VIRGINIA BOARD OF DENTISTRY

AGENDAS

December 11-12, 2014

Department of Health Professions

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

PAGE

December 11, 2014

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

December 12, 2014

9:00 a.m. **Board Business**

Call to Order – Ms. Swain, President

Evacuation Announcement – Ms. Reen

Public Comment

Approval of Minutes

- September 12, 2014 Business Meeting **P1**
- September 30, 2014 Telephone Conference Call **P11**
- October 24, 2014 Business Meeting **P12**
- November 7, 2014 Formal Hearing **P14**
- November 21, 2014 Formal Hearing **P17**

DHP Director's Report – Dr. Brown

- Executive Order 29 on Prescription Drug and Heroin Abuse **P21**
- Requirement to Report Dispensing **P24**

Prescription Monitoring Program Update – Mr. Orr

- Statute Requiring Registration **P26**

HWDC 2014 Dentistry and Dental Hygienist Survey Results – Mr. Crow

- Report on Dental Hygienists **P27**
- Report on Dentists **P56**

Liaison/Committee Reports

- BHP – Dr. Watkins **P85**
- AADB Annual Meeting in San Antonio, TX
  - Ms. Swain's report **P92**
  - Dr. Wyman's report **P96**
- ADEX Annual Meeting in Rosemont, IL
  - Dr. Rolon's House of Representative Meeting Report **P98**
  - Dr. Rizkalla's Dental Examination Subcommittee Meeting Report **P99**
- SRTA – Ms. Swecker, Dr. Watkins, & Dr. Rizkalla
- Regulatory/Legislative Committee –Dr. Wyman **P101**

PAGE

Legislation and Regulation – Ms. Yeatts
- Status Report on Regulatory Actions **P107**
- Status Report on Proposed Legislation

Board Discussion/Action
- Review of Public Comment Topics
  - VSOMS Letter on Obstructive Sleep Apnea **P108**
  - AAO Letter on "Do It Yourself" Teeth Straightening **P112**
- VDA Invitation for Dinner **P114**
- AADB Letter about Membership **P115**
- LA Board Letter to ADEX **P116**
- ADA Comments Requested: ADA Sedation & Anesthesia Guidelines **P118**

Disciplinary Activity Report/Business – Ms. Palmatier **P120**

Executive Director's Report/Business – Ms. Reen**
- Review of Executive Order Number 2 **P122**
- Review of Guidance Document 60-20 on Radiation Certification **P126**

1:30 p.m. **Formal Hearings**

Unapproved

VIRGINIA BOARD OF DENTISTRY
MINUTES
September 12, 2014

TIME AND PLACE:	The meeting of the Board of Dentistry was called to order at 9:02 a.m. on September 12, 2014, Department of Health Professions, 9960 Mayland Drive, Suite 201, Board Room 4, Henrico, Virginia 23233.
PRESIDING:	Melanie C. Swain, R.D.H., President
BOARD MEMBERS PRESENT:	John M. Alexander, D.D.S Sharon W. Barnes, Citizen Member Surya P. Dhakar, D.D.S. Charles E. Gaskins, III, D.D.S. A. Rizkalla, D.D.S. Tammy K. Swecker, R.D.H. James D. Watkins, D.D.S. Bruce S. Wyman, D.D.S.
BOARD MEMBERS ABSENT:	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:	Jamie Hoyle, DHP Chief Deputy Director James E. Rutkowski, Assistant Attorney General
ESTABLISHMENT OF A QUORUM:	With nine members of the Board present, a quorum was established. Ms. Swain introduced two new Board members, Dr. Alexander and Ms. Barnes, Ms. White, SRTA Executive Director, and Ms. Lemon, DHP Director of Enforcement Division. She added that Dr. Levin and Ms. Howard will be missed. She also thanked Board staff for their support and for keeping Board members up to date with changes.

PUBLIC COMMENT: Ms. Swain explained the purpose of the public comment period, then asked for comments.

Dr. Tegwyn Brickhouse, Chair of Department of Pediatric Dentistry at VCU School of Dentistry, stated that sedation inspections should focus on patient safety to assess emergency preparedness and airway management and that the inspectors should be pediatric dentists and/or dental anesthesiologists for pediatric practices.

Dr. Malinda Husson, Director of Dental Anesthesia Services-Department of Pediatric Dentistry at VCU School of Dentistry, stated that pediatric dentistry residents are well trained in airway management.

