERS PRESENT:** Herbert R. Boyd, III, D.D.S.  
Surya P. Dhakar, D.D.S.  
Myra Howard, Citizen Member  
Jacqueline G. Pace, R.D.H.

**MEMBERS ABSENT:** Martha C. Cutright, D.D.S.  
Robert B. Hall, Jr., D.D.S.  
Meera A. Gokli, D.D.S.  
Jeffrey Levin, D.D.S.  
Misty Mesimer, R.D.H.

**STAFF PRESENT:** Sandra K. Reen, Executive Director  
Donna Lee, Discipline Case Manager

**OTHERS PRESENT:** Howard M. Casway, Senior Assistant Attorney General

**QUORUM:** With five members present, a panel was established.

**Richard A. Smith, D.D.S.** The Board met to consider a Consent Order signed by Dr. Smith to settle his case in lieu of proceeding with a formal hearing.  
**Case Nos.: 144697,**  
**145216, and 145223**

**DECISION:** Dr. Boyd moved that the Board accept the Consent Order to settle this case in lieu of proceeding with a formal hearing. Following a second, a roll call vote was taken. The motion was passed unanimously.

**ADJOURNMENT:** With all business concluded, the Board adjourned at 5:12 p.m.

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Augustus A. Petticolos, Jr., D.D.S., Vice-President

\_\_\_\_\_  
Sandra K. Reen, Executive Director

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

## ***SRTA ANNUAL MEETING REPORT 2012***

*The 37<sup>th</sup> SRTA Annual Meeting was held in Bonita Springs, Florida at the Hyatt Regency Coconut Point. Below were the attendees:*

### *Members*

*Sherie Barbare, Chair  
Jan Jolly  
Marlene Fullilove  
Mary Ann Burch  
Dina Vaughan  
Jacki Pace*

### *State*

*South Carolina  
Arkansas  
Tennessee  
Kentucky  
West Virginia  
Virginia*

### *Guests:*

*Camille Arceneaux  
Tunde Anday  
Beth Casey  
Dianne Embry  
Katherine Cherry  
Michelle Klenk  
Evelyn Edwards  
Tanya Riffe  
Jennifer Vega  
Nan Dreves  
Janet McMurphy  
Gordon Bray, DDS  
Kathleen White  
Crystal Yap  
Jessica Bui*

### *Representing:*

*Examiner–WV  
Examiner– GA  
Examiner– TN  
Examiner– KY  
Examiner– TN  
Examiner– WV  
Examiner– TN  
Examiner– SC  
Examiner– AR  
ADEX  
Examiner – MS  
Examiner/CFC-SC  
SRTA Office  
SRTA Office  
SRTA Office*

### *Guests:*

*Barbara Ebert  
Joseph Evans  
Charles Faust  
Lisa Haddox-Heston  
Michelle Jones  
Harold Marioneaux  
Cathy Milejzak  
Lynn Russell  
Elaine Smith  
Tammy Swecker  
Janice Williams  
Eleta Reed-Morgan  
Leslie Barkley  
Randa Colbert  
Sandra Horm  
Stacy Thomas*

### *Representing:*

*Educator-WS  
Educator-WKU  
Educator-ETSU  
Educator-SWVCTC  
Educator-Roane  
Director-TNCC  
Educator-MTC  
Educator-CCC  
Educator-WCC  
Educator-VCU  
Educator-TSU  
Educator-UT  
Educator-Hiwassee  
Educator-Hiwassee  
Educator-UMiss  
Educator-WCC*

*The Dental Hygiene Exam committee met on August 2 & 3 to discuss current year's pass rates, criteria and survey results (examiner). Guests were solicited for suggestions for changes (improvements) to the exam. Recommended changes for the dental hygiene exam criteria for 2013 is attached. Dina Vaughn was re-elected to the Board of Directors as the DH representative.*

*An ADEX presentation was given by Nan Dreves which emphasized that ADEX is an organization which creates an exam to be administered by another entity. ADEX adopted most of the SRTA exam criteria for their exam with minor differences. ADEX will discuss those differences at the November annual meeting. This discussion is to bring the exams more align with each other – with emphasis on moving toward a National exam.*

*In 2012, Mississippi, New Mexico and Nevada are administering the ADEX exam in addition to the current 29 states. Hawaii is considering this exam for their candidates.*

*The SRTA DH Exam Committee voted to administer the ADEX exam for 2014.*

*Note: Attached are the Dental Exam Committee Report and the 2013 ADEX Dental Exam Content*

*Respectfully submitted,*

*Jacqueline Pace, RDH  
SRTA DHEC Member  
Member Virginia Board of Dentistry*

# DENTAL HYGIENE EXAMINATION COMMITTEE

- #1 Separate points for each criteria under case presentation
- #2 Remove medical alert notification as a gradable item
- #3 Evaluate only radiographs of the candidate's selection as either diagnostic or non-diagnostic as a separate gradable item
- #4 Revise computer-scoring program to require candidate's to enter their case selection information, their detection findings, and their periodontal probing measurements
- #5 Revise computer-scoring program to have first and second examiners enter surfaces for scoring remaining calculus and to be alerted if calculus requirements are not met
- #6 Accept the UNC probe as well as the Williams probe but must be yellow color coded
- #7 Add completion of anesthesia record as a criteria under Final Case Presentation
- #8 Revise computer program to round scores so candidates will not fail by a fraction of a point
- #9 Accept the ADEX Dental Hygiene Examination in 2014
- #10 To implement the following points system for 2013

Quad has 6 teeth	1
Quad has a molar	1
Meets calculus criteria	5
Proximal contact	1
Excessive soft debris	1
Radiographs	8
Detection	18
Removal	54
Perio	6
Tissue management	3
Final case presentation	2
<b>TOTAL</b>	<b>100</b>



## **2012 Report from the Dental Examination Committee to SRTA Board of Directors August 3, 2012**

**The Dental Exam for 2013 is SET. With only three committee members present there was no quorum. We went into Executive session. The first item discussed was the Endodontic section. After much discussion with the Educators, NERB and ADEX representatives, the 2013 Endodontic section SRTA administers has to be the same in order to be consistency with other ADEX administered agencies. Tooth number #9 will be used for the anterior procedure and #14 for the posterior procedure. The Fixed Prosthodontics will use tooth #3 and #5 for the fixed bridge, replacing #4 and tooth #8 for the all porcelain procedure. A total of 7 hours will be allowed for these sections.**

**The DSE exam for 2013 is approximately 100 questions shorter and only 3 hours long.**

**The committee makes the following recommendations for examiner training:**

- 1. This Fall, have SRTA Chiefs and Captains attend and participate in as many NER B exams as possible.(December and February)**
- 2. Send SRTA Chiefs and Captains to the training session at NERB's Annual Meeting in January. (At NERB's expense).**
- 3. Examiner Swap: For 2013, three examiners from NERB will participate in each SRTA complete exam. Three examiners from SRTA will participate in NERB exams for the same duration.**

**As per the educators, and committee members, recommendations will be made to the ADEX Dental Exam committee meeting in November. Any**

**changes will become effect for the 2014 exam year. The changes are as follows:**

- 1. In the Restoration section, change from compensatory to conjunctive so a pass on anterior and a fail on the posterior would allow re-exam for only the one section.**
- 2. Change the anterior tooth currently being used for the Endo section (clear root) to the opaque Real T from Accidental and require radiographs.**
- 3. Currently, if there are two lesions on a tooth and one is restored prior to exam, new radiographs are required. The DEC would like to change that requirement to “new radiographs are not required unless there’s a clinical reason.”**

**The committee has identified potential CFCs and SACs to be used as Captains and Chiefs for the SRTA ADEX exam.**

# 2013 ADEX DENTAL EXAM CONTENT

## **PART I: COMPUTER-BASED EXAMINATION**

1. Diagnosis, Oral Medicine, Radiology (DOR)
2. Comprehensive Treatment Planning (CTP)
3. Periodontics, Fixed Prosthodontics and Medical Considerations

## **PART II: ENDODONTIC CLINICAL EXAMINATION**

1. Access Opening on Plastic Posterior Tooth
2. Access Opening, Canal Instrumentation and Obturation on Plastic Anterior Tooth (#8)

## **PART III: FIXED PROSTHODONTIC CLINICAL EXAMINATION**

1. Preparation – PFM Crown as one 3-unit bridge abutment
2. Preparation – Full Cast Crown as the other abutment for the same 3-unit bridge – both preps must be parallel
3. Preparation – Ceramic Crown

## **PART IV: RESTORATIVE CLINICAL EXAMINATION**

One Class II and one Class III Restoration is required

1. Class II Amalgam or Class II Composite– Cavity Preparation
2. Class II Amalgam or Class II Composite – Restoration
3. Class III Composite – Cavity Preparation
4. Class III Composite Resin - Restoration

## **PART V: PERIODONTAL CLINICAL EXAMINATION (OPTIONAL AT SELECTED SITES)**

Assignment

1. Case Acceptance
2. Pocket Depth Qualification
3. Subgingival Calculus Detection

Treatment

4. Subgingival Calculus Removal
5. Supragingival Plaque/Stain Removal
6. Sulcus/Pocket Depth Measurement
7. Tissue and Treatment Management

**Agenda Item: Regulatory Actions - Chart of Regulatory Actions  
(As of August 23, 2012)**

<b>Board of Dentistry</b>	
<b>Chapter</b>	<b>Action / Stage Information</b>
Regulations Governing Dental Practice [18 VAC 60 - 20]	<u>Action:</u> Sedation and anesthesia permits for dentists <u>Stage:</u> Emergency/NOIRA - At Governor's Office for 253 days; was required to be effective 12/28/11
Regulations Governing Dental Practice [18 VAC 60 - 20]	<u>Action:</u> Periodic review; reorganizing chapter 20 into four new chapters: 15, 21, 25 and 30 <u>Stage:</u> Proposed - At Secretary's Office for 94 days
Regulations Governing Dental Practice [18 VAC 60 - 20]	<u>Action:</u> Training in pulp capping for dental assistants II <u>Stage:</u> Fast-Track - At Governor's Office for 373 days
Regulations Governing Dental Practice [18 VAC 60 - 20]	<u>Action:</u> Radiation certification <u>Stage:</u> Fast-Track - At Governor's Office for 310 days
Regulations Governing Dental Practice [18 VAC 60 - 20]	<u>Action:</u> Recovery of disciplinary costs <u>Stage:</u> Final - At Governor's Office for 371 days

**Agenda Item: Regulatory Recommendation – 2012 Legislation**

Included in the agenda package:

A copy of statutory language amending sections relating to temporary licenses and dental faculty – **HB344** (Identical Senate bill SB384)

A copy of proposed regulations to be adopted as an exempt action

Staff note:

Since the changes to regulation are “*Necessary to conform to changes in Virginia statutory law or the appropriation act where no agency discretion is involved*” (§ 2.2-4006), the action can be exempt from the Administrative Process Act.

Action:

Adoption of the **final exempt** regulations for the practice of dentistry

# VIRGINIA ACTS OF ASSEMBLY -- 2012 SESSION

## CHAPTER 20

*An Act to amend and reenact §§ 54.1-2709, 54.1-2711.1, 54.1-2712, 54.1-2713, 54.1-2714, and 54.1-2725 of the Code of Virginia and to repeal § 54.1-2714.1 of the Code of Virginia, relating to licensure of dental faculty.*

[H 344]

Approved February 28, 2012

**Be it enacted by the General Assembly of Virginia:**

**1. That §§ 54.1-2709, 54.1-2711.1, 54.1-2712, 54.1-2713, 54.1-2714, and 54.1-2725 of the Code of Virginia are amended and reenacted as follows:**

§ 54.1-2709. License; application; qualifications; examinations.

A. No person shall practice dentistry unless he possesses a current valid license from the Board of Dentistry.

B. An application for such license shall be made to the Board in writing and shall be accompanied by satisfactory proof that the applicant (i) is of good moral character; (ii) is a graduate of an accredited dental school or college, or dental department of a university or college; (iii) has passed ~~Part I and Part II~~ *all parts* of the examination given by the Joint Commission on National Dental Examinations; (iv) has successfully completed a clinical examination acceptable to the Board; and (v) has met other qualifications as determined in regulations promulgated by the Board.

C. The Board may grant a license to practice dentistry to an applicant licensed to practice in another jurisdiction if he (i) meets the requirements of subsection B; (ii) holds a current, unrestricted license to practice dentistry in another jurisdiction in the United States and is certified to be in good standing by each jurisdiction in which he currently holds or has held a license; (iii) has not committed any act that would constitute grounds for denial as set forth in § 54.1-2706; and (iv) has been in continuous clinical practice for five out of the six years immediately preceding application for licensure pursuant to this section. Active patient care in the dental corps of the United States Armed Forces, volunteer practice in a public health clinic, or practice in an intern or residency program may be accepted by the Board to satisfy this requirement.

D. The Board shall provide for an inactive license for those dentists who hold a current, unrestricted dental license in the Commonwealth at the time of application for an inactive license and who do not wish to practice in Virginia. The Board shall promulgate such regulations as may be necessary to carry out the provisions of this section, including requirements for remedial education to activate a license.

E. The Board shall promulgate regulations requiring continuing education for any dental license renewal or reinstatement. The Board may grant extensions or exemptions from these continuing education requirements.

§ 54.1-2711.1. Temporary licenses to persons enrolled in advanced dental education programs; Board regulations.

A. Upon recommendation by the dean of the school of dentistry *or the dental program director*, the Board may issue a temporary annual license to practice dentistry to persons enrolled in advanced dental education programs, *and persons* serving as dental interns, residents or post-doctoral certificate or degree candidates in hospitals or schools of dentistry that maintain dental intern, residency or post-doctoral programs accredited by the Commission on Dental Accreditation of the American Dental Association. ~~No such license shall be issued to a dental intern or resident or post-doctoral certificate or degree candidate who has not completed successfully the academic education required for admission to examination given by the Board.~~ Such license shall expire upon the holder's graduation, withdrawal or termination from the relevant program.

B. *Temporary licenses issued pursuant to this section shall authorize the licensee to perform patient care activities associated with the program in which he is enrolled that take place only within educational facilities owned or operated by, or affiliated with, the dental school or program. Temporary licenses issued pursuant to this section shall not authorize a licensee to practice dentistry in nonaffiliated clinics or private practice settings.*

C. The Board may prescribe such regulations not in conflict with existing law and require such reports from any hospital or the school of dentistry operating an accredited advanced dental education program in the Commonwealth as may be necessary to carry out the provisions of this section.

§ 54.1-2712. Permissible practices.

