VIRGINIA BOARD OF DENTISTRY
AGENDAS
December 5-6, 2013
Department of Health Professions
Perimeter Center - 9960 Mayland Drive, 2nd Floor Conference Center - Henrico, Virginia 23233

PAGE

December 5, 2013

Regulatory-Legislative Committee of the whole Board

9:00 a.m. **Call to Order – Dr. Levin, President**

Evacuation Announcement – Ms. Reen

Public Comment

Approval of Minutes

November 9, 2012 Regulatory-Legislative Committee — **P1-P6**

Review Sedation and Anesthesia Proposed Final Regulations — **P7-P68**

- Timeline of Regulatory Development
- Public Comment Received
- Adopt Recommendation to the Executive Committee

Schedule next meeting to Review the Proposed Final Regulations for Four Chapters

- Use 2/7/14 Reserve Date
- Another date between January 13 and February 21, 2014

Review and Prioritize Assigned Topics for Subsequent Meetings

- Practice Ownership*
- Guidance Document on Advertising Complaints
- Dental Role in Treating Sleep Apnea
- Fee Splitting*
- DAII Registration Options for Qualifying
- Sedation/ General Anesthesia Permit Holders Office Inspections
    - Permit holders practicing on an itinerant basis
    - Permit holders with multiple offices
    - Offices with multiple permit holders
    - Application of OMS Exemption

*The Board voted to appoint a Regulatory Advisory Panel to address Practice Ownership and Fee Spitting.

Scope of Work and Appointment of a Regulatory Advisory Panel — **P69**

12:00 p.m.* ***Board Member Service Recognition Lunch***
NO BUSINESS WILL BE CONDUCTED
****Or immediately following the conclusion of the Committee meeting***

Board Business

1:30 p.m. **Call to Order – Dr. Levin, President**

Evacuation Announcement – Ms. Reen

Public Comment

Approval of Minutes

- September 12-13, 2013 Formal Hearing **P70-P72**
- September 13, 2013 Business Meeting **P73-P79**
- September 26, 2013 Telephone Conference Call **P80-P81**
- October 9, 2013 Telephone Conference Call **P82**
- October 18, 2013 Formal Hearing **P83-P85**
- November 6, 2013 Telephone Conference Call **P86-P87**
- November 8, 2013 Public Hearing **P88-P90**

DHP Director's Report – Dr. Reynolds-Cane

Virginia's Dentistry and Dental Hygienist Workforce: 2013 – Mr. Crow **P91-P148**
Policy & Planning Specialist, Virginia Healthcare Workforce Data Center

Liaison/Committee Reports

- BHP – Dr. Levin
- AADB - Annual Year meeting in New Orleans - Ms. Swain **P149-P151**
- ADEX – Annual meeting - Dr. Watkins & Dr. Rolon **P152**
- SRTA – Dr. Watkins & Ms. Swecker

Legislation and Regulation – Ms. Yeatts

- Status Report on Regulatory Actions **P153**

Board Discussion/Action

- Review of Public Comment Topics
- Letter from Dr. Bukzin **P154-P155**
- Education Requirement for Licensure – Dr. Wyman **P156-P159**

Disciplinary Activity Report – Ms. Palmatier

Executive Director's Report/Business – Ms. Reen

- Report on the AADA Annual Meeting
- Retirement Recognition

December 6, 2013

9:00 a.m. **Formal Hearings**

Regulatory-Legislative Committee

Meeting Materials on 12/05/2013

Draft - Unapproved

VIRGINIA BOARD OF DENTISTRY
MINUTES OF REGULATORY/LEGISLATIVE COMMITTEE
NOVEMBER 9, 2012

TIME AND PLACE: The meeting of the Regulatory-Legislative Committee of the Board of Dentistry was called to order at 1:36 p.m., on November 9, 2012 in Board Room 4, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

PRESIDING: Jeffrey Levin, D.D.S., Chair

MEMBERS PRESENT: Melanie C. Swain, R.D.H.
Charles E, Gaskins, III., D.D.S.

MEMBERS ABSENT: Evelyn M. Rolon, D.D.S.

STAFF PRESENT: Sandra K. Reen, Executive Director
Huong Q. Vu, Operations Manager

OTHER BOARD MEMBER PRESENT: Herbert R. Boyd, III, D.D.S.

OTHERS PRESENT: Elaine Yeatts, Senior Policy Analyst, Department of Health Professions
Howard Casway, Senior Assistant Attorney General

ESTABLISHMENT OF A QUORUM: With three members present, a quorum was established.

PUBLIC COMMENT: Dr. Levin reminded everyone that the comment period for the NOIRA on the Sedation and Anesthesia Regulations is closed. He added that audience members will be permitted to ask questions as the Committee goes through the discussion draft later on in the agenda.

Dr. Burns, Jr with the Virginia Dentists for Intravenous Sedation and Dr. Hamlin indicated that they had intended to comment on the NOIRA and would stay for the Committee discussion.

APPROVAL OF MINUTES: Dr. Levin asked if the Committee members had reviewed the November 4, 2011 minutes. No changes or corrections were made. Dr. Gaskins moved to accept the November 4, 2011 minutes. The motion was seconded and passed.

STATUS REPORT ON REGULATORY ACTIONS: **Emergency Sedation/Anesthesia Regulations** – Ms. Yeatts stated that these regs went into effect on September 21, 2012 and will expire on

September 13, 2013, but the Board may request a 6-month extension until March 13, 2014. She added that they must be replaced by final regulations, which the Board may adopt at its December 7, 2012 meeting. She noted that the proposed regulations are not required to have the same language as the emergency regulation.

Ms. Yeatts stated that the emergency Regulations require dentists who use deep sedation/general anesthesia or conscious/moderate sedation in a dental office must have the permits by March 1, 2013. All permits will expire on March 31, 2014 and are subject to annual renewal by March 31 each year concurrent with renewal of dental licenses. She then reported that:

Periodic Review – the proposed regulations to establish four chapters have been at the Secretary's Office for 155 days.

Training in pulp capping for dental assistants – has been approved and will be effective on November 22, 2012.

Radiation Certificate – this amendment has been approved and will be effective on December 6, 2012.

Recovery of Disciplinary Costs – this regulation allows the Board to recover the administrative costs from any licensee disciplined by the Board. She added the recovered costs may not exceed a total of $5,000 and all these costs will go directly to the Board's account and shall not constitute a fine or penalty. She noted that this regulation will be effective on November 21, 2012.

Changes to temporary and faculty licensure – these will be effective on November 21, 2012.

Remote supervision of dental hygienists in public health clinics - these will be effective on November 21, 2012.

COMMENTS AND QUESTIONS ON EMERGENCY REGULATIONS FOR SEDATION AND ANESTHESIA PERMITS:

Ms. Reen stated that from comments and questions received, it was clear that there is confusion about who must have a permit because the emergency regs do not include the provisions for minimal sedation. She added that there were also a number of comments on EKG requirement for conscious/moderate sedation and the use of particular drugs. She stated that these exchanges with licensees are provided to assist the Committee in developing proposed final regulations.

Ms. Reen referred the Committee to the green page which is the current regulation for minimal sedation, 18VAC60-20-108 (Administration of

anxiolysis or inhalation analgesia) and is provided as a reference as the Committee goes through the discussion draft. Ms. Yeatts suggested changing the title to "Minimal Sedation" and adding this section in the proposed final regs to address anxiolysis and inhalation analgesia. Following discussion, Dr. Levin asked staff to develop and include this section as recommended.

DISCUSSION OF PROPOSING CHANGES TO THE SEDATION/ ANESTHESIA REGULATIONS:

Ms. Reen said the discussion draft includes highlighted sections and notes to help the Committee consider the comments received from the public and those offered by staff. Dr. Levin noted that the audience could participate in the discussion.

P82-P85
Ms. Reen stated that the definitions, which are highlighted, were addressed by Dr. Hoard who recommends adhering to the definition of general anesthesia and levels of sedation/analgesia adopted by the American Society of Anesthesiologists (ASA). She then referred the Committee to page P101 and page P102, which were provided as reference.

Mr. Casway suggested listing the definitions of the levels of supervision and the levels of sedation together to facilitate comparison. Ms. Yeatts indicated that definitions are required to be listed alphabetically and said she would see if these definitions could be grouped. Dr. Gaskins asked if Anxiolysis is still part of the definition. Ms. Reen replied yes and added that it will be linked in the Minimal Sedation section.

The Committee reviewed the definitions and decided to conform them to the to the ASA language and to group the levels of supervision and the levels of sedation.

P87
18VAC60-20-107.C – the Committee agreed with the staff recommendation to add "*any level of*" between "administration of" and "sedation".

P88
18VAC60-20-107.F – Ms. Reen noted that Dr. Hamlin requested that dentists be allowed to prescribe anti-anxiety agents to children aged 12 and under to be taken prior to arrival in the dental office. She added that the current proposed language is the national standard which comes from the guidelines adopted by the American Academy of Pediatric Dentistry and the American Academy of Pediatrics.

After discussion, Dr. Gaskins moved to strike this section with further investigation. The motion was seconded and passed.

18VAC60-20-107.G – Ms. Yeatts noted that Ms. Satterlund requested clarification of the term 'qualified dentists." The Committee agreed with Ms. Yeatts' suggestion to use *"than the dentist intended and was prepared."*

P89

18VAC60-20-110.A – Ms. Yeatts noted that Ms. Satterlund requested clarification of "no dentist may employ or use." She added that the staff recommendation is to change "employ or use" to *"administer."* Ms. Reen said the Committee needs to consider the comments made by the Virginia Association of Nurse Anesthetists (VANA) on the meaning of the Code language "provides or administers" and VANA's belief that the Board has misinterpreted the "plain meaning" of the statute by allowing dentists without permits to delegate administration to other qualified health professionals. Ms. Reen said that Board Counsel should be given time to research VANA's position in order to advise the Board so the Committee has the option of suspending discussion of the affected regulations or preceding based on the Board's interpretation of the statute in the Emergency Regulations now in effect. After discussion, the Committee decided to proceed based on the Board's interpretation and to change "employ or use" to *"administer."*

Ms. Yeatts raised the question of who is responsible for ensuring that the equipment and staffing requirements are met. The Committee said it should be made clear that the delegating dentist is responsible.

P90 and P91

18VAC60-20-110.E(1) – Ms. Yeatts noted that Ms. Satterlund requested clarification of "a dentist not qualified to administer." She added that the staff recommendation is to change to *"a dentist who does not hold a permit to administer."* The Committee agreed.

18VAC60-20-110.E(2) - Ms. Yeatts recommended that "a dentist qualified pursuant to subsection B" be changed to *"a dentist who does hold a permit to administer."* The Committee agreed.

Concerns raised in comment and by members of the audience about supervision of certified registered nurse anesthetists were considered and no action was taken by the Committee.

P92

18VAC60-20-110.F – Ms. Yeatts recommended replacing "emergency" in the title of the subsection with *"required."* The Committee agreed.

18VAC60-20-110.G(1) – Ms. Reen noted that many of the comments submitted opposed requiring the dentist to be in the operatory through

the dental procedure because having a trained staff person is adequate. Ms. Reen went on to say that these comments misinterpret the requirements but indicate the regulations should be developed to better distinguish the requirements for monitoring and treatment consistent with the four (4) steps of inducing sedation, stabilizing the level of sedation, treatment and recovery from sedation. The Committee agreed to change the word "procedure" to "treatment" and charged staff with clarifying the monitoring requirement.

P93

18VAC60-20-110.G(3)(a) – the Committee decided to add "*EKG readings*" at the beginning of the paragraph and to strike the terms "pulse and pulse oximeter."

18VAC60-20-110.G(3)(b) – the Committee revised the first sentence to read "*The patient's above vital signs and EKG readings shall be monitored, recorded every five minutes and the reported to the treating dentist throughout the administration of controlled drugs and recovery.*"

18VAC60-20-120 – the Committee agreed with the staff recommendation to add "*/moderate*" following "conscious" in the title of the subsection.

P94 and P96

The Committee agreed that the provisions on these two pages would be made consistent with the changes made in 18VAC60-20-110.

P97

18VAC60-20-120.H(2)(e) – Ms. Yeatts notes that VANA does not believe this provision falls within the scope of practice of registered nurses (RNs). Ms. Reen stated that she had worked with the Executive Director of Board of Nursing in developing this language and it is her understanding that with the level of supervision specified this is within the scope of practice of RNs. No change was made.

18VAC60-20-120.H(3) – Ms. Yeatts noted that the same change will be made as in 18VAC60-20-107.F, so no further action is needed.

P98

18VAC60-20-120.I(11) – Ms. Yeatts noted that there were quite a few comments on this provision to delete or limit the requirement for an EKG monitor to intravenous administration. Following discussion, the Committee decided to limit this requirement to intravenous administration.

18VAC60-20-120.I(12) - Ms. Yeatts noted that clarification of the term "Suction apparatus" is requested by Dr. Seirawan. The Committee decided that no clarification is needed.

18VAC60-20-120.J – Ms. Yeatts noted that the changes made in 18VAC60-20-110.G(1) will be made here.

P99
18VAC60-20-120.J(3)(c) – after discussion, the Committee decided to make the last sentence requiring a qualified person to remain on the premises a separate provision (3)(d).

P100
18VAC60-20-135 – Ms. Reen noted that Dr. McMillan requested the clarification of the term "ancillary personnel." After discussion the Committee decided to delete the word "ancillary."

Dr. Levin said that staff will draft the revised proposed regulations and send to Committee members for review and input. All agreed. Ms. Reen added that staff will need to change language and reorganize some of the provisions to accomplish the Committee's decisions.

CONSIDERING OF ISSUING A GUIDANCE DOCUMENT ON THE SEDATION/ANESTHESIA REGULATIONS: Dr. Levin suggested that a guidance document (GD) to be developed. Ms. Reen Said that a guidance document could not be developed until the interpretation of the term "provided" is addressed. Ms. Yeatts suggested that any guidance issued should be provided in the form of questions and answers. All agreed.

NEXT MEETING: The proposed date of the next meeting will be determined at a later date.

ADJOURNMENT: With all business concluded, Dr. Levin adjourned the meeting at 4:41 p.m.

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Jeffrey Levin, D.D.S., Chair

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Sandra K. Reen, Acting Executive Director

____
Date

____
Date

Agenda Item: Discussion of public comment on Proposed Regulations for Sedation/Anesthesia Permits – Replacement of Emergency Regulations

Included in the agenda package:

A copy of proposed regulations

Copies of public comment (including transcript of public hearing)

Summary of comment

Staff note:

The public comment period on proposed regulations concludes at 5:00 pm on December 6th. The Administrative Process Act requires an agency to wait 15 days after the conclusion of the comment period before final regulations are adopted. At the time of adopting final regulations, the Board must respond to public comment and adopt regulations as proposed or approve amendments to the proposed regulations.

Emergency regulations initially expired on 9/13/13 but were extended to 3/15/14. To have final regulations in effect by the 3/15/14 deadline will be difficult, so the Board needs to act as expeditiously as possible. Therefore, the Board will discuss the public comment and any possible amendments and will recommend action to the Executive Committee for adoption at a meeting scheduled for 1/10/14.

Timeline for Sedation/Anesthesia Permit Regulations

- June, 2010- Board of Dentistry votes to advance a legislative proposal stemming from the work of the Regulatory/Legislative Committee on regulatory review, which included agreement that the Board should register practices using moderate sedation, deep sedation and general anesthesia consistent with the practice of most of the other states. Virginia is one of the four states that do not have registration in place.

- Chapter 526 (Senate Bill 1146) of the 2011 Acts of the Assembly requires the Board of Dentistry to revise its regulations to provide for permits for dentists who provide or administer conscious/moderate sedation or deep sedation/general anesthesia in a dental office. Regulations must be effective within 280 days of enactment (by December 27, 2011), which is the authorization for emergency regulations.

- September 8, 2011 – Regulatory/Legislative Committee reviews draft language for registration regulations, has extensive discussion and approves recommendations for the full board.

- September 9, 2011 – Full board reviews recommendations, has extensive discussion and adopts emergency regulations.

- Emergency regulations submitted for executive branch review on 9/19/11. Secretary approves on 12/14/11; Governor approves on 9/5/12. Emergency regulations effective from 9/14/12 to 9/13/13 but extended to 3/15/14.

- Notice of Intended Regulatory Action (NOIRA) to replace the emergency regulations published with comment from 10/8/12 to 11/7/12.

- November 9, 2012 – Regulatory/Legislative Committee reviews all comments on NOIRA and discusses the emergency regulations section by section. Adopts a proposal to recommend to the full board.

- December 7, 2012 – Full board receives comments on NOIRA and the recommendations of the Committee. After extensive discussion, adopts proposed regulations to replace the emergency regulations.

- Proposed regulations submitted for executive branch review on 1/31/13. Secretary approves on 7/12/13; Governor approves on 9/16/13. Comment from 10/7/13 to 12/6/13

- November 8, 2013 – public hearing on proposed regulations

- December 5, 2013 – Regulatory/Legislative meeting of the full board meets to discuss comment on proposed regulations and develop recommendations for adoption by Executive Committee.

- January 10, 2014 – Executive Committee adopts final regulations for submission for executive branch review

Project 3535 - none

BOARD OF DENTISTRY

Sedation/anesthesia permits

Part I

General Provisions

18VAC60-20-10. Definitions.

A. The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"ADA" means the American Dental Association.

"Advertising" means a representation or other notice given to the public or members thereof, directly or indirectly, by a dentist on behalf of himself, his facility, his partner or associate, or any dentist affiliated with the dentist or his facility by any means or method for the purpose of inducing purchase, sale or use of dental methods, services, treatments, operations, procedures or products, or to promote continued or increased use of such dental methods, treatments, operations, procedures or products.

~~"Analgesia" means the diminution or elimination of pain in the conscious patient.~~

~~"Anxiolysis" means the diminution or elimination of anxiety through the use of pharmacological agents in a dosage that does not cause depression of consciousness.~~

"CODA" means the Commission on Dental Accreditation of American Dental Association.

~~"Conscious sedation" means a minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation and verbal commands, produced by pharmacological or~~

~~nonpharmacological methods, including inhalation, parenteral, transdermal or enteral, or a combination thereof.~~

~~"Deep sedation/general anesthesia" means an induced state of depressed consciousness or unconsciousness accompanied by a complete or partial loss of protective reflexes, including the inability to continually maintain an airway independently and/or respond purposefully to physical stimulation or verbal command and is produced by a pharmacological or nonpharmacological method or a combination thereof.~~

"Dental assistant I" means any unlicensed person under the direction of a dentist who renders assistance for services provided to the patient as authorized under this chapter but shall not include an individual serving in purely a secretarial or clerical capacity.

"Dental assistant II" means a person under the direction and direct supervision of a dentist who is registered to perform reversible, intraoral procedures as specified in this chapter.

"Mobile dental facility" means a self-contained unit in which dentistry is practiced that is not confined to a single building and can be transported from one location to another.

"Portable dental operation" means a nonfacility in which dental equipment used in the practice of dentistry is transported to and utilized on a temporary basis at an out-of-office location, including patients' homes, schools, nursing homes, or other institutions.

"Radiographs" means intraoral and extraoral x-rays of hard and soft tissues to be used for purposes of diagnosis.

B. The following words and terms relating to supervision as used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Direct supervision" means that the dentist examines the patient and records diagnostic findings prior to delegating restorative or prosthetic treatment and related services to a dental assistant II for completion the same day or at a later date. The dentist prepares the tooth or

teeth to be restored and remains immediately available to the dental assistant II for guidance or assistance during the delivery of treatment and related services.The dentist examines the patient to evaluate the treatment and services before the patient is dismissed.

"Direction" means the level of supervision that a dentist is required to exercise with a dental hygienist, a dental assistant I, or a dental assistant II or that a dental hygienist is required to exercise with a dental assistant to direct and oversee the delivery of treatment and related services.

~~"Enteral" means any technique of administration in which the agent is absorbed through the gastrointestinal tract or oral mucosa (i.e., oral, rectal, sublingual).~~

"General supervision" means that a dentist completes a periodic comprehensive examination of the patient and issues a written order for hygiene treatment that states the specific services to be provided by a dental hygienist during one or more subsequent appointments when the dentist may or may not be present. The order may authorize the dental hygienist to supervise a dental assistant performing duties delegable to dental assistants I.

"Immediate supervision" means the dentist is in the operatory to supervise the administration of sedation or provision of treatment.

"Indirect supervision" means the dentist examines the patient at some point during the appointment, and is continuously present in the office to advise and assist a dental hygienist or a dental assistant who is (i) delivering hygiene treatment, (ii) preparing the patient for examination or treatment by the dentist or dental hygienist, or (iii) preparing the patient for dismissal following treatment.

C. The following words and terms relating to sedation or anesthesia as used in the chapter shall have the following meanings unless the context clearly indicates otherwise:

"Conscious/moderate sedation" means a drug-induced depression of consciousness, during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. Reflex withdrawal from a painful stimulus is not considered a purposeful response. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

"Deep sedation " means a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. Reflex withdrawal from a painful stimulus is not considered a purposeful response. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

Enteral" is any technique of administration in which the agent is absorbed through the gastrointestinal tract or oral mucosa (i.e., oral, rectal, sublingual).

"General anesthesia" means a drug induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilator function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

"Inhalation" means a technique of administration in which a gaseous or volatile agent, including nitrous oxide, is introduced into the pulmonary tree and whose primary effect is due to absorption through the pulmonary bed.

~~"Inhalation analgesia" means the inhalation of nitrous oxide and oxygen to produce a state of reduced sensibility to pain without the loss of consciousness.~~

"Local anesthesia" means the loss of sensation or pain in the oral cavity or the maxillofacial or adjacent and associated structures generally produced by a topically applied or injected agent without depressing the level of consciousness.

"Minimal sedation" means a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and physical coordination may be impaired, airway reflexes, and ventilator and cardiovascular functions are unaffected. Minimal sedation includes "anxiolysis" (the diminution or elimination of anxiety through the use of pharmacological agents in a dosage that does not cause depression of consciousness) and includes "inhalation analgesia" (the inhalation of nitrous oxide and oxygen to produce a state of reduced sensibility to pain without the loss of consciousness).

~~"Mobile dental facility" means a self-contained unit in which dentistry is practiced that is not confined to a single building and can be transported from one location to another.~~

"Moderate sedation" (see meaning of conscious/moderate sedation)

"Monitoring" means to observe, interpret, assess and record appropriate physiologic functions of the body during sedative procedures and general anesthesia appropriate to the level of sedation as provided in Part IV.

"Parenteral" means a technique of administration in which the drug bypasses the gastrointestinal tract (i.e., intramuscular, intravenous, intranasal, submucosal, subcutaneous, or intraocular).

~~"Portable dental operation" means a nonfacility in which dental equipment used in the practice of dentistry is transported to and utilized on a temporary basis at an out-of-office location, including patients' homes, schools, nursing homes, or other institutions.~~

~~"Radiographs" means intraoral and extraoral x-rays of hard and soft tissues to be used for purposes of diagnosis.~~

"Titration" means the incremental increase in drug dosage to a level that provides the optimal therapeutic effect of sedation.

18VAC60-20-30. Other fees.

A. Dental licensure application fees. The application fee for a dental license by examination, a 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 faculty 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 with the exception of a routine inspection of an office in which the dentist has a conscious/moderate sedation permit or a deep sedation/general anesthesia permit.

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.

L. Conscious/moderate sedation permit. The application fee for a permit to administer conscious/moderate sedation shall be $100. The annual renewal fee shall be $100 and shall be due by March 31. A late fee of $35 shall be charged for renewal received after that date.

M. Deep sedation/general anesthesia permit. The application fee for a permit to administer deep sedation/general anesthesia shall be $100. The annual renewal fee shall be $100 and shall be due by March 31. A late fee of $35 shall be charged for renewal received after that date.

Part IV

Anesthesia, Sedation and Analgesia

18VAC60-20-107. General provisions.

A. This part (18VAC60-20-107 et seq.) shall not apply to:

1. The administration of local anesthesia in dental offices; or

2. The administration of anesthesia in (i) a licensed hospital as defined in § 32.1-123 of the Code of Virginia or state-operated hospitals or (ii) a facility directly maintained or operated by the federal government.

B. Appropriateness of administration of general anesthesia or sedation in a dental office.

1. Anesthesia and sedation may be provided in a dental office for patients who are Class I and II as classified by the American Society of Anesthesiologists (ASA).

2. Conscious sedation, deep sedation or general anesthesia shall not be provided in a dental office for patients in ASA risk categories of Class IV and V.

3. Patients in ASA risk category Class III shall only be provided general anesthesia or any level of sedation by:

a. A dentist after he has documented a consultation with their primary care physician or other medical specialist regarding potential risk and special monitoring requirements that may be necessary; or

b. An oral and maxillofacial surgeon after performing an evaluation and documenting the ASA risk assessment category of the patient and any special monitoring requirements that may be necessary.

C. Prior to administration of any level of sedation or general anesthesia, the dentist shall discuss the nature and objectives of the anesthesia or sedation planned along with the risks, benefits and alternatives and shall obtain informed, written consent from the patient or other responsible party. The written consent shall be maintained in the patient record.

D. The determinant for the application of these rules shall be the degree of sedation or consciousness level of a patient that should reasonably be expected to result from the type and dosage of medication, the method of administration and the individual characteristics of the patient as documented in the patient's record. The drugs and techniques used must carry a

margin of safety wide enough to render unlikely an unintended reduction of or loss of consciousness when factoring in titration, and the patient's age, weight and ability to metabolize drugs.

E. ~~A dentist who is administering anesthesia or sedation to patients prior to June 29, 2005, shall have one year from that date to comply with the educational requirements set forth in this chapter for the administration of anesthesia or sedation.~~ When conscious/moderate sedation, deep sedation or general anesthesia is administered, the patient record shall also include:

1. Notation of the patient's American Society of Anesthesiologists classification;

2. Review of medical history and current conditions;

3. Written informed consent for administration of sedation and anesthesia and for the dental treatment to be performed;

4. Pre-operative vital signs;

5. A record of the name, dose, strength of drugs and route of administration including the administration of local anesthetics with notations of the time sedation and anesthesia were administered;

6. Monitoring records of all required vital signs and physiological measures recorded every five minutes; and

7. A list of staff participating in the administration, treatment and monitoring including name, position and assigned duties.

F. Pediatric patients.

No sedating medication shall be prescribed for or administered to a child aged 12 and under prior to his arrival at the dentist office or treatment facility.

G. Emergency management.

1. If a patient enters a deeper level of sedation than the dentist is intended and was prepared to provide, the dentist shall stop the dental treatment until the patient returns to and is stable at the intended level of sedation.

2. A dentist in whose office sedation or anesthesia is administered shall have written basic emergency procedures established and staff trained to carry out such procedures.

H. Reporting of adverse reactions.

A written report shall be submitted to the board by the treating dentist within 30 days following any mortality or morbidity which directly results from the administration of any level of sedation or anesthesia and which occurs in the facility or during the first 24 hours immediately following the patient's departure from the facility.

I. Continuing education.

A dentist who administers or a dental hygienist who monitors patients under general anesthesia, deep sedation or conscious sedation shall complete four hours every two years of approved continuing education directly related to administration or monitoring of such anesthesia or sedation as part of the hours required for licensure renewal as specified in 18VAC60-20-50.

18VAC60-20-108. Administration of minimal sedation (anxiolysis or inhalation analgesia).

A. Education and training requirements. A dentist who utilizes anxiolysis or inhalation analgesia shall have training in and knowledge of:

1. Medications used, the appropriate dosages and the potential complications of administration.

2. Physiological effects of nitrous oxide and potential complications of administration.

B. Equipment requirements. A dentist who utilizes anxiolysis or inhalation analgesia or who directs the administration of inhalation analgesia by a dental hygienist shall maintain the following equipment in his office and be trained in its use:

1. Blood pressure monitoring equipment.

2. Positive pressure oxygen.

3. Mechanical (hand) respiratory bag.

C. Monitoring requirements.

1. The treatment team for anxiolysis shall consist of the dentist and a second person in the operatory with the patient to assist, monitor and observe the patient. Once the administration of anxiolysis has begun, the dentist shall ensure that a person qualified in accordance with 18VAC60-20-135 is present with the patient at all times to determine the level of consciousness by continuous visual monitoring of the patient.

2. A dentist or a dental hygienist who utilizes inhalation analgesia shall ensure that there is continuous visual monitoring of the patient to determine the level of consciousness.

3. If inhalation analgesia is used, monitoring shall include making the proper adjustments of nitrous oxide machines at the request of or by the dentist or a dental hygienist qualified in accordance with requirements of 18VAC60-20-81 to administer nitrous oxide during administration of the sedation and observing the patient's vital signs.

4. If any other pharmacological agent is used in addition to nitrous oxide/oxygen and a local anesthetic, requirements for the induced level of sedation must be met.

D. Discharge requirement. The dentist shall ensure that the patient is not discharged to his own care until he exhibits normal responses.

18VAC60-20-110. Requirements ~~to administer~~ for the administration of deep sedation/general anesthesia.

A. ~~Educational requirements.~~ After March 31, 2013, no dentist may administer deep sedation/general anesthesia in a dental office unless he has been issued a permit by the board. The requirement for a permit shall not apply to an oral and maxillofacial surgeon who maintains membership in the American Association of Oral and Maxillofacial Surgeons (AAOMS) and who provides the board with reports which result from the periodic office examinations required by AAOMS. Such an oral and maxillofacial surgeon shall be required to post a certificate issued by AAOMS.

B. To determine eligibility for a deep sedation/general anesthesia permit, a dentist shall submit the following:

1. A completed application form;

2. The application fee as specified in 18VAC60-20-30;

3. A copy of the certificate of completion of a CODA accredited program or other documentation of training content which meets the educational and training qualifications specified in subsection C; and

4. A copy of current certification in ACLS or PALS as required in subsection C.

C. Educational and training qualifications for a deep sedation/general anesthesia permit.

1. A dentist may ~~employ or~~ be issued a permit to use deep sedation/general anesthesia ~~on an outpatient basis~~ in a dental office by meeting one of the following educational criteria ~~and by posting the educational certificate, in plain view of the patient, which verifies completion of the advanced training as required in subdivision 1 or 2 of this subsection~~. These requirements shall not apply nor interfere with requirements for obtaining hospital staff privileges.

~~1.~~a. ~~Has completed~~ Completion of a minimum of one calendar year of advanced training in anesthesiology and related academic subjects beyond the undergraduate dental school level in a training program in conformity with published guidelines by the American Dental Association (Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry) in effect at the time the training occurred; or

~~2.~~b. Completion of ~~an American Dental Association approved~~ a CODA accredited residency in any dental specialty which incorporates into its curriculum a minimum of one calendar year of full-time training in clinical anesthesia and related clinical medical subjects (i.e. medical evaluation and management of patients), comparable to those set forth in published guidelines by the American Dental Association for Graduate and Postgraduate Training in Anesthesia in effect at the time the training occurred.

~~After June 29, 2006, dentists~~ 2. Dentists who administer deep sedation/general anesthesia shall hold current certification in advanced resuscitative techniques with hands-on simulated airway and megacode training for healthcare providers, including basic electrocardiographic interpretation, such as courses in Advanced Cardiac Life Support (ACLS) for Health Professionals or Pediatric Advanced Life Support (PALS) for Health Professionals and current Drug Enforcement Administration registration.

~~B. Exceptions.~~

~~1. A dentist who has not met the requirements specified in subsection A of this section may treat patients under deep sedation/general anesthesia in his practice if a qualified anesthesiologist, or a dentist who fulfills the requirements specified in subsection A of this section, is present and is responsible for the administration of the anesthetic.~~

~~2. If a dentist fulfills the requirements specified in subsection A of this section, he may employ the services of a certified nurse anesthetist.~~

~~C.~~D. Posting. The deep sedation/general anesthesia permit or AAOMS certificate required under subsection A of this section ~~Any dentist who utilizes deep sedation/general anesthesia shall post~~ shall be posted along with the dental license and ~~current~~ registration with the Drug Enforcement Administration~~, the certificate of education required under subsection A of this section~~. All licenses and permits must be current.

E. Delegation of administration.

1. A dentist who does not hold a permit to administer deep sedation and general anesthesia shall only use the services of a dentist with a current deep sedation/general anesthesia permit or an anesthesiologist to administer deep sedation or general anesthesia in a dental office. In a licensed outpatient surgery center, a dentist not qualified who does not hold a permit to administer deep sedation or general anesthesia shall use either a permitted dentist, an anesthesiologist or a certified registered nurse anesthetist to administer deep sedation or general anesthesia.

2. A dentist who does hold a permit may administer or use the services of the following personnel to administer deep sedation or general anesthesia:

a. A dentist with a current deep sedation/anesthesia permit;

b. An anesthesiologist; or

c. A certified registered nurse anesthetist under the medical direction and indirect supervision of a dentist who meets the educational requirements of subsection C of this section.

3. Preceding the administration of deep sedation or general anesthesia, a permitted dentist may use the services of the following personnel under indirect supervision to administer local anesthesia to anesthetize the injection or treatment site:

a. A dental hygienist with the training required in 18VAC60-20-81 to parenterally administer Schedule VI local anesthesia to persons age 18 or older; or

b. A dental hygienist, dental assistant, registered nurse or licensed practical nurse to administer Schedule VI topical oral anesthetics.

4. A dentist who delegates administration of deep sedation/general anesthesia shall ensure that:

a. All equipment required in subsection F is present, in good working order and immediately available to the areas where patients will be sedated and treated and will recover; and

b. Qualified staff is on site to monitor patients in accordance with requirements of subsection G.

~~D.~~F. ~~Emergency~~ Required equipment and techniques. A dentist who administers deep sedation/general anesthesia shall be proficient in handling emergencies and complications related to pain control procedures, including the maintenance of respiration and circulation~~,~~ and immediate establishment of an airway and cardiopulmonary resuscitation~~, and~~. He shall ~~maintain~~ have available the following ~~emergency~~ equipment in ~~the dental facility~~ sizes for adults or children as appropriate for the patient being treated and shall maintain it in working order and immediately available to the areas where patients will be sedated and treated and will recover:

1. Full face ~~mask for children or adults, as appropriate for the patient being treated~~ masks;

2. Oral and nasopharyngeal ~~airways~~ airway management adjuncts;

3. Endotracheal tubes ~~for children or adults, or both,~~ with appropriate connectors or other appropriate airway management adjunct such as a laryngeal mask airway;

4. A laryngoscope with reserve batteries and bulbs and appropriately sized laryngoscope blades for children or adults, or both;

5. Source of delivery of oxygen under controlled positive pressure;

6. Mechanical (hand) respiratory bag;

7. Pulse oximetry and blood pressure monitoring equipment available and used in the treatment room;

8. Appropriate emergency drugs for patient resuscitation;

9. EKG monitoring equipment and temperature measuring devices;

10. Pharmacologic antagonist agents;

11. External defibrillator (manual or automatic); ~~and~~

12. For intubated patients, an End-Tidal CO^2 monitor;

13. Suction apparatus;

14. Throat pack; and

15. Precordial or pretracheal stethoscope.

~~E.~~G. Monitoring requirements.

1. The treatment team for deep sedation/general anesthesia shall at least consist of the operating dentist, a second person to monitor and observe the patient and a third person to assist the operating dentist, all of whom shall be in the operatory with the patient during the dental ~~procedure~~ treatment. The second person may be the health professional delegated to administer sedation or anesthesia.

2. Monitoring of the patient ~~under~~ undergoing deep sedation/general anesthesia, including direct, visual observation of the patient by ~~a~~ one member of the treatment team, is to begin prior to induction ~~of anesthesia~~ and shall take place continuously following induction, during the dental procedure and during recovery from anesthesia. The person who administered the anesthesia or another licensed practitioner qualified to administer the same level of anesthesia must remain on the premises of the dental facility until the patient has regained consciousness and is discharged.

3. Monitoring deep sedation/general anesthesia shall include the following: ~~recording and reporting of blood pressure, pulse, respiration and other vital signs to the attending dentist.~~

a. EKG readings and baseline vital signs shall be taken and recorded prior to administration of any controlled drug at the facility to include: temperature, blood pressure, pulse, oxygen saturation, respiration and heart rate. The EKG readings and patient's vital signs shall be monitored, recorded every five minutes and reported to the treating dentist throughout the administration of controlled drugs and recovery. When depolarizing medications are administered temperature shall be monitored constantly.

b. A secured intravenous line must be established during induction and maintained through recovery.