Dr. Patricia Wunsch, Director of Advanced Education in Pediatric Dentistry at VCU School of Dentistry, stated that no one can do sedation inspections better than a person who has advanced training in airway management.

Dr. Michael Link, VDA President-Elect, thanked the Board members for their time and service. He commented that unannounced inspections are disruptive to dental practices and unfair to the 95% of licensees who practice sedation safely. He added that no other states do unannounced inspection. He noted that the true goal should be patient safety and, if the Board is concerned with licensees not being in compliance, then it should set stricter education requirements. He added that full inspections are burdensome and costly and asked the Board to delay implementation.

Dr. Jacques Riviere stated that the Board's current protocol does not, but should, address safety. He suggested that the Board follow the VSOMS model of using volunteers to test emergency preparedness.

Gerald Canaan II, Esq., of Hancock, Daniel, Johnson & Nagle, P.C., stated that he was addressing the proposal to restrict continuance requests. He said there are many reasons for last minute requests to continue a hearing, and each request should be determined based on "good cause". He added that all respondents want to have their hearings as soon as possible; then asked the Board to consider this matter carefully.

Dr. William Bennett welcomed the new members and thanked current members for their work. He asked the Board to set standards and education requirements to promote ethics and professionalism. He also encouraged the Board to work with organized dentistry and educators to address issues affecting public safety.

DHP DIRECTOR'S REPORT:

Ms. Hoyle stated that Dr. Brown was not available because he was attending the CLEAR Conference. She then reported:

- Virginia is studying acceptance of military training in state licensing policies;
- Virginia is looking into licensing more mid-level providers to increase access to health care; and
- DHP is advancing legislation to require pre-licensure criminal background checks for RNs and LPNs. The agency is beginning this initiative with the Board of Nursing and will be expanding it to other boards in the future.

APPROVAL OF MINUTES:

Ms. Swain asked for approval of the minutes as listed on the agenda. Dr. Gaskins noted that the day specified on the September 10, 2014 minutes should be Wednesday, not Friday. Ms. Swain stated that all minutes would be adopted as amended.

SRTA REPORT:

Ms. White, SRTA Executive Director, gave a power point presentation on the history of SRTA and the American Board of Dental Examiners (ADEX), and reviewed each agency's organizational structure. She invited questions.

In response to questions, Ms. White said that:

- SRTA will retain its exam committees.
- SRTA supports having its examiners do exams for other testing agencies administering the ADEX exam.
- She believes state boards should exam for all tests it accepts.
- While the content of the ADEX exam is consistent across testing agencies, administrative practices vary and these practices can affect outcomes.
- She is not sure if it is possible that there will be one national exam accepted by all states.
- Other SRTA state boards do allow its current members to examine for NERB and receive compensation.
- NERB will send invitations to examine to board members in all states where ADEX is accepted.

With no other questions, Ms. Swain thanked Ms. White for her presentation and time.

CONDUCTING FACILITY INSPECTIONS:

Ms. Lemon, DHP Director of Enforcement, introduced Leith Ellis, Senior Inspector, and Pamela Twombly, Deputy Director of Enforcement. She explained the role of Enforcement referencing §54.1-2506 of the Code of Virginia and said that inspections are conducted to promote a culture of compliance and that DHP inspectors:

- Collect and analyze data,
- Are knowledgeable about inspection procedures, and
- Have been trained to apply laws and regulations based on observations.

She stated that inspections are addressed as an educational opportunity and inspections are conducted so as not to interrupt providers. She then asked Mr. Ellis to provide further information about inspection.

Mr. Ellis said that currently there are 500 facilities inspected for the health professions boards. He noted that he mainly works with the office managers to collect information and then meets with the dentists to review the information collected before leaving.

In response to a question, Ms. Lemon stated that 70% of unannounced inspections are routine or complaint driven. She added that an example of an announced inspection would be the inspections required before a new or relocated pharmacy can open for business.

With no further question, Ms. Lemon thanked the Board and Ms. Swain thanked Ms. Lemon and Mr. Ellis for their presentations.

LIAISON/COMMITTEE REPORTS:

Board of Health Professions (BHP). Ms. Swain congratulated Dr. Watkins on his appointment to BHP.