The following activities shall be permissible:

1. Dental assistants or dental hygienists aiding or assisting licensed dentists, or dental assistants aiding or assisting dental hygienists under the general supervision of a dentist in accordance with regulations promulgated pursuant to § 54.1-2729.01;

2. The performance of mechanical work on inanimate objects only, for licensed dentists, by any person employed in or operating a dental laboratory;

3. Dental students who are enrolled in accredited D.D.S. or D.M.D. degree programs performing dental operations, under the direction of competent instructors (i) within a dental school or college, dental department of a university or college, or other dental facility within a university or college that is accredited by an accrediting agency recognized by the United States Department of Education; (ii) in a dental clinic operated by a nonprofit organization providing indigent care; (iii) in governmental or indigent care clinics in which the student is assigned to practice during his final academic year rotations; (iv) in a private dental office for a limited time during the student's final academic year when under the direct tutorial supervision of a licensed dentist holding appointment on the dental faculty of the school in which the student is enrolled; or (v) practicing dental hygiene in a private dental office under the direct supervision of a licensed dentist holding appointment on the dental faculty of the school in which the student is enrolled;

4. A licensed dentist from another state or country appearing as a clinician for demonstrating technical procedures before a dental society or organization, convention, or dental college, or performing his duties in connection with a specific case on which he may have been called to the Commonwealth; and

5. Dental hygiene students enrolled in an accredited dental hygiene program performing dental hygiene practices as a requisite of the program, under the direction of competent instructors, as defined by regulations of the Board of Dentistry, (i) within a dental hygiene program in a dental school or college, or department thereof, or other dental facility within a university or college that is accredited by an accrediting agency recognized by the United States Department of Education; (ii) in a dental clinic operated by a nonprofit organization providing indigent care; (iii) in a governmental or indigent care clinic in which the student is assigned to practice during his final academic year rotations; or (iv) in a private dental office for a limited time during the student's final academic year when under the direct supervision of a licensed dentist or licensed dental hygienist holding appointment on the dental faculty of the school in which the student is enrolled; and

6. *A graduate of an accredited dental program or a graduate of an accredited dental hygiene program engaging in clinical practice under the supervision of a licensed faculty member, but only while participating in a continuing education course offered by a dental program or dental hygiene program accredited by the Commission on Dental Accreditation of the American Dental Association.*

§ 54.1-2713. Licenses to teach dentistry; renewals.

A. Upon payment of the prescribed fee and provided that no grounds exist to deny licensure pursuant to § 54.1-2706, the Board shall may grant, without examination, a faculty license to teach dentistry in a dental program accredited by the Commission on Dental Accreditation of the American Dental Association to any applicant who (i) is meets one of the following qualifications:

1. *Is a graduate of a dental school or college or the dental department of a college or university approved by the Board of Dentistry; (ii) has a D.D.S. or D.M.D. degree and is otherwise qualified; (iii) is not, has a current unrestricted license to practice dentistry in at least one other United States jurisdiction, and has never been licensed to practice dentistry in the Commonwealth; (iv) has not failed an examination for a license to practice dentistry in Virginia; and (v) has a license to practice dentistry in at least one other state. The applicant shall also be certified to be on the faculty of an accredited program that teaches dentistry or*

2. *Is a graduate of a dental school or college or the dental department of a college or university, has completed an advanced dental education program accredited by the Commission on Dental Accreditation of the American Dental Association, and has never been licensed to practice dentistry in the Commonwealth.*

B. *The dean or program director of the accredited dental program shall provide to the Board verification that the applicant is being hired by the program and shall include an assessment of the applicant's clinical competency and clinical experience that qualifies the applicant for a faculty license.*

C. *The holder of such a license issued pursuant to this section shall be entitled to perform all operations which activities that a person licensed to practice dentistry would be entitled to perform but only for the express purpose of teaching. This license does not entitle the holder to practice dentistry intramurally or privately or to receive fees for service and that are part of his faculty duties, including all patient care activities associated with teaching, research, and the delivery of patient care, which take place only within educational facilities owned or operated by or affiliated with the dental school or program. A licensee who is qualified based on educational requirements for a specialty board certification shall only practice in the specialty for which he is qualified. A license issued pursuant to this section shall not authorize the holder to practice dentistry in nonaffiliated clinics or in private practice settings.*

D. *Any license issued under this section shall expire on the June 30 of the second year after its issuance or shall terminate when the licensee leaves employment at the accredited dental program. Such license may be renewed annually thereafter as long as the accredited program certifies to the licensee's continuing employment.*

§ 54.1-2714. Restricted licenses to teach dentistry for foreign dentists.

A. The Board may grant, without examination, a restricted license *for a temporary appointment* to teach dentistry at a dental school in this Commonwealth to any person who:

1. Is a resident of a foreign country;
2. Is licensed to practice dentistry in a foreign country;
3. Holds a faculty appointment in a dental school in a foreign country;
4. Is a graduate of a foreign dental school or college or the dental department of a foreign college or university;
5. Is not licensed to practice dentistry in Virginia;
6. Has not failed an examination for a license to practice dentistry in this Commonwealth;
7. Has received a temporary appointment to the faculty of a dental school in this Commonwealth to teach dentistry;
8. Is, in the opinion of the Board, qualified to teach dentistry; and
9. Submits a completed application, the supporting documents the Board deems necessary to determine his qualifications, and the prescribed fee.

B. A restricted license shall entitle the licensee to perform all operations which a person licensed to practice dentistry may perform but only for the purpose of teaching. No person granted a restricted license shall practice dentistry intramurally or privately or receive fees for his services.

C. A restricted license granted pursuant to this section shall expire ~~twelve~~ 24 months from the date of issuance and may not be renewed or reissued.

§ 54.1-2725. Faculty licenses to teach dental hygiene; renewals.

A. Upon payment of the prescribed fee, the Board shall grant, without examination, a license to teach dental hygiene to any applicant who (i) is a graduate of a dental hygiene school or college or the dental hygiene department of a college or university approved by the Board of Dentistry accredited by the Commission of Dental Accreditation of the American Dental Association; (ii) has a B.S., B.A., A.B., or M.S. degree and is otherwise qualified; (iii) is not licensed to practice dental hygiene; and (iv) has not failed an examination for a license to practice dental hygiene in this Commonwealth; and (v) has a license to practice dental hygiene in at least one other state *United States jurisdiction*. The applicant shall be certified to be on the faculty of an approved institution that teaches dentistry or dental hygiene.

B. The dean or program director of the accredited dental hygiene program shall provide to the Board verification that the applicant is being hired by the program and shall include an assessment of the applicant's clinical competency and clinical experience that qualifies the applicant for a faculty license.

C. The holder of such a license issued pursuant to this section shall be entitled to perform all operations which ~~activities that~~ a person licensed to practice dental hygiene would be entitled to perform but only for the express purpose of teaching. ~~This that are part of his faculty duties, including all patient care activities associated with teaching, research, and the delivery of patient care that take place only within educational facilities owned or operated by or affiliated with the dental school or program.~~ A license issued pursuant to this section does not entitle the holder to practice dental hygiene intramurally or privately or to receive fees for services in nonaffiliated clinics or other private practice settings.

D. Any license issued under this section shall expire on the second June 30 of the second year after its issuance but may be renewed or shall terminate when the licensee leaves employment at the accredited dental program. Such license may be renewed annually thereafter as long as the accredited program certifies to the licensee's continuing employment.

2. That § 54.1-2714.1 of the Code of Virginia is repealed.

**BOARD OF DENTISTRY**

**Temporary or faculty licenses**

Part II

Renewal and Fees

**18VAC60-20-20. Renewal and reinstatement.**

A. Renewal fees. Every person holding an active or inactive license or a dental assistant II registration or a full-time faculty license shall, on or before March 31, renew his license or registration. Every person holding a ~~teacher's license~~, temporary resident's license, a restricted volunteer license to practice dentistry or dental hygiene, or a temporary permit to practice dentistry or dental hygiene shall, on or before June 30, request renewal of his license.

1. The fee for renewal of an active license or permit to practice or teach dentistry shall be \$285, and the fee for renewal of an active license or permit to practice or teach dental hygiene shall be \$75. The fee for renewal of registration as a dental assistant II shall be \$50.
2. The fee for renewal of an inactive license shall be \$145 for dentists and \$40 for dental hygienists. The fee for renewal of an inactive registration as a dental assistant II shall be \$25.
3. The fee for renewal of a restricted volunteer license shall be \$15.
4. The application fee for temporary resident's license shall be \$60. The annual renewal fee shall be \$35 a year. An additional fee for late renewal of licensure shall be \$15.

B. Late fees. Any person who does not return the completed form and fee by the deadline required in subsection A of this section shall be required to pay an additional late fee of \$100 for dentists with an active license, \$25 for dental hygienists with an active license, and \$20 for a dental assistant II with active registration. The late fee shall be \$50 for dentists with an inactive license, \$15 for dental hygienists with an inactive license, and \$10 for a dental assistant II with an inactive registration. The board shall renew a license or dental assistant II registration if the renewal form, renewal fee, and late fee are received within one year of the deadline required in subsection A of this section.

C. Reinstatement fees and procedures. The license or registration of any person who does not return the completed renewal form and fees by the deadline required in subsection A of this section shall automatically expire and become invalid and his practice as a dentist, dental hygienist, or dental assistant II shall be illegal.

1. Any person whose license or dental assistant II registration has expired for more than one year and who wishes to reinstate such license or registration shall submit to the board a reinstatement application and the reinstatement fee of \$500 for dentists, \$200 for dental hygienists, or \$125 for dental assistants II.

2. With the exception of practice with a restricted volunteer license as provided in §§ 54.1-2712.1 and 54.1-2726.1 of the Code of Virginia, practicing in Virginia with an expired license or registration may subject the licensee to disciplinary action by the board.

3. The executive director may reinstate such expired license or registration provided that the applicant can demonstrate continuing competence, that no grounds exist pursuant to § 54.1-2706 of the Code of Virginia and 18VAC60-20-170 to deny said reinstatement, and that the applicant has paid the unpaid reinstatement fee and any fines or assessments. Evidence of continuing competence shall include hours of continuing

education as required by subsection H of 18VAC60-20-50 and may also include evidence of active practice in another state or in federal service or current specialty board certification.

D. Reinstatement of a license or dental assistant II registration previously revoked or indefinitely suspended. Any person whose license or registration has been revoked shall submit to the board for its approval a reinstatement application and fee of \$1,000 for dentists, \$500 for dental hygienists, and \$300 for dental assistants II. Any person whose license or registration has been indefinitely suspended shall submit to the board for its approval a reinstatement application and fee of \$750 for dentists, \$400 for dental hygienists, and \$250 for dental assistants II.

**18VAC60-20-30. Other fees.**

A. Dental licensure application fees. The application fee for a dental license by examination, ~~a license to teach dentistry~~, a full-time faculty license, or a temporary permit as a dentist shall be \$400. The application fee for dental license by credentials shall be \$500.

B. Dental hygiene licensure application fees. The application fee for a dental hygiene license by examination, a license to teach dental hygiene, or a temporary permit as a dental hygienist shall be \$175. The application fee for dental hygienist license by endorsement shall be \$275.

C. Dental assistant II registration application fee. The application fee for registration as a dental assistant II shall be \$100.

D. Wall certificate. Licensees desiring a duplicate wall certificate or a dental assistant II desiring a wall certificate shall submit a request in writing stating the necessity for a wall certificate, accompanied by a fee of \$60.

E. Duplicate license or registration. Licensees or registrants desiring a duplicate license or registration shall submit a request in writing stating the necessity for such duplicate,

accompanied by a fee of \$20. If a licensee or registrant maintains more than one office, a notarized photocopy of a license or registration may be used.

F. Licensure or registration certification. Licensees or registrants requesting endorsement or certification by this board shall pay a fee of \$35 for each endorsement or certification.

G. Restricted license. Restricted license issued in accordance with § 54.1-2714 of the Code of Virginia shall be at a fee of \$285.

H. Restricted volunteer license. The application fee for licensure as a restricted volunteer dentist or dental hygienist issued in accordance with § 54.1-2712.1 or § 54.1-2726.1 of the Code of Virginia shall be \$25.

I. Returned check. The fee for a returned check shall be \$35.

J. Inspection fee. The fee for an inspection of a dental office shall be \$350.

K. Mobile dental clinic or portable dental operation. The application fee for registration of a mobile dental clinic or portable dental operation shall be \$250. The annual renewal fee shall be \$150 and shall be due by December 31. A late fee of \$50 shall be charged for renewal received after that date.

**18VAC60-20-90. Temporary permit, teacher's license, and full-time faculty license.**

A. A temporary permit shall be issued only for the purpose of allowing dental and dental hygiene practice as limited by §§ 54.1-2715 and 54.1-2726 of the Code of Virginia.

B. A temporary permit will not be renewed unless the permittee shows that extraordinary circumstances prevented the permittee from taking the licensure examination during the term of the temporary permit.

C. A full-time faculty license shall be issued to any dentist who meets the entry requirements of § 54.1-2713 of the Code of Virginia, who is certified by the dean of a dental school in the

Commonwealth and ~~who is serving full-time to be~~ on the faculty of a the dental school or its affiliated clinics intramurally in the Commonwealth. The dean's certification shall include an assessment of the clinical competency and experience of the applicant.

1. A dentist holding a faculty license may perform activities that are part of his faculty duties, including all patient care activities associated with teaching, research, and the delivery of patient care, which take place only within educational facilities owned or operated by or affiliated with the dental school or program.

~~4.2.~~ A full-time faculty license shall remain valid only while the license holder is serving full-time on the faculty of a dental school in the Commonwealth. When any such license holder ceases to continue serving full-time on the faculty of the dental school for which the license was issued, the licensee shall surrender the license, which shall be null and void upon termination of full-time employment. The dean of the dental school shall notify the board within five working days of such termination of full-time employment.

~~2.3.~~ A full-time faculty licensee working in a ~~faculty intramural clinic~~ facility owned or operated by or affiliated with a dental school or program may accept a fee for service.

D. A temporary permit, a teacher's license issued pursuant to § 54.1-2714 and a full-time faculty license may be revoked for any grounds for which the license of a regularly licensed dentist or dental hygienist may be revoked and for any act indicating the inability of the permittee or licensee to practice dentistry that is consistent with the protection of the public health and safety as determined by the generally accepted standards of dental practice in Virginia.

E. Applicants for a full-time faculty license or temporary permit shall be required to attest to having read and understand and to remaining current with the laws and the regulations governing the practice of dentistry in Virginia.

**18VAC60-20-91. Temporary licenses to persons enrolled in advanced dental education programs.**

A. A dental intern, resident or postdoctoral certificate or degree candidate applying for a temporary license to practice in Virginia shall:

~~1. Successfully complete a D.D.S. or D.M.D. dental degree program required for admission to board-approved examinations and submit a letter of confirmation from the registrar of the school or college conferring the professional degree, or official transcripts confirming the professional degree and date the degree was received.~~

~~2. Submit~~ submit a recommendation from the dean of the dental school or the director of the accredited graduate program accredited by the Commission on Dental Accreditation, specifying the applicant's acceptance as an intern, resident or post-doctoral certificate or degree candidate in an advanced dental education program. The beginning and ending dates of the internship, residency or post-doctoral program shall be specified.