H. Discharge requirements.

1. The patient shall not be discharged until the responsible licensed practitioner determines that the patient's level of consciousness, oxygenation, ventilation and circulation are satisfactory for discharge and vital signs have been taken and recorded.

2. Postoperative instructions shall be given verbally and in writing. The written instructions shall include a 24-hour emergency telephone number for the dental practice.

3. Patients shall be discharged with a responsible individual who has been instructed with regard to the patient's care.

18VAC60-20-120. Requirements ~~to administer~~ for administration of conscious/moderate sedation.

A. After March 31, 2013, no dentist may administer conscious/moderate sedation in a dental office unless he has been issued a permit by the board. The requirement for a permit shall not apply to an oral and maxillofacial surgeon who maintains membership in the American Association of Oral and Maxillofacial Surgeons (AAOMS) and who provides the board with reports which result from the periodic office examinations required by AAOMS. Such an oral and maxillofacial surgeon shall be required to post a certificate issued by AAOMS.

B. Automatic qualification. Dentists ~~qualified~~ who hold a current permit to administer deep sedation/general anesthesia may administer conscious/moderate sedation.

C. To determine eligibility for a conscious/moderate sedation permit, a dentist shall submit the following:

1. A completed application form indicating one of the following permits for which the applicant is qualified:

a. Conscious/moderate sedation by any method;

b. Conscious/moderate sedation by enteral administration only; or

c. Temporary conscious/moderate sedation permit (may be renewed one time);

2. The application fee as specified in 18VAC60-20-30;

3. A copy of a transcript, certification or other documentation of training content which meets the educational and training qualifications as specified in D or E, as applicable; and

4. A copy of current certification in ACLS or PALS as required in subsection F.

~~B.~~D. Educational requirements for ~~administration of~~ a permit to administer conscious/moderate sedation by any method.

1. A dentist may be issued a conscious/moderate sedation permit to employ or use any method of conscious sedation by meeting one of the following criteria:

a. Completion of training for this treatment modality according to guidelines published by the American Dental Association (Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry) in effect at the time the training occurred, while enrolled at an accredited dental program or while enrolled in a post-doctoral university or teaching hospital program; or

b. Completion of ~~an approved~~ a continuing education course, offered by a provider approved in 18VAC60-20-50, and consisting of 60 hours of didactic instruction plus the management of at least 20 patients per participant, demonstrating competency and clinical experience in parenteral conscious sedation and management of a compromised airway. The course content shall be consistent with guidelines published by the American Dental Association (Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry) in effect at the time the training occurred.

2. A dentist who was self-certified in anesthesia and conscious sedation prior to January 1989 may be issued a temporary conscious/moderate sedation permit to continue to administer only conscious sedation until September 14, 2014. After September 14, 2014,

a dentist shall meet the requirements for and obtain a conscious/moderate sedation permit by any method or by enteral administration only.

C.E. Educational requirement for enteral administration of conscious sedation only. A dentist may be issued a conscious/moderate sedation permit to only administer conscious sedation by an enteral method if he has completed an approved a continuing education program, offered by a provider approved in 18VAC60-20-50, of not less than 18 hours of didactic instruction plus 20 clinically-oriented experiences in enteral and/or combination inhalation-enteral conscious sedation techniques. The course content shall be consistent with the guidelines published by the American Dental Association (Guidelines for Teaching the Comprehensive Control of Anxiety and Pain in Dentistry) in effect at the time the training occurred. The certificate of completion and a detailed description of the course content must be maintained.

D.F. Additional training required. After June 29, 2006, dentists Dentists who administer conscious sedation shall hold current certification in advanced resuscitation techniques with hands-on simulated airway and megacode training for health care providers, including basic electrocardiographic interpretation, such as Advanced Cardiac Life Support (ACLS) for Health Professionals or Pediatric Advanced Life Support (PALS) for Health Professionals as evidenced by a certificate of completion posted with the dental license, and current registration with the Drug Enforcement Administration.

G. Posting. The conscious/moderate sedation permit required under subsection A and issued in accordance with subsection C of this section or the AAOMS certificate issued to an oral and maxillofacial surgeon shall be posted along with the dental license and registration with the Drug Enforcement Administration. All licenses and permits must be current.

H. Delegation of administration.

1. A dentist who does not hold a permit to administer conscious/moderate sedation shall only use the services of a permitted dentist or an anesthesiologist to administer such sedation in a dental office. In a licensed outpatient surgery center, a dentist who does not hold a permit to administer conscious/moderate sedation shall use either a permitted dentist, an anesthesiologist or a certified registered nurse anesthetist to administer such sedation.

2. A dentist who holds a permit may administer or use the services of the following personnel to administer conscious/moderate sedation:

a. A dentist with the training required by subsection E to administer by an enteral method;

b. A dentist with the training required by subsection D to administer by any method;

c. An anesthesiologist;

d. A certified registered nurse anesthetist under the medical direction and indirect supervision of a dentist who meets the education and training requirements of subsection D or E; or

e. A registered nurse upon his direct instruction and under the immediate supervision of a dentist who meets the education and training requirements of subsection D.

3. If minimal sedation is self-administered by or to a patient age 13 or above before arrival at the dental office, the dentist may only use the personnel listed in subdivision 2 of this subsection to administer local anesthesia. No sedating medication shall be prescribed for or administered to a child aged 12 and under prior to his arrival at the dentist office or treatment facility.

4. Preceding the administration of conscious/moderate sedation, a permitted dentist may use the services of the following personnel under indirect supervision to administer local anesthesia to anesthetize the injection or treatment site:

a. A dental hygienist with the training required by 18VAC60-20-81 to parenterally administer Schedule VI local anesthesia to persons age 18 or older; or

b. A dental hygienist, dental assistant, registered nurse or licensed practical nurse to administer Schedule VI topical oral anesthetics.

5. A dentist who delegates administration of conscious/moderate sedation shall ensure that:

a. All equipment required in subsection I is present, in good working order and immediately available to the areas where patients will be sedated and treated and will recover; and

b. Qualified staff is on site to monitor patients in accordance with requirements of subsection J.

E. ~~Emergency~~ Required equipment and techniques. A dentist who administers conscious sedation shall be proficient in handling emergencies and complications related to pain control procedures, including the maintenance of respiration and circulation, immediate establishment of an airway and cardiopulmonary resuscitation, and shall ~~maintain~~ have available the following ~~emergency airway~~ equipment in ~~the dental facility~~ sizes for adults or children as appropriate for the patient being treated and shall maintain it in working order and immediately available to the areas where patients will be sedated and treated and will recover:

1. Full face ~~mask for children or adults, as appropriate for the patient being treated~~ masks;

2. Oral and nasopharyngeal ~~airways~~ airway management adjuncts;

3. Endotracheal tubes for children or adults, or both, with appropriate connectors or other appropriate airway management adjunct such as a laryngeal mask airway and a laryngoscope with reserve batteries and bulbs and appropriately sized laryngoscope blades for children or adults, or both. ~~In lieu of a laryngoscope and endotracheal tubes, a dentist may maintain airway adjuncts designed for the maintenance of a patent airway and the direct delivery of positive pressure oxygen~~;

4. Pulse oximetry;

5. Blood pressure monitoring equipment;

6. Pharmacologic antagonist agents;

7. Source of delivery of oxygen under controlled positive pressure;

8. Mechanical (hand) respiratory bag; ~~and~~

9. Appropriate emergency drugs for patient resuscitation;

10. Defibrillator;

11. Suction apparatus;

12. Temperature measuring device;

13. Throat pack;

14. Precordial and pretracheal stethoscope; and

15. Electrocardiographic monitor, if a patient is receiving parenteral administration of sedation or if the dentist is using titration.

~~F.~~J. Monitoring requirements.

1. The ~~administration~~ treatment team for conscious sedation shall at least consist of the operating dentist and a second person to assist, monitor and observe the patient. Both

shall be in the operatory with the patient throughout the dental treatment. The second person may be the health professional delegated to administer sedation.

2. Monitoring of the patient ~~under conscious~~ undergoing conscious/moderate sedation, including direct, visual observation of the patient by ~~a~~ one member of the treatment team, is to begin prior to administration of sedation, or if medication is self-administered by the patient, ~~when the patient arrives~~ immediately upon the patient's arrival at the dental office and shall take place continuously during the dental ~~procedure~~ treatment and during recovery from sedation. The person who administers the sedation or another licensed practitioner qualified to administer the same level of sedation must remain on the premises of the dental facility until the patient is ~~responsive~~ evaluated and is discharged.

3. Monitoring conscious/moderate sedation shall include the following:

a. Baseline vital signs shall be taken and recorded prior to administration of any controlled drug at the facility and prior to discharge; and

b. Blood pressure, oxygen saturation, pulse and heart rate shall be monitored continually during the administration and recorded every five minutes.

K. Discharge requirements.

1. The patient shall not be discharged until the responsible licensed practitioner determines that the patient's level of consciousness, oxygenation, ventilation and circulation are satisfactory for discharge and vital signs have been taken and recorded.

2. Postoperative instructions shall be given verbally and in writing. The written instructions shall include a 24-hour emergency telephone number of the dental practice.

3. Patients shall be discharged with a responsible individual who has been instructed with regard to the patient's care.

18VAC60-20-135. ~~Ancillary personnel~~ Personnel assisting in sedation or anesthesia.

~~After June 29, 2006, dentists~~ Dentists who employ ~~ancillary~~ personnel to assist in the administration and monitoring of any form of conscious/moderation sedation or deep sedation/general anesthesia shall maintain documentation that such personnel have:

1. Minimal training resulting in current certification in basic resuscitation techniques, with hands-on airway training for healthcare providers, such as Basic Cardiac Life Support for Health Professionals or ~~an approved,~~ a clinically oriented course devoted primarily to responding to clinical emergencies offered by an approved provider of continuing education as set forth in 18VAC60-20-50 C; or

2. Current certification as a certified anesthesia assistant (CAA) by the American Association of Oral and Maxillofacial Surgeons or the American Dental Society of Anesthesiology (ADSA).

18VAC60-20-140. ~~Report of adverse reactions.~~(Repealed.)

~~A written report shall be submitted to the board by the treating dentist within 30 days following any mortality or morbidity which directly results from the administration of local anesthesia, general anesthesia, conscious sedation, or nitrous oxide oxygen inhalation analgesia and which occurs in the facility or during the first 24 hours immediately following the patient's departure from the facility.~~

Summary of Comment on Proposed Regulations

Permits for Sedation and Anesthesia in Dental Offices

Board of Dentistry

Comment Period from 10/67/13 to 12/6/13

Public Hearing: 11/8/13

Commenter at Public Hearing	Comment
Dr. Preston Burns Va. Association of Dentists by Intravenous Sedation	Organization has been providing CE courses for dentists administering conscious sedation for nearly 10 years. Organization supports proposed regulations, except proposal to end self-certification and opposition to some of the required equipment. Was self-certified for conscious sedation in 1989 & should be allowed to continue with a permanent conscious/moderate sedation permit without additional qualifications. Contrary to the stated goal of allowing persons currently qualified to administer sedation, the proposed regulations would preclude one category of qualified dentists from practicing conscious sedation. The estimated expense for a course is $75,000 to $100,000.
Dr. James Pollard	Received training in IV sedation at MCV in '72 and have used it successfully. Opposed to limitation on ability to treat patients with that modality. The death of 3 children is reason for emergency regulations. Only a few places in the U. S. that offer the training. Self-certified dentists have an impeccable record, so the risks are very slight. Patients will have to seek other dentists, which restricts their access to good care. Oral medication may be the bigger problem but getting the titration accurate can be guesswork & then if there is a problem, you have to start an IV.
Dr. Scott Leaf	Is a pediatric dentist; has a temporary permit. Had courses in conscious sedation in residency at Georgetown but cannot produce documentation of training content from the 1980's. Met all the requirements at the time but proof of training content is problematic. Requests modification of documentation requirement.
Dr. Rod Mayberry	Been practicing moderate/conscious since 1978 & trained at MCV; have sedated many patients without serious complications. Regulations are an intrusion into practice and not in patient's best interest. Mandating ACLS and unnecessary training is unnecessary for doctors that have a proven history of success with IV sedation. Some equipment requirements are unnecessary as well, such as laryngoscopes, electrocardiograms, endotracheal tubes will never be used. CPR and cardiac defibrillators should be required for emergency but not much more is needed to preserve a life. Supports required CE updates. Problem is sedation in children; no need for blanket regulations and mandates.
Dr. Brian McAndrew	Representing the Va. Society of Oral and Maxillofacial Surgeons. Concern about definition of morbidity and which events have to be reported under the new guidelines. What events require a written report?
Kenneth Stallard	Represents Va. Association of Dentists for Intravenous Sedation;

	providing information about how other states permit dentists to do conscious/moderate sedation. Maryland allowed all dentists who held a parenteral sedation permit and facility permit to convert under its new regulations. NC also grandfathered current permit holders. In WV, the Board accepted documented evidence of equivalent training or experience for issuance of a permit. SC allows educational requirements to be waived for dentists who have been utilizing conscious sedation for at least 10 years. IL and TN allowed grandfathering of dentists holding a permit for administration of conscious sedation. CT allows an application for conscious sedation permit to be qualified by documenting completion of 12 parentally-administered procedures per year for 3 years prior to the date of application with completion of CE. Several of these jurisdictions do not require EKG. Language regarding other appropriate airway management adjunct such as a laryngeal mask airway should be deleted from its present location and reinserted after the word "adult." The association does not believe precordial and pretracheal stethoscopes are warranted in conscious/moderate sedation of adult patients. Board should allow self-certified dentists to continue administration of conscious/moderate sedation without additional educational requirements.
Dr. Michael Link	Concern about deletion of definition for anxiolysis. Should not use the term "minimum sedation" because it might increase malpractice rates if a dentist checks that he uses sedation.

Other Commenters	Comment
Dr. Stanley Dameron	Has been utilizing conscious sedation since 1979 with training at Univ. of Md hospital, general practice residency. Section 120 states that laryngeal mask airways are acceptable but a laryngoscope and blades are still necessary equipment; laryngoscopes are not used with LMA's. Self-certified dentists should be grandfathered so they can continue providing care to patients.

Stanley D Dameron, DDS
910 Littlepage Street
Fredericksburg, VA 22401
540.373.5642

November 4, 2013

Members of the Board,

I am a general dentist in Fredericksburg, Virginia who has been safely providing dental care for over a thousand patients utilizing IV conscious sedation since 1979. My training took place at the University of Maryland, University Hospital, General Practice Residency. This has offered safe, comfortable dental care for many patients who without sedation would not have received their necessary dental care.

I have two concerns with the proposed changes to the rules and regulations regarding conscious sedation. In section 18 VAC 60-20-120, I.3, it states that Laryngeal mask airways are acceptable, but a Laryngoscope and blades are still necessary equipment. As a point of information, Laryngoscopes are not used with LMA's.

My second concern is these regulations will stop the general dentists, who are grandfathered (some for over 30 years), from providing safe, effective sedation to their patients. I personally know six non oral surgeon dentists who fit this category and all of them have records of safely sedating patients for over 25 years. All of them are over 60 years old and probably will retire in the next 5-10 years. Due to their long safety record, I strongly believe it would be an unnecessary burden to require them to pay thousands of dollars to attend a class they could probably teach.

If these regulations require them to get additional, unnecessary training, most will probably stop using sedation. Patients desiring or needing sedation to obtain general dental care already have a difficult time finding a qualified dentist. I believe this change to regulation 18 VAC60-20-120 D.2 would eliminate these experienced, safe dentists and create a hardship on patients with reduced access to care.

I hope the Board will leave this regulation unchanged and allow dentists self-certified prior to 1989 to qualify for issuance of a permanent parenteral conscious/moderate sedation permit.

Respectfully,

Stanley D Dameron, DDS, FAGD

1 COMMONWEALTH OF VIRGINIA
2 DEPARTMENT OF HEALTH PROFESSIONS
3 BOARD OF DENTISTRY
4
5 MEETING TO RECEIVE PUBLIC COMMENT
6 IN RE:
7
8 SEDATION AND ANESTHESIA REGULATIONS
9
10
11 DEPARTMENT OF HEALTH PROFESSIONS
12 PERIMETER CENTER
13 9960 MAYLAND DRIVE
14 RICHMOND, VIRGINIA
15
16 NOVEMBER 8, 2013
17 9:00 A.M.
18
19
20
21
22
23
24 Farnsworth & Taylor Reporting, LLC
P.O. Box 333
25 Rockville, VA 23146
804-749-4277

1 APPEARANCES:

2

3 Board Members Present:

4

5 Jeffrey Levin, DDS, President;

6 Charles E. Gaskins, III, DDS;

7 Bruce S. Wyman, DMD;

8

ALSO PRESENT:

9

10 Elaine J. Yeatts, DHP Senior Policy Analyst;

11 Sandra K. Reen, Executive Director;

12 Huong Q. Vu, Operations Manager.

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1 NOTE: The hearing is called
2 to order at 9:03 a.m., and commences as follows:
3 DR. LEVIN: Good morning,
4 everyone. Welcome to public comment on proposed
5 regulations. I'm Dr. Jeff Levin, President of the Board
6 of Dentistry. This is a public hearing to receive
7 comments on the permits for administration of conscious/
8 moderate sedation or deep sedation/general anesthesia
9 regulations, and anxiolysis, I'm sure, can be included
10 in there too. The emergency regulations are in effect
11 until March 15th, 2014. The proposed regulations
12 will replace the emergency regulations.
13 Let me explain a little bit of
14 the process because we are here to take your comment,
15 and we're open to your comment. We are not going to
16 comment because the Board is not here, and, naturally,
17 we can't speak for the Board. We have a board meeting
18 coming up in December, December 6th, 7th. I think we
19 switched our --
20 MS. REEN: December 5th.
21 DR. LEVIN: December 5th, I'm
22 sorry. And at that time, the results of today's hearing
23 and the Board's deliberations will take place. So don't
24 expect us to get into conversations with you today.
25 It's just not going to happen.

1 At this time I will call on
2 persons -- well, first, before we do that, let me have
3 the emergency evacuation.
4 MS. REEN: In the event of a
5 fire or other emergency requiring the evacuation of the
6 building, alarms will sound. When the alarms sound,
7 leave the room immediately, follow any instructions
8 given by security staff. Exit this room through one of
9 the doors at the back of the room and turn right and
10 proceed through the emergency exit door, through the
11 parking lot to the fence at the back and await instructions
12 from security personnel.
13 Thank you.
14 DR. LEVIN: Please turn off
15 your cell phones at this time. And at this time, I will
16 begin to call on persons who have signed up to comment
17 on proposed regulations. As I call your name, please
18 come forward and have a seat at this table. Speak
19 closely into the microphone. Come forward and tell us
20 your name and where you're from.
21 After all persons on the signup
22 sheet have been called, I'll ask if there's anyone else
23 who would like to speak. It's an open hearing and we're
24 not rushing anyone. We are interested to hear how we
25 all practice in the state. Be certain that we have your

1 name and mailing address of all persons who have provided
2 comment on the signup sheet.
3 I want to remind everyone that
4 written comments on the proposed regulation should be
5 directed to Sandra Reen, Executive Director for the
6 Board, on my left. Electronic comment can be posted on
7 the Virginia Regulatory Town Hall at www.townhall.virginia.gov
8 or sent by e-mail. The comment period will close on
9 December the 6th, 2013.
10 This Board will consider all
11 comment before the adoption of final regulations on
12 January the 10th, 2014. So I'll read that again at the
13 end.
14 So at this time, I'll call on
15 Dr. James A. Pollard to come forward and address us, please.
16 DR. POLLARD: Yes, I would
17 like to defer --
18 DR. LEVIN: Just state your
19 name and where you're from.
20 DR. POLLARD: Dr. James A. Pollard
21 from Lynchburg.
22 DR. LEVIN: Thank you.
23 DR. POLLARD: Could I defer to
24 Dr. Burns? I'd like to let him go first.
25 DR. LEVIN: Sure.

1 DR. POLLARD: Is that okay?
2 DR. LEVIN: Sure.
3 DR. BURNS: Can you hear this? Yes.
4 I'm Dr. Preston Burns, Jr.,
5 President and Founder of the Virginia Association of
6 Dentists by Intravenous Sedation. Our organization has
7 provided the required continuing education courses for
8 those dentists administering conscious sedation in the
9 state of Virginia since the regulation became effective
10 nearly ten years ago.
11 I personally have used conscious
12 sedation since 1972 while enrolled at the Medical College of
13 Virginia School of Dentistry, and have sedated some
14 14,000 patients. I was self-certified in 1989 and then
15 obtained the temporary permit under the current emergency
16 regulations effective March 31st.
17 Our organization supports
18 without reservation the Board's commitment to providing
19 the citizens of the Commonwealth with the highest quality
20 dental services and the health, safety and welfare of
21 our patients while under our treatment. This is of
22 paramount concern to us.
23 I am here to speak in favor of
24 the spirit and aspirations of the Board in adopting the
25 new proposed regulations but to speak against the Board's

1 proposal to end self-certification and to some of the
2 proposed equipment required under the new regulation as
3 drafted.
4 We request that the Board
5 maintain intact the language of former 18VAC60-20-120-B.2,
6 renumbered in the proposed regulations as 18VAC60-20-120-D.2 --
7 that's the only difference -- which for a number of
8 years has allowed dentists who were self-certified in
9 anesthesia and conscious sedation prior to 1989 to
10 continue administering conscious sedation.
11 The new regulation should
12 allow the issuance of a permanent conscious/moderate
13 sedation permit to dentists who were self-certified
14 prior to 1989 without additional qualifications.
15 The ADA Guidelines for Teaching
16 Pain Control and Sedation to Dentists and Dental Students
17 recognizes that many dentists have acquired a high degree of
18 competency in the use of anxiety and pain control techniques
19 through a combination of instruction and experience. This
20 has enabled these teachers and practitioners to meet the
21 educational criteria prescribed in the guidelines.
22 In Virginia up until now, this
23 board has recognized this expertise and experience of
24 the senior members of your profession who were self-
25 certified under the former B.2. No reason exists for

1 changing this policy now. In fact, the Board has noted
2 in its publication on the proposed regulations in the
3 Virginia Register that dentists who meet the current
4 qualifications of education and training are qualified
5 for permits under the proposed regulations.
6 The goal of the amended
7 regulation is to allow persons currently qualified to
8 administer the sedation and anesthesia in dental offices
9 to continue to do so provided they administer or delegate
10 administration in a safe environment with appropriate
11 personnel and equipment to monitor and to handle
12 emergency situations.
13 Contrary to the stated goal of
14 the Board, this proposed regulation would preclude one
15 category of currently qualified dentists, those self-
16 certified prior to 1989, from practicing these techniques
17 without further education, training and expense.
18 This board can meet its
19 statutory responsibility to establish the qualifications
20 for registration, certification or licensure in accordance
21 with the applicable law which are necessary to ensure
22 competence and integrity to engage in the regulated
23 profession without disqualifying the dentists self-
24 certified prior to 1989.
25 We are not opposed to the

1 requirement of a permit which would require periodic
2 reporting, but we do oppose as unnecessary the imposition
3 of additional qualifications on our particular group of
4 currently qualified practitioners reflected in the
5 proposed D.2.
6 The proposed change to former
7 B.2 targets the most senior and experienced group of
8 parenteral conscious/moderate sedation practitioners in
9 the Commonwealth. Currently, there are less than ten of
10 us who fall into that category, mostly age sixty and
11 above, which is clearly an ever-decreasing number. Not
12 the age sixty, the number of us. I feel every one of
13 those years.
14 In addition, the estimated
15 expense for these dentists to comply with the new
16 regulation ranges from $75,000 to $100,000 and two weeks
17 away from their homes and patients, as none of these
18 courses are available in Virginia.
19 There is no justification for
20 treating one category of currently qualified practitioners
21 differently than any other qualified group, and this
22 would not be inconsistent with the goals of the regulation
23 to provide a form of oversight to those utilizing sedation
24 techniques.
25 In conclusion, we -- that's

1 VADIVS organization -- support the spirit and aspirations
2 of the Board in adopting the new proposed regulations
3 but feel that the particular changes set forth in D.2
4 are unnecessary and unfairly impose additional requirements
5 on a small subsection of the currently qualified
6 practitioners.
7 We hope that the Board will
8 see fit to leave this regulation unchanged and allow
9 practitioners self-certified prior to 1989 to qualify
10 for issuance of a permanent parenteral conscious/moderate
11 sedation permit.
12 Thank you, very much.
13 DR. LEVIN: Thank you, Doctor.
14 DR. POLLARD: My name is Dr.
15 James A. Pollard, and I am a 1972 graduate of the Medical
16 College of Virginia School of Dentistry. I was a member
17 of the first class to have received training in IV
18 sedation and have utilized that training with great
19 success over the years.
20 I am opposed to the proposal
21 to limit my ability to treat my patients with a modality
22 that they have come to rely on over the years, and I
23 hate the thought that they will have to leave my practice
24 after years of building rapport and trust with them to
25 seek treatment at another practitioner's office, which

1 practitioner is no more competent than I am in providing
2 a means of coping with a huge psychological problem.
3 In reading over the Virginia
4 Register of Regulations, I would like to go over some
5 salient points that I ran across. On page 291, this
6 addresses the crux of this problem, and that is the death
7 of three children. This is why we're having these emergency
8 proposals here.
9 There are some common threads
10 as far as I understand the history of this situation.
11 Number one is oral medication was used in these situations.
12 There were also deep sedation techniques. Specialists
13 were involved, and one case actually happened in a
14 university setting at the Medical College of Virginia,
15 which goes to show you that these things will happen. A
16 certain percentage of sedation patients or anesthesia
17 patients will have deaths, okay. I don't know what the
18 statistics are on it now, but I remember when I graduated
19 from dental school in 1972 one in 10,000 would result in
20 a death. I don't know what it is now.
21 Page 292 of the Register says
22 the proposed regulations do not introduce any new
23 education or training requirements for administration of
24 sedation and anesthesia in dental practice. Well,
25 that's totally a misstatement because that's why we're

1 here talking about this situation now. This is going to
2 entail, as Dr. Burns pointed out, a huge amount of money
3 to get the training that we need to keep up with our
4 practice of sedation. There is nowhere in the state of
5 Virginia to get this training, and there are only, as
6 far as I can tell, probably three, four or five places
7 in the whole country that offer this. So it's going to
8 require a lot of travel expense, hotel expense, meal
9 expense, plus two weeks of being away from the office
10 and the family of course. So it is a huge imposition on
11 us to be able to continue with this.
12 Page 292 of the Register also
13 states that, quote, dentists who were, quote, self-certified,
14 and in parentheses, no formal education or training
15 required, prior to January 1989 will be allowed to hold
16 a temporary permit until such and such and such and
17 such. Well, I take a little offense at this because I,
18 for one, have received formal training. As I stated
19 earlier, I was in the first class ever in the history at
20 MCV to receive the training that I got, and I feel like
21 I'm being unjustly penalized because of this.
22 Page 292 also states, quote,
23 given the significant risk of death due to errors in
24 administration of sedation and anesthesia and follow-up
25 care, to the extent that the permit program will reduce

1 this risk, the proposed amendments should create a net
2 benefit. Well, as Dr. Burns stated, there is such a few
3 number of us -- and I think it's seven or eight that are
4 doing the IV part of it -- that the impact is going to
5 be very, very slight on the public in the state of Virginia.
6 We've had an impeccable record
7 after forty years of doing this. I don't think anybody
8 has had any problem that I know of, no deaths that
9 resulted from our treatment. There haven't been any
10 problems at all that I know of, so the risk pool here is
11 very negligible. There are only seven or eight of us.
12 The chances of us having any untoward events is very,
13 very negligible.
14 And, lastly, the net benefit
15 statement here. Patients of the doctors affected will
16 not see a net benefit. These patients are going to have
17 to go out and seek treatment elsewhere, and after years
18 of building up rapport and trust with these patients,
19 they're going to have to leave the practice and go out
20 and find somebody else. This is going to restrict their
21 ability to get good care, the type of care that they need.
22 Lastly, I'd like to state that
23 it looks like you're kind of picking on the wrong people
24 here. We have done everything exactly right. The ones
25 you should be looking at are very possibly the specialists.

1 Possibly they don't have the training to do IV sedation.
2 I'm not sure about that, but possibly they should be
3 doing it more often. I think the oral medication route
4 has faults. I mean even for children and adults. They
5 have a problem with getting the titration of the
6 medication proper. It's just guesswork basically is
7 what you're doing with it. And if you do have a problem,
8 you have to immediately institute IV access. And this
9 is very, very difficult with someone who's had cardiovascular
10 collapse. It's especially difficult with children. I
11 don't know how they do this, but I'm glad I don't have
12 to treat the young children. I'm glad we've got the
13 specialists there to do this.
14 But if you do have a problem
15 with the oral medication route, your chances are greatly
16 diminished unless you can establish IV access. So I
17 think in eliminating us, this small group of doctors who
18 have done this for years and years, you're really hurting
19 the public by doing this. Okay.
20 DR. LEVIN: Thank you, Dr. Pollard.
21 Dr. Scott Leaf, please.
22 DR. LEAF: Good morning. My
23 name is Scott Leaf. I'm a pediatric dentist from Northern
24 Virginia. I came here this morning from Alexandria. I
25 received my dental training at Georgetown University and

1 graduated in 1981. That's the same year I received my
2 license to practice dentistry in Virginia. I then spent
3 the next two years at Children's Hospital in Washington,
4 D.C. I am here to clarify my position and to try to better
5 understand the future regulations to administer light to
6 moderate conscious sedation in combination with inhalation
7 agents.
8 Part of my residency training
9 included courses in conscious sedation. Part of my
10 training included six weeks in the anesthesiology
11 department at Children's Hospital. Also, over a period
12 of two years under the guidance at Children's Hospital,
13 we took care of a minimum of forty patients that were
14 sedated.
15 I've been doing this since
16 1983 in private practice using oral sedation probably
17 three to four patients a week. I've had a lot of
18 experience, and I gather because of my experience I was
19 one of the ones that was grandfathered in with a
20 temporary permit. My situation I'd like to clarify is
21 going forward.
22 One of the regulations specifically
23 states a copy of a transcript, certification or other
24 documentation of training content which meets the
25 educational and training qualifications as specified.

1 Well, Georgetown University is defunct. I cannot get a
2 transcript. I have a certificate. I have a diploma. I
3 even have a certificate from Children's Hospital, but it
4 also has Georgetown University School of Dentistry.
5 They were the ones that really were in control of all
6 the didactic classes and all of the hours I spent at
7 Children's Hospital. So, because of the word documentation
8 of training, I would not qualify to get a permit going
9 forward.
10 I've been to Children's Hospital.
11 No one is there from when I graduated in 1983, and I
12 have no idea of how to get a transcript from Georgetown
13 from 1981, so I am asking the Board to possibly make
14 some sort of exception. Instead of saying certificate
15 or documentation of training content, just to say a
16 certificate or documentation or diploma or certification.
17 I am positive that Children's
18 Hospital and Georgetown University met all of the
19 requirements at the time I graduated, and I am sure that
20 they held all their students to the highest standard of
21 care. I completed my program successfully, and I believe
22 I should be able to have a permit going forward so I can
23 take care of my patients using light to moderate conscious
24 sedation with inhalation agents.
25 Thank you.

1 DR. LEVIN: Thank you, Dr. Leaf.
2 Dr. Mayberry, please.
3 DR. MAYBERRY: My name is Rod
4 Mayberry. I'm a general dentist from Oakton, Virginia.
5 I've been practicing IV conscious/moderate sedation since
6 1978. I was trained in the oral surgery department at
7 MCV Dental School as an undergraduate under the direction
8 of Jimmy P. Watkins and Elmer Bear who were directed by
9 the dean, John DiBiaggio, the great educational pioneer.
10 I've sedated many thousands of
11 patients without serious complications over the last 35
12 years. I could not practice dentistry today without the
13 benefit of the sedation techniques I employ almost daily.
14 I am a member of the Virginia
15 Dentists Association for IV Sedation and the American
16 Dental Association of Anesthesiology. Our group has been
17 actively opposing the creeping intrusion of government
18 regulation into our practice of dentistry for more than
19 a decade. We have witnessed the state regulators come
20 under pressure from special interest groups inside and
21 outside of dentistry to remedy a problem that does not
22 exist within the practice of IV conscious/moderate sedation.
23 We believe the focus on mandating
24 additional blanket regulations further redistricting our
25 freedom to practice as we know best is not right or in

1 anyone's best interest. As we search the record of
2 tragedies associated with sedation dentistry, we see
3 they have been primarily related to pediatric sedation.
4 The cases of record have happened in situations not
5 associated with general dentistry and IV sedation but in
6 cases of oral medications in hospital settings where
7 even the most highly trained of doctors could not make a
8 difference.
9 We are opposed to mandating
10 new, unnecessary and burdensome requirements for the
11 continuation of our historically-safe and incident-free
12 practice of IV conscious/moderate sedation. Mandating
13 ACLS and unnecessary training is similar to requiring
14 maternity insurance for old men as part of their health
15 insurance since it covers more options. One size does
16 not fit all. This is especially true for doctors that
17 have a proven history of success with IV conscious/moderate
18 sedation over many decades.
19 These proposed new mandates
20 are burdensome, restrictive and will only increase the
21 cost of care to the public. We are not opposed to
22 continuing education programs to maintain currency, but
23 there are programs other than mandated ACLS courses and
24 unnecessary equipment that can be employed to deal with
25 medical emergencies we rarely, if ever, encounter.