AADB. Ms. Swain noted that she, Dr. Wyman, and Ms. Reen will attend the AADB meeting in October, 2014, in Texas.

ADEX. Dr. Rizkalla stated that he and Dr. Rolon will attend the meeting in November, 2014, in Chicago.

SRTA. Dr. Rizkalla, Ms. Swecker and Dr. Watkins stated they had no information to add to their written reports.

LEGISLATION AND REGULATIONS:

Status Report on Regulatory Actions. Ms. Yeatts reported that the Periodic Review to reorganize Chapter 20 into four new chapters: 15, 21, 25 and 30, is still pending review by the Secretary of Health and Human Resources (SHHR).

Status Report on Proposed Legislation on Fee-Splitting. Ms. Yeatts reported that the wording was changed slightly since the Board's adoption in response to public comment and that the proposed legislation has been advanced to the SHHR for review.

BOARD DISCUSSION/ACTION:

Review of Public Comment Topics. Ms. Swain opened the floor for discussion of the comments addressed to the Board then moved to the next agenda item when there was no response.

Continuance Requests. Dr. Wyman asked the Board to direct that notices for disciplinary proceedings require attendance if a continuance request is not submitted at least two weeks in advance of the scheduled proceeding. Mr. Rutkowski stated that he and the presiding officer discuss all the continuance requests and that the Commonwealth is generally asked if it objects to the continuance. He advised the Board not to restrict the presiding officer's authority to grant continuances because each decision is very fact specific, and the right of the respondent must be taken into account.

DANB's NELDA Program. Ms. Swain asked if there were any questions about the information provided about the new program then moved to the next agenda item when there was no response.

REPORT ON CASE ACTIVITY:

Ms. Palmatier reported on the Board's disciplinary case statistics, noting that for the fourth quarter of FY2014, the Board received 84 cases and closed 52 cases for a 62% clearance rate; which is down from 77% from last quarter, and 63% of the patient care cases were closed within 250 days, as compared to 74% from last quarter.

She pointed out that based on DHP Quarterly Performance Measures for the fourth quarter of FY2014, the Boards of Nursing and Medicine received three times the cases that Dentistry did in the fourth quarter, yet their numbers are consistently and significantly higher. She noted that essentially only five Board members are consistently returning within three weeks. She added that, on the previous day, the Board read 38 cases and also

received 9 new cases. She also noted that one dentist and one hygienist were summarily suspended, and one dentist was mandatorily suspended between May 28 and August 25, 2014.

Ms. Palmatier stated that effective as of July 1, 2014, an addition to Virginia Code §54.1-2400(10) changed the process for handling cases where there may be grounds to deny an application for licensure, certification, registration or permit. She noted that this change allows Special Conference Committees (SCC) to deny applications rather than make a recommendation to the Board. She requested guidance on whether or not the Board wants to have all the conferences addressing applications heard by the same SCC, or to divide the applicant cases among all the SCCs. She said that the benefit for keeping them with one committee is consistency in applying the requirements for licensure and the benefit to having all the SCCs hear these cases would be to reduce the length of time an applicant waits for a conference. Dr. Rizkalla moved to keep these cases with the same SCC. The motion was seconded and passed.

GUIDANCE FROM BOARD COUNSEL:

Mr. Rutkowski asked board members to be mindful of their demeanor during formal hearings and informal conferences, he advised Board members to focus on developing the facts of the case by asking respondents and witnesses questions related to the allegations and avoiding "I" statements. He said board members should never lecture, badger or engage in a debate with the respondent or with witnesses then noted that the appropriate place to educate the respondent is in the findings of fact and conclusions of law.

EXECUTIVE DIRECTOR'S REPORT/BUSINESS:

SRTA and ADEX. Ms. Reen asked the Board what action should be pursued in regards to NERB's expectation that sitting board members will examine for NERB. She explained that the legal advice received on this subject is that sitting Board members can examine for SRTA and participate in ADEX because the Board is a member of both agencies with all expenses related to travel for both agencies being reimbursed by SRTA in keeping with the State Travel Regulations. She added that the Board is not a member of NERB and has no agreement with that agency about travel expenses.

Ms. Swecker moved to explore the ability for sitting Board members to be examiners for testing agencies who administer the ADEX exam. The motion was seconded and passed.

Ms. Reen said she will explore if sitting Board members can examine for agencies administering the ADEX exam, and cautioned that the testing agencies might not agree to address reimbursement consistent with Virginia's State Travel Regulations.