B. The temporary license applies only to practice in the hospital or outpatient clinics of the hospital or dental school where the internship, residency or post-doctoral time is served. Outpatient clinics in a hospital or other facility must be ~~a recognized part of an advanced dental education program~~ owned or operated by, or affiliated with the dental school or program.

C. The temporary license may be renewed annually, for up to five times, upon the recommendation of the dean of the dental school or director of the accredited graduate program.

D. The temporary license holder shall be responsible and accountable at all times to a licensed dentist, who is a member of the staff where the internship, residency or postdoctoral candidacy is served. The temporary licensee is prohibited from employment outside of the advanced dental education program where a full license is required.

E. The temporary license holder shall abide by the accrediting requirements for an advanced dental education program as approved by the Commission on Dental Accreditation of the American Dental Association.

**Agenda Item: Regulatory Recommendation – 2012 Legislation**  
**Senate Bill 146**

Included in the agenda package:

A copy of statutory language amending sections relating to the practice of dental hygienists under remote supervision by dentists employed by the Department of Health

A copy of proposed regulations to be adopted as an exempt action

Staff note:

A copy of the protocol from the Department of Health for practice of dental hygienists under remote supervision, which is to be incorporated by reference into dental regulations, will be provided to board members as soon as it is approved by VDH. It will be available for review prior to adoption of regulations.

Since the changes to regulation are “*Necessary to conform to changes in Virginia statutory law or the appropriation act where no agency discretion is involved*” (§ 2.2-4006), the action can be exempt from the Administrative Process Act.

Action:

Adoption of the **final exempt** regulations for the practice of dental hygiene

# VIRGINIA ACTS OF ASSEMBLY -- 2012 SESSION

## CHAPTER 102

*An Act to amend and reenact § 54.1-2722 of the Code of Virginia and to repeal the third enactments of Chapters 99 and 561 of the Acts of Assembly of 2009, as amended by Chapter 289 of the Acts of Assembly of 2011, relating to dental hygienists' scope of practice.*

[S 146]

Approved March 6, 2012

**Be it enacted by the General Assembly of Virginia:**

**1. That § 54.1-2722 of the Code of Virginia is amended and reenacted as follows:**

§ 54.1-2722. License; application; qualifications; practice of dental hygiene.

A. No person shall practice dental hygiene unless he possesses a current, active, and valid license from the Board of Dentistry. The licensee shall have the right to practice dental hygiene in the Commonwealth for the period of his license as set by the Board, under the direction of any licensed dentist.

B. An application for such license shall be made to the Board in writing, and shall be accompanied by satisfactory proof that the applicant (i) is of good moral character, (ii) is a graduate of an accredited dental hygiene program offered by an accredited institution of higher education, (iii) has passed the dental hygiene examination given by the Joint Commission on Dental Examinations, and (iv) has successfully completed a clinical examination acceptable to the Board.

C. The Board may grant a license to practice dental hygiene to an applicant licensed to practice in another jurisdiction if he (i) meets the requirements of subsection B of this section; (ii) holds a current, unrestricted license to practice dental hygiene in another jurisdiction in the United States; (iii) has not committed any act that would constitute grounds for denial as set forth in § 54.1-2706; and (iv) meets other qualifications as determined in regulations promulgated by the Board.

D. A licensed dental hygienist may, under the direction or general supervision of a licensed dentist and subject to the regulations of the Board, perform services that are educational, diagnostic, therapeutic, or preventive. These services shall not include the establishment of a final diagnosis or treatment plan for a dental patient. Pursuant to subsection V of § 54.1-3408, a licensed dental hygienist may administer topical oral fluorides under an oral or written order or a standing protocol issued by a dentist or a doctor of medicine or osteopathic medicine.

A dentist may also authorize a dental hygienist under his direction to administer Schedule VI nitrous oxide and oxygen inhalation analgesia and, to persons 18 years of age or older, Schedule VI local anesthesia. In its regulations, the Board of Dentistry shall establish the education and training requirements for dental hygienists to administer such controlled substances under a dentist's direction.

For the purposes of this section, "general supervision" means that a dentist has evaluated the patient and prescribed authorized services to be provided by a dental hygienist; however, the dentist need not be present in the facility while the authorized services are being provided.

*For the purposes of this section, "remote supervision" means that a public health dentist has regular, periodic communications with a public health dental hygienist regarding patient treatment, but such dentist may not have done an initial examination of the patients who are to be seen and treated by the dental hygienist and may not be present with the dental hygienist when dental hygiene services are being provided.*

The Board shall provide for an inactive license for those dental hygienists who hold a current, unrestricted license to practice in the Commonwealth at the time of application for an inactive license and who do not wish to practice in Virginia. The Board shall promulgate such regulations as may be necessary to carry out the provisions of this section, including requirements for remedial education to activate a license.

E. (Expires July 1, 2012) Notwithstanding any provision of law or regulation to the contrary, a dental hygienist employed by the Virginia Department of Health who holds a license issued by the Board of Dentistry may provide educational and preventative dental care in the Cumberland Plateau, Southside, and Lenowisco Health Districts, which are designated as Virginia Dental Health Professional Shortage Areas by the Virginia Department of Health Commonwealth under the remote supervision of a dentist employed by the Department of Health. A dental hygienist providing such services shall practice pursuant to a protocol adopted by the Commissioner of Health on September 23, 2010, having been developed jointly by (i) the medical directors of each of the districts, the Cumberland Plateau, Southside, and Lenowisco Health Districts; (ii) dental hygienists employed by the Department of Health; (iii) the Director of the Dental Health Division of the Department of Health; (iv) one representative of the Virginia Dental Association; and (v) one representative of the Virginia Dental Hygienists' Association. *Such protocol shall be adopted by the Board as regulations.*

F. A report of services provided by dental hygienists pursuant to such protocol, including their impact upon the oral health of the citizens of these districts *the Commonwealth*, shall be prepared and submitted by the medical directors of the three health districts *the Department of Health* to the Virginia Secretary of Health and Human Resources by January 1, 2012 *annually*. Nothing in this section shall be construed to authorize or establish the independent practice of dental hygiene.

**2. That the third enactments of Chapters 99 and 561 of the Acts of Assembly of 2009, as amended by Chapter 289 of the Acts of Assembly of 2011, are repealed.**

**BOARD OF DENTISTRY**

**Remote supervision of dental hygienists in the Health Department**

**18VAC60-20-220. Dental hygienists.**

A. The following duties shall only be delegated to dental hygienists under direction and may be performed under indirect supervision:

1. Scaling and/or root planing of natural and restored teeth using hand instruments, rotary instruments and ultrasonic devices under anesthesia.
2. Performing an initial examination of teeth and surrounding tissues including the charting of carious lesions, periodontal pockets or other abnormal conditions for assisting the dentist in the diagnosis.
3. Administering nitrous oxide or local anesthesia by dental hygienists qualified in accordance with the requirements of 18VAC60-20-81.

B. The following duties shall only be delegated to dental hygienists and may be delegated by written order in accordance with § 54.1-3408 of the Code of Virginia to be performed under general supervision when the dentist may not be present:

1. Scaling and/or root planing of natural and restored teeth using hand instruments, rotary instruments and ultrasonic devices.
2. Polishing of natural and restored teeth using air polishers.
3. Performing a clinical examination of teeth and surrounding tissues including the charting of carious lesions, periodontal pockets or other abnormal conditions for further evaluation and diagnosis by the dentist.

4. Subgingival irrigation or subgingival application of topical Schedule VI medicinal agents.

5. Duties appropriate to the education and experience of the dental hygienist and the practice of the supervising dentist, with the exception of those listed in subsection A of this section and those listed as nondelegable in 18VAC60-20-190.

C. Nothing in this section shall be interpreted so as to prevent a licensed dental hygienist from providing educational services, assessment, screening or data collection for the preparation of preliminary written records for evaluation by a licensed dentist.

D. A dentist hygienist employed by the Virginia Department of Health may provide educational and preventative dental care under remote supervision, as defined in subsection D of § 54.1-2722, by a dentist employed by the Department of Health and in accordance with a protocol adopted by the Commissioner of Health, which is hereby incorporated by reference.

[Exit this survey](#)

## American Association of Dental Boards Opioid Prescribing Practices

At a recent AADB Mid-Year Meeting, data were presented about opioid prescribing by dentists. This brief survey is designed to elicit non-identifiable information about the views and opinions of dental licensing boards. Your responses are confidential. The aggregated data will be used to inform the American Academy of Orofacial Pain task force to develop prescribing guidelines. AADB is participating in this effort. Thank you for your help.

**1. Prescribing data from 2009 and 2010 demonstrate that dentists prescribe immediate-release opioid/acetaminophen combination drugs overwhelmingly when choosing an opioid (narcotic) for their patients. Across all ages 10 and above, the average number of tablets/capsules prescribed in a single prescription was 18. In your opinion, is this amount:**

- Too few
- About right
- Too many

**2. There may be valid reasons why different dental specialties, or particular specialists, prescribe varying amounts of opioids/narcotics. Thinking about dentistry as a whole and your board's regulatory role, what do you think the average number of opioid tablets/capsules should typically be prescribed by dentists.**

**3. Would an expert-consensus based guideline on routine post-procedural prescribing of opioids by dentists be of use to your board in protecting the public?**

- Yes
- No
- Undecided

Other

4. Do you have any suggestions for how such guidelines should be developed?

Thank you very much for your time and expertise.

Done

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# The Virginia NEWS LETTER

## Oral Health in Virginia: Trends, Disparities, and Policy Implications

by Terance J. Rephann and Tanya Nicole Wanchek

### Introduction

It is widely recognized that oral health—the health of teeth, gums and mouth—is an important component of general health.<sup>1</sup> Traditionally the consequences of poor oral health were viewed in terms of esthetics or localized pain and were compartmentalized from overall health. Recent research, however, has found numerous links from oral health to overall health and well-being.<sup>2</sup>

Oral disease has negative economic consequences for both individuals and society. Problems with teeth, gums or mouth increase consumers' direct spending on care and also create indirect expenditures through lost worker hours. Expenditures on dental services are expected to increase significantly in the coming decade. Between 2012 and 2020, the Centers for Medicare and Medicaid Services (CMS) project that annual spending on dental services in the United States will climb from \$109.6 billion to \$167.9 billion, a 53 percent increase in current dollars.<sup>3</sup> These expenditures could be reduced with a greater investment in preventive care, including better oral hygiene habits, more families consuming fluoridated water, and greater use of dental sealants (thin plastic seals applied to chewing surfaces to protect them from decay).<sup>4</sup>

Adults experience reduced hours of work from dental and related problems. Interestingly,



Terance J. Rephann



Tanya Nicole Wanchek

preventative visits account for the most episodes of lost time, but the fewest hours of lost work, suggesting that delaying treatment results in greater treatment need.<sup>5</sup> Not only is there a loss in hours worked due to the time needed to receive treatment, but unsatisfactory oral health also appears to affect earnings more generally.<sup>6</sup> Among children, oral disease is correlated with greater absenteeism and below par academic performance.<sup>7</sup> Children with oral health pain are more likely to miss school due to pain and missing school due to pain results in poorer school achievement.<sup>8</sup>

This article, which is drawn in part from an earlier Cooper Center study<sup>9</sup>, examines oral health in Virginia. The topic is divided into six parts. (1) A review of the progress that Virginia's residents have made in dental care access and oral health over the years and disparities that remain. (2) A description of dental care resources available within the state. (3) An examination of policy actions at the state and national level that influence utilization of dental care. (4) An explanation of past and ongoing oral health strategic planning processes and the ramifications of the Affordable Care Act.<sup>10</sup> (5) A comparison of state policies to national best practice benchmarks. (6) An assessment of evidence regarding the effectiveness of various proposed policy actions. With this knowledge a practical roadmap to better policy effectiveness is drawn up.



*“Over the past few decades, oral health has improved dramatically for the average American.”*

## Progress That Virginia’s Residents Have Made in Dental Care and Disparities That Remain

There are many factors that ultimately determine an individual’s oral health, including use of dental services, oral hygiene behaviors, dietary choices, tobacco use, genetics, tastes and preferences, and age. This section examines the performance of Virginia over time compared to the nation on important dimensions of oral health, including dental caries (also known as tooth decay or a cavity) and tooth loss. Utilization of dental services plays an important role in oral health. Also, dental insurance is an important component in the decision to seek care. These three areas—oral health conditions, utilization, and insurance—have also been the targets of public policies to improve oral health outcomes.

### Oral Health Conditions

Over the past few decades, oral health has improved dramatically for the average American. The provision of dental sealants for children and adults has increased, resulting in a lower incidence of tooth decay.<sup>11</sup> Also, the elderly are less likely to have total tooth loss and periodontitis because of improved dental care utilization and lower lifetime prevalence and severity of dental disease.<sup>12</sup> These trends are evident in Virginia too, with the state performing somewhat better than the national average. However, limited data availability, small sample sizes and significant time lags in data release pose a challenge in monitoring and comparing changes in national and state oral health conditions. The principal sources of data on state oral health comes from the Virginia Department of Health [including data collected as part of the Centers for Disease Prevention and Control (CDC) Behavioral Risk Factor Surveillance System (BRFSS) initiative], periodic third grade public school clinical dental screenings and parental questionnaires, and administrative records describing application of treatments and utilization levels for programs targeted at low-income children such as Medicaid and Family Access to Medical Insurance Security (FAMIS).

Data available from samples of Virginia third grade public school clinical dental screenings suggest that child oral health improved in the decade from 1999-2009. The percentage of children with sealants improved from 36 percent to 49.4 percent, while those with untreated caries (dental cavities or tooth decay) dropped from 27 percent to 15.4 percent.<sup>13</sup> Virginia children do comparatively well, with the third lowest incidence among states for untreated tooth decay and eighth best for percentage with dental sealants.<sup>14</sup> If Virginia’s

experience mirrors the nation in other ways, progress among child subgroups is uneven, with preschoolers, young males, ethnic minorities and low-income children cohorts doing poorer than previous cohorts on some oral health indicators.<sup>15</sup>

Adult dental health in Virginia has improved markedly as well. The percentage of adults 65 and over missing all teeth (the edentulous population) dropped from 29.4 percent in 1999 to 15 percent in 2010, a better rate of improvement than the median for all states (from 26.2 percent to 16.9 percent) over the same time period (see **Figure 1**). The same pattern of improvement was evident for seniors missing any teeth. In Virginia they dropped from 55.2 percent in 1999 to 38.6 percent in 2010.