1 It is pointless to mandate
2 laryngoscopes, electrocardiograms, endotracheal tubes
3 for our offices when they'll never be used. I've heard
4 EMT's say that doctors unfamiliar with such instruments
5 making good-faith attempts to intubate patients cause
6 more harm than good.
7 When I was nineteen years old,
8 I was a draftee in Vietnam. I was taught the most
9 effective of emergency techniques to deal with gunshot
10 wounds. I was taught to keep my comrade breathing, stop
11 his bleeding and to keep his heart beating. That is all
12 that's required until the medevac arrives and you'll
13 save a life.
14 It is just as true today, 46
15 years later. CPR training and cardiac defibrillators
16 are a major improvement since those days and they should
17 be mandated in every dental office, but not much more is
18 needed to preserve life in an emergency in most dental
19 offices.
20 Yet, the most important aspect
21 of dealing with medical emergencies is good diagnostic
22 judgment, and that is something that cannot be mandated.
23 Nevertheless, requiring regular continuing education
24 updates will go a long way to help increase good judgment.
25 The problem we see is sedation

1 in children. This is where the problem has been manifest
2 in the majority of these reported tragic cases. We
3 agree mandating children be seen and sedated only by
4 dental pediatric specialists. We believe that it is the
5 best way to protect the public interest. We do not
6 believe, and will actively oppose, new blanket regulations
7 and mandates that will not solve the perceived problems
8 as they relate to IV conscious/moderate sedation. Such
9 blanket restrictions on doctors with no need for
10 additional burdensome regulations benefit no one and
11 only increase the cost of care to the public.
12 We wholeheartedly encourage
13 the Governor, the Board and all others with an interest
14 in these proposed restrictions to take our recommendations
15 most seriously.
16 Thank you for your consideration.
17 DR. LEVIN: Thank you.
18 Dr. Brian McAndrew.
19 DR. MCANDREW: Good morning.
20 Brian McAndrew, Virginia Society of Oral and Maxillofacial
21 Surgeons. I'll be very brief.
22 As most of you know, I've
23 spoken here before regarding this topic. The only thing
24 that I'd really want to address today on behalf of the
25 VSOMS is Section 8 under general provisions. There's

1 been some concern amongst our membership just as far as
2 really more a point of clarification as far as what the
3 Board is going to consider morbidity and which events
4 actually have to be reported under these new guidelines.
5 You know, as an example, a
6 patient that develops immediate postoperative nausea and
7 vomiting in the office or develops them within those
8 first 24 hours afterwards, is that something that the
9 Board is going to want a written report on even though
10 it was managed with antiemetics or anything of that
11 nature?
12 So, really what we would just
13 like the Board to consider is defining a little bit
14 better which events they actually want reported to them
15 in a written report afterwards.
16 Thank you.
17 DR. LEVIN: Kenneth Stallard.
18 MR. STALLARD: Good morning,
19 Ladies and Gentlemen of the Board, Ms. Reen. My name is
20 Kenneth Stallard. I'm an attorney from Fairfax County,
21 Virginia. I practice primarily in Washington, D.C., and
22 I represent the Virginia Association of Dentists for
23 Intravenous Sedation, Dr. Burns' and Dr. Mayberry's group.
24 The Association has asked me
25 to appear this morning to apprise the Board of several

1 other jurisdictions which in addressing the permitting
2 of dentists to perform conscious/moderate sedation have
3 continued allowing grandfathering of their more senior
4 experienced practitioners. While we didn't conduct an
5 exhaustive search of all jurisdictions, we have come up
6 with what we believe is a representative sample, and it
7 includes some of our neighboring jurisdictions.
8 First Maryland. Maryland
9 recently amended its regulations for issuance of anesthesia
10 and sedation permits, and their new regulations allow
11 all dentists who held a current parenteral sedation
12 administration permit and facility permit on the effective
13 date of the regulation to convert that permit under the
14 new regulations without additional educational requirements
15 other than the continuing educational requirements
16 required for all permit renewals.
17 Next, North Carolina's new
18 state regulation says that any dentist who held an
19 active parenteral conscious sedation permit as of the
20 regulation's effective date shall be deemed to hold an
21 active moderate conscious sedation permit subject to the
22 usual annual renewal requirements.
23 In West Virginia, in lieu of
24 other educational requirements, the Board may accept
25 documented evidence of equivalent training or experience

1 in conscious sedation anesthesia for issuance of a
2 comprehensive parenteral permit.
3 South Carolina says that
4 educational requirements may be waived by the Board for
5 licensed dentists who have been utilizing conscious
6 sedation for at least ten years prior to the effective
7 date of that regulation.
8 Illinois recently changed its
9 requirements to obtain a permit to administer conscious/
10 moderate sedation. That was in 2010. Those changes
11 allowed grandfathering of dentists then holding a permit
12 for the administration of conscious sedation. Those
13 dentists were allowed to continue practicing these
14 techniques without additional application or requirements.
15 In Tennessee, dentists who
16 already possess current valid intravenous conscious
17 sedation permits at the time of the new regulation are
18 permitted to be issued new comprehensive conscious
19 sedation permits.
20 And finally in Connecticut.
21 Connecticut allows an application for conscious sedation
22 permit to be qualified by documenting completion of
23 twelve parentally-administered conscious sedation
24 procedures per year for three years prior to the date of
25 the application along with completion of continuing

1 education in anesthesia, parenterally-administered
2 conscious sedation or emergency medicine within three
3 years of the application.
4 The Association has also asked
5 me to apprise the Board of several representative
6 jurisdictions that do not require EKG machines for
7 practicers using conscious/moderate sedation techniques.
8 Of those jurisdictions that we've looked at, those not
9 requiring EKG equipment are North Carolina, South
10 Carolina, Georgia, West Virginia, Illinois, and also Ohio.
11 Regarding the proposed regulations
12 addressing endotracheal tubes, laryngoscopes and laryngeal
13 mask airways as part of the required equipment -- and
14 this is at 18VAC60-20-120-E. And I know for the Board
15 that under the regulations as they appear in the Virginia
16 Register there are two section E's. So you should check
17 the numbering of those paragraphs, but I'm referring to
18 the second paragraph labeled E dealing with the equipment
19 requirements.
20 The Association -- and this
21 deals with the requirement of endotracheal tubes,
22 laryngoscopes and laryngeal mask airways. The Association
23 proposes that Subparagraph 3 of that section be amended
24 such that the proposed additional language that appears
25 in the Register when it reads or other appropriate airway

1 management adjunct such as a laryngeal mask airway be
2 deleted from its present location but reinserted later
3 in the same sentence after the word adults.
4 The reason for this is that a
5 laryngoscope is required for the endotracheal tubes but
6 would be inconsistent with the use of the laryngeal mask
7 airway. And the way it reads right now is it's sort of
8 just the opposite, and this proposed amendment would
9 cure that logical inconsistency that we believe is there
10 in the proposed regulation.
11 The Association also asked me
12 to point out to the Board its requirement for precordial
13 and pretracheal stethoscopes. The Association does not
14 believe that these devices are warranted in conscious/moderate
15 sedation of adult patients. The Association notes that
16 the jurisdictions we've been able to identify that have
17 these equipments as required equipment limits the
18 requirement to deep sedation or general anesthesia of
19 pediatric patients -- and that's Kentucky and Maryland --
20 or for any patient involving deep sedation or general
21 anesthesia. And that was Connecticut.
22 On behalf of the Virginia
23 Association of Dentists for Intravenous Sedation, I ask
24 that the Board reconsider its position on proposed
25 regulation 120-D-2 and allow dentists self-certified

1 prior to January 1989 to continue qualifying for a
2 permanent permit to administer conscious/moderate
3 sedation without additional educational requirements.
4 And I do have for the Board my
5 comments in written form, along with copies of relevant
6 portions of the regulations I've cited. I don't know if
7 it's appropriate to submit that at this time. And I
8 also have copies if that would be helpful, but I can at
9 least submit the original.
10 Thank you, very much.
11 DR. LEVIN: Thank you, sir.
12 Dr. Link.
13 DR. LINK: Greetings. I'm
14 Michael Link, and I'm president-elect of the Virginia
15 Dental Association. Not too long ago I was sitting on
16 that side. It seems like yesterday.
17 DR. LEVIN: Congratulations.
18 DR. LINK: First of all, I
19 want to thank you-all for all of y'all's hard work. The
20 citizens of Virginia dentistry is in good hands.
21 I want to touch base a little
22 bit about a little bit of the history on the regulations
23 and what my concerns are. Back in about 2001, 2002,
24 this board undertook rewriting or starting regulations
25 dealing with sedation. The late Dr. Dick Wilson and

1 myself, we were the main people writing the regulation,
2 and we had a lot of input from oral and maxillofacial
3 surgery and a lot of different groups. And we came up
4 with a document at that time that was really good. I
5 applaud y'all's effort in as far as going forward making
6 it more stringent, and, you know, notwithstanding some
7 of the comments and concerns of my colleagues here, I
8 think you ought to consider some of that.
9 My major concern is the word
10 or taking away the word anxiolysis. Now, back ten years
11 ago when we were doing the document the first time it
12 was brought to our attention that if we had anxiolysis,
13 the use of nitrous oxide, that that could possibly
14 increase our malpractice rate, hence, increase the cost
15 to the citizens of Virginia.
16 I still feel like that may be
17 an issue going forward, and basically I understand where
18 y'all are going, that you want to try to make the
19 regulation similar to the ADA; however, back when we did
20 it, we made the regulation stricter than the ADA and I
21 think that was needed at that time and I think Virginia
22 has led this as far as the regulations are concerned in
23 dealing with sedation.
24 Going forward I think you need
25 to consider putting either anxiolysis back in or trying

1 not to use the word minimum sedation because a lot of
2 times us practitioners have to fill out surveys every
3 now and then concerning whether we do sedation, and if I
4 say I'm doing the anxiolysis, then that is not sedation.
5 However, if you term the terminology as now minimum
6 sedation, then I would have to check yes and that would
7 possibly increase costs all the way around.
8 Thank you for your time and
9 your service to the Commonwealth.
10 DR. LEVIN: Thank you.
11 At this time, this completes
12 anyone who has signed up to comment. Is there anyone else?
13 Dr. Sarrett, would you care to
14 make any comment or not?
15 DR. SARRETT: No, Dr. Levin.
16 DR. LEVIN: Thank you, sir.
17 Anybody else any comments?
18 DR. WYMAN: If I could ask a
19 question of Dr. Leaf?
20 DR. LEAF: Yes.
21 DR. WYMAN: You showed us a
22 copy of your certification certificate in pediatric
23 residency at Children's Hospital, along with Georgetown
24 University. I can understand Georgetown is not available.
25 Are there no records at all in the university pertaining?

1 DR. LEAF: I'm not sure of
2 that fact. What I am sure of though is that the didactic
3 work was done in combination with Georgetown University
4 and Dr. Charlie Broring's pediatric dental program
5 there, but I never actually -- I don't know that I
6 actually received a transcript of my graduate work. I
7 don't know what actually was written down.
8 I just know that this says I
9 completed all of the requirements, but it doesn't
10 actually say anything about moderate, light or any type
11 of sedation. But that was part of the program, and I
12 don't know anyone who's still involved with the program
13 from thirty years ago.
14 DR. LEVIN: Okay. Make sure
15 that we do have your name and address, and I want to
16 remind anyone that comments on proposed regulations
17 should be directed to Ms. Reen.
18 Yes, sir?
19 DR. BURNS: I was just wondering
20 if I could submit my written comments.
21 DR. LEVIN: Sure. Yeah, anyone
22 can submit your written comment. And we have a court
23 reporter here today, so every comment that was made has
24 been recorded so I have no concern about that, but we
25 certainly would like your written comment if you want.

1 So basically to reiterate what
2 I said before, the comment period will close on December
3 the 6th, 2013. This board will consider all comment
4 before the adoption of final regulations on January 10th,
5 2014.
6 This concludes our hearing.
7 Thank you.
8 HEARING CONCLUDED
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1 CERTIFICATE OF COURT REPORTER

2

3 I, Wanda T. Blanks, hereby

4 certify that I was the Court Reporter before the

5 Virginia Board of Dentistry public hearing on November

6 8, 2013.

7 I further certify that the

8 foregoing transcript is, to the best of my ability, a

9 true and accurate record of the incidents of the hearing

10 herein.

11 Given under my hand this 17th

12 day of November, 2013.

13

14

15

16 WANDA T. BLANKS
Court Reporter

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CONTINUUM OF DEPTH OF SEDATION: DEFINITION OF GENERAL ANESTHESIA AND LEVELS OF SEDATION/ANALGESIA *

Committee of Origin: Quality Management and Departmental Administration

(Approved by the ASA House of Delegates on October 13, 1999, and amended on October 21, 2009)

	Minimal Sedation Anxiolysis	*Moderate Sedation/ Analgesia ("Conscious Sedation")*	*Deep Sedation/ Analgesia*	*General Anesthesia*
Responsiveness	Normal response to verbal stimulation	Purposeful** response to verbal or tactile stimulation	Purposeful** response following repeated or painful stimulation	Unarousable even with painful stimulus
Airway	Unaffected	No intervention required	Intervention may be required	Intervention often required
Spontaneous Ventilation	Unaffected	Adequate	May be inadequate	Frequently inadequate
Cardiovascular Function	Unaffected	Usually maintained	Usually maintained	May be impaired

Minimal Sedation (Anxiolysis) is a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and physical coordination may be impaired, airway reflexes, and ventilatory and cardiovascular functions are unaffected.

Moderate Sedation/Analgesia ("Conscious Sedation") is a drug-induced depression of consciousness during which patients respond purposefully** to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

* Monitored Anesthesia Care does not describe the continuum of depth of sedation, rather it describes "a specific anesthesia service in which an anesthesiologist has been requested to participate in the care of a patient undergoing a diagnostic or therapeutic procedure."

** Reflex withdrawal from a painful stimulus is NOT considered a purposeful response.

Agenda item: Scope of Work and Appointment of a Regulatory Advisory Panel

The Board decided to convene an advisory panel to address practice ownership and fee slitting.

The Board's Public Participation Guidelines permit the appointment of a panel.

> **18VAC60-11-70. Appointment of regulatory advisory panel.**
>
> A. The agency may appoint a regulatory advisory panel (RAP) to provide professional specialization or technical assistance when the agency determines that such expertise is necessary to address a specific regulatory issue or action or when individuals indicate an interest in working with the agency on a specific regulatory issue or action.
>
> B. Any person may request the appointment of a RAP and request to participate in its activities. The agency shall determine when a RAP shall be appointed and the composition of the RAP.
>
> C. A RAP may be dissolved by the agency if:
>
> 1. The proposed text of the regulation is posted on the Town Hall, published in the Virginia Register, or such other time as the agency determines is appropriate; or
> 2. The agency determines that the regulatory action is either exempt or excluded from the requirements of the Administrative Process Act.

Action Options:

- Defer discussion based on prioritization of assigned topics
- Discuss the specialization and/or technical assistance needed to develop policy recommendations
- Give directions to staff for researching the topics, locating the needed expertise and forming the panel

Board Business

Meeting Materials on 12/05/2013

VIRGINIA BOARD OF DENTISTRY
FORMAL HEARING
September 12-13, 2013

TIME AND PLACE:	The meeting of the Virginia Board of Dentistry was called to order at 9:06 a.m. on September 12, 2013 in Board Room 4, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico, Virginia.
PRESIDING:	Jeffrey Levin, D.D.S., President
MEMBERS PRESENT:	Charles E. Gaskins, III, D.D.S. Al Rizkalla, D.D.S. Melanie C. Swain, R.D.H. Tammy K. Swecker, R.D.H.
MEMBER ABSENT:	Surya P. Dhakar, D.D.S. Bruce S. Wyman, D.M.D.
STAFF PRESENT:	Sandra K. Reen, Executive Director Huong Vu, Operations Manager
COUNSEL PRESENT:	Charis A. Mitchell, Assistant Attorney General
OTHERS PRESENT:	Corie Wolf, Assistant Attorney General Indy Toliver, Adjudication Specialist Denise Holt, Court Reporter, Crane-Snead & Associates, Inc.
ESTABLISHMENT OF A QUORUM:	With five members present, a panel was established.
Robert B. Johnson, D.M.D. Case Nos. 134272 and 132325:	Dr. Johnson appeared with counsel, D. Heath Gates, Jr., and Alan Dumoff (appearing *pro hac vice*), in accordance with a Notice of the Board dated July 12, 2013.

Dr. Levin swore in the witnesses.

Following Ms. Wolf's opening statement; Dr. Levin admitted into evidence Commonwealth's exhibits 1 through 9.

Following Mr. Dumoff's opening statement; Dr. Levin admitted into evidence Respondent's exhibit 1.

Testifying on behalf of the Commonwealth were the followings:
In Person: Maima Fellers, DHP Senior Investigator, Andy Inge, DHP Investigative Assistant, William Lee, MD, Sushma Hirani, MD, Shaw Jones, MD, and Gary D. Klasser, DMD, Associate Professor of Louisiana State University Health Science Center-School of Dentistry.
By Phone: Patient BB, Patient I, Patient O, and Patient L.

Testifying on behalf of Dr. Johnson were the followings:
By video conference: Stephen D. Blood, DO and Michael Hattwick, MD.
In Person: Mark McClure, DMD

Dr. Johnson testified on his own behalf.

RECESSED: The Board recessed at 9:50 p.m. on September 12, 2013. Dr. Levin stated that the hearing will reconvene the next day, September 13, 2013 at 12:30 p.m. in the same room. Dr. Levin reminded the witnesses that they are still under oath.

RECONVENE: The meeting of the Virginia Board of Dentistry was called to order at 12:30 p.m. on September 13, 2013 in Board Room 4, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico, Virginia

PRESIDING: Jeffrey Levin, D.D.S., President

MEMBERS PRESENT: Charles E. Gaskins, III, D.D.S.
Al Rizkalla, D.D.S.
Melanie C. Swain, R.D.H.
Tammy K. Swecker, R.D.H.

MEMBER ABSENT: Surya P. Dhakar, D.D.S.
Bruce S. Wyman, D.M.D.

STAFF PRESENT: Sandra K. Reen, Executive Director
Huong Vu, Operations Manager

COUNSEL PRESENT: Charis A. Mitchell, Assistant Attorney General

OTHERS PRESENT: Corie Wolf, Assistant Attorney General
Indy Toliver, Adjudication Specialist
Sherelle A. Weaver, Court Reporter, Crane-Snead & Associates, Inc.

Testimony resumed.

Closed Meeting: Ms. Swain moved that the Board enter into a closed meeting pursuant to §2.2-3711(A)(27) of the Code of Virginia to

deliberate for the purpose of reaching a decision in the matter of Dr. Johnson. Additionally, it was moved that Board staff, Sandra Reen, Huong Vu, and Board Counsel, Charis Mitchell, attend the closed meeting because their presence in the closed meeting was deemed necessary and would aid the Board in its deliberations. The motion was seconded and passed.

Reconvene: Ms. Swain moved to certify that only public matters lawfully exempted from open meeting requirements under Virginia law were discussed in the closed meeting and only public business matters as were identified in the motion convening the closed meeting were heard, discussed or considered by the Board. The motion was seconded and passed.

The Board reconvened in open session pursuant to § 2.2-3712(D) of the Code.

Decision: Dr. Gaskins moved to adopt the Findings of Fact and Conclusions of Law. The motion was seconded and passed.

Ms. Swecker moved to revoke Dr. Johnson's license. The motion was seconded and passed.

ADJOURNMENT: The Board adjourned at 12:15 a.m. on September 14, 2013.

Jeffrey Levin, D.D.S., President	Sandra K. Reen, Executive Director
Date	Date

Unapproved

VIRGINIA BOARD OF DENTISTRY
MINUTES
SEPTEMBER 13, 2013

TIME AND PLACE: The meeting of the Board of Dentistry was called to order at 9:06 a.m. on September 13, 2013, in Board Room 4, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

PRESIDING: Jeffrey Levin, D.D.S., President

BOARD MEMBERS PRESENT:
Charles E. Gaskins, III, D.D.S.
Myra Howard, Citizen Member
Al Rizkalla, D.D.S.
Melanie C. Swain, R.D.H.
Tammy K. Swecker, R.D.H.
James D. Watkins, D.D.S.
Bruce S. Wyman, D.D.S.

BOARD MEMBERS ABSENT:
Surya P. Dhakar, D.D.S.
Evelyn M. Rolon, D.M.D.

STAFF PRESENT:
Sandra K. Reen, Executive Director for the Board
Elaine J. Yeatts, DHP Senior Policy Analyst
Kelley Palmatier, Deputy Executive Director for the Board
Huong Vu, Operations Manager for the Board

OTHERS PRESENT: None

ESTABLISHMENT OF A QUORUM: With eight members of the Board present, a quorum was established.

PUBLIC COMMENT: Dr. Robert Allen, of Hampton, VA, said he was again asking the Board to address who may own and operate a dental practice in VA since as he did not receive a response to this question following the September 2012 meeting of the Board.

Dr. William Bennett, of Williamsburg, VA, stated that he Board needs to reform its operations to address ethical issues that come from a changing professional environment. He encouraged a joint initiative with the Virginia Dental Association (VDA) to address unprofessional activity and provided a letter expressing his concerns.

Dr. Kirk Norbo, President of VDA, invited the Board to have a representative attend the VDA Board of Director meetings.

APPROVAL OF

MINUTES:

Dr. Levin asked if the Board members had reviewed the July 31, 2009 and September 6, 2012 New Member Orientation minutes. Ms. Howard moved to accept the minutes. The motion was seconded and carried.

Dr. Levin asked if the Board members had reviewed the March 7, 2013 and March 8, 2013 Business minutes. Ms. Swain moved to accept the minutes. The motion was seconded and carried.

Dr. Levin asked if the Board members had reviewed the April 2, 2013 and April 24, 2013 Telephone Conference Call minutes. Dr. Gaskins moved to accept these minutes. The motion was seconded and carried.

Dr. Levin asked if the Board members had reviewed the June 6, 2013 Formal Hearing and June 6, 2013 Case Recommendation minutes. Dr. Gaskins moved to accept these minutes. The motion was seconded and carried.

Dr. Levin asked if the Board members had reviewed the July 26, 2013 New Member Orientation and August 29, 2013 Telephone Conference Call minutes. Dr. Gaskins moved to accept these minutes. The motion was seconded and carried

DHP DIRECTOR'S REPORT:

Dr. Levin noted that Dr. Cane is not available to attend today.

LIAISON/COMMITTEE REPORTS:

Board of Health Professions (BHP). Dr. Levin stated that the May 2013 meeting was cancelled. He added that at the previous meeting, the Board discussed the use of audio visual technology at formal hearings to facilitate observation by dental students.

AADB. Dr. Levin stated that Dr. Boyd attended the Mid-Year meeting in April 2013 and his report is provided in the agenda package.

ADEX. Dr. Watkins stated that he will attend the annual meeting in November 2013.

SRTA. Ms. Swecker reported that she attended the Dental Hygiene Educators meeting on August 8, 2013. She added that her report is provided in the agenda package and she will be happy to answer any questions.

Dr. Watkins had no additional information and his report is provided in the agenda package.

Examination Committee. Ms. Swecker said that the minutes of the last Committee meeting is provided in the agenda package.

LEGISLATION AND REGULATIONS:

Status Report on Regulatory Actions. Ms. Yeatts reported the following:

- Sedation and Anesthesia permits for dentists - The proposed final regulations are at the Governor's Office awaiting approval to publication for public comment and the emergency regulations will expire today, September 13, 2013, unless the requested six-month extension is granted.
- Periodic Review – The proposed regulations to establish four chapters are at the Governor's Office awaiting approval for publication for public comment.
- Addition of AAHD to approved continuing education (CE) providers – the petition was submitted by the American Academy of Dental Hygiene (AADH) to be added to the list of approved CE sponsors. The Board accepted the petition using the fast-track action regulatory process. It will be effective on September 26, 2013.

Response to Petition for Rulemaking from Ms. Hickman. Ms. Yeatts stated that Deborah Hickman submitted the petition to add a different pathway to obtain DA II registration. She added that after speaking with the Dental Assisting National Board (DANB), Ms. Hickman submitted the amended petition. She noted that the amended petition includes DA II information from NC, SC, and D.C. She stated that the petition is presented for Board action.

Ms. Reen noted that the two duties noted as examples of expanded functions in SC are duties any dental assistant might perform in VA. Ms. Yeatts noted that some comments received agreed that the Board's current pathway is sufficient, others favored an alternate pathway.

Ms. Yeatts stated that the Board has three action options. If the Board accepts the petition, then the regulatory process starts. If the Board rejects the petition completely, it must state its reason for denial. Or the Board can deny the initial petition but will consider modifying the requirements for obtaining registration.

Dr. Wyman moved to deny and refer the petition to the Regulatory-Legislative Committee for further review. The motion was seconded and passed.

Response to Petition for Rulemaking from Dr. Dickinson. Ms. Yeatts stated that Terry Dickinson, Executive Director of Virginia Dental Association (VDA), submitted the petition to prohibit fee splitting. She added that the petition is presented for Board action.

Ms. Yeatts provided sections from the VA Medical Practice Act on sharing fees and receiving remuneration for referrals. She noted that most of the comments received favored the petition. She added that since there is no Board Counsel present, she recommended that the Board deny the petition and refer the request to a committee for further consideration.

Dr. Gaskins move to deny the petition and to refer the request to the Regulatory-Legislative Committee for further consideration. The motion was seconded and passed.

Response to Petition for Rulemaking from Mr. Tavakoli. Ms. Yeatts stated that Vahid Tavakoli submitted the petition to require a mandatory five year warranty on crowns and bridges from the day of installation. She added that the petition is presented for Board action. She noted that the Board has three action options to consider.

Ms. Yeatts added that the majority of the comments received opposed the petition. By consensus, the Board agreed that there are many reasons for the failure of crown and bridge work not all of which can be controlled by the dentist.

Dr. Gaskins moved to deny the petition. The motion was seconded and passed.

§54.1-2713.D. License to Teach Dentistry; renewal. Ms. Yeatts stated that this Code section was amended in 2012 and as a result the regulations need to be amended to conform to the statutory provision for renewal of this type of license.

Dr. Watkins move to delete "*or a faculty license*" in 18VAC60-20-20.A to conform to the Code. The motion was seconded and passed.

BOARD DISCUSSION/ACTION:

Review of Public Comment Topics. Dr. Levin asked if the Board wanted to address who may own a dental practice and no response was made.

Dr. Vaughan's Comment - Ms. Reen noted that there was written comment to consider from Dr. Vaughan about having a retired license status. She commented that it might be possible to have this option added to the database. Dr. Watkins recommended having staff to investigate establishing this option. The recommendation was adopted by consensus.

Raven Blanco Foundation Emergency Preparedness - Ms. Reen stated this is a new request from the Foundation to require emergency preparedness in all dental offices. Ms. Yeatts added that the current regs and the proposed final regs on sedation and anesthesia do address emergency preparedness. By consensus, the Board took no action and asked staff to respond.

ADAA Position Paper - Ms. Reen stated that the ADAA is asking state boards to establish education requirements and credentialing of all dental assistants. The Board agreed by consensus to accept the ADAA position statement as information and to take no action.

AADB Guidance - Ms. Reen stated that the AADB is asking for comments regarding daft "Guidelines on Standards of Conduct and Ethics for State Boards and Board Members." The Board agreed by consensus to take no action.

REPORT ON CASE ACTIVITY:

Ms. Palmatier reviewed the last quarter's numbers for patient care cases received and closed. She then went over the case process and the time allotted to the different stages a complaint goes through to closure. She pointed out that the Board is allotted only 120 work days to complete work related to determining probable cause and taking disciplinary action. She said it is imperative that Board members complete a case review within 15 days. She also went over staff's suggested solutions to meet the key performance measures that the agency has set.

BOARD COUNSEL REPORT:

Off Duty Scrutiny - Ms. Reen stated that Mr. Casway is out on extended leave and that no Assistant Attorney General is currently assigned to the Board. She added that Mr. Casway had asked that the article be reviewed by Board members.

EXECUTIVE DIRECTOR'S REPORT/BUSINESS:

2014 Proposed Calendar – Ms. Reen noted that the Board usually votes on the proposed calendar in June but adoption was delayed since the June business meeting was cancelled. She added that it is offered for adoption since staff had not received any requests for changes. Ms. Swecker moved to adopt the proposed 2014 calendar. The motion was seconded and passed.

CODA Recognition of Canadian Accreditation- Ms. Reen asked the Board if it wanted to consider acceptance of dental education programs holding Canadian accreditation based on the reciprocal arrangement between CODA and CDAC. She noted that this agreement does not granted CODA accreditation, which is currently required for licensure in VA. She added that in recent months she has worked with a number of Canadian applicants who believed they were eligible for licensure in VA based on this reciprocal arrangement. Dr. Rizkalla moved to accept this report as information and take no action. The motion was seconded and passed.

SCDDE Annual Meeting - Ms. Reen stated that the SCDDE meeting will be held in VA in January 2014 and is being planned and hosted by the VCU School of Dentistry. She added that the announcement of the meeting, which was issued by the secretary/treasurer of SCDDE, listed the VA Board of Dentistry as a co-host even though she had no advance knowledge of the designation. She said Dr. Cane, the director of DHP, told her the Board would need approval from the Secretary of Health and Human Resources in order to be a host or sponsor of any meeting or conference. Ms. Reen expressed concern that such a request is likely to take months to process and recommended that the Board authorize her to renew her request that the Board no longer be identified as a co-host or sponsor of the 2014 meeting. Dr. Gaskin moved to accept this recommendation. The motion was seconded and passed.

Portability of AAOMS Certificates – Ms. Reen stated that she needed guidance on the Board's intent regarding accepting AAMOS certificates in

lieu of requiring oral and maxillofacial surgeons (OMSs) to obtain a sedation/anesthesia permit. She reported that she is concerned that the emergency regulations and the proposed regulations fail to address inspections for itinerant permit holders, practices with multiple permit holders, and for OMSs with practices in VA and in one or more other states.

She noted that she has consulted with Board Counsel and was advised that the permit exemption for OMSs only applies when the AAOMS office examinations are conducted on offices in VA. By consensus, the Board agreed to refer this matter to the Regulatory-Legislative Committee for further study and agreed with the guidance given by Board Counsel.

Revisions of Guidance Documents (GD).
60-1 Confidential Consent Agreements – Ms. Reen stated that this guidance document needs to be revised since the probable cause process has changed. She added that the proposed revision is presented for Board action. Dr. Watkins moved to adopt the revised GD 60-1. The motion was seconded and passed.

60- 6 Practicing with an Expired License – Ms. Reen stated that the Administrative Proceeding Division asked that this policy be amended to make it clear that the subject addressed is practicing with an expired license. She added that the proposed revision is presented for Board action. Dr. Watkins moved to adopt the revised GD 60-6. The motion was seconded and passed.

60-17 Recovery of Disciplinary Costs – Ms. Reen noted that the revision of GD 60-7 is presented for action to revise the cost figure to reflect FY13 expenditures. Dr. Watkins moved to adopt the revised GD 60-17. The motion was seconded and passed.

VDHA 2013 Annual House of Delegates Invitation – Ms. Reen stated that this was provided as information only, no action needed. She added that she will ask Dr. Levin to assign a representative.

Committee of the Whole – Ms. Reen noted that this matter was not on the agenda but she wanted to bring it to the Board's attention. She stated that since the Board has many new members, 5 in 2012 and 2 in 2013, she is recommending that the needed Regulatory-Legislative Committee meeting be held as a committee of the whole to help Board members become familiar with the process and substance of regulatory actions. All agreed.

NOMINATING COMMITTEE REPORT:

Dr. Levin reported that the Nominating Committee met this morning and nominated the following officers for 2013-2014:

Jeffrey Levin, DDS – President
Melanie C. Swain, RDH – Vice President
Charles E. Gaskins, DDS – Secretary-Treasurer

Dr. Levin added an apology for not asking Board members about their interest in serving or in offering nominations. He then opened the floor for further nominations and no response was made.

Dr. Watkins move to elect the nominees as reported. The motion was seconded and passed.

ADJOURNMENT: With all business concluded, the meeting was adjourned at 11:45 a.m.

Jeffrey Levin, D.D.S., President

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 5:15 p.m., on September 26, 2013, at the Department of Health Professions, Perimeter Center, 2nd Floor Conference Center, 9960 Mayland Drive, Henrico, Virginia 23233.
PRESIDING:	Jeffrey Levin, D.D.S., President
MEMBERS PRESENT:	Charles E. Gaskins, III, D.D.S. Evelyn M. Rolon, D.M.D. Tammy K. Swecker, R.D.H. James D. Watkins, D.D.S. Bruce S. Wyman, D.M.D.
MEMBERS ABSENT:	Surya P. Dhakar, D.D.S. Myra Howard A. Rizkalla, D.D.S. Melanie Swain, R.D.H.
QUORUM:	With six members present, a quorum was established.
STAFF PRESENT:	Sandra K. Reen, Executive Director Lorraine McGehee, Deputy Director, Administrative Proceedings Division Indy Toliver, Adjudication Specialist Donna Lee, Discipline Case Manager
OTHERS PRESENT:	Erin Barrett, Assistant Attorney General Wayne Halbleib, Senior Assistant Attorney General
Christopher Dail, D.D.S. **Case No.: 151235**	The Board received information from Mr. Halbleib in order to determine if Dr. Dail's impairment from substance abuse constitutes a substantial danger to public health and safety.
Closed Meeting:	Dr. Gaskins moved that the Board 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 Christopher Dail. Additionally, Dr. Gaskins moved that Ms. Reen, Ms. Barrett, and Ms. Lee 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. Gaskins 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.

DECISION:

Dr. Wyman moved that the Board summarily suspend Dr. Dail's license to practice dentistry in the Commonwealth of Virginia due to impairment resulting from substance abuse, and schedule him for a formal hearing. Dr. Wyman further moved that the Board offer Dr. Dail a consent order for the voluntary surrender of his license to practice dentistry in lieu of a formal hearing. Following a second and discussion, a roll call vote was taken. The motion passed unanimously.

The Board did not consider a proposed consent order for the possible resolution of a disciplinary matter because a quorum was lost when Dr. Gaskins and Dr. Rolon recused themselves.

ADJOURNMENT:

With all business concluded, the Board adjourned at 6:13 p.m.

Jeffrey Levin, D.D.S., President

Sandra K. Reen, Executive Director

Date

Date

UNAPPROVED DRAFT

VIRGINIA BOARD OF DENTISTRY

MINUTES
TELEPHONE CONFERENCE CALL

CALL TO ORDER: A panel of the Board convened on October 9, 2013, at 5:20 p.m., in Hearing Room 4, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico, VA 23233.

PRESIDING: Melanie C. Swain, R.D.H.

MEMBERS PRESENT: Myra Howard
Tammy K. Swecker, R.D.H.
James D. Watkins, D.D.S.
Bruce S. Wyman, D.M.D.

MEMBERS ABSENT: A. Rizkalla, D.D.S.

BOARD PANEL: With five members present, a panel was established.

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

STEVEN BECKER, D.M.D.
Case No.: 139723

The panel received information from Ms. Reen regarding a Consent Order signed by Dr. Becker as a settlement offer for his case in lieu of holding the formal hearing scheduled for October 18, 2013.

DECISION: Ms. Swecker moved that the panel adopt the Consent Order pertaining to Dr. Becker with an edit to page 5, paragraph b, to change the reference to "Patient H" to "Patient I". The motion was seconded and passed unanimously.

ADJOURNMENT: With all business concluded, the panel adjourned at 5:23 p.m.

Melanie C. Swain, R.D.H., Chair

Sandra K. Reen, Executive Director

Date

Date

Unapproved

VIRGINIA BOARD OF DENTISTRY
FORMAL HEARING
October 18, 2013

TIME AND PLACE: The meeting of the Virginia Board of Dentistry was called to order at 9:05 a.m., on October 18, 2013 in Board Room 4, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico, Virginia.

PRESIDING: Myra Howard, Citizen Member, Chair

MEMBERS PRESENT: A. Rizkalla, D.D.S.
Tammy K. Swecker, R.D.H.
James D. Watkins, D.D.S.
Bruce S. Wyman, D.M.D.

MEMBERS EXCUSED: Charles E. Gaskins, III, D.D.S
Jeffrey Levin, D.D.S.
Melanie C. Swain, R.D.H.

MEMBER ABSENT: Surya P. Dhakar, D.D.S.
Evelyn M. Rolon, D.M.D.

STAFF PRESENT: Sandra K. Reen., Executive Director
Huong Q. Vu, Operations Manager

COUNSEL PRESENT: Erin Barrett, Assistant Attorney General

OTHERS PRESENT: Corie E. Tillman Wolf, Assistant Attorney General
Indy Toliver, Adjudication Specialist
Wanda Blanks, Court Reporter, Farnworth & Taylor Reporting

ESTABLISHMENT OF A QUORUM: With five members present, a panel was established.

Deborah D. Adams, C.D.A.
Case No.: 148819 Ms. Adams appeared without counsel in accordance with a Notice of the Board dated August 9, 2013.

Ms. Adams asked to withdraw her appeal for this hearing because she has no legal counsel available.

Closed Meeting: Dr. Watkins moved that the Board enter into a closed meeting pursuant to §2.2-3711(A)(7) of the Code of Virginia for consultation with legal counsel pertaining to Ms. Adams' request

to withdraw her appeal. Additionally, it was moved that Board staff, Ms. Reen, Ms. Vu, and Board counsel, Ms. Barrett, attend the closed meeting because their presence in the closed meeting was deemed necessary and would aid the Board in its deliberations. The motion was seconded and passed.

Reconvene:

Dr. Watkins moved to certify that only public matters lawfully exempted from open meeting requirements under Virginia law were discussed in the closed meeting and only public business matters as were identified in the motion convening the closed meeting were heard, discussed or considered by the Board. The motion was seconded and passed.

The Board reconvened in open session pursuant to § 2.2-3712(D) of the Code.

Ms. Howard stated that Ms. Adams' request to withdraw her appeal is denied. She added that Ms. Adams received notice of the hearing in advance and had time to acquire legal counsel for the hearing. She said that the hearing will proceed.

Ms. Howard swore in the witness.

Following Ms. Adams' opening statement; Ms. Howard admitted into evidence Applicant's exhibit 1.

Following Ms. Wolf's opening statement; Ms. Howard admitted into evidence Commonwealth's exhibits 1 and 2.

Ms. Adams testified on her own behalf.

Closed Meeting:

Dr. Watkins moved that the Board enter into a closed meeting pursuant to §2.2-3711(A)(27) and Section 2.2-3712(F) of the Code of Virginia for the purpose of reaching a decision in the matter of Ms. Adams. Additionally, it was moved that Board staff, Ms. Reen, Ms. Vu, and Board counsel, Ms. Barrett, attend the closed meeting because their presence in the closed meeting was deemed necessary and would aid the Board in its deliberations. The motion was seconded and passed.