Adding Emergency Scenarios to Permit Inspections. Ms. Reen referred the Board to the questions and answers regarding sedation and anesthesia permits and inspections noting that the questions were sent from the VDA and that she added the answers.

She said that, as requested at the last Board meeting, she has obtained the Virginia Society of Oral and Maxillofacial Surgeons' emergency scenarios and begun discussion with Enforcement staff on the feasibility of adding this component to the Board's inspections. She said she will also explore adding regulatory language for continuing education course requirements to have permit holders demonstrate competence to address emergency scenarios similar to the current requirements for ACLS courses.

She then noted her concern about the level of fear being experienced by permit holders over the prospect of being inspected and the advertisements of continuing education providers which foster that fear to promote participation in their course offerings. She reminded the Board that it has the non-disciplinary options of advisory letters and confidential consent agreements to address inspection findings.

Ms. Yeatts added that in regard to public comment calling for contracting with dentists to perform sedation inspection, the Code of Virginia requires inspectors to be DHP employees and sworn officers.

Practice Ownership. Ms. Reen stated that she met with Dr. Brown and Ms. Hoyle to discuss the Board's interest in convening a Regulatory Advisory Panel to discuss the influence of owners over the practice of dentistry. She added that Dr. Brown and Deputy Secretary Lee are facilitating a meeting with the Department of Medical Assistance Services to discuss this issue.

Guidance Documents (GD). Ms. Reen noted that in response to the Board's discussion at its last meeting, she has removed seven

or eight GDs from the Board's website pending their amendment to reflect changes in the regulations. She said she would bring additional revised documents to the December meeting, then presented two revised documents for action as follows:

- GD 60-17 has been updated to base the costs to be recovered on the actual expenditures in SFY 2014. Dr. Gaskins moved to adopt the revised GD 60-17. The motion was seconded and passed.
- GD 60-5 has been revised to reflect the current practice of having one person review a case for probable cause and the practice of offering pre-hearing consent orders in certain cases. Dr. Watkins moved to adopt the revised GD 60-5. The motion was seconded and passed.

Board Staff. Ms. Reen introduced Christine Houchens who is the licensing manager for the Board. Ms. Swain welcomed Ms. Houchens to the Board. Ms. Reen then reported that:

- Contracts are in place with a new OMS consultant and with a former board member to assist in case reviews,
- A request for professional case managers has been submitted, and
- Kathy Lackey, a Licensing Specialist who has been with the Board over 20 years and with the State over 49 years, is retiring. Her last day with the Board is October 17, 2014. Ms. Reen would like one official Board member to attend the recognition party for Ms. Lackey on October 14th. Ms. Reen added that Dr. Brown has approved the recruitment to fill this position.

Information Security Standard. Ms. Reen stated she learned that some Board members were downloading disciplinary cases to their smart phones for review. She provided the Information Technology Resource Management Standard which prohibits this action explaining that Board records can only be stored on state controlled equipment.

Invitations to Board Members. Ms. Reen asked Board members to be aware that they cannot accept free courses from CE providers.

Sedation Inspection. Ms. Reen asked the Board whether it wants to move forward with the sedation inspections or to delay implementation. Following discussion, a motion to suspend the inspections failed.

Regulatory-Legislative Committee meeting 10/24. Ms. Reen stated that this is provided as information only. She added that the

Exam Committee has not met due to the current workload and she hopes to schedule a meeting soon.

Southern Conference of Deans and Dental Examiners. Ms. Reen noted that typically the Board sends one member to attend the meeting but that Dr. Brown is encouraging sending more than one member to meetings such as this. She said that anyone interested in attending should let Ms. Swain know.

JCHC Oral Health Study. Ms. Reen requested guidance from the Board on how to respond to the inquiry about allowing dental hygienists to take classes, to qualify to perform expanded duties such as those permitted for dental assistants II as specified in 18VAC60-20-230 (DA II).

Ms. Yeatts suggested referring this matter to Regulatory-Legislative Committee at its 10/24 meeting. All agreed.

ELECTION OF OFFICERS:

Ms. Swain stated that the Nominating Committee met and the slate for officers are:

- Ms. Swain for President
- Dr. Gaskins for Vice-President
- Dr. Wyman for Secretary-Treasurer

Ms. Swain opened the floor for other nominations for each office. No additional nominations were made and nominations then were closed. Ms. Swecker moved to elect the officers as presented. The motion was seconded and passed.