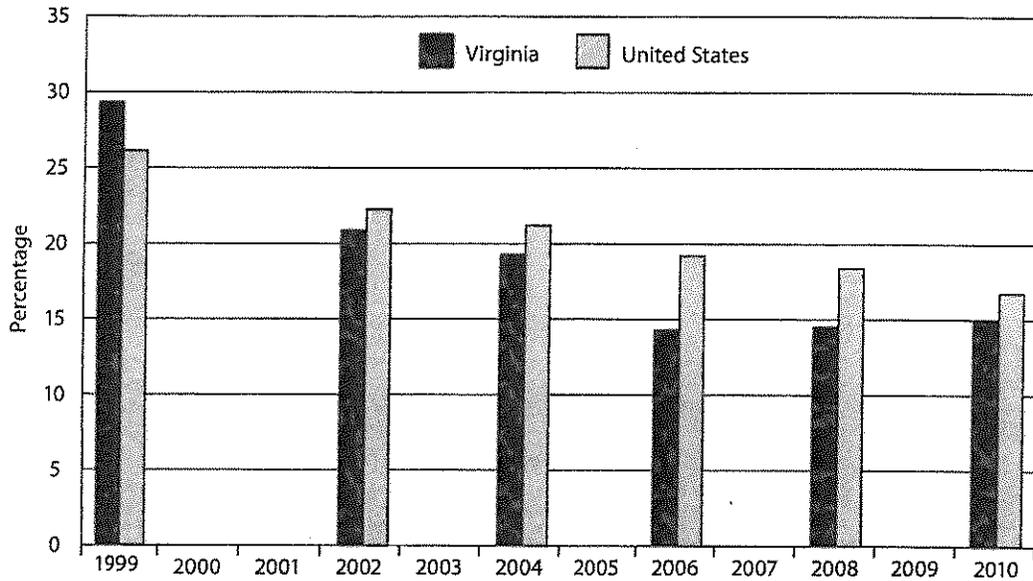
### Utilization of Dental Care

Among the reasons for continued improvements to oral health are increased utilization of dental care, improved quality of dental care, improved technology, dietary changes, better oral hygiene practices, and widespread adoption of fluoridation in public water supplies and fluoride in dental hygiene products. Nationwide, utilization of dental services increased dramatically from a little over 30 percent for adults 18 and over in 1950 to 66 percent in 1998 before leveling off.<sup>16</sup> As a result of general improvement in oral health, demand for dental services has shifted toward preventive, diagnostic, and cosmetic care and away from restorative work.<sup>17</sup>

These national improvements are reflected in Virginia data with some notable differences. In 2010 Virginia adults were more likely to report utilizing dental care in the past year (78.4 percent) than the average U.S. resident (70.1 percent), and recent data suggest that utilization rates have begun to increase again after stalling for several years, a pattern not yet evident in the nation at large (see **Figure 2**). In 2008, 75.5 percent of Virginia adults reported visiting a dentist or dental hygienist for teeth cleaning. Third grade survey data collected by the Virginia Department of Health in 2009 show that 82.1 percent of third grade children were reported to have visited a dentist in the past year.<sup>18</sup> Additionally, 82.8 percent of those children were reported to have had an exam, check-up, or cleaning as the reason for their last visit, versus 17.2 percent having had treatment.

Despite these impressive figures overall, some segments of the population continue to lag behind. In particular, there are still significant disparities along the dimensions of race, socioeconomic status, and geographical region. Age group and gender differences are generally less pronounced. **Figure 3** shows that blacks are less likely to have

**Figure 1: Percentage of Adults 65 and Over Who Have Had All Their Natural Teeth Extracted, 1999 to 2010**



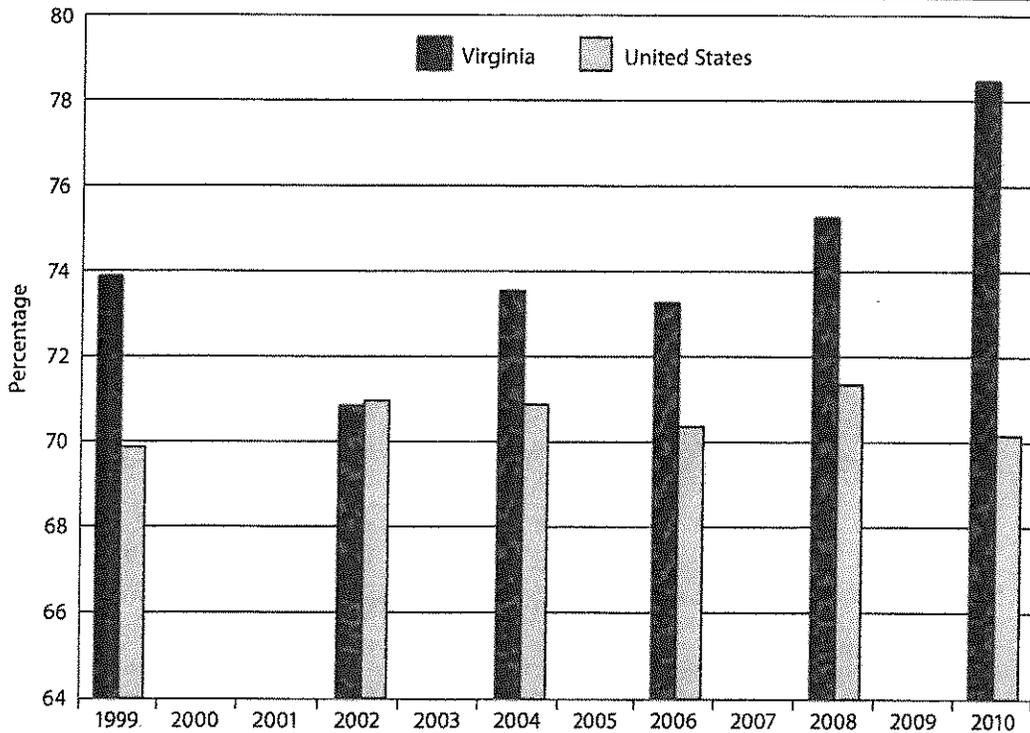
Source: Centers for Disease Control and Prevention (CDC), Behavioral Risk Factor Surveillance System (BRFSS).

visited a dentist or dental clinic in the past year than other racial groups. In addition, residents with higher levels of education exhibit greater utilization levels. The most significant barrier to utilization is financial. Individuals with less than \$15,000 in annual household income are only half as likely to report dental care utilization in the last year compared to those with \$50,000 or more in

income. There is also a strong regional pattern to dental utilization (see Figure 4) with residents in the northern and eastern planning districts of Virginia more likely to report having received dental care than residents of the western and southern districts. This pattern likely reflects underlying demographic and socioeconomic characteristics of the population. But, it also may be influenced

*“The most significant barrier to [dental] utilization is financial.”*

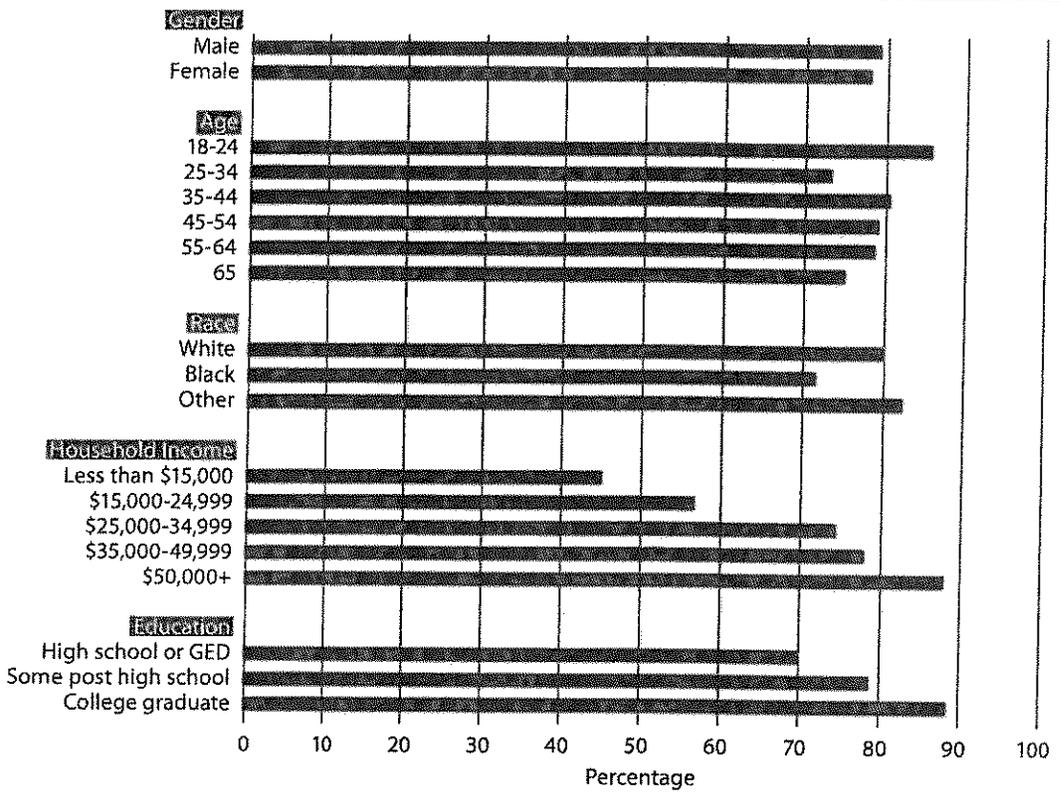
**Figure 2: Percentage of Persons 18 Years and Older Who Have Visited a Dentist or Dental Clinic Within the Past Year for Any Reason, 1999 to 2010**



Source: Centers for Disease Control and Prevention (CDC), Behavioral Risk Factor Surveillance System (BRFSS).

*“Research suggests that having dental insurance significantly increases dental utilization levels.”*

**Figure 3: Percentage of Virginia Adults 18 and Over Who Visited a Dentist or Dental Clinic Within the Past Year for Any Reasons by Demographic Group, 2010**



Source: Centers for Disease Control and Prevention (CDC), Behavioral Risk Factor Surveillance System (BRFSS).

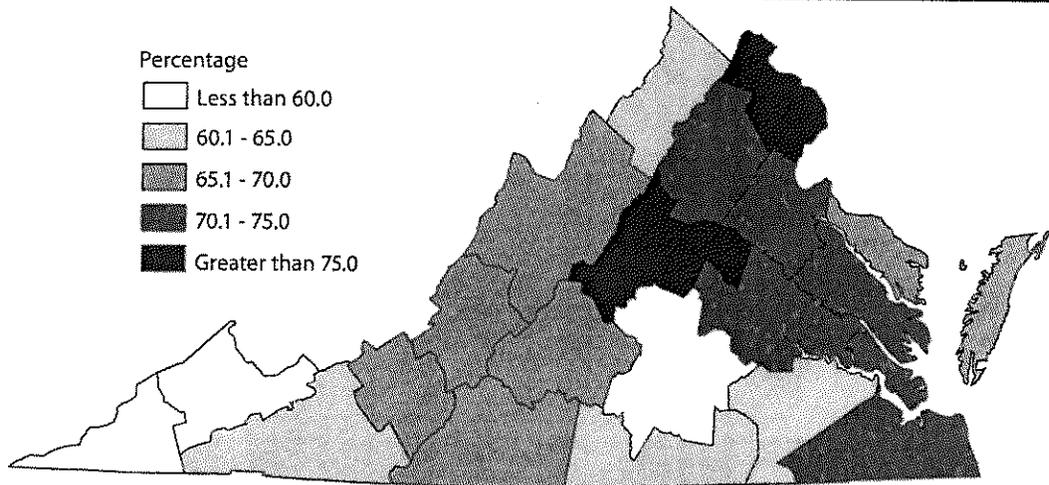
by geographical access to dental care since lower utilization areas are observed in more rural areas where the availability of dentists is lower.

**Dental Insurance**

Research suggests that having dental insurance significantly increases dental utilization levels.

Nationally, among those with private dental coverage in 2004, 56.9 percent had a dental visit compared to only 31.9 percent of those with public coverage and 26.9 percent of those with no dental coverage.<sup>19</sup> In addition, among people with a dental visit in the last year, having insurance was

**Figure 4: Percentage of Virginia Adults 18 Years and Older Who Have Visited a Dentist or Dental Clinic Within the Past Year for Any Reason by Planning District, 2005 - 2009 Average**



Source: Centers for Disease Control and Prevention (CDC), Behavioral Risk Factor Surveillance System (BRFSS).

associated with more visits per year and higher dental expenditures.<sup>20</sup>

According to the third grade survey (using a parent questionnaire) conducted by the Virginia Department of Health, 84.8 percent of children statewide had dental insurance in 2009. This result is high in part because the Medicaid program offers comprehensive dental care. In Virginia, children ages 1-5 are eligible for Medicaid if their families are at or below 133 percent of the federal poverty level (FPL). Children ages 6-19 are eligible if their family income is at or below 100 percent of the FPL. The dental insurance under Virginia's State Children's Health Insurance Program (SCHIP), called Family Access to Medical Insurance Security (FAMIS), also provides dental insurance and applies to children ages 6-19 whose families are at or below 133 percent of the FPL.

In 2008, 72 percent of Virginia adults reported having dental insurance, according to BRFSS. The percentage of adults covered has increased since 2000 (see Figure 5). Unlike children, adults generally do not have access to publicly funded dental insurance. Aside from pregnant low-income women, Medicaid covers limited medically necessary oral surgery services for adults (age 21 and older) such as emergency extractions. Medicare for seniors does not include dental coverage, a result largely attributable to the opposition of the dental lobby.<sup>21</sup>

#### Dental Resources

In addition to characteristics such as education, income and dental insurance, the supply of dental resources can also affect dental utilization levels. The state's dental resources include its dental

workforce, its educational and training institutions, and its network of clinics that provide dental care to low-income and uninsured residents, also known as safety-net providers. The amount and distribution of these resources reflect both local population characteristics and public policy initiatives aimed at educating future providers and bringing services to underserved populations.