Reconvene:

Dr. Watkins moved to certify that only public matters lawfully exempted from open meeting requirements under Virginia law were discussed in the closed meeting and only public business matters as were identified in the motion convening the closed meeting were heard, discussed or considered by the Board. The motion was seconded and passed.

The Board reconvened in open session pursuant to § 2.2-3712(D) of the Code.

Decision: Ms. Howard asked Ms. Barrett to report the Findings of Fact, Conclusions of Law and Sanctions adopted by the Board.

Ms. Barrett reviewed the findings and conclusions then reported that the Board decided to deny Ms. Adams' dental assistant II application.

Ms. Swecker moved to adopt the Findings of Fact, Conclusions of Law and Sanctions as read by Ms. Barrett. The motion was seconded and passed.

THOMAS HUNTER, D.D.S.
Case No.: 149886

The panel received information from Ms. Reen regarding a Consent Order signed by Dr. Hunter as resolution to his disciplinary case in lieu of proceeding with the informal conference scheduled for November 15, 2013.

DECISION: Dr. Watkins moved that the panel adopt the Consent Order pertaining to Dr. Hunter as presented. The motion was seconded and passed unanimously.

ADJOURNMENT: The Board adjourned at 11:05 a.m.

____
Myra Howard, Citizen Member, Chair

____
Date

____
Sandra K. Reen, Executive Director

____
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 5:20 p.m., on November 6, 2013, at the Department of Health Professions, Perimeter Center, 2nd Floor Conference Center, Hearing Room 4, 9960 Mayland Drive, Henrico, Virginia 23233.
PRESIDING:	Jeffrey Levin, D.D.S., President
MEMBERS PRESENT:	Charles E. Gaskins, III, D.D.S. A. Rizkalla, D.D.S. Melanie C. Swain, R.D.H. Tammy K. Swecker, R.D.H. James D. Watkins, D.D.S.
MEMBERS ABSENT:	Surya P. Dhakar, D.D.S Myra Howard Evelyn M. Rolon, D.M.D. Bruce S. Wyman, D.M.D.
QUORUM:	With six members present, a quorum was established.
STAFF PRESENT:	Sandra K. Reen, Executive Director Indy Toliver, Adjudication Specialist Donna Lee, Discipline Case Manager
OTHERS PRESENT:	Allyson Tysinger, Senior Assistant Attorney General/Chief Wayne Halbleib, Senior Assistant Attorney General
Deborah Johnson, R.D.H. **Case No.: 150265**	The Board received information from Mr. Halbleib in order to determine if Ms. Johnson's impairment from alcohol abuse constitutes a substantial danger to public health and safety.
Closed Meeting:	Ms. Swain moved that the Board 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 Deborah Johnson. Additionally, Ms. Swain moved that Ms. Reen, Ms. Tysinger, and Ms. Lee 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:	Ms. Swain 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.

DECISION: Ms. Swain moved that the Board summarily suspend Ms. Johnson's license to practice dental hygiene in the Commonwealth of Virginia due to impairment resulting from alcohol abuse, and schedule her 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 5:45 p.m.

Jeffrey Levin, D.D.S., President	Sandra K. Reen, Executive Director
Date	Date

UNAPPROVED

BOARD OF DENTISTRY
PUBLIC HEARING

Friday, November 8, 2013

Perimeter Center
9960 Mayland Drive, Suite 201
Richmond, Virginia 23233-1463
Board Room 2

CALL TO ORDER: The Virginia Board of Dentistry convened a Public Hearing at 9:00 a.m. to receive comments on the proposed Sedation/anesthesia permit regulations for dentists.

PRESIDING: Jeffrey Levin, D.D.S., President

MEMBERS PRESENT: Charles E. Gaskins, III., D.D.S.
Bruce S. Wyman, D.D.S.

STAFF PRESENT: Sandra K. Reen, Executive Director
Huong Vu, Operations Manager

OTHERS PRESENT: Elaine Yeatts, Senior Policy Analyst, Department of Health Professions

COURT REPORTER: Wanda Blanks, Court Reporter, Farnsworth & Taylor Reporting

QUORUM: Not required.

PUBLIC COMMENTS: Dr. G. Preston Burns, Jr., President and Founder of the Virginia Association of Dentists for Intra-Venous Sedation (VADIVS), stated that he was self-certified in 1989 to administer conscious sedation, has sedated about 14 thousands patients, and currently holds a temporary permit required by the emergency regulations. He said that VADIVS supports without reservation the Board's adopting the new proposed regulations but is against the proposal to end self-certification and proposed required equipment. He added that VADIVS feels that particular changes set out in 18VAC60-20-120.D.2 are unnecessary and unfairly impose additional requirements on self-certified practitioners. He asked the Board to allow self-certified practitioners to qualify for issuance of a permanent parenteral conscious/moderate sedation permit without additional requirements.

Dr. James A. Pollard stated that he graduated in 1972 from MCV and was a member of the first class to receive training in IV sedation. He added that he has utilized that training with great success over the years. He opposed the proposed regulations which require self-

certified practitioners to obtain additional costly education requirements in order to continue administering sedation.

Dr. Scott Leaf stated that he is a Pediatric dentist from Northern Virginia and graduated in 1981. He added that he has practiced oral sedation since 1983 and was self-certified in 1989. He asked the Board to make an exception in regard to documents required to obtain the sedation permit since his school has since closed and he is unable to obtain a transcript.

Dr. Rodney Mayberry stated that he is a general dentist from Oakton, VA and has been practicing IV conscious/moderate sedation since 1978. He added that he is a member of the VADIVS and the American Dental Association of Anesthesiology. He noted that the Associations oppose the proposed regulations which are mandated due to tragedies associated with pediatric sedation dentistry and has nothing to do with general dentistry and IV sedation. He added that the associations also oppose mandating ACLS courses and unnecessary emergency equipments which will only increase the cost of care to the public.

Dr. Brian McAndrew stated that he was speaking for the Virginia Society of Oral Maxillofacial Surgeons which supports the regulations but does request that item H in the General Provisions section be expanded to explain what the term "morbidity" covers.

Mr. Kenneth Stallard, an attorney from Fairfax County, stated that he represents the VADIVS. He stated that the Association asks the Board to allow some form of grandfathering of dentists qualified to perform conscious/moderate sedation by experience and training, without educational requirements. He added the Association also asks the Board to stop requiring on-site EKG machines, endo tubes an stethescopes for administering conscious/moderate sedation.

Dr. Michael Link, President-Elect of the Virginia Dental Association (VDA), asked the Board to put the definition of the term "Anxiolysis" in the proposed regulations and not use the term "Minimal Sedation". He said that the Board has stricter sedation regulations than the American Dental Association (ADA) standards.

The proceedings of the public hearing were recorded by a certified court reporter. The transcript is attached as part of these minutes.

Dr. Levin announced the deadline for submitting public comments is December 6, 2013 and indicated that the Board will consider all comments received before issuing final regulations.

Jeffrey Levin, President

Sandra K. Reen, Executive Director

Date

Date

Agenda item: Virginia's Dentistry and Dental Hygienist Workforce: 2013

Justin Crow, MPA, the Policy and Planning Specialist with the Healthcare Workforce Data Center will present the latest findings from the surveys completed by dentists and dental hygienists during license renewal.

Information provided on this item:

- Virginia's Dentistry Workforce : 2013 Exposure Draft Report
- Virginia's Dental Hygienist Workforce: 2013 Exposure Draft Report

Action Options:

- Receive as information
- Discuss and make recommendations

Virginia's Dentistry Workforce: 2013

Healthcare Workforce Data Center

October 2013

Exposure Draft

Virginia Department of Health Professions
Healthcare Workforce Data Center
Perimeter Center
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Over 4,800 Dentists voluntarily participated in this survey. Without their efforts the work of the center would not be possible. The Department of Health Professions, the Healthcare Workforce Data Center, and the Board of Dentistry express our sincerest appreciation for your ongoing cooperation.

Thank You!

Virginia Department of Health Professions

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The Dentistry Workforce: At a Glance:

The Workforce

Background

Current Employment

Survey Response Rate

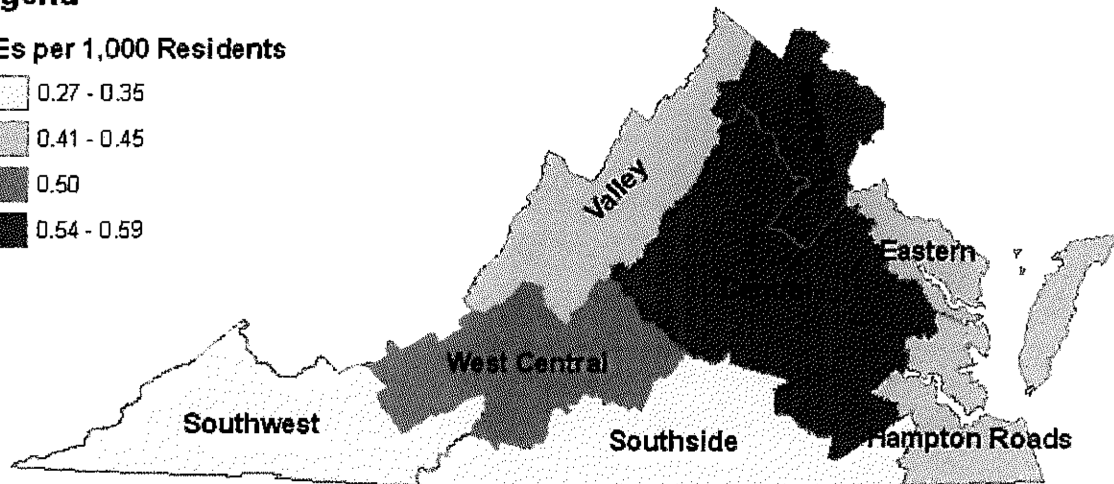
Education

Job Turnover

Demographics

Finances

Typical FTE Time



Source: Va. Healthcare Workforce Data Center

More than 4,800 dentists voluntarily took part in the 2013 Dentistry Workforce Survey. The Virginia Department of Health Professions' Healthcare Workforce Data Center (HWDC) administers the survey during the license renewal process, which takes place every March for dentists. These survey respondents represent 70% of the 6,875 dentists who are licensed in the state and 78% of renewing practitioners.

The HWDC estimates that about 5,240 dentists participated in Virginia's workforce in 2012, which is defined as those who worked at least a portion of the year in the state or who live in the state and intend to return to work as a dentist at some point in the future. Virginia's dentistry workforce provided 4,490 "full-time equivalency units" in 2012, which the HWDC defines simply as working 2,000 hours a year (or 40 hours per week for 50 weeks with 2 weeks off).

Only 3% of dentists were not employed in the profession at the time of the survey. 71% held one full-time position, while 12% held one part-time position. As a group, dentists are very happy in their profession—96% indicated they were satisfied with their current employment situation, including nearly three out of four who indicated they were "very satisfied".

30% of all dentists are women, although women do represent a majority of dentists who are under the age of 35. The median age of dentists is 50, which is considerably higher than the median age of Virginia's labor force as a whole. Virginia's dentistry workforce is not as diverse as Virginia's population as a whole. In a random encounter between two dentists, there is 48% probability that they would be of different races or ethnicities. For the Virginia population as a whole, the odds are somewhat higher at 54%. However, the subset of Virginia's dentists who are under the age of 40 are more diverse than the overall population.

More than one in five dentists grew up in a rural area; of this group, only 21% currently work in non-Metro areas of the state. 42% of Virginia's dentistry workforce graduated from high school in Virginia, while 41% received their initial professional degree in the state. In total, approximately half of Virginia' dentists received either a high school or professional degree in the state. New York, Maryland and Pennsylvania were among the largest sources of dentists outside of Virginia.

Nearly all dentists have earned their doctorate or a professional degree. Dentists are well remunerated for their work: the median yearly income for Virginia's dentistry workforce is between $125,000 and $150,000 per year. In addition, one-quarter of Virginia's dentists earn more than $250,000 per year for their services. However, less than half of dentists received at least one employer-sponsored benefit, and only one-third of dentists received health insurance from their employer.

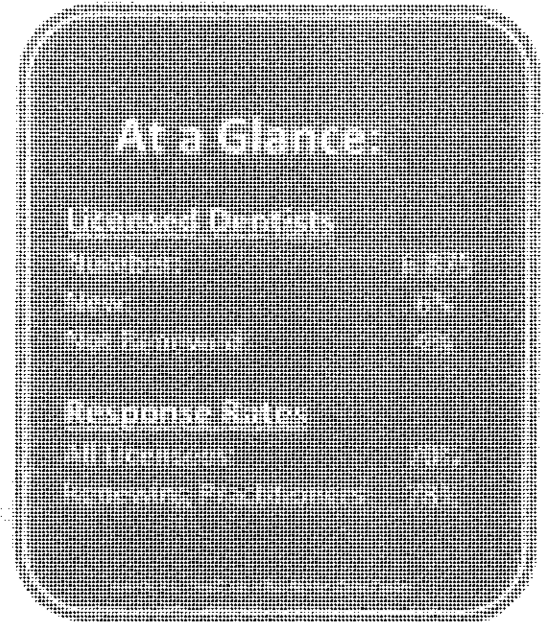
More than four in five dentists who are under the age of 40 currently carry educational debt, and the median debt burden for this age group is between $120,000 and $130,000. However, the employment situation for Virginia's dentists is quite good. More than three out of four dentists have been employed at their primary work location for at least two years. Only 4% of dentists switched jobs at some point during the year. 91% of all dentists worked in private practice, including 89% who worked in for-profit organizations.

Like most other medical professionals in Virginia, dentists focused most of their efforts on patient care activities. The typical dentist spent 85% of their time on patient care and 15% on administration tasks; very little time was spent teaching or conducting research. 93% of dentists are in positions that focus primarily on patient care.

A Closer Look:

Licensees		
License Status	#	%
Renewing Practitioners	6,186	90%
New Licensees	433	6%
Non-Renewals	256	4%
All Licensees	6,875	100%

Source: Va. Healthcare Workforce Data Center



Our surveys tend to achieve very high response rates. Nearly four out of five renewing dentists submitted a survey. These represent 70% of dentists who held a license at some point in 2012.

Response Rates	
Completed Surveys	4,829
Response Rate, all licensees	70%
Response Rate, Renewals	78%

Source: Va. Healthcare Workforce Data Center

Response Rates			
Statistic	Non Respondents	Respondent	Response Rate
By Age			
Under 30	63	147	70%
30 to 34	238	548	70%
35 to 39	219	657	75%
40 to 44	243	606	71%
45 to 49	184	479	72%
50 to 54	193	508	73%
55 to 59	220	576	72%
60 and Over	686	1,308	66%
Total	2,046	4,829	70%
New Licenses			
Issued 4/2012 to 3/2013	188	245	57%
Metro Status			
Non-Metro	140	277	66%
Metro	1,408	3,555	72%
Not in Virginia	489	970	66%

Source: Va. Healthcare Workforce Data Center

Definitions

1. **The Survey Period:** The survey was conducted in March 2013.
2. **Target Population:** All Dentists who held a Virginia license at some point in 2012.
3. **Survey Population:** The survey was available to dentists who renewed their licenses online. It was not available to those who did not renew, including some dentists newly licensed in 2013.

At a Glance:

Workforce

Utilization Ratios

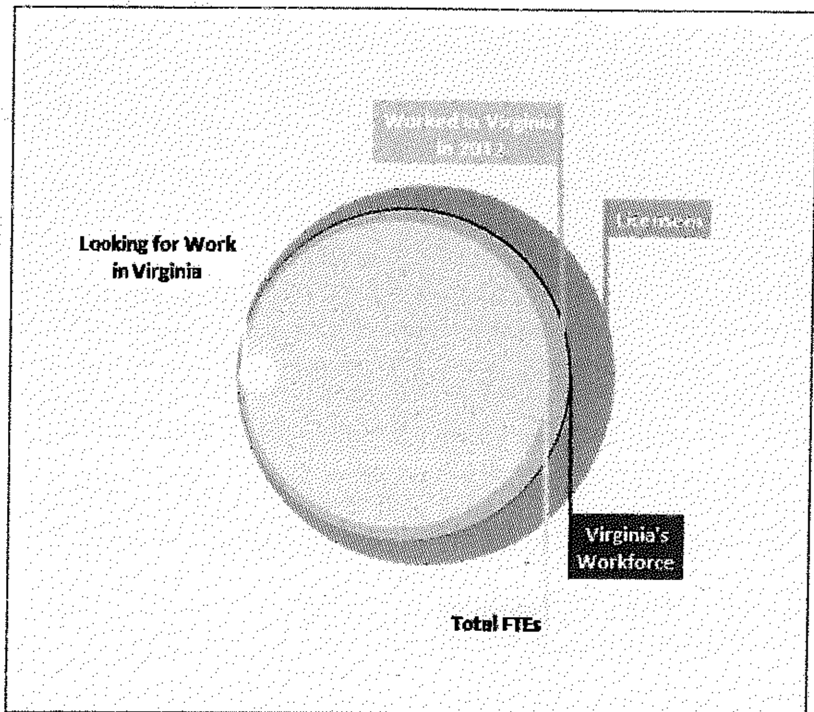
Virginia's Dentistry Workforce		
Status	**#**	**%**
Worked in Virginia in Past Year	5,240	99%
Looking for Work in Virginia	72	1%
Virginia's Workforce	5,312	100%
Total FTEs	4,490	
Licensees	6,875	

Source: Va. Healthcare Workforce Data Center

This report uses weighting to estimate the figures in this report. Unless otherwise noted, figures refer to the Virginia Workforce only. For more information on HWDC's methodology visit: www.dhp.virginia.gov/hwdc

Definitions

1. **Virginia's Workforce:** A licensee with a primary or secondary work site in Virginia at any time in 2012 or who indicated intent to return to Virginia's workforce at any point in the future.
2. **Full Time Equivalency Unit (FTE):** The HWDC uses 2,000 (40 hours for 50 weeks) as its baseline measure for FTEs.
3. **Licensees in VA Workforce:** The proportion of licensees in Virginia's Workforce.
4. **Licensees per FTE:** An indication of the number of licensees needed to create 1 FTE. Higher numbers indicate lower licensee participation.
5. **Workers per FTE:** An indication of the number of workers in Virginia's workforce needed to create 1 FTE. Higher numbers indicate lower utilization of available workers.



Source: Va. Healthcare Workforce Data Center

A Closer Look:

Age & Gender						
Age	Male		Female		Total	
	#	% Male	#	% Female	#	% in Age Group
Under 30	69	46%	82	54%	151	3%
30 to 34	274	47%	306	53%	580	11%
35 to 39	363	54%	309	46%	672	13%
40 to 44	368	57%	279	43%	648	12%
45 to 49	340	65%	182	35%	522	10%
50 to 54	380	71%	158	29%	538	10%
55 to 59	478	82%	108	18%	586	11%
60 +	1,383	92%	120	8%	1,503	29%
Total	3,656	70%	1,544	30%	5,200	100%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Gender

Age

Diversity

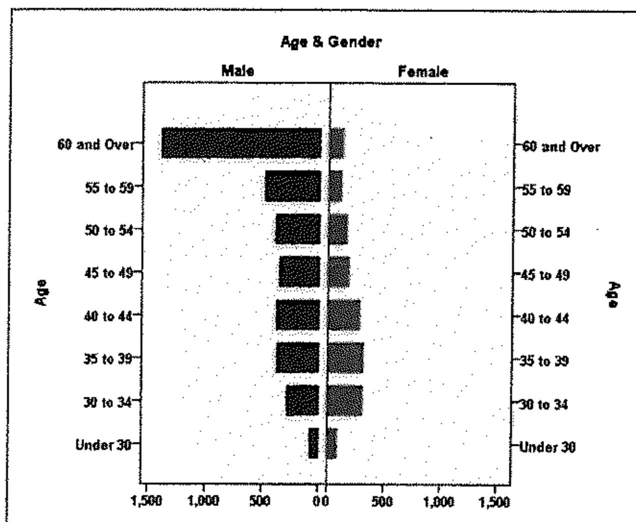
Race & Ethnicity					
Race/ Ethnicity	Virginia*	Dentists		Dentists Under 40	
	%	#	%	#	%
White	64%	3,659	70%	735	53%
Black	19%	276	5%	85	6%
Asian	6%	822	16%	391	28%
Other Race	0%	167	3%	75	5%
Two or more races	2%	91	2%	27	2%
Hispanic	8%	199	4%	81	6%
Total	100%	5,214	100%	1,394	100%

*Population data in this chart is from the US Census, ACS 1-yr estimates, 2011 vintage.

Source: Va. Healthcare Workforce Data Center

In a chance encounter between two dentists, there is a 48% chance they would be of a different race/ethnicity (a measure known as the Diversity Index), compared to a 54% chance for Virginia's population. However, the diversity index for those under 40 increases to 63%.

Seven out of ten dentists are male, although females represent a majority of dentists under the age of 35. The median age of all dentists is 50, while only 27% are under the age of 40.



Source: Va. Healthcare Workforce Data Center

At a Glance:

Childhood

Virginia Background

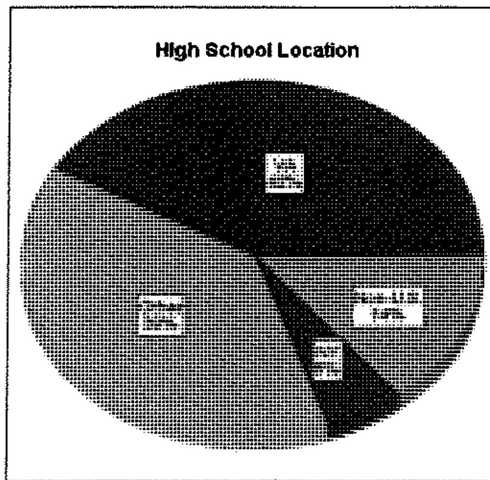
Location Choice

A Closer Look:

Primary Location: USDA Rural Urban Continuum		Rural Status of Childhood Location		
Code	Description	Rural	Suburban	Urban
	Metro Counties			
1	Metro, 1 million+	16%	59%	26%
2	Metro, 250,000 to 1 million	33%	54%	14%
3	Metro, 250,000 or less	29%	54%	18%
	Non-Metro Counties			
4	Urban pop 20,000+, Metro adj	40%	42%	18%
6	Urban pop, 2,500-19,999, Metro adj	52%	33%	15%
7	Urban pop, 2,500-19,999, nonadj	68%	18%	14%
8	Rural, Metro adj	49%	38%	14%
9	Rural, nonadj	47%	33%	21%
	Overall	**21%**	**56%**	**23%**

Source: Va. Healthcare Workforce Data Center

High School Location

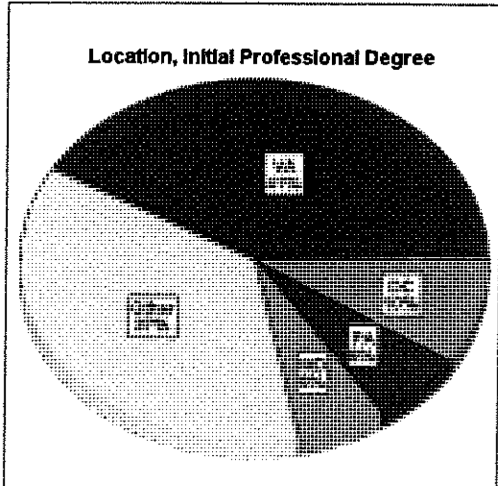


Source: Va. Healthcare Workforce Data Center

More than one in five dentists grew up in self-described rural areas, but less than 10% of all dentists work in Non-Metro counties. Only 21% of dentists who grew up in rural areas work in Non-Metro counties.

Nearly half of Virginia's dentists have a background in the state, including nearly one-third who received both their high school and initial professional degrees in Virginia.

Location, Initial Professional Degree



Source: Va. Healthcare Workforce Data Center

Top Ten States for Dentist Recruitment

Rank	All Dentists			
	High School	#	Dental School	#
1	Virginia	2,137	Virginia	2,088
2	Outside of U.S.	739	Washington, D.C.	488
3	New York	288	Pennsylvania	327
4	Maryland	232	Maryland	309
5	Pennsylvania	201	New York	208
6	New Jersey	121	Outside of U.S.	198
7	California	115	Massachusetts	155
8	West Virginia	109	West Virginia	128
9	Florida	106	Tennessee	124
10	North Carolina	101	Ohio	116

Source: Va. Healthcare Workforce Data Center

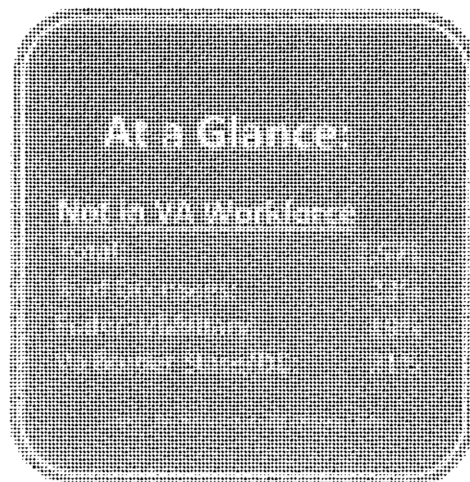
Outside of Virginia, Maryland, New York & Pennsylvania are the largest contributors to Virginia's dental workforce. Additionally, a significant number of dentists received their high school degree outside of the U.S. or Canada.

Rank	Licensed in the Past 5 Years			
	High School	#	Dental School	#
1	Outside of U.S.	318	Virginia	244
2	Virginia	302	Outside of U.S.	112
3	California	46	New York	103
4	Maryland	46	Pennsylvania	99
5	Pennsylvania	36	Maryland	68
6	New York	30	Massachusetts	67
7	North Carolina	27	Washington, D.C.	57
8	Canada	25	California	51
9	Florida	24	Ohio	32
10	Ohio	21	West Virginia	27

Source: Va. Healthcare Workforce Data Center

Among dentists who received their initial license in the past five years, a greater number obtained their high school degree in a foreign county (outside the U.S. or Canada) than in Virginia. However, about one-third of this group went to dental school in the Commonwealth.

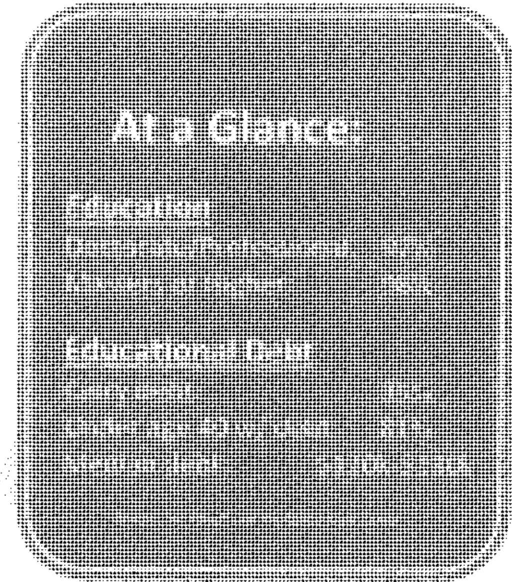
Nearly one in four licensees did not participate in Virginia's dental workforce in 2012. Nearly 90% of these licensees worked at some point in the past year, including 86% who worked in the dental profession. Nearly one in five of these dentists worked for the federal government, including 15% who worked for the military.

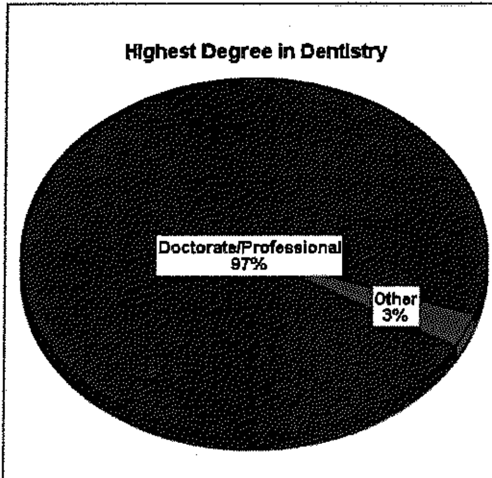


A Closer Look:

Highest Dental Degree		
Degree	#	%
Baccalaureate	54	1%
Graduate Certificate	46	1%
Masters	57	1%
Doctorate/Professional	4,933	97%
Total	**5,089**	**100%**

Source: Va. Healthcare Workforce Data Center





Source: Va. Healthcare Workforce Data Center

Nearly all dentists hold either a doctorate (Ph.D.) or a professional (DDS or DMD) degree. More than one-third of dentists carry educational debt, including more than four in five dentists under the age of 40. For those under age 40, the median educational debt is between $120,000 and $130,000.

Educational Debt				
Amount Carried	All Dentists		Dentists under 40	
	#	%	#	%
None	2,880	65%	224	19%
$50,000 or less	275	6%	105	9%
$50,001-$60,000	57	1%	26	2%
$60,001-$70,000	78	2%	35	3%
$70,001-$80,000	51	1%	25	2%
$80,001-$90,000	69	2%	38	3%
$90,001-$100,000	103	2%	57	5%
$100,001-$110,000	82	2%	50	4%
$110,001-$120,000	41	1%	23	2%
$120,001-$130,000	74	2%	58	5%
$130,001-$140,000	55	1%	40	3%
$140,000-$150,000	66	1%	46	4%
Over $150,000	575	13%	470	39%
Total	**4,406**	**100%**	**1,197**	**100%**

Nearly half of all Virginia's dentists have completed a residency or specialty training program. The General Practice Residency (GPR-1) was the most common residency program completed, with 724 dentists having satisfied its requirements. Advanced Education in Dentistry and Orthodontics were also relatively common residency programs that were completed by Virginia's dentistry workforce.

A Closer Look:

Residencies/Special Training Programs		
Residency	#	%
General Practice Residency (GPR-1)	724	14%
Advanced Education in General Dentistry	525	10%
Orthodontics	362	7%
Pediatric Dentistry	226	4%
Oral and Maxillofacial Surgery	210	4%
Periodontology	203	4%
General Practice Residency (GPR-2)	174	3%
Endodontics	169	3%
Prosthodontics	142	3%
Dental Public Health	27	1%
Oral and Maxillofacial Pathology	16	0%
Oral and Maxillofacial Radiology	3	0%
At Least One[1]	**2,414**	**45%**

Source: Va. Healthcare Workforce Data Center

[1] Respondents were able to select multiple residencies/special training programs.

P104

A Closer Look:

Current Work Status		
Status	#	%
Employed, capacity unknown	8	0%
Employed in a dentistry related capacity	4,975	97%
Employed, NOT in a dentistry related capacity	15	0%
Not working, reason unknown	0	0%
Involuntarily unemployed	19	0%
Voluntarily unemployed	59	1%
Retired	72	1%
Total	**5,149**	**100%**

Source: Va. Healthcare Workforce Data Center

Current Positions		
Positions	#	%
No Positions	150	3%
One Part-Time Position	600	12%
Two Part-Time Positions	231	5%
One Full-Time Position	3,522	71%
One Full-Time Position & One Part-Time Position	334	7%
Two Full-Time Positions	27	1%
More than Two Positions	101	2%
Total	**4,965**	**100%**

Source: Va. Healthcare Workforce Data Center

Current Weekly Hours		
Hours	#	%
0 hours	150	3%
1 to 9 hours	105	2%
10 to 19 hours	175	3%
20 to 29 hours	406	8%
30 to 39 hours	2,307	46%
40 to 49 hours	1,413	28%
50 to 59 hours	305	6%
60 to 69 hours	82	2%
70 to 79 hours	31	1%
80 or more hours	42	1%
Total	**5,016**	**100%**

Source: Va. Healthcare Workforce Data Center

Nearly all licensed dentists were employed in the dentistry profession. In addition, most licensed dentists who were not employed were either retired or voluntarily unemployed. More than seven in ten dentists held one full-time position, while 14% worked two or more jobs. Nearly three in four dentists worked between 30 and 49 hours per week, while only 4% worked at least 60 hours per week.

A Closer Look:

Income		
Hourly Wage	#	%
Volunteer Work Only	38	1%
$25,000 or less	165	4%
$25,001-$50,000	163	4%
$50,001-$75,000	235	6%
$75,001-$100,000	423	11%
$100,001-$125,000	514	13%
$125,001-$150,000	461	12%
$150,001-$175,000	333	8%
$175,001-$200,000	293	7%
$200,001-$225,000	267	7%
$225,001-$250,000	239	6%
$250,001-$275,000	161	4%
$275,001-$300,000	164	4%
More than $300,000	530	13%
Total	**3,986**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Earnings

Benefits

Satisfaction

Employer-Sponsored Benefits		
Benefit	#	%
Signing/Retention Bonus	160	3%
Dental Insurance	486	10%
Health Insurance	1,619	33%
Paid Leave	906	18%
Group Life Insurance	574	12%
Retirement	1,541	31%
Receive at least one benefit	**2,297**	**46%**

*From any employer at time of survey.

Source: Va. Healthcare Workforce Data Center

The median income for dentists is between $125,000 and $150,000 per year, and one-quarter of dentists earned more than $250,000 per year.

96% of dentists are satisfied with their job, including nearly three in four who are very satisfied with their current work circumstances.

Job Satisfaction		
Level	#	%
Very Satisfied	3,659	74%
Somewhat Satisfied	1,103	22%
Somewhat Dissatisfied	150	3%
Very Dissatisfied	67	1%
Total	**4,979**	**100%**

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Employment Instability in Past Year		
In the past year did you . . .?	#	%
Experience involuntary unemployment?	57	1%
Experience voluntary unemployment?	182	3%
Work Part-time or temporary positions, but would have preferred a full-time/permanent position?	181	3%
Work two or more positions at the same time?	800	15%
Switch employers or practices?	226	4%
Experienced at least 1	**1,128**	**21%**

Source: Va. Healthcare Workforce Data Center

Only 1% of Virginia's dentists experienced involuntary unemployment at some point in the renewal cycle. By comparison, Virginia's average monthly unemployment rate was 5.9% in 2012.[2]

At a Glance:

Unemployment Experience 2012

[illegible]

Turnover & Tenure

[illegible]

Employment Type

[illegible]

Location Tenure				
Tenure	Primary		Secondary	
	#	%	#	%
Not Currently Working at this Location	94	2%	80	7%
Less than 6 Months	186	4%	119	10%
6 Months to 1 Year	367	7%	133	11%
1 to 2 Years	539	11%	206	17%
3 to 5 Years	712	14%	217	18%
6 to 10 Years	771	16%	153	13%
More than 10 Years	2,264	46%	275	23%
Subtotal	**4,932**	**100%**	**1,182**	**100%**
Did not have location	74		4,084	
Item Missing	305		45	
Total	5,312		5,312	

Source: Va. Healthcare Workforce Data Center

More than 75% of dentists have worked at their primary location for more than 2 years—the job tenure normally required to get a conventional mortgage loan.

Approximately two-thirds of dentists are salary or wage employees. Nearly three in ten receive income from their own practice.

Employment Type		
Primary Work Site	#	%
Salary/ Commission	2,554	62%
Hourly Wage	145	4%
By Contract	183	4%
Business/ Practice Income	1,172	29%
Unpaid	41	1%
Subtotal	4,094	100%
Did not have location	74	
Item Missing	1,144	

Source: Va. Healthcare Workforce Data Center

[2] As reported by the US Bureau of Labor Statistics. The not seasonally adjusted monthly unemployment rate ranged from 6.4% in January to 5.4% in November.