CASE RECOMMENDATIONS:

Case # 154001:

Closed Meeting: Dr. Gaskins 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 to deliberate for the purpose of reaching a decision in the matter of case #150265. Additionally, it was moved that Board staff, Ms. Reen, Ms. Palmatier, Ms. Vu, and Mr. Rutkowski, Board Counsel 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. Gaskins subsequently 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. Watkins moved to accept the recommendation from the Credentials Committee. The motion was seconded and passed.

ADJOURNMENT: With all business concluded, the meeting was adjourned at 12:30 p.m.

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Melanie C. Swain, R.D.H., 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 5:20 p.m., September 30, 2014, at the Department of Health Professions, Perimeter Center, 2nd Floor Conference Center, 9960 Mayland Drive, Henrico, VA 23233.

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

MEMBERS PRESENT:
Sharon W. Barnes
Surya P. Dhakar, D.D.S.
Charles E. Gaskins, III, D.D.S.
A. Rizkalla, D.D.S.
Evelyn M. Rolon, D.M.D.
James D. Watkins, D.D.S.
Bruce S. Wyman, D.M.D.

MEMBERS ABSENT:
John M. Alexander, D.D.S.
Tammy K. Swecker, R.D.H.

QUORUM: With eight members present, a quorum was established.

STAFF PRESENT:
Kelley W. Palmatier, Deputy Executive Director
Donna Lee, Discipline Case Manager

OTHERS PRESENT: James E. Rutkowski, Assistant Attorney General

Crystal R. Zook, R.D.H. Case No.: 155945 The Board received information from Ms. Palmatier that a Special Conference Committee heard the disciplinary matter pertaining to Ms. Zook and offered a consent order for the indefinite suspension of her license to practice dental hygiene for not less than two years in lieu of proceeding with a formal hearing. Ms. Palmatier informed the Board that Ms. Zook signed the consent order and that it was being presented to the Board for ratification.

DECISION: Dr. Watkins moved that the Board accept the consent order that was signed by Ms. Zook in lieu of proceeding to a formal hearing. The motion was seconded and passed. Following a second, a roll call vote was taken. The motion passed unanimously.

ADJOURNMENT: With all business concluded, the Board adjourned at 5:24 p.m.

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Melanie C. Swain, R.D.H., Chair	Sandra K. Reen, Executive Director
______________________________	______________________________
Date	Date

UNAPPROVED

VIRGINIA BOARD OF DENTISTRY

BUSINESS MINUTES

CALL TO ORDER:	The meeting of the Board of Dentistry was called to order at 3:00 p.m., on October 24, 2014, at the Department of Health Professions, Perimeter Center, 2nd Floor Conference Center, Board Room 4, 9960 Mayland Drive, Henrico, Virginia 23233.
PRESIDING:	Melanie C. Swain, R.D.H., President
MEMBERS PRESENT:	Charles E. Gaskins, III, D.D.S. A Rizkalla, D.D.S. Tammy K. Swecker, R.D.H. James D. Watkins, D.D.S. Bruce S. Wyman, D.M.D.
MEMBERS ABSENT:	John M. Alexander, D.D.S. Sharon W. Barnes, Citizen Surya P. Dhakar, D.D.S. Evelyn M. Rolon, D.M.D.
QUORUM:	With six members present, a quorum was established.
STAFF PRESENT:	Sandra K. Reen, Executive Director Kelley W. Palmatier, Deputy Executive Director Huong Q. Vu, Operations Manager
OTHERS PRESENT:	James E. Rutkowski, Assistant Attorney General
Case No.: 159087	Consent Order signed by licensee for the possible resolution of disciplinary matter
Closed Meeting:	Dr. Gaskins moved that the Board convene a closed meeting pursuant to § 2.2-3711(A)(27) and 2.2-3712(F) of the Code of Virginia for the purpose of considering a Consent Order regarding Case # 159087. Additionally, Dr. Gaskins moved that Ms. Reen, Ms. Palmatier, Ms. Vu, and Mr. Rutkowski attend the closed meeting because their presence in the closed meeting is deemed necessary and their presence will aid the Board 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. Rizkalla moved to accept the signed Consent Order. The motion was seconded and passed.