#### Dental Workforce

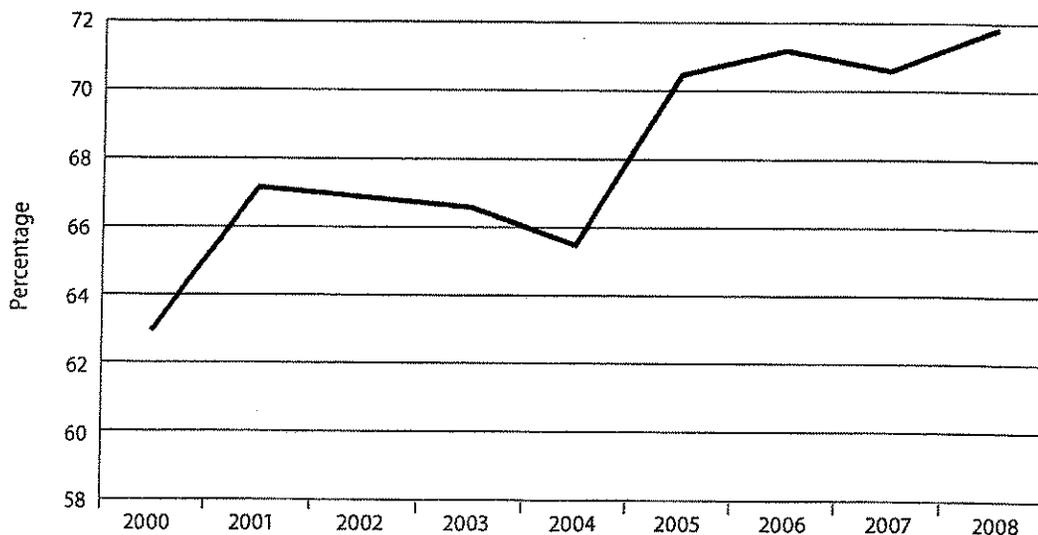
Virginia is slightly below the national average for dentists per capita. In 2009, it had a 78 licensed dentists per 100,000 residents compared to 80 dentists per 100,000 residents in the nation.<sup>22</sup> Dentist-to-population ratios provide one way to gauge access gaps but they are imperfect measures for a variety of reasons, including state differences in per capita demand, average hours practiced, and dentist productivity.<sup>23</sup>

Within Virginia there are significant regional disparities. Figure 6 shows the distribution of licensed dentists by county in 2010.<sup>24</sup> The dentist-to-population ratio is generally greater in heavily urbanized regions (such as in Northern Virginia, the Richmond metropolitan area, and the Hampton Roads region) than in rural areas such as the Southwest and Southside regions. Four counties did not have a single licensed dentist. They are all rural counties east of Richmond with relatively high percentages of African Americans: Charles City County, King and Queen County, Surry County, and Sussex County.

Dental offices rely on other professional staff to provide dental services and increase productivity. Registered dental hygienists bring the widest variety of skills to the dental practice. Dental

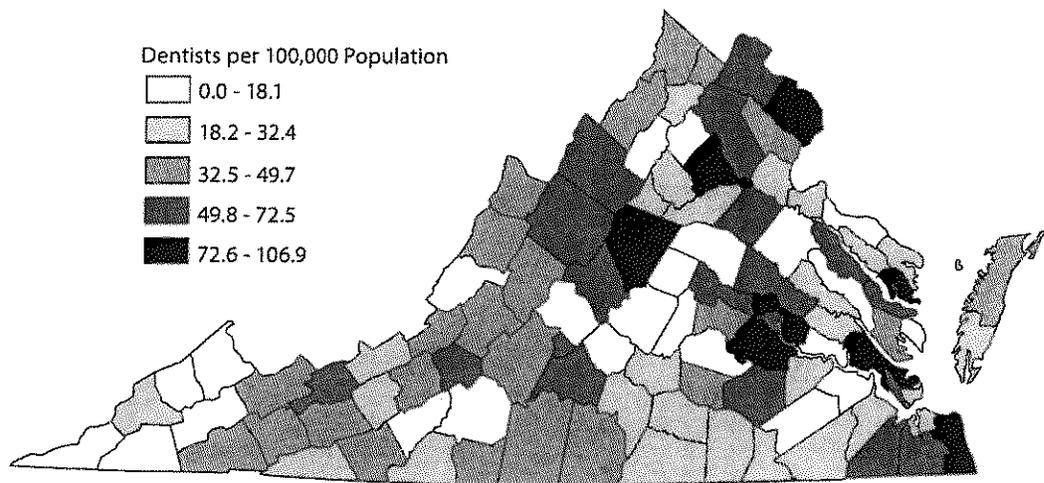
*“Unlike children, adults generally do not have access to publicly funded dental insurance.”*

**Figure 5: Percentage of Virginia Adults 18 and Over Reporting Dental Insurance Coverage, 2000 to 2008**



Source: Centers for Disease Control and Prevention (CDC), Behavioral Risk Factor Surveillance System (BRFSS).

Figure 6: Virginia Dentists Per 100,000 Population, 2010



Source: Virginia Board of Dentistry and U.S. Census Bureau.

*“The number of licensed dental hygienists with state addresses has grown dramatically from 3,280 in 2006 to 4,081 in 2010, a 24 percent increase.”*

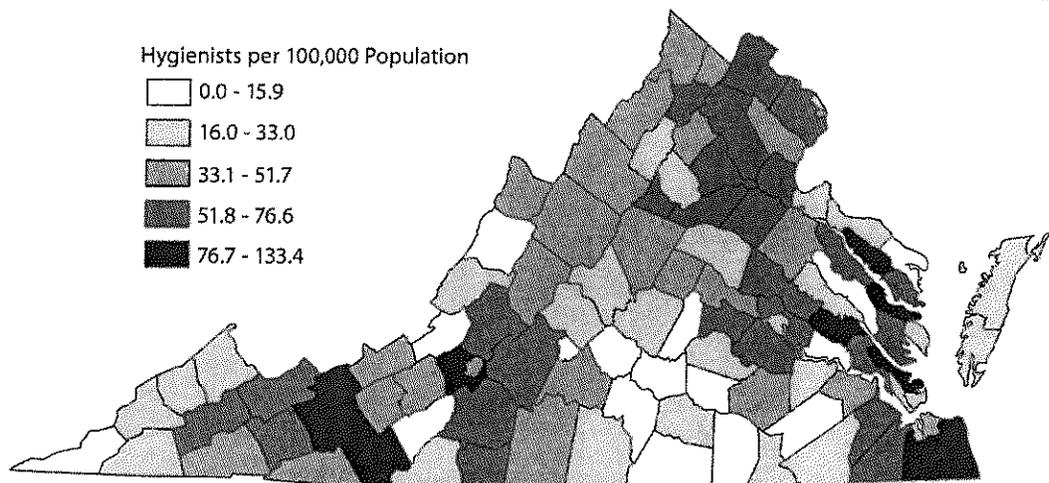
hygienists are state-licensed health workers who provide preventive dental services, including X-rays and teeth cleanings under the supervision of a licensed dentist. The number of licensed dental hygienists with state addresses has grown dramatically from 3,280 in 2006 to 4,081 in 2010, a 24 percent increase.<sup>25</sup> According to the Virginia Employment Commission long-term occupational employment projections, employment of dental hygienists is projected to grow to 5,414 by 2018, a 33 percent increase from 2010.<sup>26</sup>

The geographic pattern of dental hygienists is similar to that of dentists (see Figure 7). A few anomalies can be found in the some parts of the state. For instance, counties in the vicinity of Wytheville Community College in Wythe County and Western Community College in Roanoke,

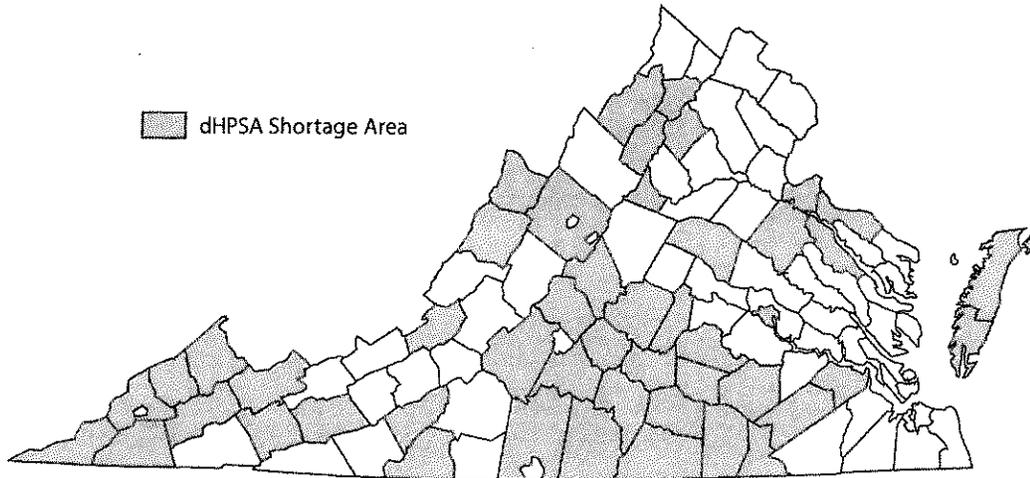
where dental hygiene associate degree programs have been established, exhibit high concentrations of dental hygienists. This pattern may persist because of a greater tendency for resident graduates of those programs to remain in the region. In addition, the concentrations of dental hygienists in some urbanized regions such as Northern Virginia and the Richmond metropolitan area are less pronounced.

Virginia has recognized regional disparities in dental workforce availability. Eighty-four areas are federally designated dental Health Professional Shortage Areas (dHPSAs), defined as a geographic area where the population has an insufficient number of dentists to serve their dental needs. Forty-five counties and cities are identified as dHPSAs (see Figure 8). According to program

Figure 7: Dental Hygienists per 100,000 Population, 2010



Source: Virginia Board of Dentistry and U.S. Census Bureau.

**Figure 8: Virginia Dental Health Professional Shortage Areas, 2011**

Source: U.S. Department of Health and Human Services, Health Resources and Services Administration.

data, 15.6 percent of Virginia's population lives in dHPSAs and 9.1 percent of the population is underserved, close to the national averages of 16.4 percent and 10.7 percent, respectively. Approximately 102 additional dentists would be needed in these Virginia dHPSAs to remove the shortage designation.<sup>27</sup>

#### Dental Education

Virginia has one dental school, located at the Medical College of Virginia (MCV), a division of Virginia Commonwealth University (VCU). The Medical College produces the lion's share of Virginia dentists. An estimated 67.1 percent of graduates during the period 1985-95 were state residents in 2004 (a minimum of nine years after graduation), and approximately 56.8 percent of all dental school graduates from that period still residing in Virginia are from MCV.<sup>28</sup> The school expanded its class size from 80 students to 90 students seven years ago and again to 100 in the last three years. It enrolled a total of 374 pre-doctoral program students in academic year 2008-2009, and 56 percent of the 102 first-year students enrolled that year were from Virginia.

Students from Virginia attend dental school throughout the United States. The state produced about the same number of applicants on a per capita basis as the nation in 2006-2007 (3.34 applicants per person for Virginia compared to 3.35 nationwide).<sup>29</sup> Enrollment rates are lower. In 2008-09, some 99 individuals from Virginia were enrolled in dental school nationally for a rate of 1.26 students per 100,000. This ranked 34th in the nation and lower than the 1.52 dental students enrolled per 100,000 residents for the United

States.<sup>30</sup> Enrollment rates ranged from 4.81 in Utah to 0.30 in Maine.

Virginia has six additional sites where advanced dental education is offered.<sup>31</sup> Five are operated by the U.S. Department of Defense (Langley AFB, Mid-Atlantic Naval Dental Clinic, Naval Medical Center in Portsmouth) and U.S. Department of Veteran's Affairs (V.A. Medical Center in Hampton, Department of Veteran's Affairs Medical Center in Richmond). The University of Virginia Medical Center in Charlottesville has a general practice dental residency program of 12 months duration.

Dental hygiene programs are offered by five colleges in Virginia: The Medical College of Virginia, Wytheville Community College, Northern Virginia Community College, Virginia Western Community College in Roanoke, and Thomas Nelson Community College Historic Triangle Campus in Williamsburg. In addition, two community colleges offer affiliate programs in conjunction with established dental hygiene programs (Germana Community College in cooperation with Northern Virginia Community College and Lord Fairfax in Middletown in partnership with Virginia Western Community College).

#### Safety Net Providers

Safety net providers offer health care services to uninsured, Medicaid, and other low-income patients. A substantial portion of the funding for these providers is derived from federal, state, and local government and charitable sources. There are at least four types of agencies or organizations that serve as safety net providers for Virginia dental care needs: community health centers, local health departments, free clinics, and mobile

*"Safety net providers offer health care services to uninsured, Medicaid, and other low-income patients. A substantial portion of the funding for these providers is derived from federal, state, and local government and charitable sources."*

*“For uninsured patients, hospital emergency room care is the only regularly available recourse for painful oral infections and oral trauma.”*

clinics. Hospital emergency rooms serve as a provider of last resort for cases requiring urgent care, including dental infections and facial injuries.

Local health departments are funded by the state and deliver medical services, school health services, child health and immunization services, environmental health inspections, and other services. They are an important source of dental care for low-income children. Some local health departments also offer limited services to low-income adults when time and resources are available. However, these services have been curtailed in the face of state budget stresses caused by the recent recession in what has become a familiar national pattern.<sup>32</sup> In 2007, 68 local health departments offered both preventive and restorative services. By 2009, as the recession continued, their number had decreased to 38.<sup>33</sup> The Virginia Health Department has estimated that approximately 22,000 patients received dental care services on 37,000 visits through local health department fixed or mobile clinics in FY 2010.<sup>34</sup>

Community health centers, of which Federally Qualified Health Care Centers (FQHCs) are the most important component, form the most significant part of the dental safety net.<sup>35</sup> Nationwide, there were 1,080 FQHCs in 2008 of which 75 percent provided comprehensive dental services.<sup>36</sup> They are community non-profit organizations that provide primary health, oral and mental health care services to patients regardless of their ability to pay. Fees are charged on a sliding scale based on family income levels, family size, and insurance status. Part of the funding to cover uncompensated care comes from grants under Section 330 of the federal Public Service Act. There are 25 FQHCs in Virginia, most of which provide comprehensive dental services. They account for a growing number of dental patients and visits: 33,003 patients on 77,576 visits in 2010, up from 25,063 patients and 58,675 visits in 2007.<sup>37</sup>

Free clinics are non-profit organizations that provide health care at low cost or no charge to low income uninsured patients. These organizations rely heavily on care donated by volunteer health professionals, charitable monetary contributions, partnerships with other health-care organizations, such as community health clinics, as well as public assistance program funds like Medicaid/FAMIS and service fees. There are 61 free clinics in Virginia, of which 26 provide dental care. Free clinics treated 16,301 patients in 2010 on 45,178 dental visits.<sup>38</sup>

The Virginia Dental Association Foundation (VDAF)/Mission of Mercy (MOM) and Remote Area Medical Foundation (RAM) host, in conjunction with other state and regional partners,

free dental clinics in various locations around the state. The first clinic at the Virginia/Kentucky Fairgrounds in Wise was begun in 2000 and has been held annually ever since, growing nearly every year into what is said to be the largest regularly scheduled RAM clinic in the nation.<sup>39</sup> The geographical reach of these programs has expanded considerably over the last ten years. An estimated five to seven clinics are now held each year. Among the locations where free dental clinics have been offered are at Grundy in Buchanan County, Martinsville, Roanoke, Buena Vista, Petersburg, Emporia, Middle Peninsula, Norfolk, Eastern Shore, Northern Virginia, and Orange. Since 2000, they have treated over 46,000 patients for a total value of donated dental care estimated to be \$26.5 million.<sup>40</sup> Even with such extraordinary volunteer efforts, only a small proportion of individuals with dental needs can be seen and the long lines and huge number of extractions performed testifies to the large gaps remaining in the dental safety net.