At a Glance:

Concentration

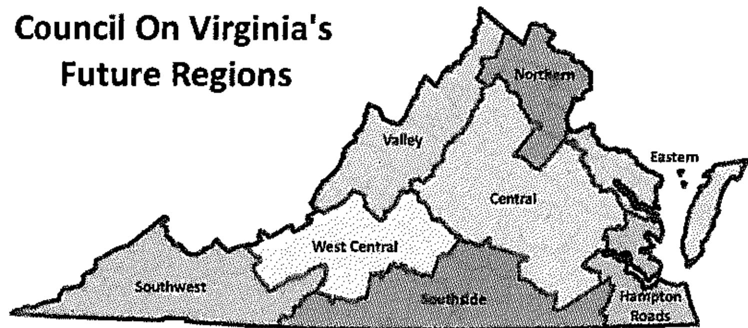
Locations

> *More than three out of four dentists worked in one of three regions: Northern Virginia, Central Virginia and Hampton Roads. Less than 10% worked in Southwest, Southside or Eastern Virginia.*

A Closer Look:

Regional Distribution of Work Locations				
COVF Region	Primary Location		Secondary Location	
	#	%	#	%
Central	984	20%	231	19%
Eastern	80	2%	16	1%
Hampton Roads	868	18%	197	17%
Northern	1,953	40%	425	36%
Southside	148	3%	31	3%
Southwest	135	3%	25	2%
Valley	229	5%	42	4%
West Central	440	9%	78	7%
Virginia Border State/DC	35	1%	58	5%
Other US State	32	1%	86	7%
Outside of the US	0	0%	3	0%
Total	4,904	100%	1,192	100%
Item Missing	333		36	

Source: Va. Healthcare Workforce Data Center



Number of Work Locations				
Locations	Work Locations in 2012		Work Locations Now*	
	#	%	#	%
0	73	1%	138	3%
1	4,013	76%	3,750	75%
2	742	14%	685	14%
3	381	7%	356	7%
4	43	1%	26	1%
5	32	1%	24	1%
6 or More	28	1%	15	0%
Total	5,312	100%	4,992	100%

*At the time of survey completion, March 2013.

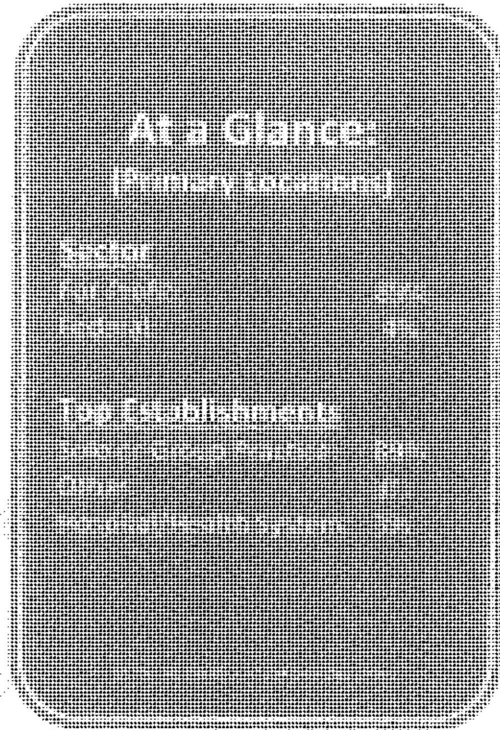
Source: Va. Healthcare Workforce Data Center

> *More than three out of four dentists had just one work location in 2012. Only 10% of dentists had at least three work locations in 2012.*

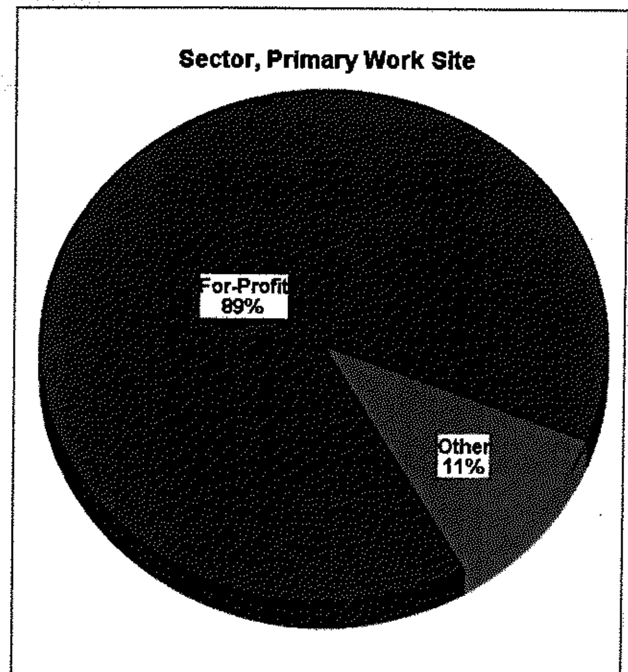
A Closer Look:

Location Sector				
Sector	Primary Location		Secondary Location	
	#	%	#	%
For-profit	4,220	89%	936	80%
Non-profit	115	2%	99	8%
State/local government	213	5%	91	8%
Veterans Administration	23	0%	7	1%
U.S. Military	143	3%	36	3%
Other Federal Government	14	0%	3	0%
Total	**4,728**	**100%**	**1,172**	**100%**
Did not have location	74		4,084	
Item missing	511		56	

Source: Va. Healthcare Workforce Data Center



91% of dentists worked in the private sector; most of these dentists worked in a for-profit enterprise. 4% of dentists worked for the federal government, including 3% who served in the military.



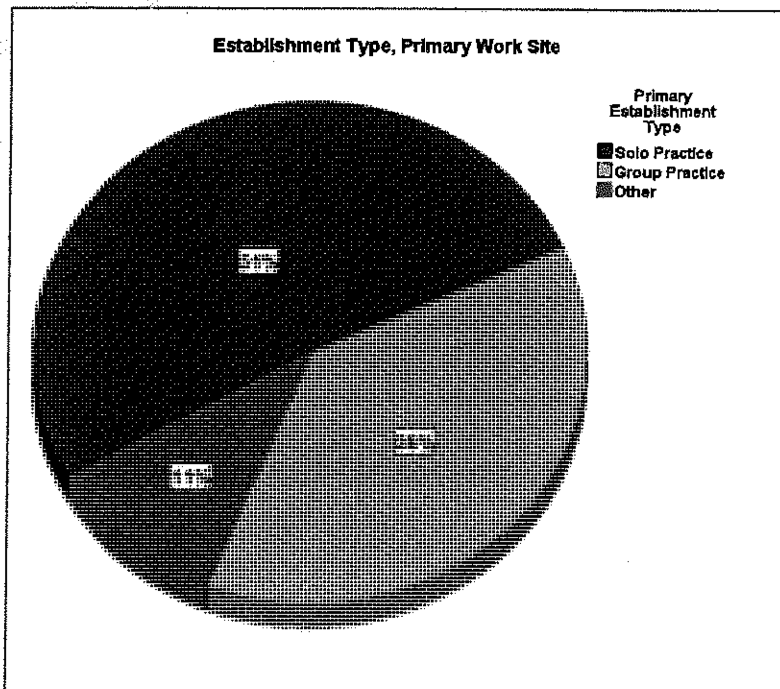
Source: Va. Healthcare Workforce Data Center

Establishment Type	Location Type			
	Primary Location		Secondary Location	
	#	%	#	%
Solo Practice	2,401	51%	363	31%
Group Practice	1,772	38%	525	45%
Hospital/Health System	128	3%	54	5%
Dental School (including combined Dental/Dental Hygiene)	97	2%	50	4%
Outpatient Community Clinic	62	1%	56	5%
Public Health Program	44	1%	20	2%
Dental Hygiene Program (Community College)	12	0%	12	1%
Nursing Home/Long-Term Care Facility	11	0%	10	1%
Insurance	10	0%	3	0%
K-12 School or Non-Dental College	4	0%	6	1%
Supplier Organization	3	0%	3	0%
Dental Hygiene Program (Technical School)	0	0%	4	0%
Other	129	3%	59	5%
Total	4,673	100%	1,165	100%
Does not have location	74		4,084	

Source: Va. Healthcare Workforce Data Center

More than half of all dentists worked in a solo practice at their primary work location, while another 38% worked in a group practice. Among those dentists who did not work in a dental practice, nearly half worked in either a hospital/health system or a dental school.

Among those dentists who also had a secondary work location, more than three in four were in private practice, including 45% who worked in a group practice. In addition, nearly one in ten worked at a hospital/health system or a dental school.



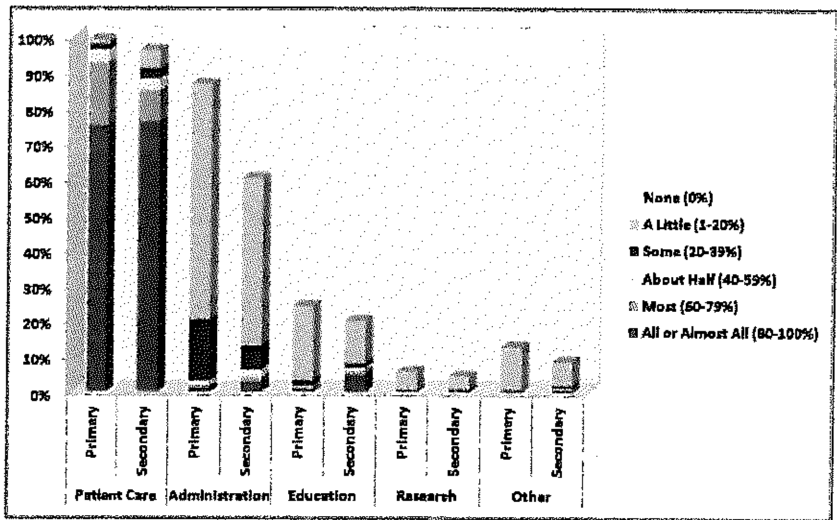
Source: Va. Healthcare Workforce Data Center

At a Glance:
(Primary Locations)

A Typical Dentist's Time

Roles

A Closer Look:



Source: Va. Healthcare Workforce Data Center

A typical dentist spends approximately 85% of their time in patient care activities, with most of the remaining time spent performing administrative tasks. 93% of dentists fill a patient care role, defined as spending 60% or more of their time on patient care activities.

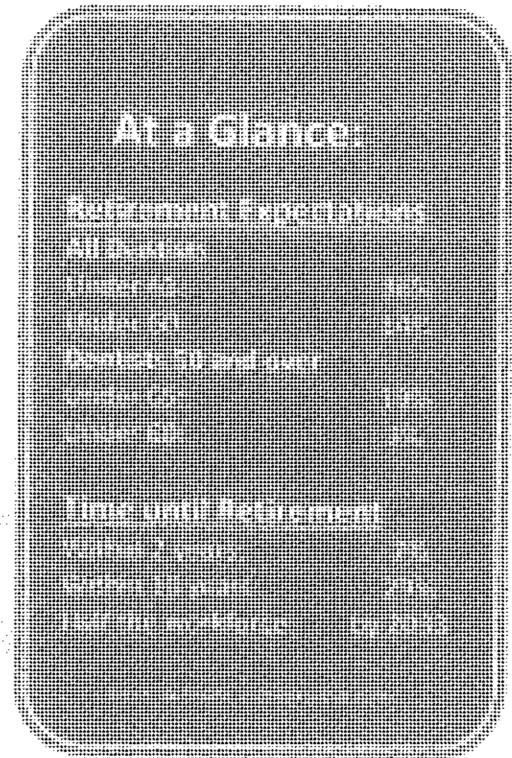
Time Allocation										
Time Spent	Patient Care		Admin.		Education		Research		Other	
	Prim. Site	Sec. Site	Prim. Site	Sec. Site	Prim. Site	Sec. Site	Prim. Site	Sec. Site	Prim. Site	Sec. Site
All or Almost All (80-100%)	75%	76%	1%	3%	1%	5%	0%	0%	0%	1%
Most (60-79%)	18%	9%	0%	1%	0%	1%	0%	0%	0%	0%
About Half (40-59%)	4%	3%	1%	2%	0%	1%	0%	0%	0%	0%
Some (20-39%)	2%	3%	17%	7%	2%	1%	0%	0%	0%	1%
A Little (1-20%)	1%	5%	66%	47%	21%	12%	5%	4%	12%	7%
None (0%)	1%	4%	13%	40%	76%	80%	94%	96%	87%	91%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Retirement Expectations				
Expected Retirement Age	All Dentists		Dentists over 50	
	#	%	#	%
Under age 50	58	1%	0	0%
50 to 54	149	3%	0	0%
55 to 59	392	9%	75	3%
60 to 64	953	22%	340	16%
65 to 69	1,315	31%	736	34%
70 to 74	737	17%	542	25%
75 to 79	225	5%	179	8%
80 or over	102	2%	66	3%
I do not intend to retire	364	8%	246	11%
Total	**4,295**	**100%**	**2,184**	**100%**

Source: Va. Healthcare Workforce Data Center



Nearly one-third of all dentists expect to retire between the ages of 65 and 69, and more than half expect to retire at some point in their 60s. Among those dentists who are over the age of 50, approximately one in five expect to retire before age 65. Nearly half of dentists who are over age 50 expect to work to at least age 70, including more than one in ten who do not intend to retire.

Within the next two years, only 3% of Virginia's dentists plan on leaving either the profession or the state. Meanwhile, 17% of dentists plan on increasing their patient care activities, and 14% plan on pursuing additional educational activities.

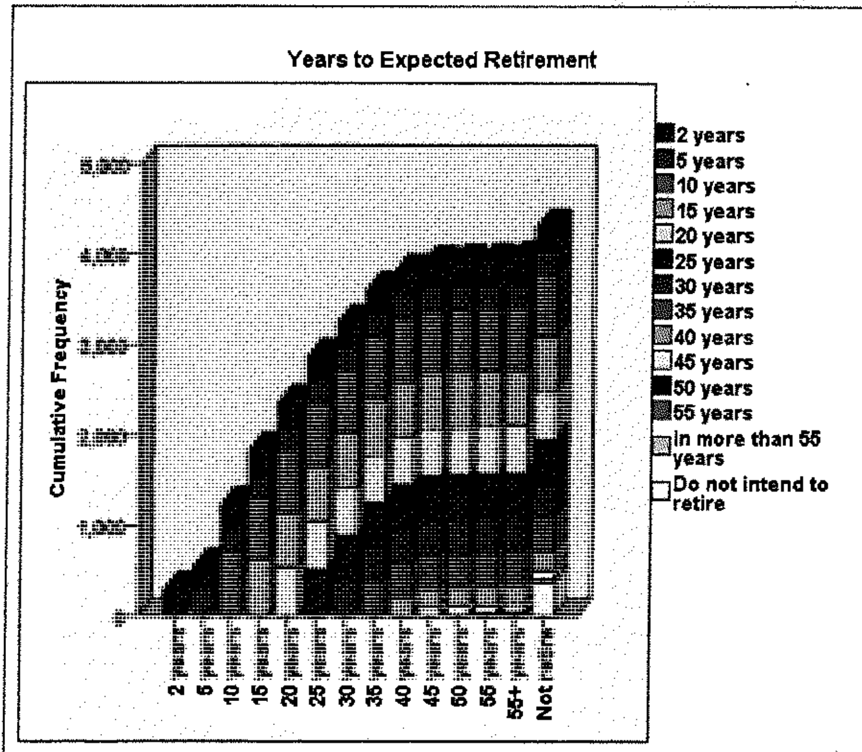
Future Plans		
2 Year Plans:	#	%
Decrease Participation		
Leave Profession	61	1%
Leave Virginia	108	2%
Decrease Patient Care Hours	554	10%
Decrease Teaching Hours	31	1%
Increase Participation		
Increase Patient Care Hours	918	17%
Increase Teaching Hours	297	6%
Pursue Additional Education	720	14%
Return to Virginia's Workforce	32	1%

Source: Va. Healthcare Workforce Data Center

By comparing retirement expectation to age, we can estimate the maximum years to retirement for dentists. 7% of dentists expect to retire within the next two years, while nearly 30% expect to retire in the next ten years. More than half of the current dentistry workforce expects to retire before 2033.

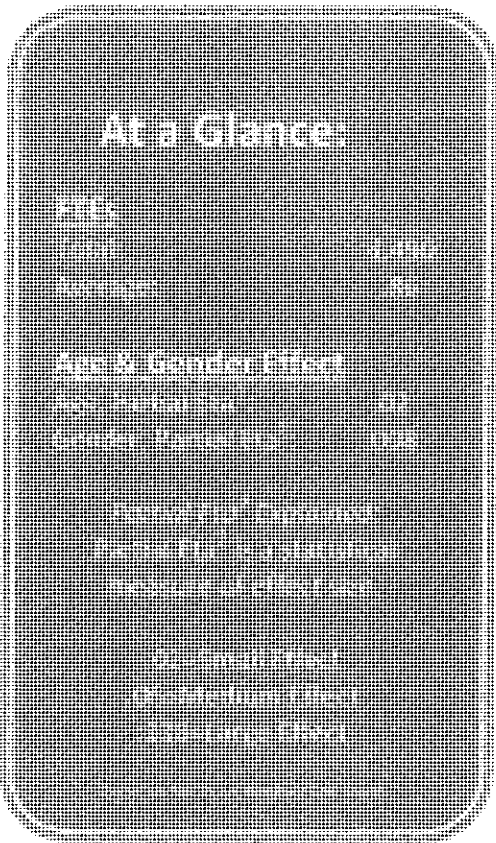
Time to Retirement			
Expect to retire within. . .	#	%	Cumulative %
2 years	286	7%	7%
5 years	253	6%	13%
10 years	686	16%	29%
15 years	604	14%	43%
20 years	522	12%	55%
25 years	514	12%	67%
30 years	371	9%	75%
35 years	364	8%	84%
40 years	203	5%	89%
45 years	88	2%	91%
50 years	17	0%	91%
55 years	10	0%	91%
In more than 55 years	13	0%	92%
Do not intend to retire	364	8%	100%
Total	**4,293**	**100%**	

Source: Va. Healthcare Workforce Data Center

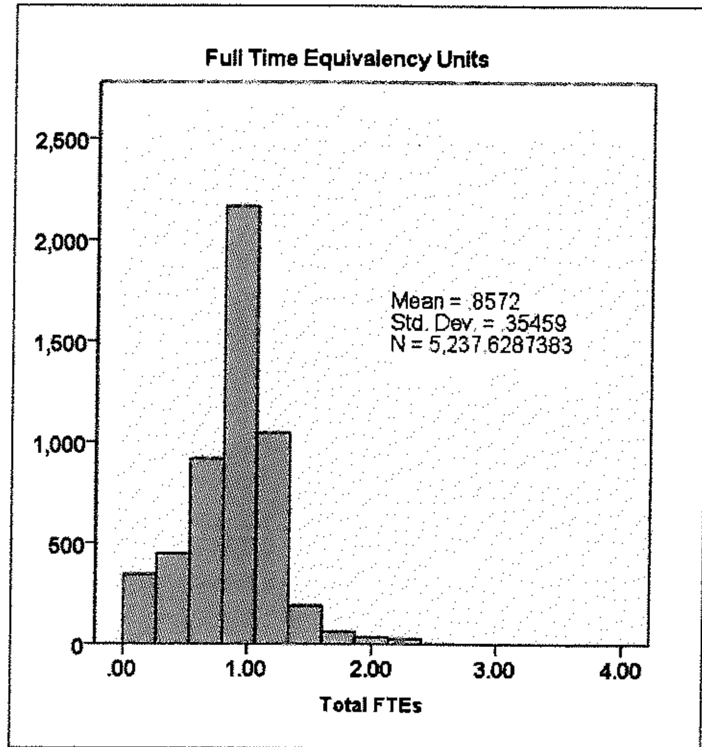


Source: Va. Healthcare Workforce Data Center

Using these estimates, retirements will begin to reach over 10% of the workforce every 5 years by 2023. Retirements will peak at 16% of the workforce around the same time period before declining to under 10% of the workforce around 2043. In total, more than half of all dentists plan on retiring between 2023 and 2038.



A Closer Look:

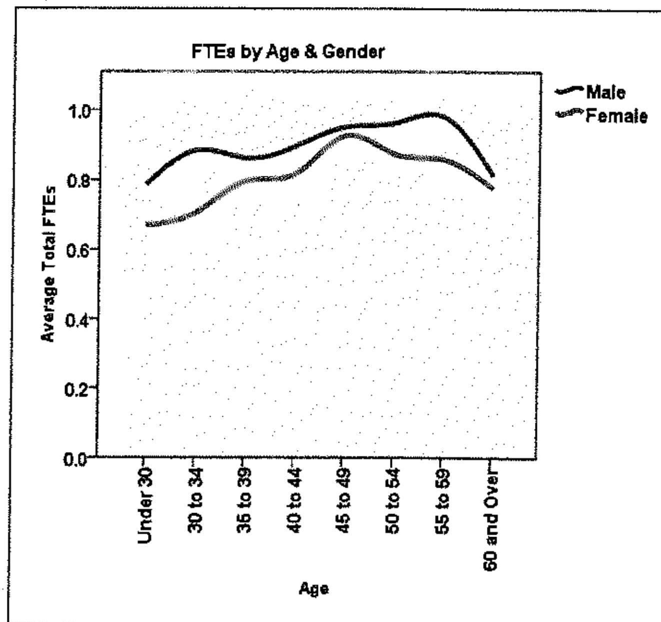


Source: Va. Healthcare Workforce Data Center

The typical (median) dentist provided 0.88 FTEs in 2012, or approximately 34 hours per week for 52 weeks. Although FTEs appear to vary by age and gender, statistical tests did not verify a difference exists.[2]

Full-Time Equivalency Units		
Age	**Average**	**Median**
Age		
Under 30	0.72	0.74
30 to 34	0.79	0.82
35 to 39	0.83	0.88
40 to 44	0.86	0.88
45 to 49	0.94	0.89
50 to 54	0.94	0.89
55 to 59	0.96	0.88
60 and Over	0.81	0.84
Gender		
Male	0.88	0.88
Female	0.80	0.84

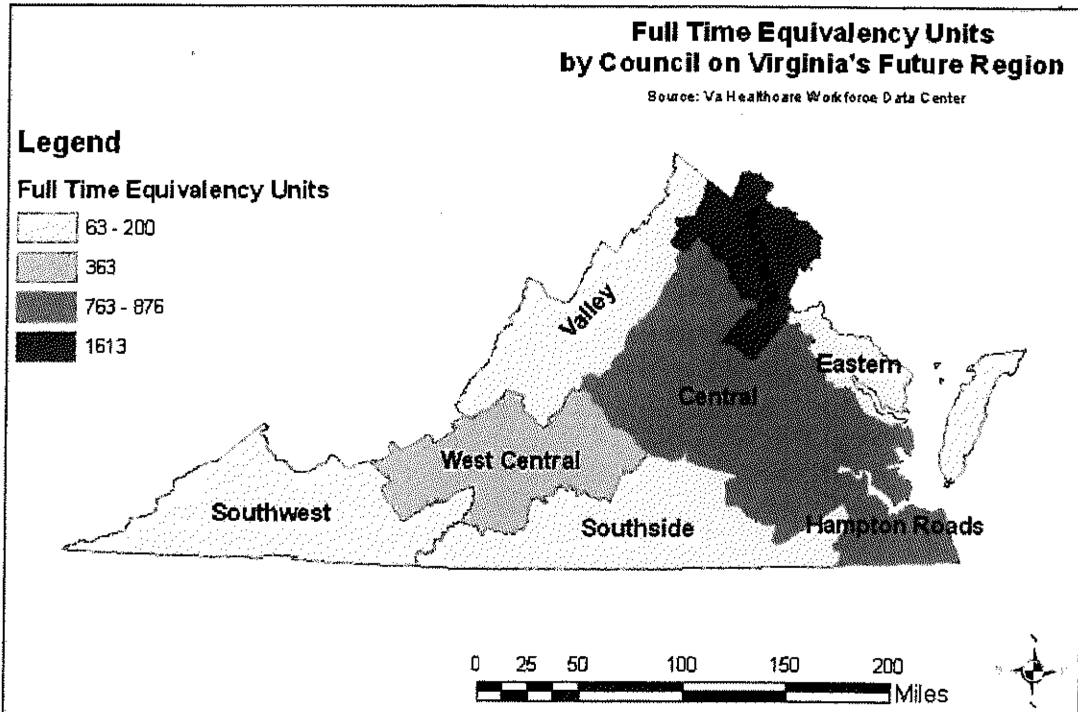
Source: Va. Healthcare Workforce Data Center

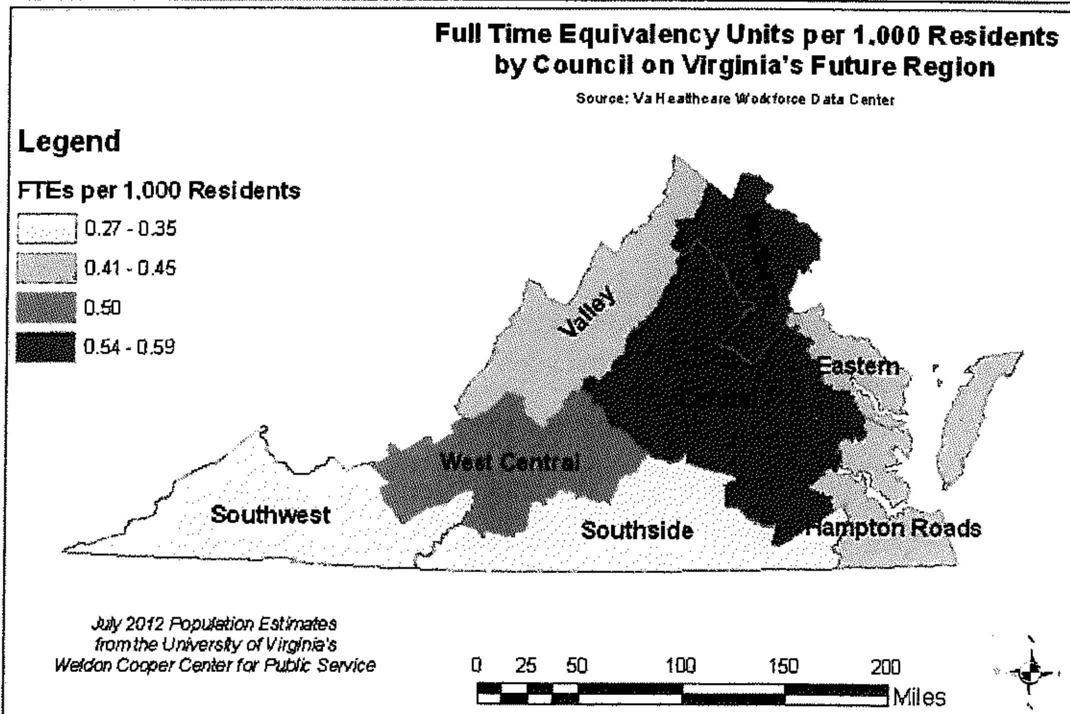


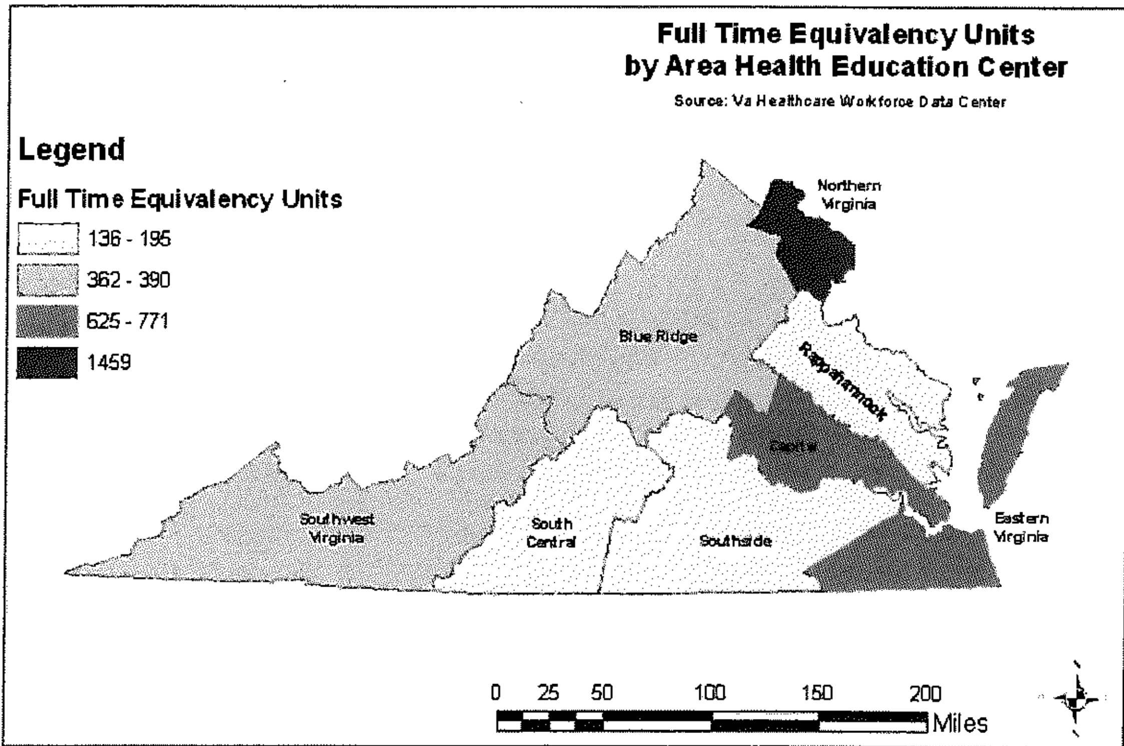
Source: Va. Healthcare Workforce Data Center

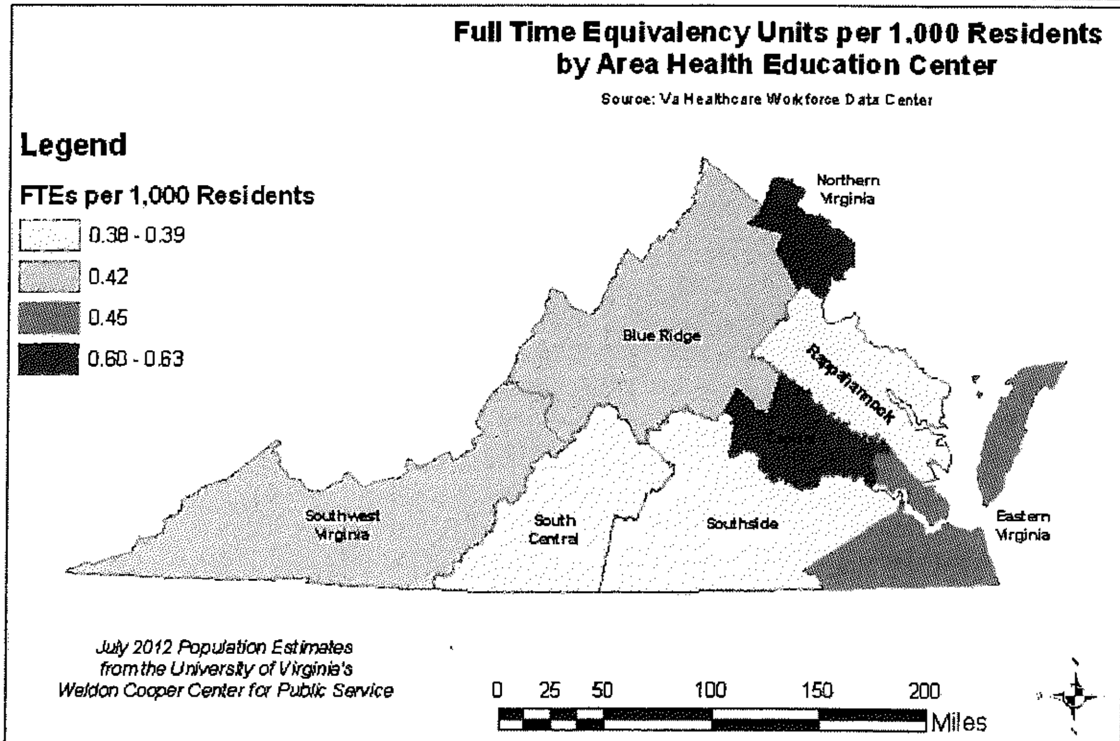
[3] Due to assumption violations in Mixed between-within ANOVA (Levene's Test & Interaction effect are significant)