For uninsured patients, hospital emergency room care is the only regularly available recourse for painful oral infections and oral trauma. The services offered in emergency settings are generally restricted to prescribing antibiotics and painkillers with referral to a dentist for care. Although state figures on utilization of hospital emergency rooms for oral/dental urgent and emergency care are not available, one national study found that dental/oral complaints account for almost 1 percent of emergency room visits, with most patients either having Medicaid or no insurance.<sup>41</sup> An analysis of Utah, Vermont, and Wisconsin found that oral health diagnoses account for 1.3 to 2.7 percent of emergency department visits, with the same payment pattern.<sup>42</sup> A state senate resolution (SJ 50) adopted in February 2012 asks the Joint Commission on Health Care to study the use of hospital emergency departments for dental-related diagnoses and its associated fiscal impact, but the resolution was tabled by the House Committee on Rules.<sup>43</sup>

### **Policy Actions That Influence Utilization of Dental Care**

In addition to funding programs to educate the public and increase awareness of oral health issues, Virginia's current policy efforts have focused on strategic initiatives in four areas: funding and improved management of public dental insurance, implementing programs targeted at at-risk children, sponsoring programs to address medically underserved areas, and increasing public water supply fluoridation. Although not a Virginia initiative per se, state agencies will also

be charged with implementing provisions of the recently adopted federal Affordable Care Act that could have a considerable effect in the first three areas.

**Public Insurance**

Virginia is mandated to provide comprehensive dental coverage for children. But payment rates historically have been low, resulting in low participation by dentists. Virginia reformed its Medicaid program in 2005, implementing *Smiles for Children*, which is administered by the Virginia Department of Medical Assistance Services (DMAS). The program increased reimbursement rates for dental services by 32 percent, resulting in fees that were 62 percent of commercial fees. The reform also simplified reimbursement procedures and reduced administrative barriers, improved case management with clients to reduce missed appointments, conducted efforts with state dentists, and established the Dental Advisory Board to guide changes.<sup>44</sup> As a result, Virginia has made huge strides in increasing child enrollment and dentist participation in Medicaid/FAMIS to improve children’s oral health statewide. It uses private dentists who choose to participate in the program, as well as dentists who work in public health clinics. Since the program was begun, provider participation increased from 620 in 2005 to 1,648 in 2012 (approximately one third of professionally active dentists in the state).<sup>45</sup> Also, utilization more than doubled from 21.8 percent of children aged 1-18 enrolled in Medicaid or CHIP in 2000 to 48.2 percent in 2010 (see **Figure 9**),

moving from below the national average to above the national average but still lagged the leading state of Idaho at 64.2 percent. Utilization for the 3-21 year age group rose from 27 percent in 2001 to 55.6 percent in 2011.<sup>46</sup> The Virginia program demonstrates that states can improve utilization rates among Medicaid children with a well-structured program and sufficient investment.

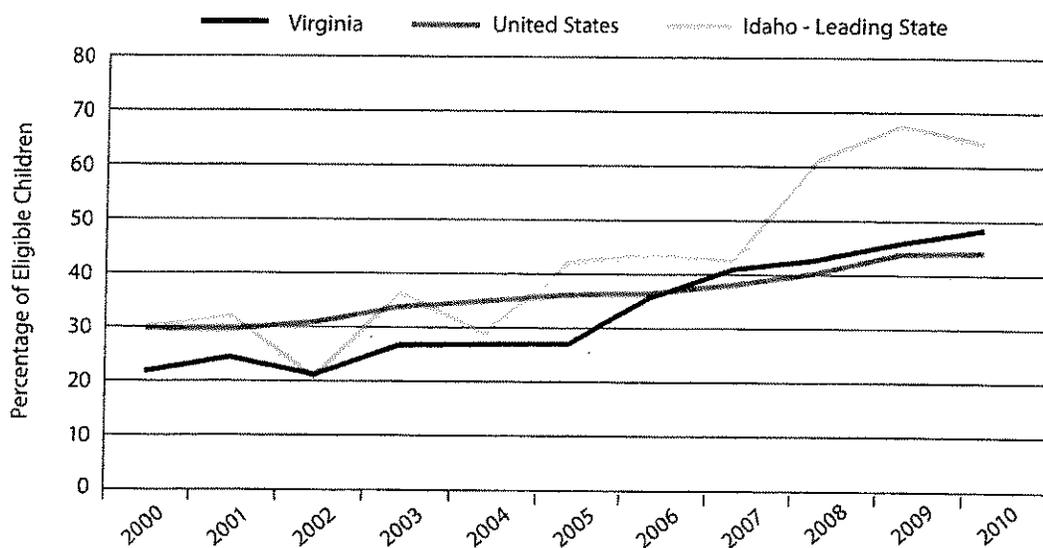
Virginia offers very limited dental services to its adults for two reasons. First, the state Medicaid eligibility rules for adults are fairly stringent and exclude some categories of low-income individuals who would be covered by other states. The income eligibility limit for working adult parents is the sixth lowest among the states and non-disabled childless adults are excluded from Medicaid.<sup>47</sup> Second, Medicaid-eligible adults are generally offered only emergency services, which includes infection control and emergency extractions of teeth. The states vary on the range of services offered under Medicaid.<sup>48</sup> In 2008, six states covered no dental services for adults while sixteen states offered only emergency services. Thirteen states offered at least one category of restorative or preventative service and sixteen offered comprehensive coverage.

**Programs for Children**

The Virginia Department of Health operates several oral health programs for at-risk children. These programs include an early childhood fluoride treatment program—“Bright Smiles for Babies”—designed to reach children at an early age, a school-based sealant program, a

*“The Virginia program demonstrates that states can improve utilization rates among Medicaid children with a well-structured program and sufficient investment.”*

**Figure 9: Medicaid Utilization for Children 1 to 18, 2000 - 2010**



Source: Pew Center on the States, 2000-2009 (2011) and Centers for Medicare and Medicare Services (2010). <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-Periodic-Screening-Diagnosis-and-Treatment.html>. Percentages calculated by dividing the number of children ages 1-18 receiving any dental service by the total enrollment of ages 1-18.

*“Current state planning efforts are directed toward expanding fluoride varnish, sealant, and dental services for children with special needs.”*

school-based fluoride mouth rinse program, and pilot programs in high poverty counties that allow dental hygienists an expanded scope of operation.

The school-based programs have been enhanced in some regions by allowing dental hygienists working for the Virginia Department of Health to provide additional preventive services without the direct supervision of a dentist. To promote dental sealants for underserved children, the Virginia Department of Health set up a pilot program that allowed dental hygienists to work under remote supervision in schools in Southside and Southwest Virginia to provide dental sealants. New legislation recently authorized remote supervision in limited settings throughout the state.<sup>49</sup>

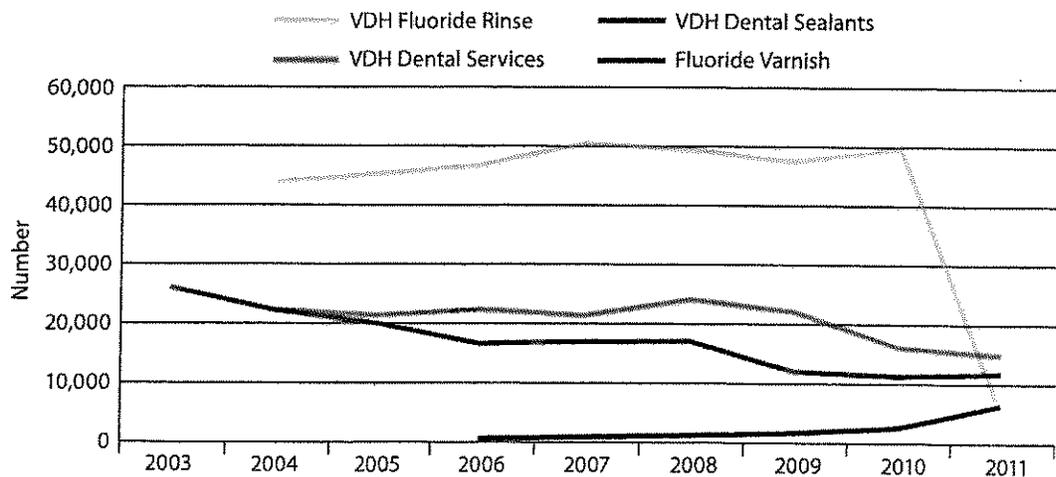
Current state planning efforts are directed toward expanding fluoride varnish, sealant, and dental services for children with special needs.<sup>50</sup> “Bright Smiles for Babies” provides children under the age of three with two fluoride varnishes per year. Statewide, the fluoride varnish program has grown from a network of 24 Medicaid providers and 516 claims in FY 2006 to 118 providers and 6,262 claims in FY 2011 (see Figure 10). Virginia Department of Health (VDH) spending for several other oral health areas has been decreased over the past decade because of budgetary constraints. The Virginia Department of Health had previously operated a weekly topical fluoride mouth rinse program for communities without water fluoridation that treated approximately 50,000 children each year until the end of the 2010 school year when state funding was eliminated.<sup>51</sup> The number of dental sealants applied in FY2011 was less than half the amount in FY 2003.<sup>52</sup> Also, the number of children served by local health department public health dental staff has decreased markedly from 25,961 in FY 2003 to 14,714 in FY 2011.<sup>53</sup>

While these service level decreases might seem to imply lower child dental care access, the reality is quite the opposite. Private service providers have more than filled the void by increased participation in the Medicaid program. The number of Virginians under the age of 20 receiving dental services grew by 30,000 in FY2011 alone for a total of 347,145 children, a figure that dwarfs the Health Department service numbers.<sup>54</sup> These improvements have been made possible by substantial funding increases. State and federal funds for Medicaid dental services dramatically increased between FY 2002 and FY 2008 before state funds began to flatten out (see Figure 11). The principal source of increase in the last couple of years has been federal funds from the American Revitalization and Recovery Act of 2009, which ran out in June 2011. A big question is how long current efforts can be sustained without replacing those funds.

#### Medically Underserved Areas

Virginia benefits from several federal government programs administered by the Health Resources and Services Administration such as the National Health Service Corp (NHSC), Rural Clinic Program, and other Title VII programs to place dentists in underserved areas. In addition, the Virginia Department of Health has operated its own program that offers a scholarship and loan repayments for dental students who practice in underserved areas and agree to treat low-income and Medicaid patients. Between 1986 and 2008, VDH administered 63 scholarships. Twenty-three dentists completed practice in underserved areas and stayed; 9 completed practice and stayed, but the areas involved are no longer underserved; 10 completed practice, but then moved to

**Figure 10: Virginia Childhood Oral Health Service Measures, FY 2003 to FY 2011**



Source: Virginia Performs; Virginia Department of Medical Assistance Services.

non-underserved areas; and 21 did not fulfill their obligation.<sup>55</sup> State funding for these educational assistance programs was eliminated in FY 2009, and they now rely on periodic infusions of federal aid to continue.

**Fluoridation**

Fluoridation of drinking water has been hailed by the U.S. Centers for Disease Control as “one of the ten great public health achievements of the 20th century.”<sup>56</sup> Studies show that it has reduced dental cavities and tooth disease by from 11 to 40 percent.<sup>57</sup> Some studies also suggest that demand for dental treatment such as costly restorative procedures is reduced.<sup>58</sup>

Virginia has the sixth highest rate of fluoridation of public water systems in the nation. In 2010, more than 95 percent of the population on public water supply systems received fluoridated water, compared to 74 percent nationwide. This is a marked improvement for Virginia from earlier decades (see Figure 12). Because about 18 percent of Virginia residents rely on well water, the percentage of the total population receiving fluoridated water is only 76.5 percent.<sup>59</sup> These residents are located primarily in rural areas, which helps explain the large geographical disparities in water fluoridation (see Figure 13).

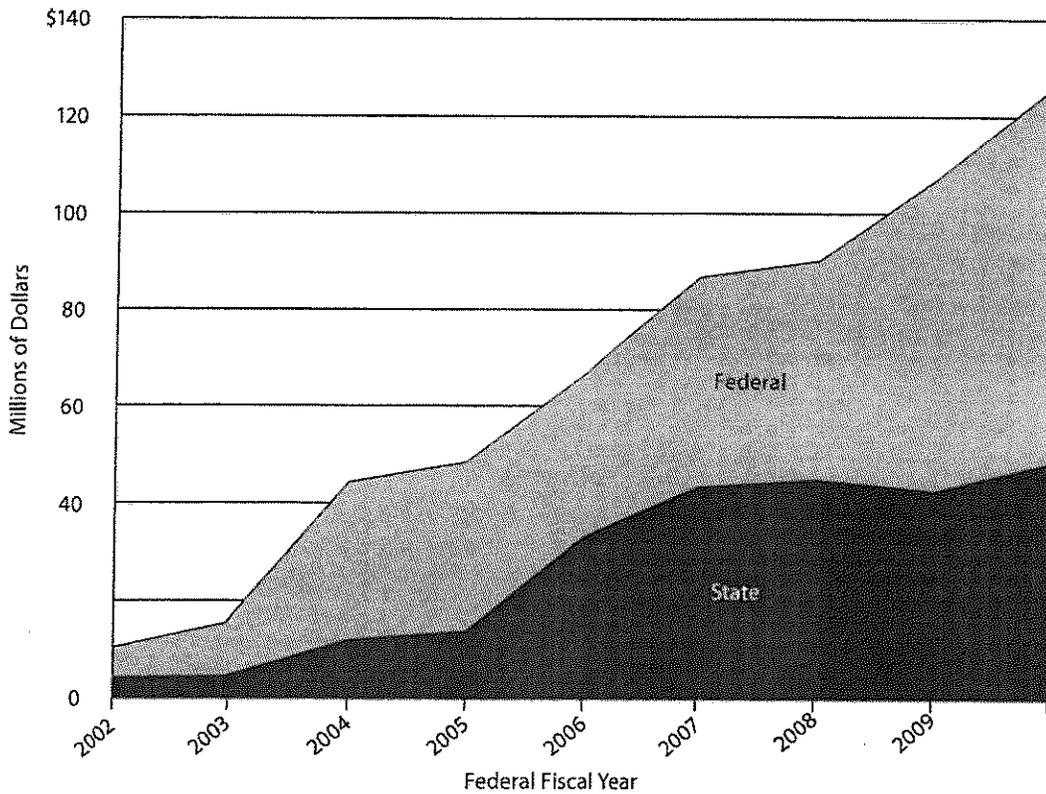
Virginia has already exceeded the national objective of the federal government’s *Healthy People 2020* program to provide fluoridated water for about 80 percent of the population on public water supply systems. Therefore, the focus has shifted from expansion to maintenance. Most of Virginia’s fluoridation infrastructure was installed during the 1970s and aging infrastructure will require reinvestment.<sup>60</sup>