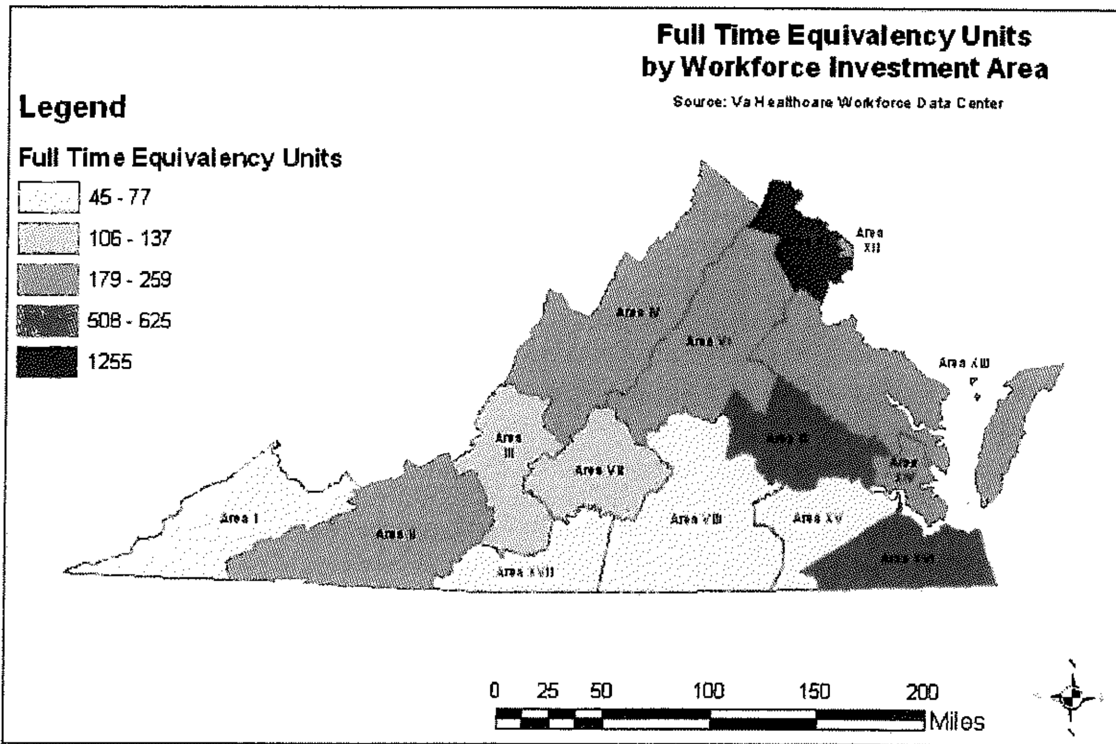
Council on Virginia's Future Regions

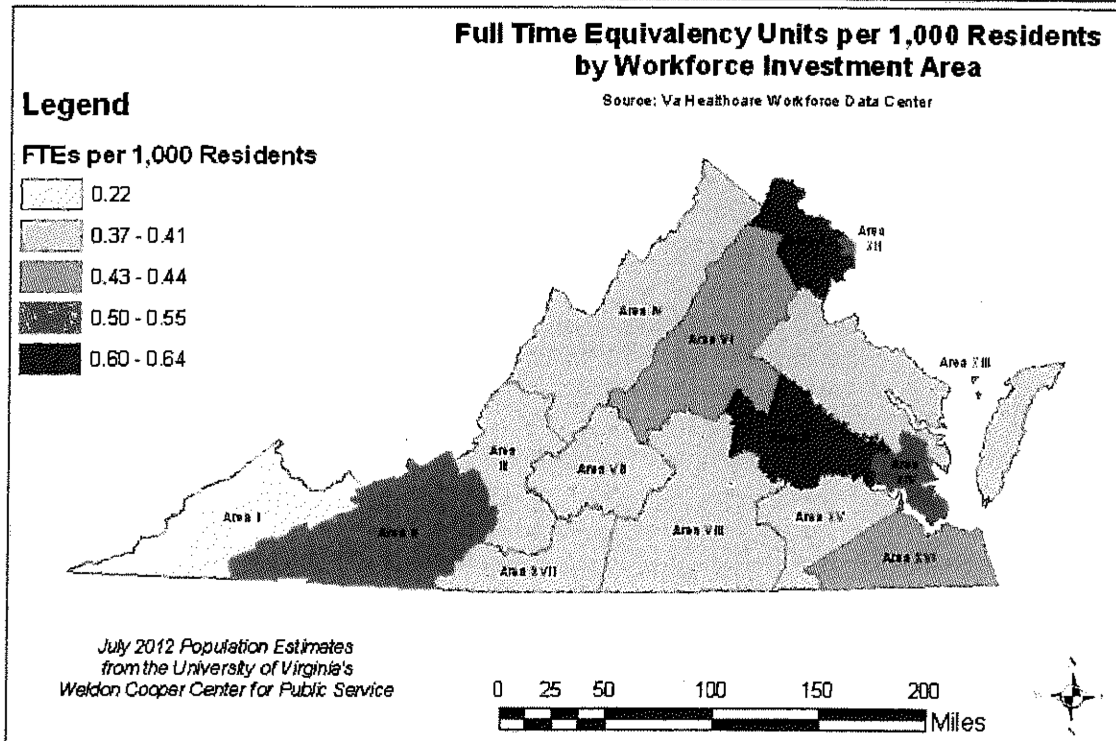


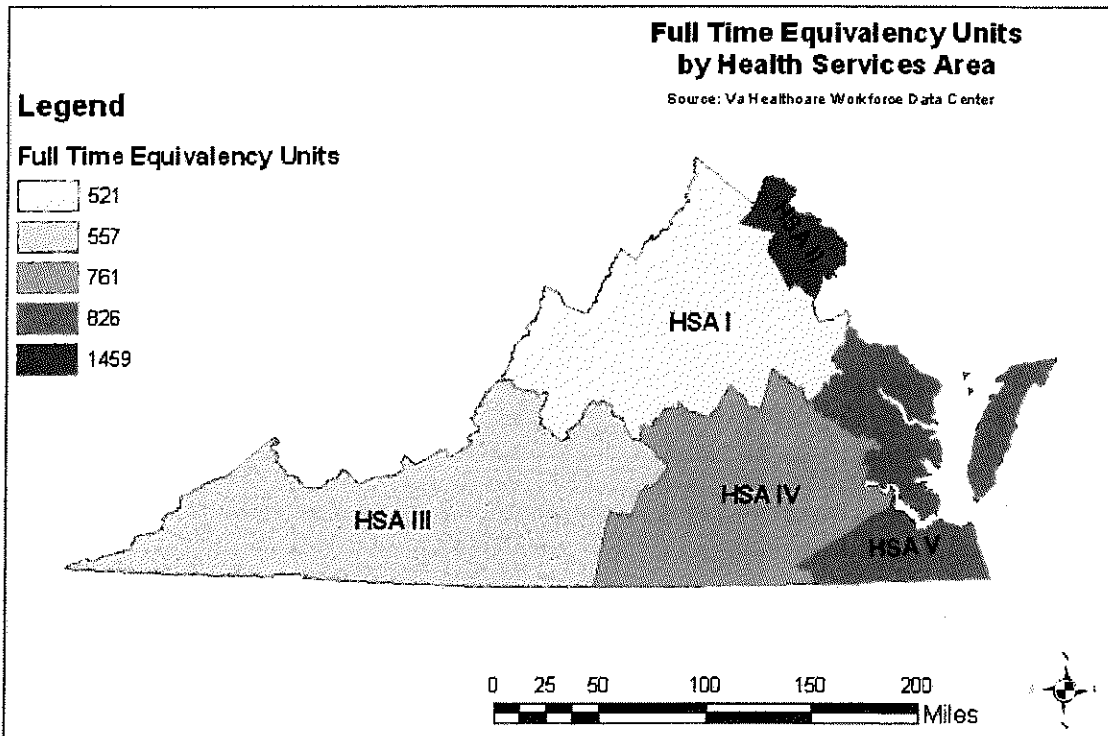


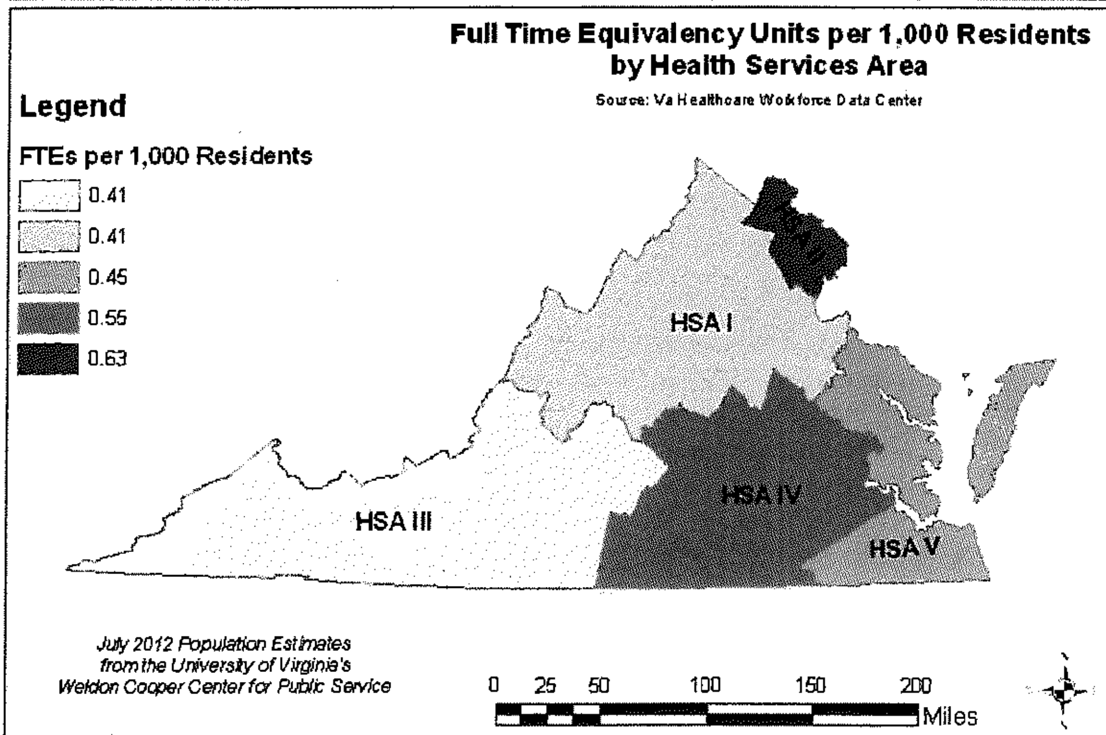

Full Time Equivalency Units
by Area Health Education Center
Source: Va Healthcare Workforce Data Center
Legend
Full Time Equivalency Units
136 - 195
362 - 390
625 - 771
1459
Northern Virginia
Blue Ridge
Rappahannock
Capital
Southwest Virginia
South Central
Southside
Eastern Virginia
0 25 50 100 150 200
Miles

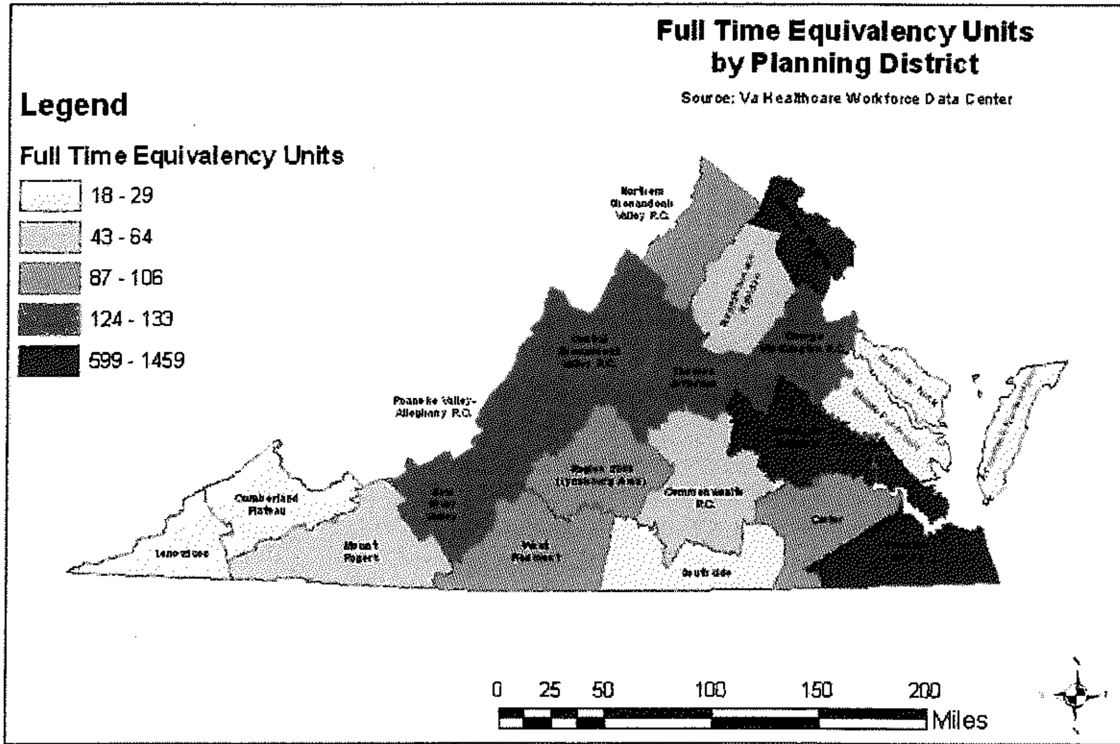

Full Time Equivalency Units per 1,000 Residents
by Area Health Education Center
Source: Va Healthcare Workforce Data Center
Legend
FTEs per 1,000 Residents
0.38 - 0.39
0.42
0.45
0.60 - 0.63
Northern Virginia
Blue Ridge
Rappahannock
Southwest Virginia
South Central
Southside
Eastern Virginia
July 2012 Population Estimates
from the University of Virginia's
Weldon Cooper Center for Public Service
0 25 50 100 150 200
Miles

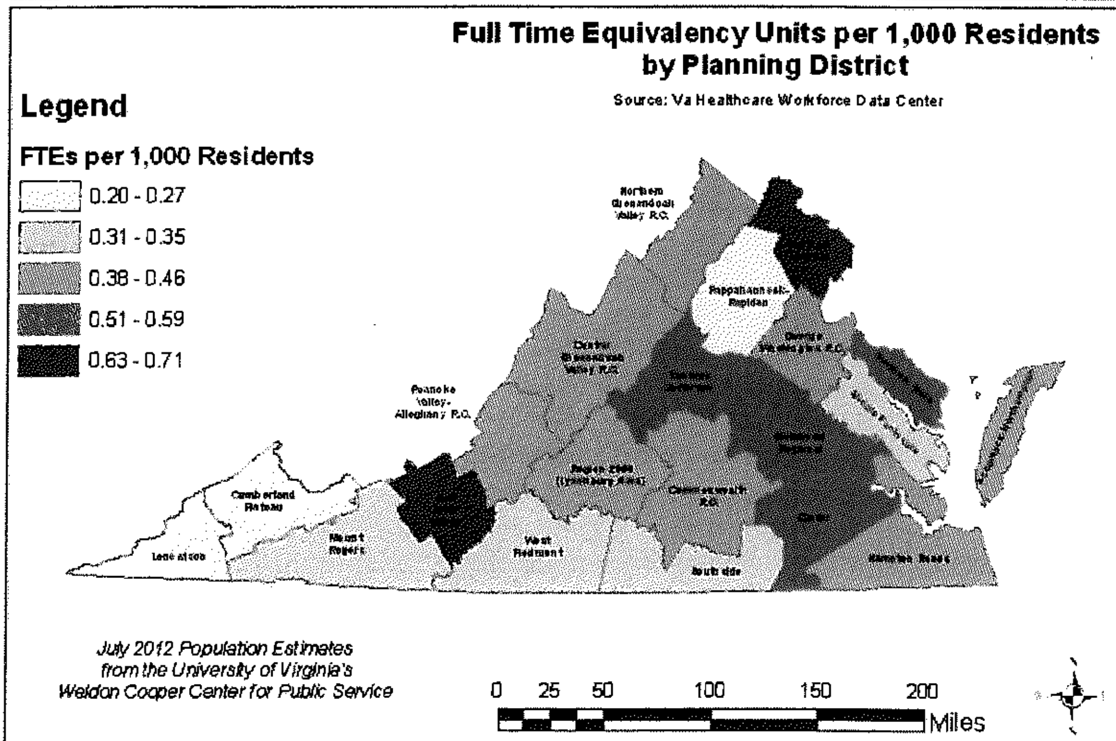

Full Time Equivalency Units
by Workforce Investment Area
Source: Va Healthcare Workforce Data Center
Legend
Full Time Equivalency Units
45 - 77
106 - 137
179 - 259
508 - 625
1255
Area XII
Area IV
Area VI
Area XIII
Area III
Area VII
Area I
Area II
Area VIII
Area XV
Area XVII
0 25 50 100 150 200
Miles


Full Time Equivalency Units per 1,000 Residents
by Workforce Investment Area
Source: Va Healthcare Workforce Data Center
Legend
FTEs per 1,000 Residents
0.22
0.37 - 0.41
0.43 - 0.44
0.50 - 0.55
0.60 - 0.64
Area XII
Area IV
Area VI
Area XIII
Area III
Area VII
Area I
Area II
Area VIII
Area XV
Area XVII
July 2012 Population Estimates
from the University of Virginia's
Weldon Cooper Center for Public Service
0 25 50 100 150 200
Miles


Full Time Equivalency Units
by Health Services Area
Source: Va Healthcare Workforce Data Center
Legend
Full Time Equivalency Units
521
557
761
826
1459
HSA I
HSA II
HSA III
HSA IV
HSA V
0 25 50 100 150 200
Miles


Full Time Equivalency Units per 1,000 Residents
by Health Services Area
Source: Va Healthcare Workforce Data Center
Legend
FTEs per 1,000 Residents
0.41
0.41
0.45
0.55
0.63
HSA I
HSA II
HSA III
HSA IV
HSA V
July 2012 Population Estimates
from the University of Virginia's
Weldon Cooper Center for Public Service
0 25 50 100 150 200
Miles


Full Time Equivalency Units
by Planning District
Source: Va Healthcare Workforce Data Center
Legend
Full Time Equivalency Units
18 - 29
43 - 64
87 - 106
124 - 133
599 - 1459
Northern Shenandoah Valley P.D.
Roanoke Valley-Alleghany P.D.
Cumberland Plateau
Mount Rogers
West Piedmont
Southside
Commonwealth P.D.
0 25 50 100 150 200
Miles


Full Time Equivalency Units per 1,000 Residents
by Planning District
Source: Va Healthcare Workforce Data Center
Legend
FTEs per 1,000 Residents
0.20 - 0.27
0.31 - 0.35
0.38 - 0.46
0.51 - 0.59
0.63 - 0.71
Northern Shenandoah Valley P.D.
Rappahannock-Rapidan
Roanoke Valley-Alleghany P.D.
Cumberland Plateau
Mount Rogers
West Piedmont
Southside
Commonwealth P.D.
Hampton Roads
July 2012 Population Estimates
from the University of Virginia's
Weldon Cooper Center for Public Service
0 25 50 100 150 200
Miles

Appendix A: Weights

Rural Status	Location Weight			Total Weight	
	#	Rate	Weight	Min	Max
Metro, 1 million+	4,165	71.67%	1.39531	1.306996	1.494352
Metro, 250,000 to 1 million	362	70.44%	1.419608	1.329756	1.520374
Metro, 250,000 or less	436	72.25%	1.384127	1.296521	1.482375
Urban pop 20,000+, Metro adj	73	75.34%	1.327273	1.243265	1.421485
Urban pop 20,000+, nonadj	0	NA	NA	NA	NA
Urban pop, 2,500-19,999, Metro adj	147	61.90%	1.615385	1.513141	1.730048
Urban pop, 2,500-19,999, nonadj	75	80.00%	1.25	1.170883	1.338727
Rural, Metro adj	86	60.47%	1.653846	1.549168	1.771239
Rural, nonadj	36	52.78%	1.894737	1.774812	2.029229
Virginia border state/DC	718	67.97%	1.471311	1.378187	1.575748
Other US State	741	65.05%	1.537344	1.44004	1.646468

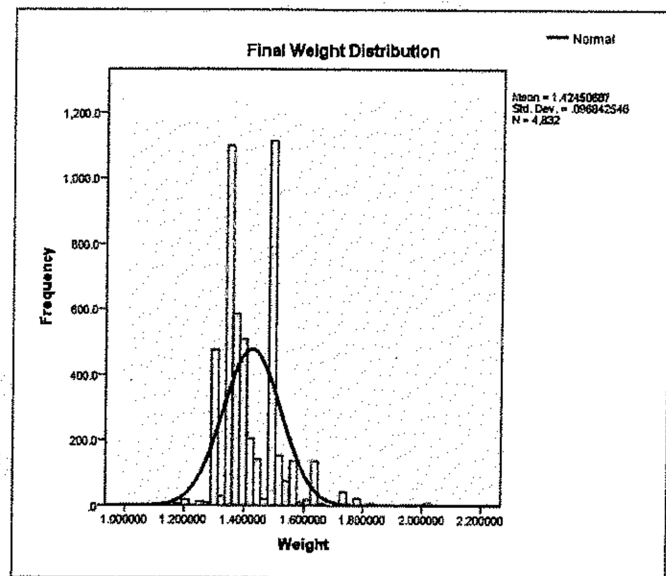
Age	Age Weight			Total Weight	
	#	Rate	Weight	Min	Max
Under 30	210	70.00%	1.428571	1.254518	1.621223
30 to 34	786	69.72%	1.434307	1.259554	1.909219
35 to 39	876	75.00%	1.333333	1.170883	1.774812
40 to 44	849	71.38%	1.40099	1.230297	1.864871
45 to 49	663	72.25%	1.384134	1.215494	1.842433
50 to 54	701	72.47%	1.379921	1.211795	1.836826
55 to 59	796	72.36%	1.381944	1.213571	1.839519
60 and Over	1,994	65.60%	1.524465	1.338727	2.029229

See the Methods section on the HWDC website for details on HWDC Methods:

Final weights are calculated by multiplying the two weights and the overall response rate:

ageweight x ruralweight x responserate = final weight.

Overall Response Rate: 0.702530



Virginia's Dental Hygienist Workforce: 2013

Healthcare Workforce Data Center

October 2013

EXPOSURE DRAFT

Virginia Department of Health Professions
Healthcare Workforce Data Center
Perimeter Center
9960 Mayland Drive, Suite 300
Richmond, VA 23233
804-367-2115, 804-527-4466(fax)
E-mail: ***HWDC@dhp.virginia.gov***

Follow us on Tumblr: ***www.vahwdc.tumblr.com***

Nearly 4,300 Dental Hygienists voluntarily participated in this survey. Without their efforts the work of the center would not be possible. The Department of Health Professions, the Healthcare Workforce Data Center, and the Board of Dentistry express our sincerest appreciation for your ongoing cooperation.

Thank You!

Virginia Department of Health Professions

Dianne L. Reynolds-Cane, M.D.
Director

Arne W. Owens
Chief Deputy Director

Healthcare Workforce Data Center Staff:

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Director	*Research Analyst*	*Operations Manager*	*Research Assistant*

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The Dental Hygienist Workforce: At a Glance:

The Workforce

Background

Current Employment

Survey Response Rate

Education

Job Turnover

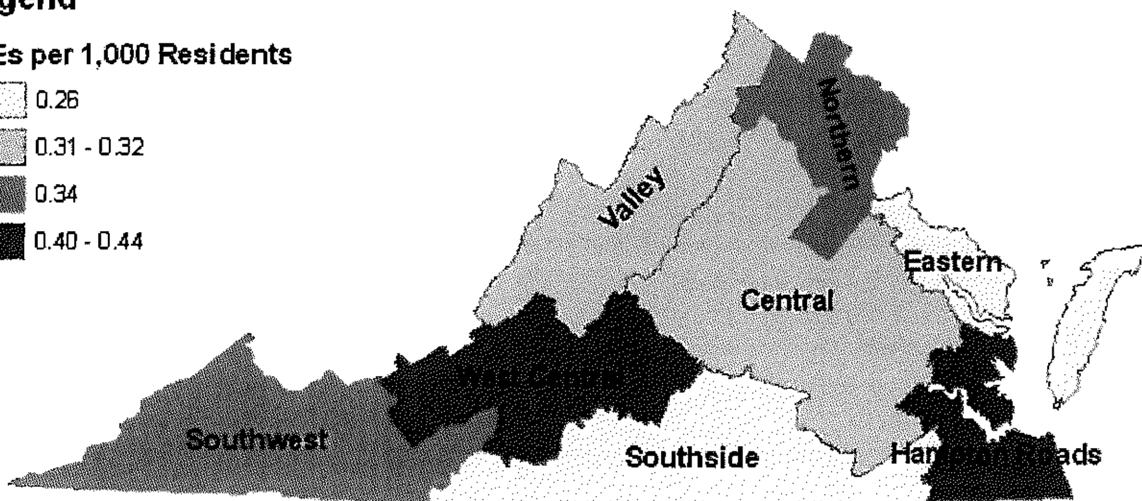
Demographics

Finances

Time Allocation

Full Time Equivalency Units per 1,000 Residents by Council on Virginia's Future Region

Source: Va Healthcare Workforce Data Center



July 2012 Population Estimates from the University of Virginia's Weldon Cooper Center for Public Service

Source: Va. Healthcare Workforce Data Center

Nearly 4,300 dental hygienists voluntarily took part in the 2013 Dental Hygienist Workforce Survey. The Virginia Department of Health Professions' Healthcare Workforce Data Center (HWDC) administers the survey during the license renewal process, which takes place every March for dental hygienists. These survey respondents represent 79% of the 5,425 dental hygienists who are licensed in the state and 88% of renewing practitioners.

The HWDC estimates that 4,496 dental hygienists participated in Virginia's workforce in 2012, which is defined as those who worked at least a portion of the year in the state or who live in the state and intend to return to work as a dental hygienist at some point in the future. Virginia's dental hygienist workforce provided 3,062 "full-time equivalency units" in 2012, which the HWDC defines simply as working 2,000 hours a year (or 40 hours per week for 50 weeks with 2 weeks off).

More than nine out of ten dental hygienists were employed in the profession at the time of the survey, and 69% have been employed at their primary work location for at least two years. However, less than half held one full-time position, while nearly 30% held one part-time position. Dental hygienists are very happy in their profession—92% indicated they were satisfied with their current employment situation, including 63% who indicated they were "very satisfied."

Nearly all dental hygienists are female. Their median age is 44, which is slightly higher than the median age of Virginia's labor force as a whole. Virginia's dental hygienist workforce is somewhat less diverse than Virginia's population as a whole. In a random encounter between two dental hygienists, there is only a 29% probability that they would be of different races or ethnicities. For the Virginia population as a whole, this same probability is 54%. There is greater diversity among dental hygienists who are under the age of 40, but this group is also less diverse than Virginia's overall population.

More than one in three dental hygienists grew up in a rural area, but only 19% of these professionals who were raised in a rural setting currently work in non-Metro areas of the state. Meanwhile, 56% of Virginia's dental hygienist workforce graduated from high school in Virginia, while 62% received their initial professional degree in the state. In total, two out of three of Virginia's dental hygienists have some educational background in the state. New York, North Carolina, Maryland and Pennsylvania were among the largest sources of dental hygienists outside of Virginia.

Just over half of dental hygienists have earned an associate's degree as their highest professional degree, while 41% have received a bachelor's degree. Approximately half of dental hygienists who are under the age of 40 currently carry educational debt. The median debt burden for those with educational debt is between $10,000 and $20,000. The median annual income for dental hygienists is between $50,000 and $55,000, while one-quarter earn more than $70,000 per year. In addition to monetary compensation, two-thirds of Virginia's dental hygienists receive at least one employer-sponsored benefit.

Dental hygienists focused their efforts almost exclusively on patient care activities. The typical dental hygienist spent between 90% and 99% of her time on patient care and between 1% and 9% on administrative tasks. 93% of dental hygienists spent at least 60% of their work time on patient care activities.

A Closer Look:

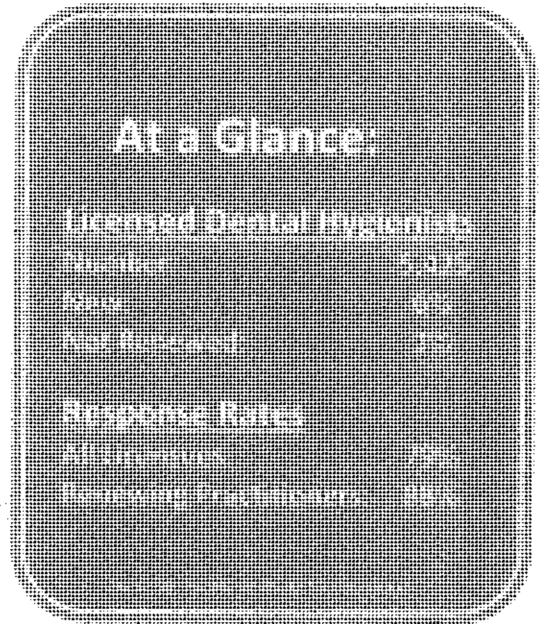
Licensees		
License Status	#	%
Renewing Practitioners	4,899	90%
New Licensees	341	6%
Non-Renewals	185	3%
All Licensees	5,425	100%

Source: Va. Healthcare Workforce Data Center

Our surveys tend to achieve very high response rates. Nearly nine out of ten renewing dental hygienists submitted a survey. These represent 79% of dental hygienists who held a license at some point in 2012.

Response Rates			
Statistic	Non Respondents	Respondent	Response Rate
By Age			
Under 30	115	592	84%
30 to 34	122	588	83%
35 to 39	140	556	80%
40 to 44	123	578	83%
45 to 49	141	530	79%
50 to 54	147	565	79%
55 to 59	132	498	79%
60 and Over	213	385	64%
Total	1,133	4,292	79%
New Licenses			
Issued 4/2012 to 3/2013	79	262	77%
Metro Status			
Non-Metro	90	406	82%
Metro	762	3,227	81%
Not in Virginia	278	640	70%

Source: Va. Healthcare Workforce Data Center



Response Rates	
Completed Surveys	4,292
Response Rate, all licensees	79%
Response Rate, Renewals	88%

Source: Va. Healthcare Workforce Data Center

Definitions

1. **The Survey Period:** The survey was conducted in March 2013.
2. **Target Population:** All dental hygienists who held a Virginia license at some point in 2012.
3. **Survey Population:** The survey was available to dental hygienists who renewed their licenses online. It was not available to those who did not renew, including some dental hygienists newly licensed in 2012 or 2013.

At a Glance:

Workforce

Utilization Ratios

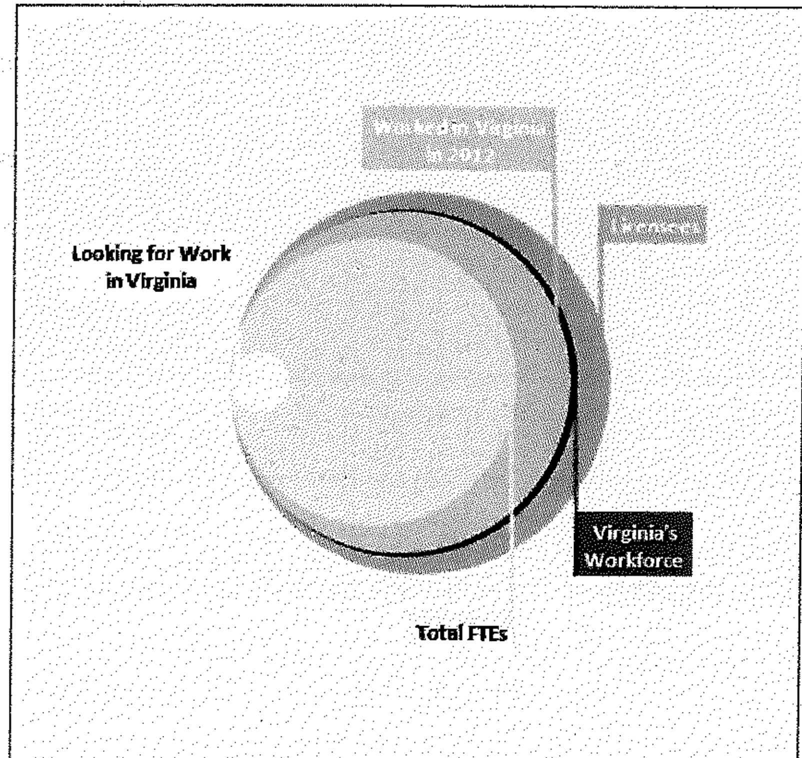
Definitions

1. **Virginia's Workforce:** A licensee with a primary or secondary work site in Virginia at any time in 2012 or who indicated intent to return to Virginia's workforce at any point in the future.
2. **Full Time Equivalency Unit (FTE):** The HWDC uses 2,000 (40 hours for 50 weeks) as its baseline measure for FTEs.
3. **Licensees in VA Workforce:** The proportion of licensees in Virginia's Workforce.
4. **Licensees per FTE:** An indication of the number of licensees needed to create 1 FTE. Higher numbers indicate lower licensee participation.
5. **Workers per FTE:** An indication of the number of workers in Virginia's workforce needed to create 1 FTE. Higher numbers indicate lower utilization of available workers.

Virginia's Dental Hygienist Workforce		
Status	#	%
Worked in Virginia in Past Year	4,359	97%
Looking for Work in Virginia	137	3%
Virginia's Workforce	4,496	100%
Total FTEs	3,062	
Licensees	5,425	

Source: Va. Healthcare Workforce Data Center

This report uses weighting to estimate the figures in this report. Unless otherwise noted, figures refer to the Virginia Workforce only. For more information on HWDC's methodology visit: www.dhp.virginia.gov/hwdc

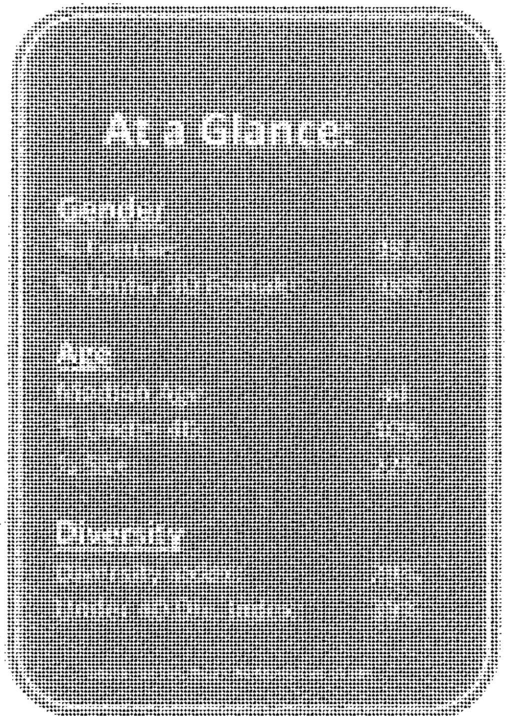


Source: Va. Healthcare Workforce Data Center

A Closer Look:

Age & Gender						
Age	Male		Female		Total	
	#	% Male	#	% Female	#	% in Age Group
Under 30	18	3%	596	97%	614	14%
30 to 34	11	2%	583	98%	594	13%
35 to 39	15	3%	547	97%	561	13%
40 to 44	11	2%	565	98%	576	13%
45 to 49	4	1%	531	99%	535	12%
50 to 54	4	1%	564	99%	568	13%
55 to 59	2	1%	495	100%	498	11%
60 +	9	2%	459	98%	468	11%
Total	73	2%	4,340	98%	4,413	100%

Source: Va. Healthcare Workforce Data Center

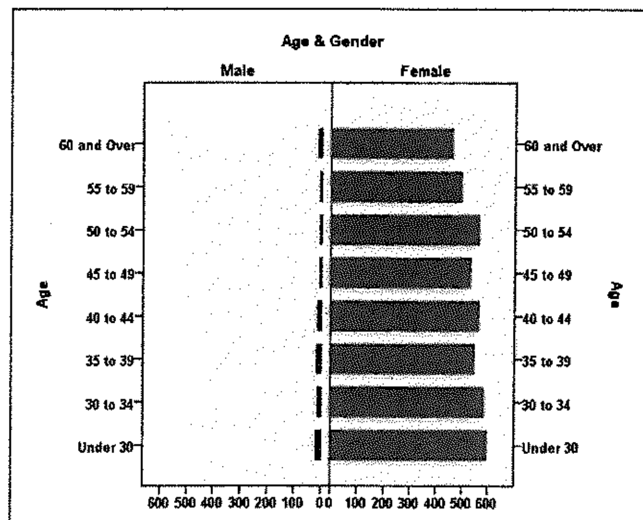


Race & Ethnicity					
Race/ Ethnicity	Virginia*	Dental Hygienists		Dentists Hyg. under 40	
	%	#	%	#	%
White	64%	3,712	84%	1,369	77%
Black	19%	189	4%	95	5%
Asian	6%	233	5%	143	8%
Other Race	0%	60	1%	29	2%
Two or more races	2%	81	2%	52	3%
Hispanic	8%	160	4%	88	5%
Total	100%	4,435	100%	1,776	100%

*Population data in this chart is from the US Census, ACS 1-yr estimates, 2011 vintage.
Source: Va. Healthcare Workforce Data Center

In a chance encounter between two dental hygienists, there is only a 29% chance they would be of a different race/ethnicity (a measure known as the Diversity Index), compared to a 54% chance for Virginia's population. The diversity index for those under 40 increases to 39%.

Nearly all dental hygienists are female. The median age of all dental hygienists is 44. 40% of dental hygienists are under the age of 40.



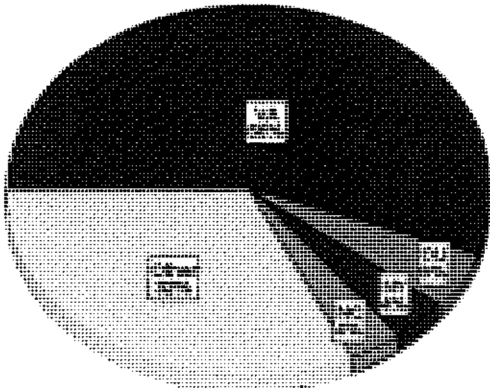
Source: Va. Healthcare Workforce Data Center

At a Glance:

A Closer Look:

Primary Location: USDA Rural Urban Continuum		Rural Status of Childhood Location		
Code	Description	Rural	Suburban	Urban
	Metro Counties			
1	Metro, 1 million+	24%	61%	15%
2	Metro, 250,000 to 1 million	51%	40%	9%
3	Metro, 250,000 or less	57%	35%	9%
	Non-Metro Counties			
4	Urban pop 20,000+, Metro adj	62%	29%	10%
6	Urban pop, 2,500-19,999, Metro adj	64%	28%	8%
7	Urban pop, 2,500-19,999, nonadj	83%	12%	5%
8	Rural, Metro adj	67%	26%	7%
9	Rural, nonadj	78%	22%	0%
	Overall	**34%**	**53%**	**13%**

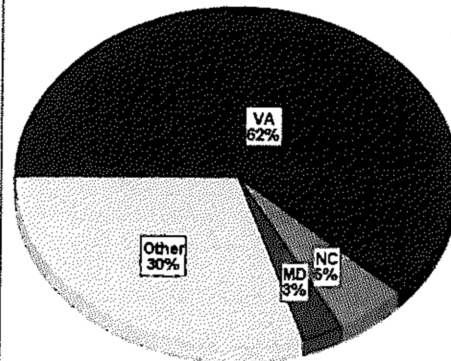
Source: Va. Healthcare Workforce Data Center


High School Location

Source: Va. Healthcare Workforce Data Center

More than one in three dental hygienists grew up in self-described rural areas, but only 9% of dental hygienists work in Non-Metro counties. Less than one in five dental hygienists who grew up in rural areas work in Non-Metro counties.

More than two-thirds of Virginia's dental hygienists have a background in the state, including nearly half who received both their high school and initial professional degrees in Virginia.



Location, Initial Professional Degree

Source: Va. Healthcare Workforce Data Center

Top Ten States for Dental Hygienist Recruitment

Rank	All Dental Hygienists			
	High School	#	Init. Prof Degree	#
1	Virginia	2,459	Virginia	2,686
2	Outside U.S.	216	North Carolina	232
3	New York	170	Maryland	133
4	North Carolina	155	New York	130
5	Pennsylvania	141	West Virginia	121
6	Maryland	138	Pennsylvania	110
7	West Virginia	128	Florida	103
8	Florida	112	Tennessee	98
9	New Jersey	99	Michigan	72
10	Michigan	90	Washington, D.C.	65

Source: Va. Healthcare Workforce Data Center

Outside of Virginia, New York, North Carolina, Pennsylvania and Maryland are the largest contributors to Virginia's dental hygienist workforce. Additionally, a significant number of dental hygienists received their high school degree outside of the U.S. or Canada.