**The Affordable Care Act’s Impact on Dental Health**

The Affordable Care Act, recently upheld by the Supreme Court but still politically controversial, was created to improve health care insurance coverage and help contain rising health care costs. The act has a number of provisions that would affect dental insurance, the dental safety net, numbers of dental health professionals, and school-based dental service availability.<sup>61</sup> The most significant portion of the legislation expands pediatric oral health care insurance by mandating that oral health plans for children be included as part of family health care insurance plans offered by state health insurance exchanges to be established. These plans must also offer preventive services without an out-of-pocket charge. Combined

*“Virginia has the sixth highest rate of fluoridation of public water systems in the nation.”*

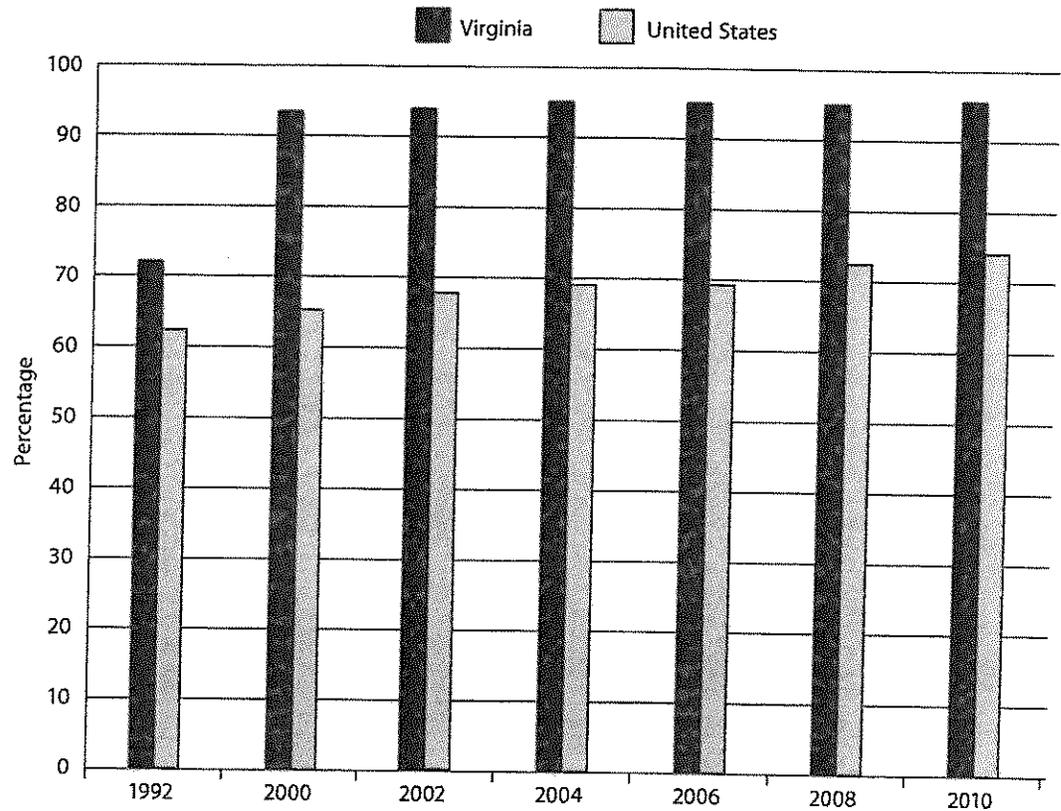
**Figure 11: Medicaid Expenditures for Dental Services, Virginia, FY 2002 to FY 2010**



Source: Centers for Medicaid and Medicare Services, CMS-64 Quarterly Expense.

*"[combined] with existing Medicaid and CHIP programs, the [Affordable Care Act] establishes near-universal dental coverage for children."*

**Figure 12: Percentage of Population on Public Water Supply Systems Receiving Fluoridated Water, Virginia and United States, 1992 to 2010**

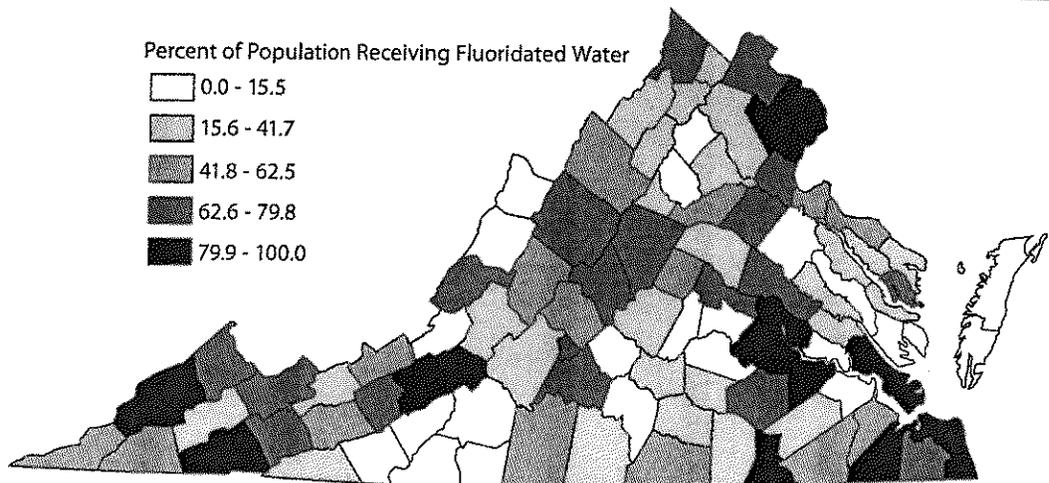


Source: Centers for Disease Control, Water Fluoridation Reporting System (WFRS).

with existing Medicaid and CHIP programs, the act establishes near-universal dental coverage for children. It also authorizes funding for an expansion in the system of Federally Qualified Health Care Centers (FQHC) and grants for school-based health centers that may include oral health

services. In addition, the act authorizes expansion of the school-based sealant program to all 50 states. The legislation provides additional funding for scholarship and loan repayment programs for dental students and establishes a demonstration

**Figure 13: Percentage of Total Population Receiving Fluoridated Water, by Locality, 2009**



Source: Centers for Disease Control, Water Fluoridation Reporting System (WFRS).

Note: In the map, independent cities that occupy a relatively small land area are combined with a surrounding county.

program to train or employ alternative dental health providers.

### Measuring Virginia Policy against an Inventory of Best Practices

State and local agencies as well as state public health and oral health advocacy groups have developed strategic plans that address improving oral health within the commonwealth. State agency plans invariably link their goals and benchmarks to the U.S. Department of Health and Human Services (HHS) *Healthy People* plan, an apparent prerequisite to qualify for various kinds of federal program funding support.<sup>62</sup>

Virginia also has an oral health strategic plan, although it is unclear how successful such planning has been in influencing the policy agenda. The Virginia plan, which was introduced in 2004, went further in reach and specificity of objectives outlined in the *Healthy People 2010* plan. For example, the Virginia plan cites the goal of improving service in “areas of need” by funding scholarship and loan programs, improving reimbursement rates for private providers, and increasing funding for dental clinics. It calls for increased funding for dental schools. It broaches the controversial topic of dental health profession regulation, including the need to consider new categories of providers, expanded scopes of practice, and license transferability from other states. It advocates increased funding for children’s programs, increased reimbursement for Medicaid dental care, streamlined administrative processes and improved case management to improve child access, and improved efforts to combat the problem of unhealthy food and drinks available in schools. It also supports expanding the dental safety net and increasing Medicaid coverage for adults.

With federal funding, the Virginia Oral Health Coalition, a recently created advocacy organization composed of public health representatives and non-profit groups, is creating an update of the 2004 Virginia plan.<sup>63</sup> The coalition has identified 19 objectives, some of which follow the 2004 plan. But it also includes new recommendations such as encouraging the establishment of permanent relationships between low-income patients and providers (also known as “dental homes”) and making greater use of information technology and telecommunications in dental care (also known as “teledentistry”). It also calls for greater collaboration between medical and dental care providers in preventing dental problems.

One can gain a better understanding of how well the state is performing on oral health objectives from two online reporting systems. The National Oral Health Surveillance System

(NOHSS) and the Synopses of State and Territorial Dental Public Health Programs, maintained by the Centers for Disease Control and Prevention (CDC) and the Association of State and Territorial Dental Directors (ASTDD) provide comparative state data on oral health inputs, outputs and outcomes.

New research, the experiences of other states, and oral health policy watchdog group evaluations can also inform public policy in this area. In the last year, the Institute of Medicine/National Academies of Science has published two blueprints for oral health policy informed by current dental policy research.<sup>64</sup> The Association of State and Territorial Dental Directors (ASTDD) maintains an up-to-date inventory of best practices drawn from its membership based on their experiences. The Pew Study on the States Children’s Dental Campaign monitors and evaluates programming related to child oral health while Oral Health America rates oral health programming for all age groups.

Virginia garners mixed assessments using such benchmarks. In the *Oral Health America National Grading Project 2003*, Virginia receives a mediocre grade of “C+” for its efforts. The Pew Center on the States gives the state a grade of “C” in its most recent report for dental public policy for children, *The State of Children’s Dental Health: Making Coverage Matter*.<sup>65</sup> Virginia meets or exceeds benchmarks in the four areas of water supply fluoridation, child Medicaid dental utilization, reimbursement by Medicaid for preventive services, and participation in the National Oral Health Surveillance System. But, it falls short in the reach of its child sealant program in at-risk schools, the scope of dental hygienist practice allowed for school-based programs, Medicaid reimbursement rates, and authorization of alternative dental care providers.

### Policy Implications

While large unfinished policy agendas and mediocre grades can be a great motivator to do more, policy-making entails allocating scarce resources that have alternative uses. Doing so is fraught with difficulties when results are imperfectly measured, uncertainty exists about the amount of resources dedicated to oral health, and comparative cost-effectiveness studies are not available. There are several policy areas under discussion that are relatively promising in Virginia and others that are considerably less so. These broad areas, discussed below, include dental workforce education, workforce distribution, children’s programs, the dental safety net, and the use of alternative providers.

*“[Virginia] falls short in the reach of its child sealant program in at-risk schools, the scope of dental hygienist practice allowed for school-based programs, Medicaid reimbursement rates, and authorization of alternative dental care providers.”*

*“State and local policymakers have discussed the possibility of establishing a second dental school in Virginia to help alleviate regional disparities.”*

#### Dental Workforce Education

State and local policymakers have discussed the possibility of establishing a second dental school in Virginia to help alleviate regional disparities. At least two possible locations have been mentioned: one in the Roanoke-Blacksburg region that would be affiliated with the Edward Via College of Osteopathic Medicine and another at the University of Virginia at Wise campus in Norton. A regional dental school could bring about a sizeable improvement in the availability of dentists in a region.<sup>66</sup> A clinic as part of the dental school would be the primary means for improving dental care among underserved residents. The retention of graduate dentists would play a much more modest role. However, establishing a dental school is likely to encounter significant obstacles, including the high cost of setting up the necessary academic infrastructure and physical plant, recruiting and retaining faculty, and operating a school-based clinic outside a major metropolitan area. Current dental school models located in less densely populated areas, such as East Carolina University, rely on a network of regional public dental clinics to serve as training sites for students and residents and to reinforce their missions of expanding rural and public dental care practice.

Less expensive options for obtaining the same results as a new dental school include encouraging dental professionals to practice in underserved areas. Education pipelines starting with pre-professional preparation in high school and college are a promising approach. Because individuals from rural and disadvantaged areas are more likely than some to choose those areas to practice, efforts could be made to facilitate their preparation and entry into dental school. A dental pipeline through a joint college-dental school program or college preparatory program could shorten the length and tuition of undergraduate and dental education. Such a program would require state or federal support.

#### Workforce Distribution

Financial incentives to practice in underserved areas can potentially expand the pool of dental professionals there.<sup>67</sup> The effectiveness of such programs in meeting these goals may be sensitive to program design characteristics, including the method of selecting and preparing participants, the magnitude and timing of the benefits, and the severity of penalties for not complying with (or “buying out” of) the service requirements. Typically, such incentives take the form of scholarships, loans, and direct financial incentives with requirements that awardees practice in an underserved area or serve a threshold of underserved

or disadvantaged patients (e.g., Medicaid patients) for a period of time. If successful, such programs provide benefits that are twofold. First, disadvantaged patients unlikely to otherwise obtain care receive it. Second, insured and out-of-pocket paying patients may save on travel or waiting times, which may enhance the likelihood of seeking care, number of visits, and mix of services. Programs vary in the amount of importance attached to serving disadvantaged patients versus locating in underserved areas. Thus, it is difficult to estimate the relative magnitude of benefits that accrue to serving these different populations or whether they exceed program costs.

While politically attractive, the actual evidence on the effectiveness of such programs is surprisingly limited and the evidence that is available often unfavorable. Results indicate that the proportion of graduates who fulfill their obligation to work in underserved areas, the rate of long-term retention of practitioners in underserved areas, and the amount of importance of the incentive in location choice are actually low. Most financial incentive programs experience high attrition rates from the start of training through the period of service obligation, particularly student scholarship and loan programs.<sup>68</sup> Some research suggests that approximately half of recipients who obtain financial assistance continue to either serve in an underserved region or work with underserved populations.<sup>69</sup> But, they are unlikely to remain at the site of initial practice.<sup>70</sup> Moreover, it is not clear that the incentive programs assist rural retention or ultimately alter the locational choices of graduates.<sup>71</sup> For instance, a study of physicians who served in the National Health Services Corp indicates that graduates who were already predisposed to working in underserved regions because of their backgrounds self-selected themselves into the NHSC program.<sup>72</sup>

Another option considered by states to deal with underserved areas is to relax standards for foreign dentist licensure and allow them to be recruited through the H-1B visa program. A small number of international dental school graduates are licensed to practice in the United States after completing a supplemental education program (2-3 years in duration) at an accredited U.S. institution.<sup>73</sup> Wisconsin allows foreign trained dentists to complete a one-year dentistry residency program in order to qualify for sitting for national and regional licensure examinations. The limited evidence available on the locational patterns of international dentists and other medical professionals such as physicians suggests they have low retention rates in underserved areas and tend to

locate in the same higher income regions as U.S. dental graduates.<sup>74</sup>

Even if these programs were successful in placing dentists in underserved areas, it is unclear if they ultimately achieve the goal of rebalancing the geographical distribution in favor of areas with low numbers of dentists. If dentists participating in financial-incentive programs competitively displace non-participating dentists because of limited realizable demand for dental services, they have accomplished nothing. Moreover, even if the supply of dentists increase in underserved areas, it is not clear that the programs result in tangible social net economic benefits, particularly if the services provided are provided to higher income patients who incur few travel and waiting time burdens, or that the costs of the programs exceed the benefits. Thus, policymakers may have more success trying to alter demand characteristics by expanding dental insurance coverage, childhood dental programs, or improving citizen oral health awareness rather than focusing on altering the number of providers.