Rank	Licensed in the Past 5 Years			
	High School	#	Init. Prof Degee	#
1	Virginia	603	Virginia	660
2	Outside U.S.	88	North Carolina	69
3	North Carolina	41	Michigan	38
4	Michigan	41	Maryland	34
5	West Virginia	35	Florida	29
6	Maryland	28	West Virginia	26
7	New York	25	New York	24
8	Pennsylvania	25	Pennsylvania	22
9	California	23	Tennessee	20
10	Florida	20	Ohio	19

Source: Va. Healthcare Workforce Data Center

Of those dental hygienists licensed in the past five years, North Carolina and Michigan were the most significant contributors to Virginia's dental hygienist workforce. A large proportion also went to high school outside of the United States or Canada.

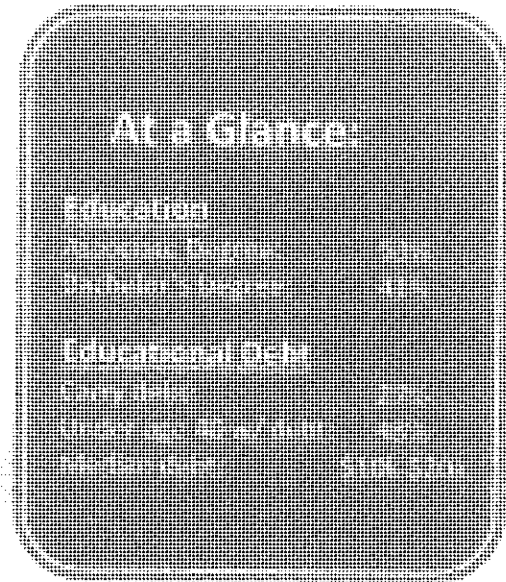
17% of Virginia's licensees did not participate in Virginia's dental hygienist workforce in 2012. More than four in five of these licensees worked at some point in the past year, including 71% who worked in the dental hygienist profession. Only 6% worked for the federal government; most of these dental hygienists worked for the military.

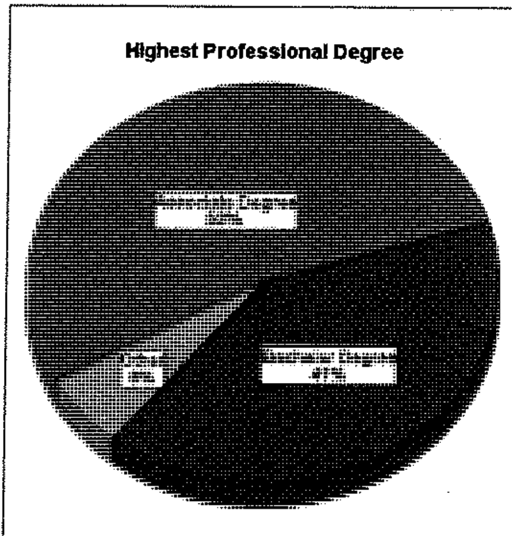
At a Glance:

A Closer Look:

Highest Degree		
Degree	#	%
Certificate	114	3%
Associate	2,323	53%
Bachelors	1,770	41%
Post-Graduate	18	0%
Masters	120	3%
Doctorate	8	0%
Total	**4,353**	**100%**

Source: Va. Healthcare Workforce Data Center

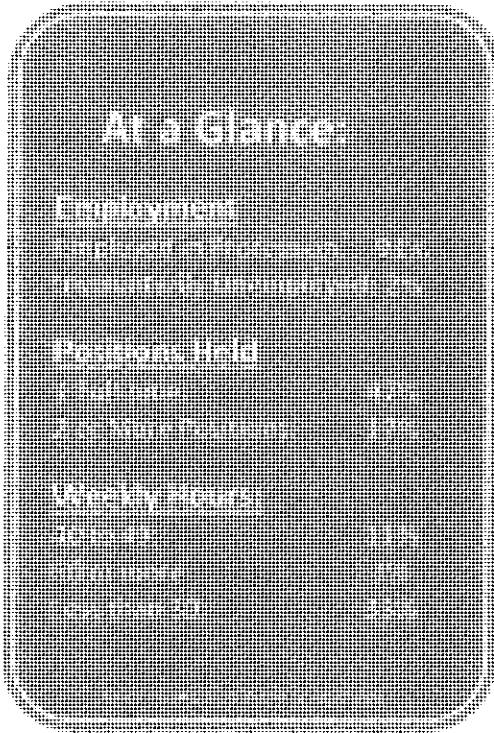




Source: Va. Healthcare Workforce Data Center

More than half of all dental hygienists have an associate degree as their highest professional degree, while 41% have earned a bachelor's degree. Approximately one in four of all dental hygienists carry educational debt. The median debt burden for these dental hygienists is between $10,000 and $20,000.

Educational Debt				
Amount Carried	All Dental Hygienists		Dental Hyg. under 40	
	#	%	#	%
None	2,854	73%	816	52%
$10,000 or less	298	8%	222	14%
$10,001-$20,000	258	7%	184	12%
$20,001-$30,000	178	5%	146	9%
$30,001-$40,000	96	2%	75	5%
$40,001-$50,000	68	2%	45	3%
$50,001-$60,000	33	1%	24	2%
$60,001-$70,000	29	1%	19	1%
$70,001-$80,000	26	1%	18	1%
$80,001-$90,000	12	0%	11	1%
$90,001-$100,000	6	0%	4	0%
$100,000-$110,000	11	0%	10	1%
$110,001-$120,000	5	0%	2	0%
More than $120,000	14	0%	5	0%
Total	**3,888**	**100%**	**1,581**	**100%**



A Closer Look:

Current Work Status		
Status	#	%
Employed, capacity unknown	1	0%
Employed in a dentistry related capacity	4,013	91%
Employed, NOT in a dentistry related capacity	130	3%
Not working, reason unknown	0	0%
Involuntarily unemployed	71	2%
Voluntarily unemployed	180	4%
Retired	40	1%
Total	4,435	100%

Source: Va. Healthcare Workforce Data Center

Current Positions		
Positions	#	%
No Positions	291	7%
One Part-Time Position	1,291	29%
Two Part-Time Positions	428	10%
One Full-Time Position	2,067	47%
One Full-Time Position & One Part-Time Position	219	5%
Two Full-Time Positions	1	0%
More than Two Positions	90	2%
Total	4,387	100%

Source: Va. Healthcare Workforce Data Center

Current Weekly Hours		
Hours	#	%
0 hours	291	7%
1 to 9 hours	170	4%
10 to 19 hours	406	9%
20 to 29 hours	874	20%
30 to 39 hours	2,060	47%
40 to 49 hours	466	11%
50 to 59 hours	43	1%
60 to 69 hours	13	0%
70 to 79 hours	12	0%
80 or more hours	11	0%
Total	4,346	100%

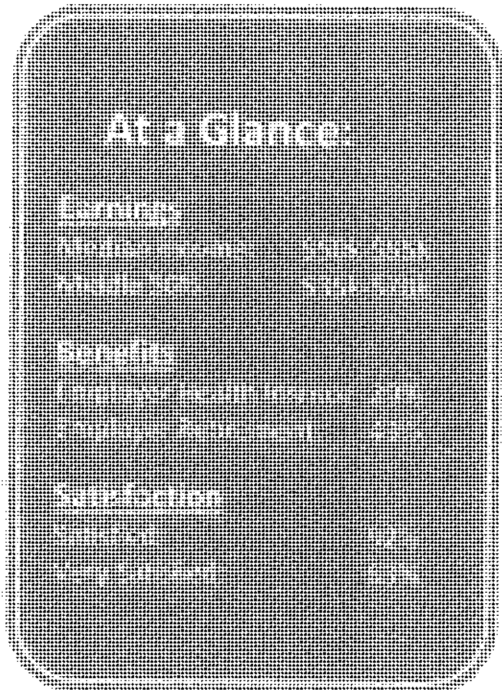
Source: Va. Healthcare Workforce Data Center

More than nine in ten dental hygienists were employed in their profession. Less than half of dental hygienists held one full-time job, while almost 30% had one part-time job. 17% held multiple jobs. Half of dental hygienists worked between 30 and 39 hours per week, while 13% worked less than 20 hours per week.

A Closer Look:

Income		
Hourly Wage	#	%
Volunteer Work Only	44	1%
$30,000 or less	510	14%
$30,001-$35,000	213	6%
$35,001-$40,000	237	7%
$40,001-$45,000	263	7%
$45,001-$50,000	331	9%
$50,001-$55,000	321	9%
$55,001-$60,000	354	10%
$60,001-$65,000	328	9%
$65,001-$70,000	286	8%
$70,001-$75,000	204	6%
$75,001-$80,000	163	5%
$80,001-$85,000	97	3%
$85,001-$90,000	61	2%
More than $90,000	135	4%
Total	**3,544**	**100%**

Source: Va. Healthcare Workforce Data Center



Employer-Sponsored Benefits		
Benefit	#	%
Signing/Retention Bonus	106	3%
Dental Insurance	542	14%
Health Insurance	1,162	29%
Paid Leave	1,960	49%
Group Life Insurance	295	7%
Retirement	1,722	43%
Receive at least one benefit	**2,667**	**66%**

*From any employer at time of survey.

Source: Va. Healthcare Workforce Data Center

The median income for dental hygienists is between $50,000 and $55,000 per year, while one-quarter of dental hygienists earned more than $70,000 per year. In addition, two out of three dental hygienists received at least one employer-sponsored benefit at their place of work.

More than nine in ten dental hygienists are satisfied with their job, including nearly two-thirds who are very satisfied with their current work circumstances.

Job Satisfaction		
Level	#	%
Very Satisfied	2,704	63%
Somewhat Satisfied	1,247	29%
Somewhat Dissatisfied	237	6%
Very Dissatisfied	114	3%
Total	**4,303**	**100%**

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Employment Instability in Past Year		
In the past year did you . . .?	**#**	**%**
Experience Involuntary Unemployment?	196	4%
Experience Voluntary Unemployment?	299	7%
Work Part-time or temporary positions, but would have preferred a full-time/permanent position?	537	12%
Work two or more positions at the same time?	884	20%
Switch employers or practices?	254	6%
Experienced at least 1	**1,575**	**35%**

Source: Va. Healthcare Workforce Data Center

Only 4% of Virginia's dental hygienists experienced involuntary unemployment at some point during the renewal cycle. By comparison, Virginia's average monthly unemployment rate was 5.9% in 2012.[2]

At a Glance:

Unemployment Experience 2012

[illegible]

Turnover & Tenure

[illegible]

Employment Type

[illegible]

Location Tenure				
Tenure	**Primary**		**Secondary**	
	#	**%**	**#**	**%**
Not Currently Working at this Location	174	4%	363	27%
Less than 6 Months	215	5%	136	10%
6 Months to 1 Year	343	8%	153	11%
1 to 2 Years	553	13%	171	13%
3 to 5 Years	831	20%	202	15%
6 to 10 Years	803	19%	170	13%
More than 10 Years	1,257	30%	146	11%
Subtotal	**4,176**	**100%**	**1,340**	**100%**
Did not have location	179		3,052	
Item Missing	140		103	
Total	4,496		4,496	

Source: Va. Healthcare Workforce Data Center

More than two-thirds of dental hygienists have worked at their primary location for more than 2 years—the job tenure normally required to get a conventional mortgage loan.

Employment Type		
Primary Work Site	**#**	**%**
Salary/ Commission	800	23%
Hourly Wage	2,593	74%
By Contract	59	2%
Business/ Practice Income	5	0%
Unpaid	25	1%
Subtotal	3,482	100%
Did not have location	179	
Item Missing	835	

Source: Va. Healthcare Workforce Data Center

Nearly three out of four dental hygienists receive an hourly wage at their primary work location. Among those who don't receive an hourly wage, nearly all receive a salary.

[1] As reported by the US Bureau of Labor Statistics. The non-seasonally adjusted monthly unemployment rate ranged from 6.4% in January to 5.4% in November.

At a Glance:

Concentration

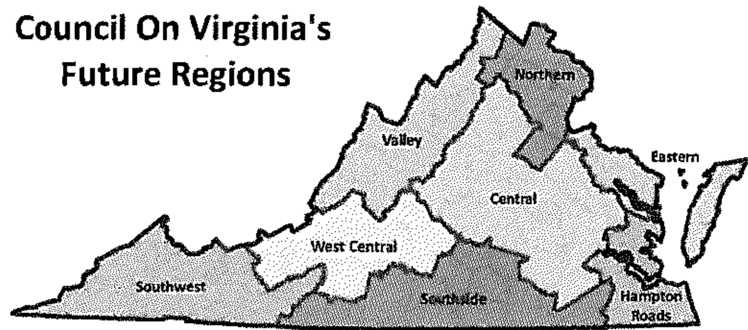
Locations

Three out of four dental hygienists worked in Northern Virginia, Hampton Roads or Central Virginia. Less than 10% of all dental hygienists worked in Southwest Virginia, Southside Virginia or Eastern Virginia.

A Closer Look:

Regional Distribution of Work Locations				
COVF Region	Primary Location		Secondary Location	
	#	%	#	%
Central	725	17%	194	17%
Eastern	57	1%	16	1%
Hampton Roads	1,051	25%	250	21%
Northern	1,347	32%	422	36%
Southside	133	3%	39	3%
Southwest	189	5%	46	4%
Valley	211	5%	45	4%
West Central	406	10%	98	8%
Virginia Border State/DC	14	0%	23	2%
Other US State	13	0%	28	2%
Outside of the US	3	0%	2	0%
Total	4,149	100%	1,163	100%
Item Missing	168		30	

Source: Va. Healthcare Workforce Data Center



Number of Work Locations				
Locations	Work Locations in 2012		Work Locations Now*	
	#	%	#	%
0	42	1%	297	7%
1	3,147	70%	3,009	70%
2	774	17%	609	14%
3	391	9%	353	8%
4	44	1%	13	0%
5	27	1%	8	0%
6 or More	70	2%	24	1%
Total	4,496	100%	4,313	100%

*At the time of survey completion, March 2013.

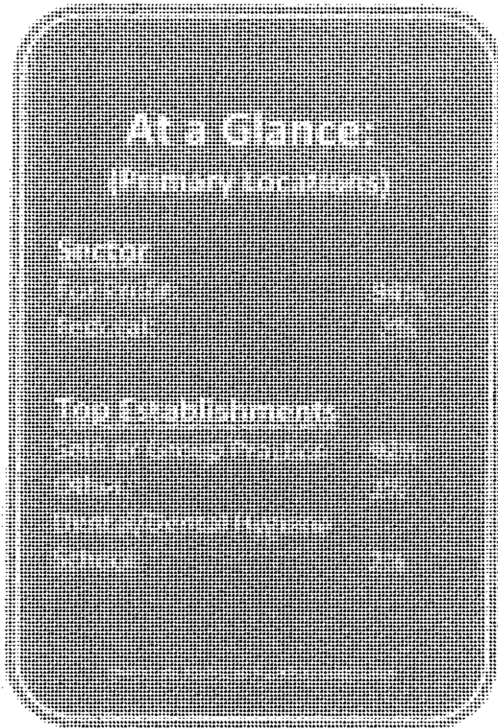
Source: Va. Healthcare Workforce Data Center

70% of all dental hygienists had just one work location in 2012. Only 12% of dental hygienists had at least three primary work locations in 2012.

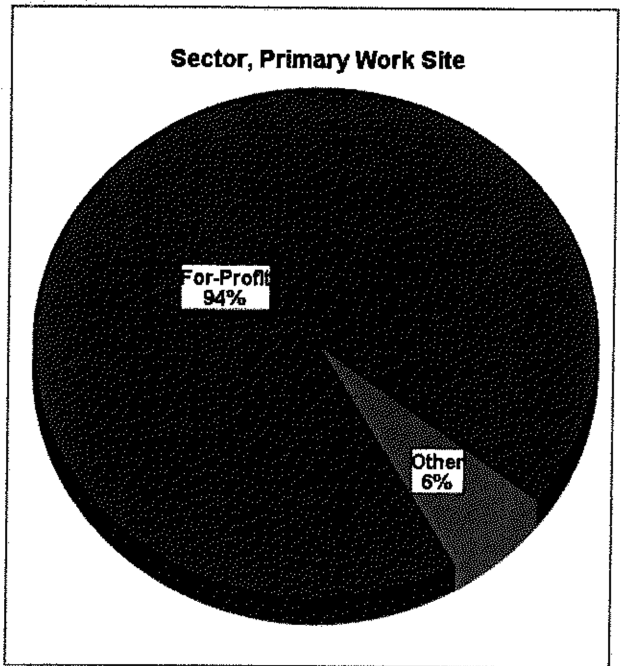
A Closer Look:

Location Sector				
Sector	Primary Location		Secondary Location	
	#	%	#	%
For-Profit	3,780	94%	933	89%
Non-Profit	56	1%	38	4%
State/Local Government	114	3%	66	6%
Veterans Administration	10	0%	2	0%
U.S. Military	65	2%	4	0%
Other Federal Government	6	0%	6	1%
Total	**4,031**	**100%**	**1,049**	**100%**
Did not have location	179		3,302	
Item Missing	285		145	

Source: Va. Healthcare Workforce Data Center



95% of dental hygienists worked in the private sector. 3% of dental hygienists worked for either a state or local government, while 2% worked for the federal government. Most federal government employees worked for the military.



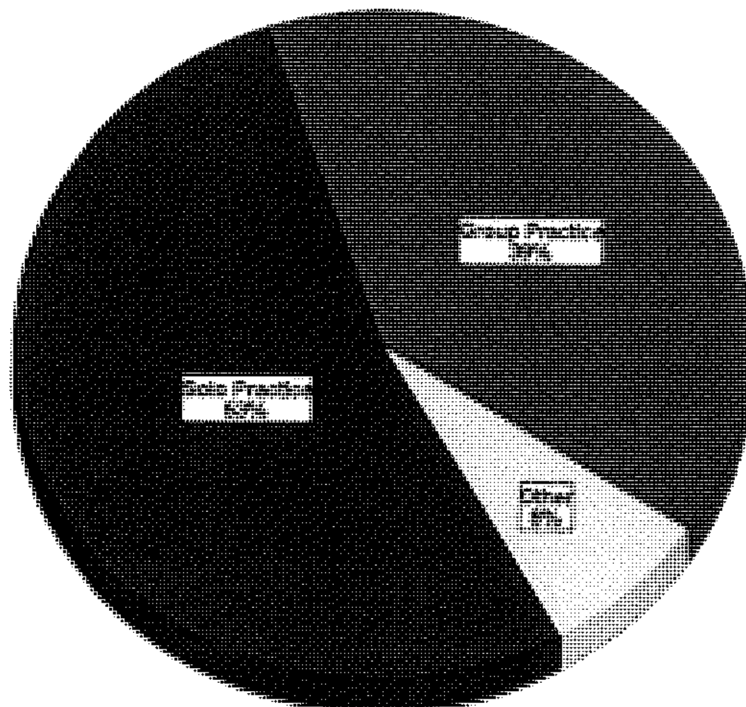
Source: Va. Healthcare Workforce Data Center

Location Type				
Establishment Type	Primary Location		Secondary Location	
	#	%	#	%
Solo Practice	2,118	53%	564	55%
Group Practice	1,567	39%	343	33%
Dental/Dental Hygiene School	62	2%	43	4%
Hospital/Health System	58	1%	5	0%
Public Health Program	31	1%	15	1%
Outpatient Community Clinic	20	1%	13	1%
Insurance	18	0%	2	0%
Nursing Home/Long-Term Care Facility	13	0%	4	0%
K-12 School or Non-Dental College	7	0%	0	0%
Supplier Organization	3	0%	3	0%
Other	92	2%	39	4%
Total	3,989	100%	1,031	100%
Does not have location	179		3,302	

Source: Va. Healthcare Workforce Data Center

92% of all dental hygienists worked in either a solo or group practice at their primary work location. Dental/dental hygiene schools and hospital/health systems were common establishment types for dental hygienists who did not work in solo or group practices.

Among those dental hygienists who also had a secondary work location, nearly 90% were in private practice. Among those who did not work in dental practices, more than one-third worked in a dental or dental hygiene school.

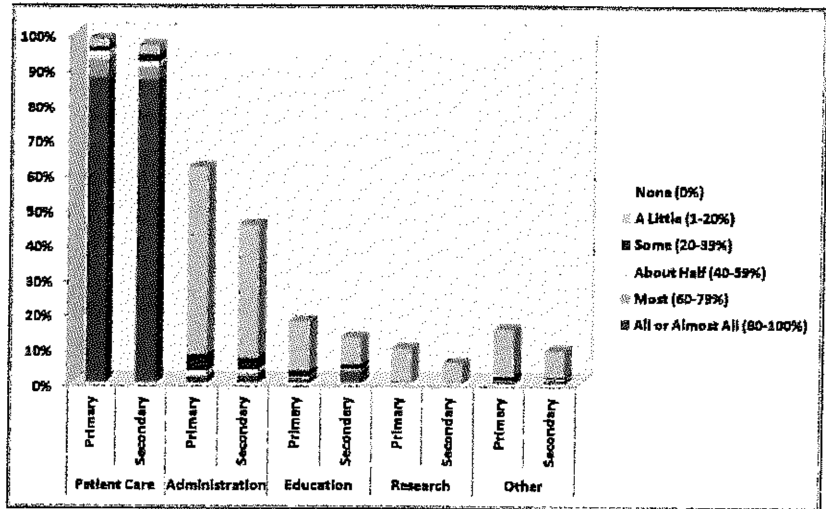


Source: Va. Healthcare Workforce Data Center

At a Glance:

(Primary Locations)

A Closer Look:



Source: Va. Healthcare Workforce Data Center

A typical dental hygienist spends nearly all of their time on patient care activities, with most of the remaining time spent on administrative tasks. 93% of dental hygienists fill a patient care role, defined as spending 60% or more of their time on patient care activities.

Time Spent	Patient Care		Admin.		Education		Research		Other	
	Prim Site	Sec. Site	Prim Site	Sec. Site	Prim Site	Sec. Site	Prim Site	Sec. Site	Prim Site	Sec. Site
All or Almost All (80-100%)	87%	87%	1%	2%	1%	3%	0%	0%	0%	1%
Most (60-79%)	5%	3%	0%	1%	0%	1%	0%	0%	0%	0%
About Half (40-59%)	2%	2%	1%	1%	0%	0%	0%	0%	0%	1%
Some (20-39%)	1%	2%	5%	3%	2%	1%	0%	0%	1%	0%
A Little (1-20%)	2%	3%	54%	38%	14%	8%	9%	5%	13%	7%
None (0%)	2%	3%	38%	55%	82%	87%	90%	94%	85%	91%

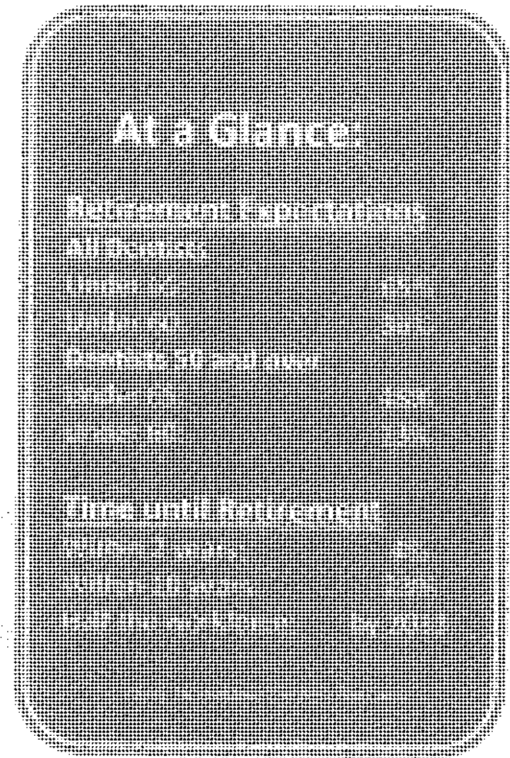
Table title: Time Allocation

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Retirement Expectations				
Expected Retirement Age	All Dental Hygienists		Dental Hyg. over 50	
	#	%	#	%
Under age 50	288	8%	-	0%
50 to 54	378	10%	-	0%
55 to 59	686	18%	140	11%
60 to 64	1,109	29%	457	36%
65 to 69	826	22%	418	33%
70 to 74	189	5%	128	10%
75 to 79	35	1%	18	1%
80 or over	22	1%	8	1%
I do not intend to retire	253	7%	98	8%
Total	**3,786**	**100%**	**1,267**	**100%**

Source: Va. Healthcare Workforce Data Center



Nearly 30% of dental hygienists expect to retire between the ages of 60 and 64, and more than half expect to retire at some point in their 60s. Among dental hygienists who are over the age of 50, nearly half expect to retire by age 65, and 69% expect to retire at some point in their 60s. One in five dental hygienists who are age 50 and over expect to work through at least age 70, including 8% who do not intend to retire.

Within the next two years, only 5% of Virginia's dental hygienists plan on leaving either the profession or the state. Meanwhile, twice as many dental hygienists plan on increasing patient care hours rather than decreasing such hours. In addition, more than one in ten dental hygienists plan on pursuing additional educational opportunitites.

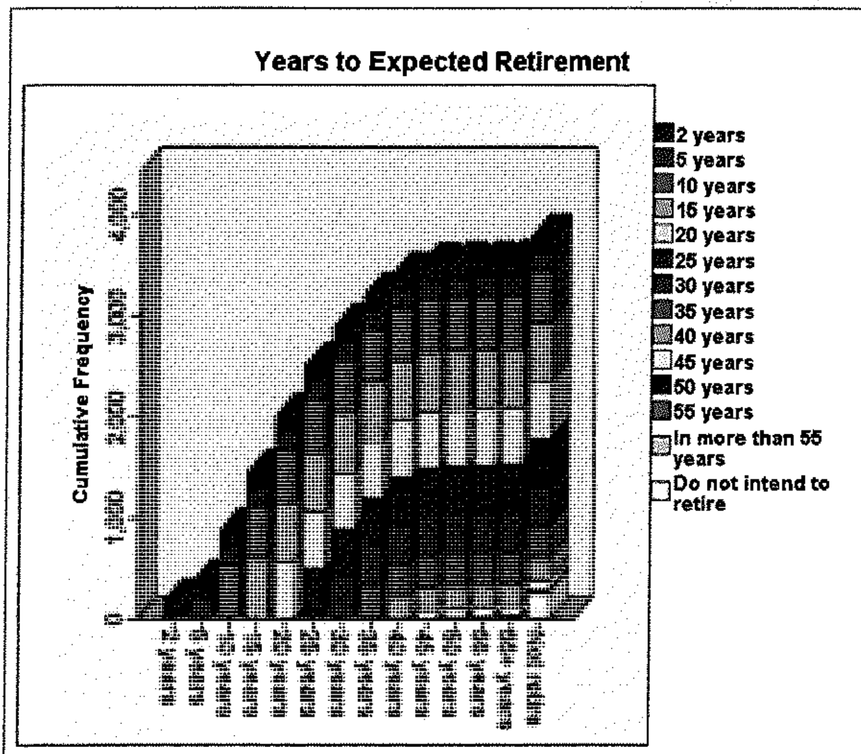
Future Plans		
2 Year Plans:	#	%
Decrease Participation		
Leave Profession	87	2%
Leave Virginia	144	3%
Decrease Patient Care Hours	376	8%
Decrease Teaching Hours	28	1%
Increase Participation		
Increase Patient Care Hours	733	16%
Increase Teaching Hours	169	4%
Pursue Additional Education	512	11%
Return to Virginia's Workforce	34	1%

Source: Va. Healthcare Workforce Data Center

By comparing retirement expectation to age, we can estimate the maximum years to retirement for dental hygienists. Fewer than one out of ten dental hygienists expect to retire in the next five years, while nearly one in four expect to retire in the next 10 years. More than half of the current dental hygienist workforce expects to retire by 2033.

Time to Retirement			
Expect to retire within. . .	#	%	Cumulative %
2 years	168	4%	4%
5 years	187	5%	9%
10 years	515	14%	23%
15 years	579	15%	38%
20 years	560	15%	53%
25 years	496	13%	66%
30 years	390	10%	77%
35 years	308	8%	85%
40 years	206	5%	90%
45 years	87	2%	92%
50 years	15	0%	93%
55 years	6	0%	93%
In more than 55 years	13	0%	93%
Do not intend to retire	253	7%	100%
Total	**3,783**	**100%**	

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

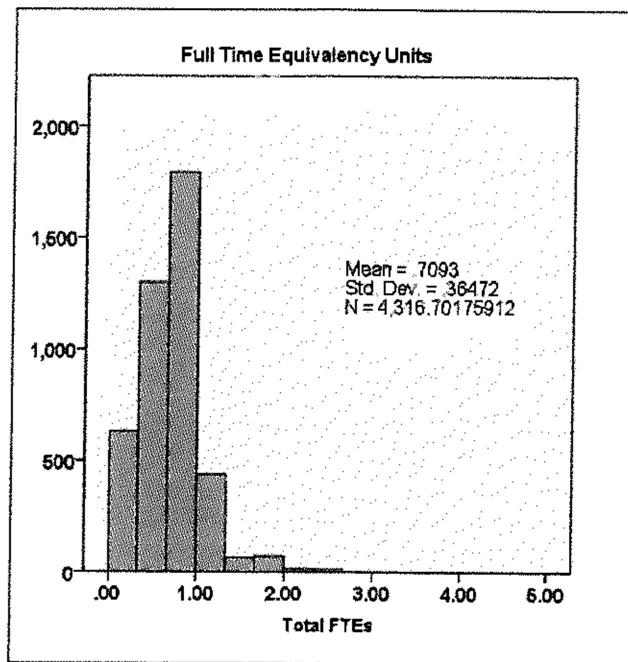
Using these estimates, retirements will begin to reach over 10% of the current workforce every 5 years by 2023. Retirements will peak at 15% of the current workforce around 2028-2033 before declining to under 10% of the current workforce around 2048. In total, two-thirds of all dental hygienists expect to retire between 2023 and 2043.

At a Glance:

FTEs:

Age & Gender Effect

A Closer Look:

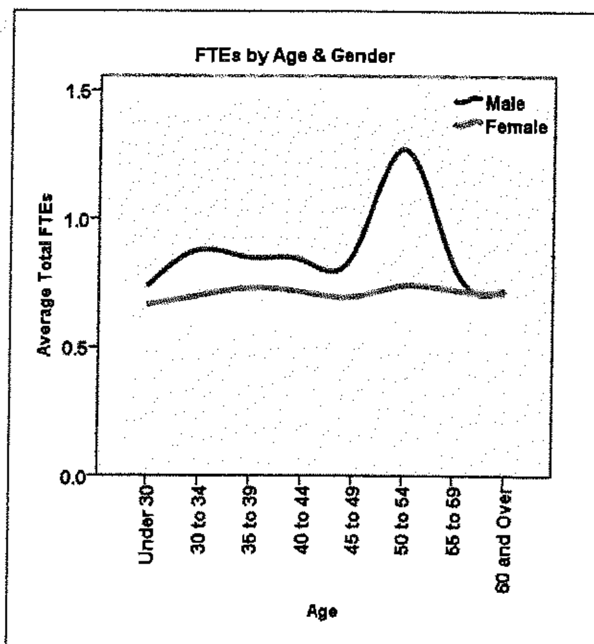


Source: Va. Healthcare Workforce Data Center

The typical (median) dental hygienist provided 0.75 FTEs in 2012, or approximately 29 hours per week for 52 weeks. Although FTEs appear to vary by gender, statistical tests did not verify a difference exists.[2]

Full-Time Equivalency Units		
Age	**Average**	**Median**
Age		
Under 30	0.66	0.70
30 to 34	0.70	0.81
35 to 39	0.73	0.78
40 to 44	0.72	0.77
45 to 49	0.69	0.72
50 to 54	0.74	0.82
55 to 59	0.72	0.72
60 and Over	0.70	0.69
Gender		
Male	0.83	0.86
Female	0.71	0.75

Source: Va. Healthcare Workforce Data Center

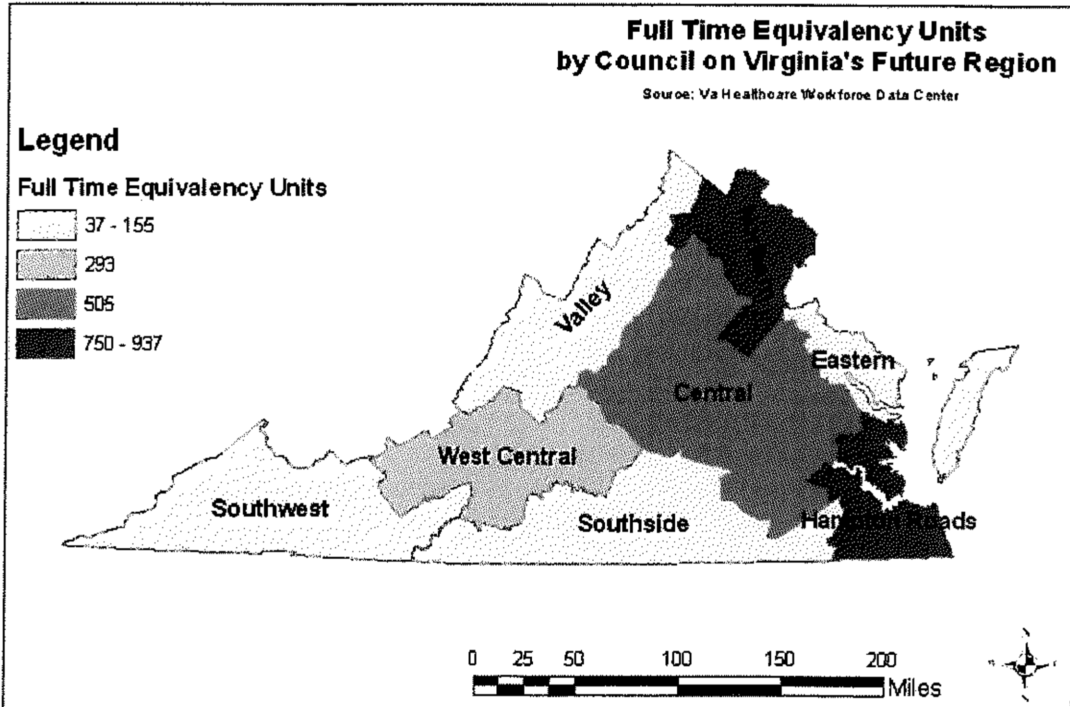


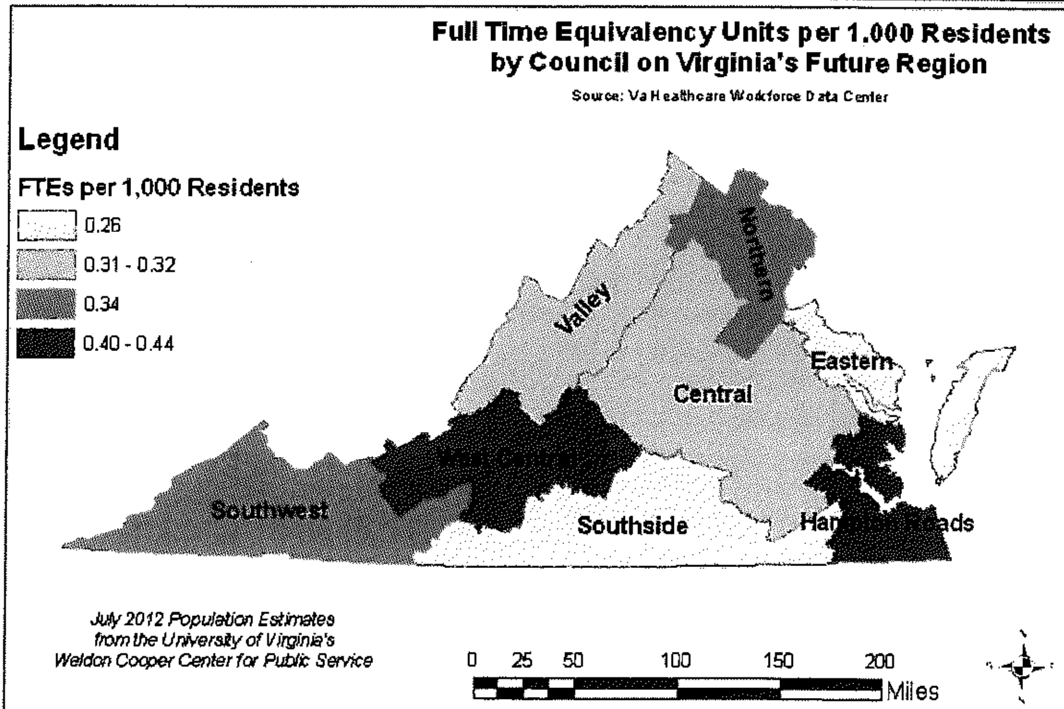
Source: Va. Healthcare Workforce Data Center