#### Children's Programs

Virginia's *Smiles for Children*, like state programs elsewhere in the nation, has been very successful in expanding participation of dentists in Medicaid and improving utilization of dental services by children. Utilization rates of around 55.6 percent were achieved for 3 to 21 year olds enrolled in Virginia Medicaid/FAMIS in FY 2011<sup>75</sup> were comparable to nationwide utilization rates of 55 percent achieved for privately insured children 2 to 18 in 2004-05.<sup>76</sup> However, there are still obstacles to children receiving care, including transportation costs, job responsibilities, and oral health literacy levels and low-income children still show significantly higher rates of tooth decay. At some point, utilization levels will plateau even with high levels of provider Medicaid participation. If the goal is to move low-income children to levels of utilization comparable to privately insured children, that goal appears within sight. On the other hand, if the goal is to improve low-income children's oral health to levels of privately insured children, a much higher utilization level may be needed because they have more risk factors.

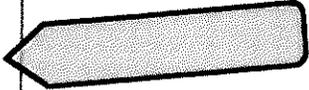
Schools serve as an important gateway for delivering health, nutrition and social services. They seem a natural fit too for a dental care delivery system that would reach disadvantaged children or any children who might lack proper dental care. Research suggests that for current efforts targeting children from low-income families, preventive services, such as dental sealants and fluoride application, are a cost-effective way

of preventing cavities for permanent teeth.<sup>77</sup> In order to continue progress, at some point, an expansion of this approach may be needed. One promising model is a school-based dental program at high-need schools that provides on-site screening and preventive care by dental hygienists and support staff with on-site or off-site restorative care by private and public dentists. There are such clinics in operation in Virginia, including sites in Accomack and Caroline counties.<sup>78</sup> One study shows that a school-based program is financially feasible if Medicaid fees are 60.5 percent of mean national fees, which is about where Virginia is now. Moreover, the unit costs of providing child dental care can be cut nearly in half, meaning that more children could obtain care or program funds could be reduced or directed elsewhere.<sup>79</sup>

#### Dental Safety Net

Unlike children, adults typically do not have public dental insurance available, making them even less likely to seek dental care. Examining adults and children in 2000, one study found that out of 82 million low-income, underserved people only 27.8 percent visited a dentist.<sup>80</sup> The primary sources of care were dental clinics in community health centers, hospitals, public schools and dental schools, which combined have a capacity to care for 7 to 8 million people annually. The study estimated that the safety net could be expanded by 10 million people annually by increasing the number of community clinics and their efficiency, requiring one-year of residency training for students in dental schools, and requiring senior dental students and residents to work 60 days in community clinics. Even with this increase, there would still be a significant shortfall in available low-income care.

There are opportunities to improve the dental safety net in Virginia. The Virginia Health Care Foundation reports that there are 62 Virginia localities that have no safety net dental clinic.<sup>81</sup> Plugging the remaining geographical gaps, particularly at a time when increased federal funds may be available for FQHC dental clinic expansion as part of the Affordable Care Act, would seem to be an appealing option. FQHCs are attractive because the federal government will bear much of the expense. Efforts could be made to increase the number of FQHC sites that offer a full array of dental services. However, funding remains subject to changes in federal policy. While free clinics and charity care, such as the Virginia Dental Association's Missions of Mercy (MoM), currently provide an impressive amount of care to disadvantaged individuals, they cannot be expected to solve the access problem and may discourage other avenues



*“Virginia’s Smiles for Children, like state programs elsewhere in the nation, has been very successful in expanding participation of dentists in Medicaid and improving utilization of dental services by children.”*

of providing care to the needy. These programs rely on a finite and exhaustible supply of volunteer services. They cannot provide regular preventive services, and patient waiting lists and lines are often long.

#### Alternative Providers of Service

There is considerable evidence that improvements in oral health in underserved populations could be achieved by expanding the services offered by dental professionals other than dentists. Expanding the functions that dental hygienists can perform and relaxing the requirements for supervision by dentists would increase the quantity of services actually delivered to underserved residents and would lower the price of receiving basic care.<sup>82</sup> In particular, allowing hygienists to offer fluoride varnish and routine cleaning without supervision by a dentist has the potential to generate significant health improvements at low cost. The resulting increase in visits by those previously not receiving care has a very important side benefit. The hygienist providing the service would be in a position to identify patients in need of additional care and to refer the patient to a dentist for treatment of the condition. Many of the people with these undiagnosed conditions would have ended up waiting until the condition had worsened and would require extraction or even emergency room care. The incidental savings from wider availability of routine care may be large.

Alternative providers of services could also be used to lower cost and expand the distribution of services available. For example, the dental health aide therapist is a provider that performs cleanings, dental restorations and uncomplicated extractions under varying levels of remote dental supervision. Dental therapists are used in more than 50 countries worldwide. Within the United States, only Minnesota and some remote parts of Alaska license dental therapists, but several other states are considering them. A recent study of the safety and effectiveness of dental therapists in Alaska found that dental therapists exercised good judgment, provided appropriate care, and received high patient satisfaction ratings.<sup>83</sup> Another study found that dental therapists would allow more patients to be served at lower cost, while maintaining or improving the financial bottom line of dental practices.<sup>84</sup> There are also proposals to create additional oral health providers, such as the advanced dental hygiene practitioner (a new level dental hygienist with two years of graduate education that would permit them to perform some restorations and simple extractions) and community dental health coordinator.<sup>85</sup> The ultimate effect of

introducing these new practitioners remains to be seen.

Expanding the use of primary care physicians in applying dental sealants, as well as providing education, is another way to reach more children. Although Medicaid already reimburses physicians for services such as fluoride varnish, expanding the range of prophylactic services that can be administered in the offices of primary care physicians could increase services to children, as children are more likely to visit physicians than to visit dentists for checkups under public insurance programs.

The expansion of alternative providers may also improve the viability of alternative service delivery models. For example, offering a limited number of affordable and transparently priced dental services in a retail setting such as a retail outlet or mall, have gained popularity and are a promising avenue for expanding preventive care access.<sup>86</sup> Improved access to the underserved depends on how this model evolves. But, ultimately, its viability may depend on permitting mid-level professionals to practice independently.

Any changes would be likely to meet opposition from providers, including both dentists and dental hygienists. However, as the recent adoption of the Dental Assistant II certification by the General Assembly in 2011 shows, it is possible to expand certifications and also expand effective care, and increase the productivity of dental offices. Moreover, as one academic dentist points out, if providers do "not address the access problem in Virginia, and do it through new workforce models that promote care for under-served Virginians, someone else surely will."<sup>87</sup>

#### A Practical Roadmap to Better Policy Effectiveness

Although some political leaders, public health officials and advocacy groups have sometimes used stark language such as "crisis" or "silent epidemic" to describe the contemporary oral health landscape, the reality is that the nation has made slow but steady progress in improving dental and oral health and increasing access to care over the last several decades. There are various explanations for this. One is that more citizens are able to afford care as incomes have risen and private insurance has increased. More employers are offering dental benefits than ever before. Another reason is that younger generations of Americans have grown up with fluoridation and modern dental technology, are often better educated, and are more likely to place emphasis on personal appearance and a healthy lifestyle than some earlier generations. Still another reason is that prudent,

*"There is considerable evidence that improvements in oral health in underserved populations could be achieved by expanding the services offered by dental professionals other than dentists."*

carefully targeted public policies have expanded access for underserved populations. The goal that the newest generation will have better oral health than their parents seems within reach and bodes well for the future.

Virginia performs better on most measures of oral health than the nation at large. In part, this reflects its relatively high average income level, which affects the ability of residents to afford dental care and the state's capacity to attract providers of these services. However, the improvements have not been evenly distributed, with tooth decay continuing to be a major problem among low-income, rural, and minority populations.

The state has made some notable progress in improving care for these populations, and in some public policy areas such as low-income children's access and utilization, the state compares very favorably with best practices. However, the state draws only an average "C" rating from oral health monitoring organizations. If Virginia measures its success by continued progress towards improving oral health for all its citizens, regardless of race, income, or where they live, new and more creative policy initiatives will be needed in the near future.

Among such measures and proposals being discussed today, many are sensitive to the political debates over the Affordable Care Act and the continuation of other U.S. Department of Health and Human Services funding. If funding for some programs is cut, many options are likely to fall by the wayside. These would include expanding children's private and public dental insurance coverage, increasing the number of dental clinics, and providing additional resources to increase the number of dental health professional and residency programs. With drops in funding, other proposed efforts such as expanding the number of school-based dental clinics will be made more difficult.

The debate over increasing resources for public dentistry programs will continue to be affected by state budgetary constraints and the need to adequately fund other pressing health, social, educational, infrastructure and public safety needs. Oral health programs, particularly those that benefit adults, are often among the first programs to be cut when budgetary problems arise. That has certainly been the case in Virginia's recent budgets, as it has been elsewhere in the nation. The Virginia Department of Health has seen funds for several dental programs either cut or eliminated in recent years. In the future, proponents will need to demonstrate not only how additional spending and new programs can improve oral health, but also how such programs or modifications to dental care delivery can be used to save taxpayer

money. New models for providing dental care to needy and underserved populations should also be strongly considered, as well as expanding the use of hygienists and other health professionals to make dental care more widely available to all Virginians.

#### ABOUT THE AUTHORS

Terance Rephann is an economist at the University of Virginia's Weldon Cooper Center for Public Service. He is an expert on regional economics and has published papers in a variety of economics, planning, and public policy journals. He holds a B.A. from Frostburg State University and a Ph.D. in economics from West Virginia University. Rephann and Wanchek are co-authors of a recent study, *Oral Health and the Dental Care Workforce in Southwest Virginia*.

Tanya Wanchek is an assistant professor in the Department of Public Health Sciences at the School of Medicine and in the Center for Economic and Policy Studies at the Weldon Cooper Center at the University of Virginia. She received her B.A. in economics at the University of California, Davis, Ph.D. in economics from the University of Washington in 2003, and J.D. degree from the University of Virginia School of Law in 2006. She currently conducts economic and legal research projects related to mental health, oral health, advanced dementia treatment, and cleft lip and palate.

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*"If Virginia measures its success by continued progress towards improving oral health for all its citizens, regardless of race, income, or where they live, new and more creative policy initiatives will be needed in the near future."*

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## Recommendation to Change the Definition of Physical Injury in Report on Sanction Reference Points

**Current language** - Physical injury includes any injury requiring medical care ranging from first aid treatment to hospitalization. Patient death would also be included here.

**Language Proposed by Visual Research** – Physical injury includes any injury which impairs the patient's ability to perform normal daily functions. Patient death would also be included here.

**Staff Recommendation** - Physical injury includes any injury requiring medical care ranging from first aid treatment to hospitalization; sexual abuse; improper or excessive restraint; protracted impairment of health; or death.

# **Assessing the Effectiveness of Sanctioning Reference Points**

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***Board of Dentistry – BHP Status Update***

***Draft – Working Papers***

***May 2012***

**Prepared by:**  
VisualResearch, Inc.  
P.O. Box 1025  
Midlothian, VA 23113  
804.794.3144

**Prepared for:**  
Virginia Department of Health Professions  
Virginia Board of Health Professions  
Perimeter Center  
9960 Mayland Drive, Suite 300  
Richmond, VA 23233-4400

The Virginia Board of Health Professions began its Sanctions Reference Points (SRP) research program in 2001 which has subsequently provided SRPs tailored for each of the boards within the Department of Health Professions. In May of 2010, the Board of Health Professions began a formal and ongoing evaluation of SRPs to determine whether the program has met the objectives set forth in 2001. In addition to measuring effectiveness, the study is designed to identify potential improvements to the SRP system and recommend any additional changes related to future SRP operations.

The Board of Dentistry was one of the earliest boards to participate in the study. The Board adopted and began using Sanctioning Reference Points (SRP) worksheets in July 2005. Since that time, approximately 130 Dentistry SRP worksheets have been completed, which provide a sufficient basis to begin analysis. This study is designed to evaluate the performance of the worksheets, user satisfaction, and to make any necessary changes that the board or staff, indicate are needed.

In order to facilitate this evaluation and gather meaningful information on worksheet use and performance, researchers have conducted detailed interviews with Board members and the Board's Deputy Director. The interviewees were asked several open-ended questions that focused on their experiences using the SRPs, such as:

- Are the case types that come before the Board still adequately represented by the SRP system?
- Do you feel the sanctioning recommendations made by the SRP worksheets reflect the Board's sanctioning goals for various offenses (i.e. re-educate, monitor)?
- Are there any specific changes that can be made to the worksheets in terms of the factors, their scoring, or the recommended sanctions?
- Do you feel SRPs have had an impact on case processing time? Disposition method?

Based on data gathered at interviews, the following recommendations to the Board of Dentistry's SRP manual should be considered.

1. Currently, the Board's definition for "Patient Injury" states:  
*Physical injury includes any injury requiring medical care ranging from first aid treatment to hospitalization. Patient death would also be included here.*

Recommended modification of "Patient Injury" to:  
*Physical injury includes any injury which impairs the patient's ability to perform normal daily functions. Patient death would also be included here.*

2. Recently, the Board of Nursing's (BON) SRP worksheets were automated in Microsoft Excel.

It is recommended that Dentistry's SRP worksheets also be automated in a similar fashion to those produced for the BON.

3. Each quarter a report is produced that details each Board's cumulative rate of agreement with the SRP sanctioning recommendations. Interviewees largely report being unaware of Dentistry's present agreement rate.

It is recommend that the reporting of quarterly SRP agreement rates to Board staff be made routine, so Board members are kept up-to-date with current SRP status.

Some interviewees reported that the SRPs help to reduce time spent in closed session by focusing the discussion around factors that directly impact sanctioning. One member stated that the SRPs helped to speed acceptance rates for violations. All interviewees agree that SRP's are a useful tool when sanctioning respondents and are particularly helpful for new Board members.

#### Summary

At this time the board felt that any revising of worksheets factors or scoring was not needed. This is an important observation, since some boards have had varying degrees of change in both sanctioning practice and culture; this has caused their worksheets to undergo more significant revisions. As of now, Dentistry did not feel this was the case, and indicated the worksheet factors, their scoring, and the recommended sanctions, were still up-to-date and relevant. As far as the recommendations made above, VisualResearch, Inc. is available to make formal recommendations at a time convenient to the Board of Dentistry.