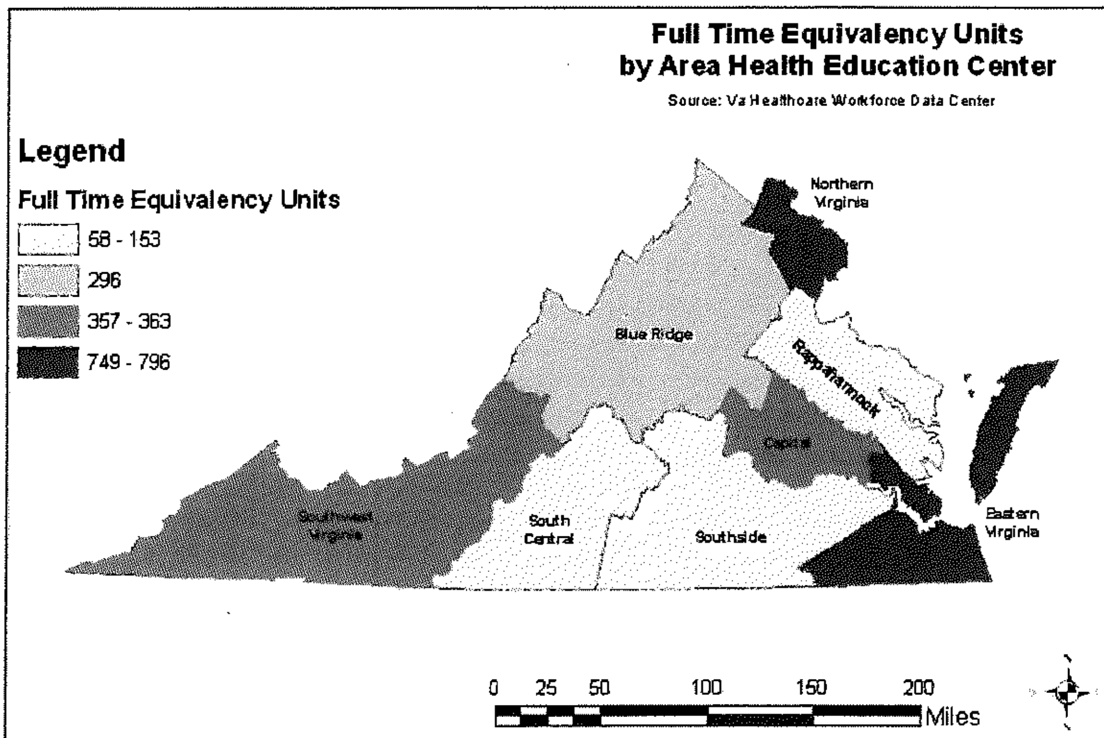
[2] Due to assumption violations in Mixed between-within ANOVA (Levene's Test is significant)

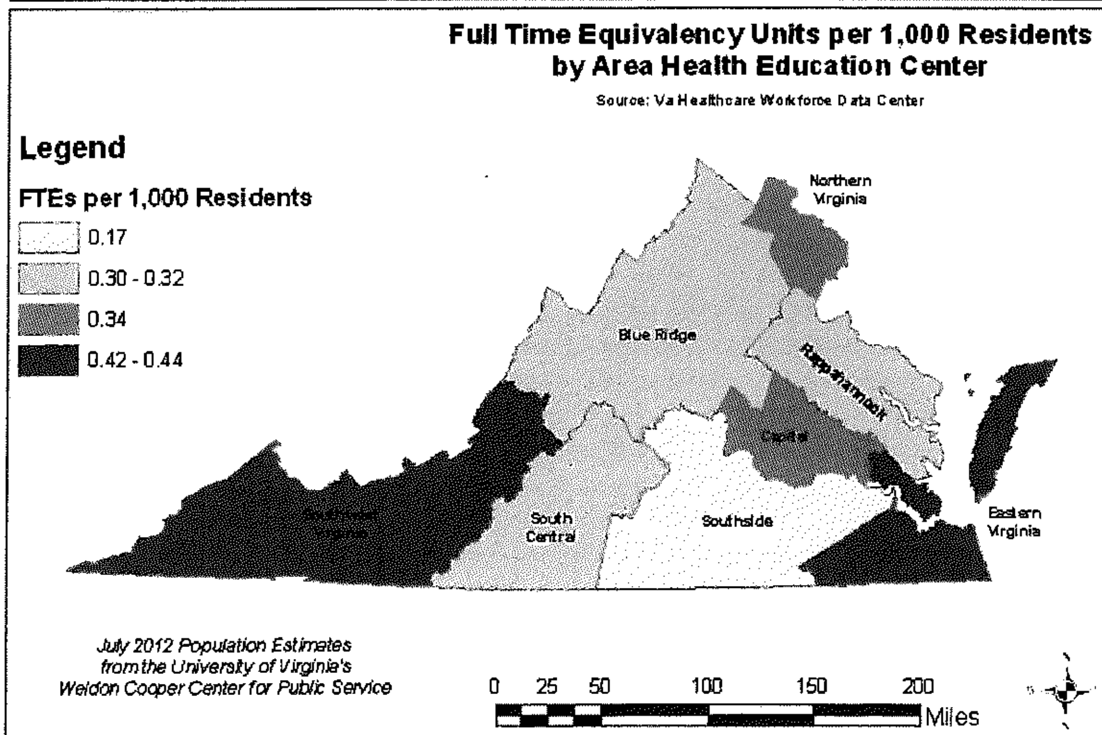
Maps

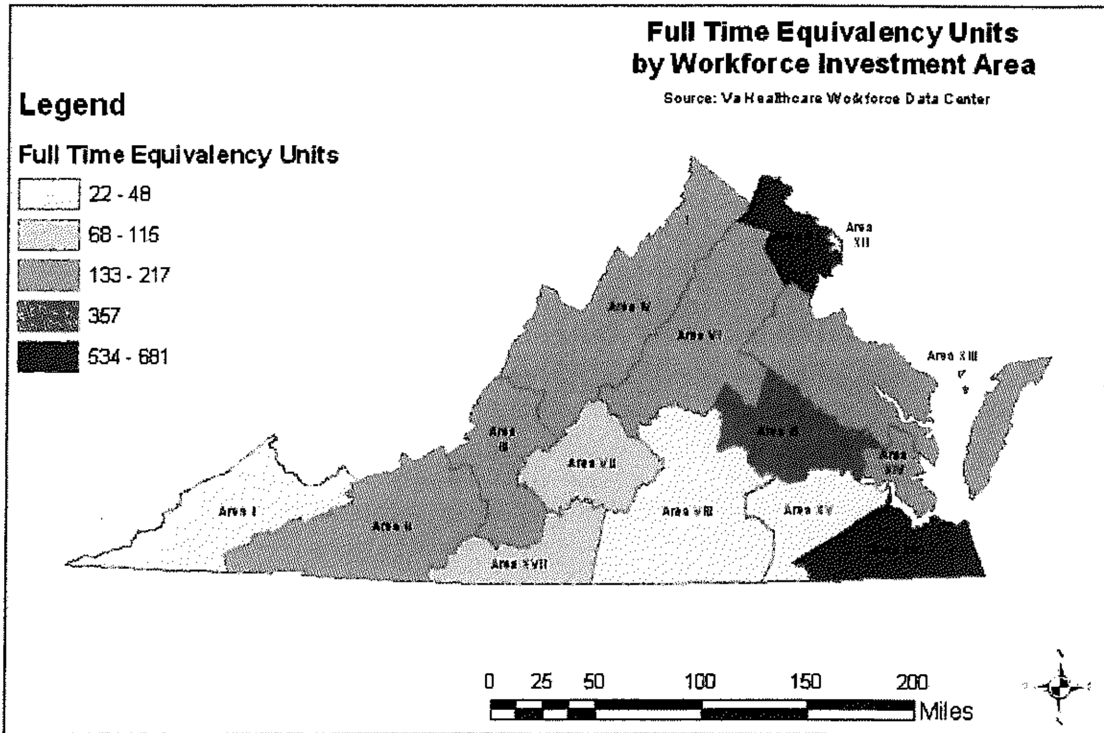
Council on Virginia's Future Regions

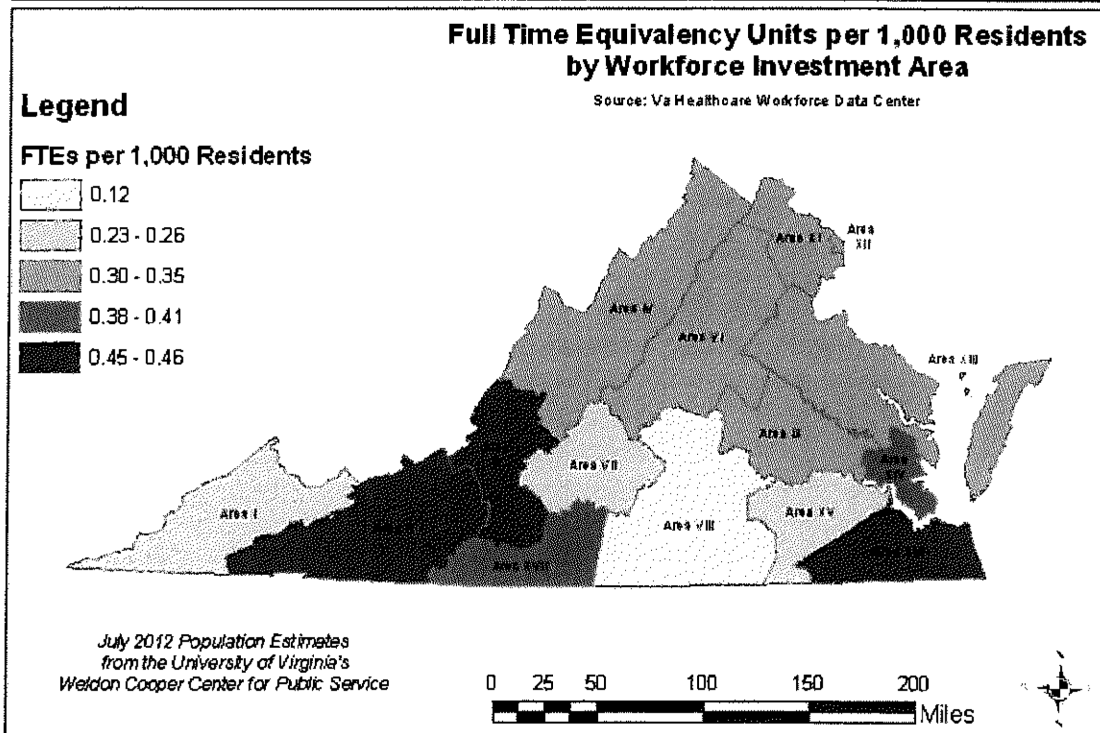


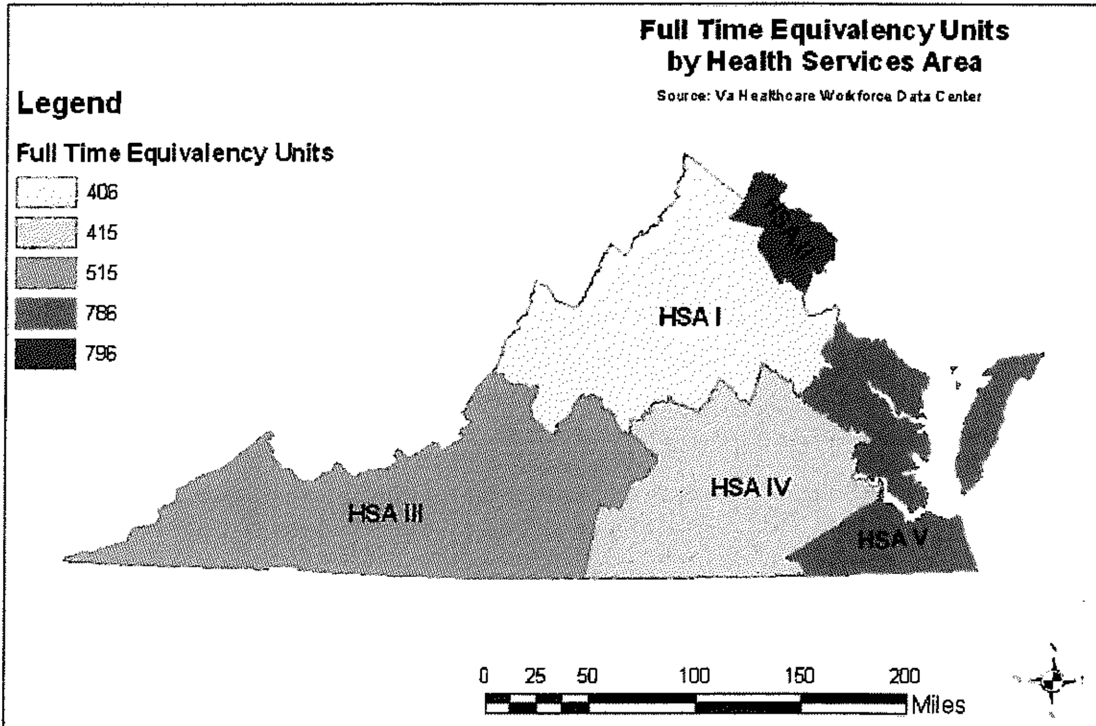


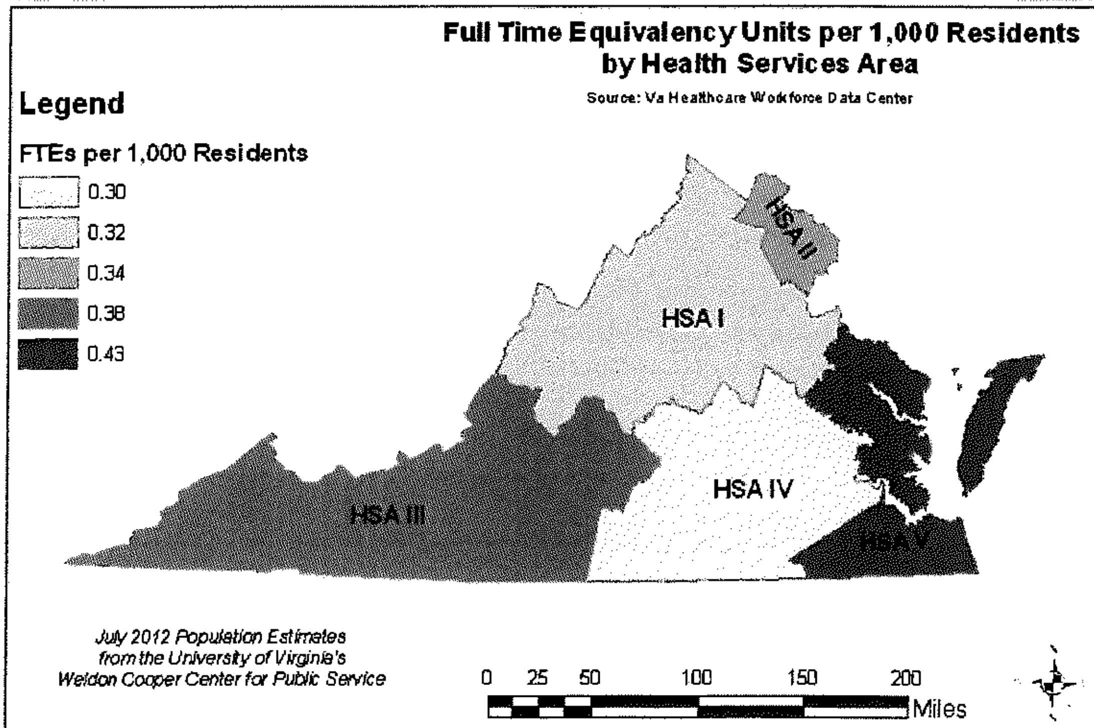

Full Time Equivalency Units
by Area Health Education Center
Source: Va Healthcare Workforce Data Center
Legend
Full Time Equivalency Units
58 - 153
296
357 - 363
749 - 796
Northern Virginia
Blue Ridge
Rappahannock
Capital
Southwest Virginia
South Central
Southside
Eastern Virginia
0 25 50 100 150 200 Miles


Full Time Equivalency Units per 1,000 Residents
by Area Health Education Center
Source: Va Healthcare Workforce Data Center
Legend
FTEs per 1,000 Residents
0.17
0.30 - 0.32
0.34
0.42 - 0.44
Northern Virginia
Blue Ridge
Rappahannock
Capital
Southwest Virginia
South Central
Southside
Eastern Virginia
July 2012 Population Estimates
from the University of Virginia's
Weldon Cooper Center for Public Service
0 25 50 100 150 200 Miles


Full Time Equivalency Units
by Workforce Investment Area
Source: Va Healthcare Workforce Data Center
Legend
Full Time Equivalency Units
22 - 48
68 - 115
133 - 217
357
534 - 681
0 25 50 100 150 200
Miles


Full Time Equivalency Units per 1,000 Residents
by Workforce Investment Area
Source: Va Healthcare Workforce Data Center
Legend
FTEs per 1,000 Residents
0.12
0.23 - 0.26
0.30 - 0.35
0.38 - 0.41
0.45 - 0.46
July 2012 Population Estimates
from the University of Virginia's
Weldon Cooper Center for Public Service
0 25 50 100 150 200
Miles


Full Time Equivalency Units
by Health Services Area
Source: Va Healthcare Workforce Data Center
Legend
Full Time Equivalency Units
406
415
515
786
796
HSA I
HSA II
HSA III
HSA IV
HSA V
0 25 50 100 150 200
Miles


Full Time Equivalency Units per 1,000 Residents
by Health Services Area
Source: Va Healthcare Workforce Data Center
Legend
FTEs per 1,000 Residents
0.30
0.32
0.34
0.38
0.43
HSA I
HSA II
HSA III
HSA IV
HSA V
July 2012 Population Estimates
from the University of Virginia's
Weldon Cooper Center for Public Service
0 25 50 100 150 200
Miles

Full Time Equivalency Units by Planning District

Source: Va Healthcare Workforce Data Center

Legend

Full Time Equivalency Units

- 10 - 26
- 48 - 80
- 85 - 141
- 339
- 739 - 796

0 25 50 100 150 200 Miles

Full Time Equivalency Units per 1,000 Residents by Planning District

Source: Va Healthcare Workforce Data Center

Legend

FTEs per 1,000 Residents

- 0.10 - 0.14
- 0.22 - 0.24
- 0.26 - 0.31
- 0.33 - 0.36
- 0.44 - 0.51

July 2012 Population Estimates from the University of Virginia's Weldon Cooper Center for Public Service

0 25 50 100 150 200 Miles

Appendix A: Weights

Rural Status	Location Weight			Total Weight	
	#	Rate	Weight	Min	Max
Metro, 1 million+	3,253	80.66%	1.23971	1.170952	1.522936
Metro, 250,000 to 1 million	382	82.98%	1.205047	1.138211	1.480354
Metro, 250,000 or less	354	80.79%	1.237762	1.169112	1.520543
Urban pop 20,000+, Metro adj	88	81.82%	1.222222	1.154434	1.501453
Urban pop 20,000+, nonadj	0	NA	NA	NA	NA
Urban pop, 2,500-19,999, Metro adj	176	82.95%	1.205479	1.138619	1.480885
Urban pop, 2,500-19,999, nonadj	110	81.82%	1.222222	1.154434	1.501453
Rural, Metro adj	84	78.57%	1.272727	1.202137	1.563496
Rural, nonadj	38	84.21%	1.1875	1.121637	1.458798
Virginia border state/DC	444	71.62%	1.396226	1.318787	1.71521
Other US State	474	67.93%	1.47205	1.390405	1.808356

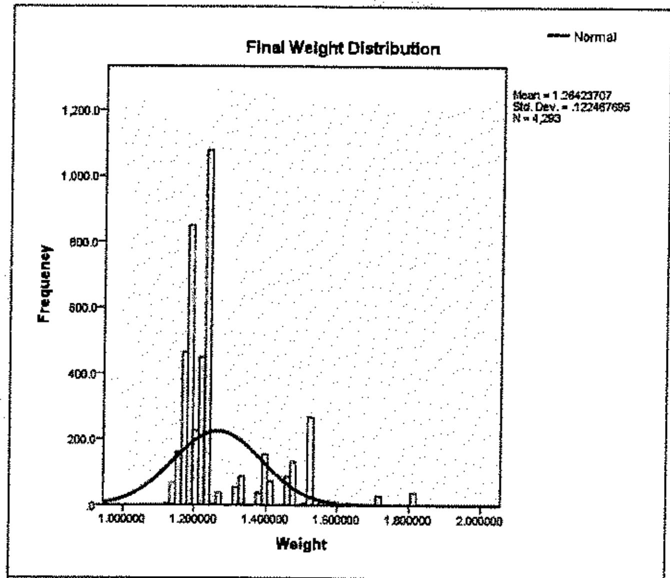
Age	Age Weight			Total Weight	
	#	Rate	Weight	Min	Max
Under 30	707	83.73%	1.194257	1.121637	1.390405
30 to 34	710	82.82%	1.207483	1.134059	1.405803
35 to 39	696	79.89%	1.251799	1.17568	1.457397
40 to 44	701	82.45%	1.212803	1.139055	1.411997
45 to 49	671	78.99%	1.266038	1.189053	1.473975
50 to 54	712	79.35%	1.260177	1.183549	1.467152
55 to 59	630	79.05%	1.26506	1.188135	1.472837
60 and Over	598	64.38%	1.553247	1.458798	1.808356

See the Methods section on the HWDC website for details on HWDC Methods:

Final weights are calculated by multiplying the two weights and the overall response rate:

ageweight x ruralweight x responserate = final weight.

Overall Response Rate: 0.790899



130th American Association of Dental Boards Annual Meeting
October 30-31, 2013
Hyatt Regency, New Orleans

AADB President upate, Dr. R. Mark Hinrichs

- AADB is in the process of updating a current Strategic Plan
- AADB is collaborating with DANB
- AADB shares Dental Practice Acts which is accessible to their members

Electronic Patient Record, Dr. Robert Faiella, ADA President

- Electronic records is currently voluntary
- Systematized Nomenclature of Dentistry (SNODENT) / (SNOMED) is a vocabulary designed for use in the electronic environment—for electronic health and dental records. The intended purpose is to:
  1. Provide standardized terms for describing dental disease
  2. Capture clinical detail and patient characteristics
  3. Permit analysis of patient care services and outcomes
  4. To be interoperable with Electronic Health Records (HER) and Electronic Dental Records (EDR)
- Contact for Dr. Robert Faiella : faiellar@ada.org ; (508) 367-0799

Electronic Patient Record-Issues Facing Dental Baords, Dr. Paul Kleinstrub, Dental Director/Chief Investigator for the Oregon Dental Board of Dentistry

- Consider authenticity of electronic records as they can be easily altered at any time
- Templates on computer programs poses challenges to verify records
- Time and date can be altered with chart notes and records
- "Back screens" can be modified
- Challenges with PDF and Jpegs—make sure they're not altered by requesting for Disc directly from computer vs. individual sheets and copies submitted
- Dextrix software allows treatment plans to disappear once treatment is completed, which poses a problem with record keeping (Recommend to keep a copy of the treatment plan in patient charts)

Virtual Dental Home, Dr. Paul Glassman, Professor of Dental Practice, Diretor, Community Oral health, Director, Pacific Center for Special Care, University of the Pacific

- Access to care for underserved update—
  1. 1 out of every 16 children in the US did not receive needed dental care because their families could not afford it.
  2. Underserved individuals include racial and ethnic minorities, people with special health care needs, older adults, pregnant women, populations of lower socioeconomic status, and rural populations.

- Lack of access to oral health contributes to profound and enduring oral health disparities in the US.
- Access to care is limited by a variety of social, cultural, economic, structural and geographic factors.
- The IHI Triple Aim
    1. Improving the patient experience of care (including quality and satisfaction)
    2. Improving the health of populations
    3. Reducing the per capita cost of health care
- Technology with our current practice: charting is available on Cloud; Nomad x-ray machine and sensor
- Consideration of in person exams vs. virtual dental exams—still congruent exams with DDS decision
- Intertherapeutic restorations practiced in California
- Telehealth considerations
    1. Cross state licensure, expanded scopes and interoperable records
    2. Allow RDH to place interim therapeutic restorations and decide which teeth need sealants
    3. Reimbursement regulations

Teledentistry-licensure Issues Across Borders, Dr. Quinn Dufurrena, Executive Director, Colorado Dental Association

- Use of iPhone App as intra oral camera to assist with teledentistry and diagnosis
- Compact Template to cross reference ADA, AADB and AAPD
- Issues—payment, patient abandonment, strict product liability training, privacy issues, malpractice, informed consent, waivers/liability, standards of and change (recent cases of MD's being sued for not using telemedicine), international

Learning Style and Distance Learning, Dr. Chet A. Smith, Director of Curriculum and Instruction, LSU School of Dentistry

- Review of 7 learning styles—visual, physical, social, verbal, aural, logical and solitary
- Addressed specific tools to aid with each learning style

ASP Update-Case Experience, Dr. Guy Shampaine, MD

- D-Prep provides training and consulting services for disaster preparation and emergency response. Their primary audience is to law enforment personnel.
- D-Prep training and consulting services for Disaster Preparation and Critical Incident Response

Washington Update, Michael Graham, ADA Senior Vice-President, Government and Public Affairs

- Medicaid—fix since it's not working
- Mid level providers currently in 16 states
- Corporate dentistry—an appealing option to recent grads

Attorney Update, Craig Bussey, JD, ADA Chief Legal Counsel

- FTC development with NC Dental Board regarding whitening case and anti trust laws
- NC is seeking support from other states by requesting a letter from the Attorney General's office
- Current case of certiorari will determine the future of this case in the US Supreme Court

Board Attorney Update, Angela Dougherty, Esq., WY and Lili Reitz, Esq., OH

- Suggested using a separate email address for board members -not work related or shared for confidentiality
- Do not forward emails
- Do not reply all when responding to emails with other board members since it can be considered a private meeting

Dental Hygiene Update, Denise Bowers, RDH, PhD, ADHA President

- Currently there are 36 Direct Access states
- Request for CODA testimonies to urge CODA to develop dental therapy standards for a dental hygiene-based dental therapy track
- ADHA' s policies support the establishment of new dental hygiene-based provider models that result in providers who are graduates of accredited education programs, are licensed, and are able to provide care directly to patients.

REGIONAL MEETING with neighboring states (VA, WVA, DC and MD)

1. Cross CE between states
2. Drug Diversion Issue and Coalition
3. Corporate Dentistry (non-dentist owned)—Best practices to convey between states. Standard of Care should be consistent and universal between states.
4. Cross borders licensees
5. Newsletter to share with other states including Legislative updates
6. Upcoding activity
7. WVA will be offering an online CE course

**Copy of notes to be emailed to all Executive Directors

Respectfully submitted by,

Melanie C. Swain BSDH, RDH
Board member

NINTH ANNUAL ADEX MEETING
Chicago, IL

Report of the Dental Examination Committee by Dr. James D. Watkins

The ADEX meeting was held at the Doubletree Hilton Hotel O'Hare on November 8-10, 2013.

NOTABLE ANNOUNCEMENT: CITA HAS JOINED ADEX WHICH MAKES THE ADEX EXAMINATION AN ACCEPTABLE EXAM FOR 45 JURISDICTIONS.

The meeting was called to order at 1:30pm on Friday, November 8th with 53 members of the committee sitting at the table.

The meeting usually begins with a report from Dr. Klein, ADEX Testing Specialist, on examination validity issues; but he had to cancel attendance at the last minute; so a report will be forth-coming to committee members.

The discussions on the various sections of the Examination centered around a number of factors that were determined to be mostly "administrative issues" whose handling could be determined by the individual testing agencies. Any issues that were presented today to make significant changes to the dental examination were assigned to various committees (committee members assigned by the Chair) for discussion with a report to come back to this Committee at its next meeting. After a considerable number of examination changes were presented and it was determined that "further study" of the request was needed; it was decided to create a number of STANDING committees that would allow for direct referral of new issues presented to the Dental Examination Committee. These Standing committees will meet for a half day before the DEC meets and report their decisions to the DEC for its disposition. The representation on the Standing committees will include a member from each testing agency in ADEX.

Most of the testing agencies had NOT created their 2014 Candidate Manuals yet, so it was determined that any issues that could be agreed upon at this session could be placed in the individual manuals. A few of the changes that were accepted to begin in 2014 were a revised medical history form; any shroud is acceptable and no penalty for damage to a shroud at the exam site; no sharing of patients between candidates for the Class III procedure; both Accadental and Columbia typodont teeth are being used for the Endo procedure; and CFE's will be required to check modification forms before the patient goes to the express chair during the exam.

With no other business to discuss, this committee was adjourned at noon on Saturday, November 9th.

Agenda Item: Regulatory Actions - Chart of Regulatory Actions (As of November 20, 2013)

Chapter		Action / Stage Information
[18 VAC 60 - 20]	Regulations Governing Dental Practice	Periodic review; reorganizing chapter 20 into four new chapters: 15, 21, 25 and 30 [Action 3252] Proposed - *Register Date: 11/4/13* *Comment period: 11/4/13 to 1/11/14*
[18 VAC 60 - 20]	Regulations Governing Dental Practice	Sedation and anesthesia permits for dentists [Action 3564] Proposed - *Register Date: 10/7/13* *Comment period: 10/7/13 to 12/6/13* *Board discussion of comment: 12/6/13* *Executive comment adoption of final rules: 1/10/14*
[18 VAC 60 - 20]	Regulations Governing Dental Practice	(E) Correction of renewal deadline for faculty licenses [Action 4081] Final - *At Attorney General's Office for 68 days*

Agenda item: Letter from Dr. Bukzin

Dr. Bukzin expresses his concern about fraud and the work of the Board.

Action Options:

- Receive as information
- Direct the response to be given

DHP NOV 07 2013

MITCHELL J. BUKZIN, D.D.S.

4391 RIDGEWOOD CENTER DRIVE • SUITE C • WOODBRIDGE, VA 22192 • (703) 590-4666

2 November 2013

RECEIVED
NOV 07 2013
Board of Dentistry

Jeffrey Levin, D.D.S.
President, Virginia Board of Dentistry
9960 Mayloand Dr., Suite 300
Henrico, VA 23233-1463

Dear Dr. Levin,

I am writing this letter because of the frustration and anger dealing with patients who come to me for a second opinion when they get fraudulent diagnosis and treatment plans. I know you must be aware of the outright crooks that have plagued not only our state, but probably all states. Patients are having their health reduced by greedy dentists who are tearing up their healthy teeth for the money.

When I wrote complaining about a local dentist that gave a former patient of mine and her husband a $7500 treatment plan, the Board took no action. There was NO caries and no need for any treatment. The full series of radiographs show nothing but healthy teeth. How you all can ignore the solid evidence the "treatment" was bogus is beyond my understanding. I have heard from a colleague (Dr. Robert Allen of Hampton) that because caries is "subjective" that you have your hands tied. It is with great restraint I only say phooey. I have seen other cases like this where the radiographs are taken mainly to get a fee and not diagnose any need for treatment. Then you all, it appears, blow off these as not being worthy of calling these crooks in for questioning. There is nothing subjective about radiographs that show no disease.

The confidence in dentists built up over decades of honest dealings by the great majority of dentists in the U.S. is now being trashed by criminals. Is there nothing you all can do to discipline these frauds?

Sincerely,

Mitchell J. Bukzin, DDS

Mitchell J. Bukzin, D.D.S.

Agenda item: Education Requirement for Licensure

Dr. Wyman requests discussion of the regulation that allows a foreign trained dentist to be licensed by completion of an accredited 12 month General Dentistry program or an accredited post doctoral specialty program.

The subject regulation is in the Regulations Governing Dental Practice, Part III. Entry Requirements.

> **18VAC60-20-60. Educational requirements for dentists and dental hygienists.**
>
> A. Dental licensure. An applicant for dental licensure shall be a graduate and a holder of a diploma or a certificate from a dental program accredited by the Commission on Dental Accreditation of the American Dental Association, which consists of either a pre-doctoral dental education program or at least a 12-month post-doctoral advanced general dentistry program or a post-doctoral dental education program in any other specialty.
>
> B. Dental hygiene licensure. An applicant for dental hygiene licensure shall have graduated from or have been issued a certificate by a program of dental hygiene accredited by the Commission on Dental Accreditation of the American Dental Association.

Information provided on this item:

- The list of CODA accredited advanced programs
- Informal Survey Results of Other States' Acceptance of Advanced Programs

A data report on the licensees who were licensed by completing only advanced education has been requested for distribution at the meeting.

Action Options:

- Discussion Only
- Discuss and refer to Legislative/Regulatory Committee for further study and development of a proposed amendment

Search Advanced Programs

Search DDS/DMD Programs
Search Advanced Programs
Search Dental Assisting, Hygiene and Lab Technology Programs
Accreditation Notices
Accreditation Status Definitions

U.S. Programs

Canadian Programs
Military Outside U.S.

Using the drop-down menus, you can search for an accredited advanced specialty education or postdoctoral general dentistry education programs in the United States by state and/or discipline. The information includes mailing address, on-site evaluation years and current accreditation status.

State : All

Programs : All

Search

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Chicago, IL 60611-2678
312 - 440 - 2500

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vanced Prog...

U.S. Programs

Canadian Programs

Military Outside U.S.

Using the drop-down m... or postdoctoral general dentistry educ... ormation includes mailing address, on-sit...

All
Advanced Education in General Dentistry 12 Months
Advanced Education in General Dentistry 24 Months
Clinical Fellowship in Craniofacial and Special Care Orthodontics
Dental Anesthesiology
Dental Public Health
Endodontics
General Practice Residency 12 Months
General Practice Residency 24 Months
Maxillofacial Prosthetics
Oral and Maxillofacial Pathology
Oral and Maxillofacial Radiology
Oral and Maxillofacial Surgery
Oral and Maxillofacial Surgery Clinical Fellowships Cosmetic
Oral and Maxillofacial Surgery Clinical Fellowships Craniofacial
Oral and Maxillofacial Surgery Clinical Fellowships Oncology
Oral Medicine
Orofacial Pain
Orthodontics & Dentofacial Orthopedics
Orthodontics/Periodontics
Pediatric Dentistry
Periodontics
Prosthodontics
Prosthodontics/Maxillofacial Prosthetics

State :

Programs : All Search

Informal Survey of Other States' Acceptance of Advanced Program
Conducted by Huong Vu, Operations Manager

The question asked was "Can foreign trained dentists who complete a CODA accredited Specialty program ONLY be able to obtain general dental license?"

Here are the responses received from other states:

AK – currently no, but the Board is in the process of amending language

AZ – no, must received a DDS or DMD diploma from ADA accredited program

ID – no, must received a DDS or DMD diploma from ADA accredited program

IL – yes if complete CODA accredited programs as of July 2006 or non-CODA program (**Section 1220-140.g** - must be approved by the Division)

KY – yes

LA – yes

MD – Limited license only

MI – yes

MO – no, must received a DDS or DMD diploma from ADA accredited program

MS – yes

NV - no, must received a DDS or DMD diploma from ADA accredited program

NY – yes

OR – no

SC – yes

TN – no, must received a DDS or DMD diploma from ADA accredited program

WV – yes

WY – no, must received a DDS or DMD diploma from ADA accredited program