ADJOURNMENT: With all business concluded, the Board adjourned at 3:10 p.m.

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Melanie C. Swain, R.D.H., President	Sandra K. Reen, Executive Director
____________________________	____________________________
Date	Date

UNAPPROVED

VIRGINIA BOARD OF DENTISTRY
FORMAL HEARING
November 7, 2014

TIME AND PLACE:	The meeting of the Virginia Board of Dentistry was called to order at 9:07 a.m., on November 7, 2014 in Board Room 4, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico, Virginia.
PRESIDING:	Melanie C. Swain, R.D.H., President
MEMBERS PRESENT:	John M. Alexander, D.D.S. Sharon W. Barnes, Citizen Member Charles E. Gaskins, III, D.D.S. 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. Al Rizkalla, D.D.S. Evelyn M. Rolon, D.M.D.
STAFF PRESENT:	Kelley W. Palmatier, Deputy Executive Director Huong Q. Vu, Operations Manager
COUNSEL PRESENT:	James E. Rutkowski, Assistant Attorney General
OTHERS PRESENT:	Corie E. Tillman Wolf, Assistant Attorney General Gerald A. Milsky, Adjudication Specialist Andrea Pegram, Court Reporter, Court Reporting Services, LLC.
ESTABLISHMENT OF A QUORUM:	With seven members present, a quorum was established.
Peter Sae Lee, D.D.S. Case No.: 145211 and 158204	Dr. Lee was present with legal counsel, Jerry Canaan, in accordance with an Amended Notice of the Board dated September 10, 2014. Ms. Swain swore in the witnesses. Following Ms. Wolf's opening statement, Ms. Swain admitted into evidence Commonwealth's Exhibits 1 through 6. Testifying on behalf of the Commonwealth were the following:

In person: Joyce M. Shelton-Jones, DHP Senior Investigator, and Gayle E. Miller, DHP Senior Investigator.

Following Mr. Canaan's opening statement, Ms. Swain admitted into evidence Respondent's Exhibits A and B.

Testifying on behalf of Dr. Lee were the following:
By phone: Navin Hukmani, DDS, Russell Mullen, DDS, and Niloofar Mofakhami, DDS.

In person: Owen Lee, Senior Pastor

Closed Meeting: Dr. Gaskins 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 deliberation to reach a decision in the matter of Dr. Lee. Additionally, he moved that Board staff, Ms. Palmatier, Ms. Vu, and Board counsel, Mr. Rutkowski to 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. 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.

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

Decision: Dr. Gaskins moved to accept the Findings of Facts and Conclusion of Law as presented by the Commonwealth, amended by the Board, and read by Mr. Rutkowski. The motion was seconded and passed.

Dr. Gaskins moved to accept the Board's decision to reinstate Dr. Lee's license on indefinite probation pursuant to terms and conditions. The motion was seconded and passed.

ADJOURNMENT: The Board adjourned at 12:35 p.m.

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Melanie C. Swain, R.D.H., President	Kelley W. Palmatier, Deputy Executive Director
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Date	Date

UNAPPROVED

VIRGINIA BOARD OF DENTISTRY
FORMAL HEARING
November 21, 2014

TIME AND PLACE:	The meeting of the Virginia Board of Dentistry was called to order at 9:06 a.m., on November 21, 2014 in Board Room 3, Department of Health Professions, 9960 Mayland Drive, Suite 201, Henrico, Virginia.
PRESIDING:	Melanie C. Swain, R.D.H., President
MEMBERS PRESENT:	Sharon W. Barnes, Citizen Member Surya P. Dhakar, D.D.S. Evelyn M. Rolon, D.M.D. Tammy K. Swecker, R.D.H. James D. Watkins, D.D.S.
MEMBERS EXCUSED:	Al Rizkalla, D.D.S. Bruce S. Wyman, D.M.D.
MEMBERS ABSENT:	John M. Alexander, D.D.S. Charles E. Gaskins, III, D.D.S.
STAFF PRESENT:	Sandra K. Reen, Executive Director Huong Q. Vu, Operations Manager
COUNSEL PRESENT:	James E. Rutkowski, Assistant Attorney General
OTHERS PRESENT:	Wayne H. Halbleib, Sr., Assistant Attorney General Shevaun Roukous, Adjudication Specialist Theresa J. Pata, Court Reporter, Crane Snead & Associates Inc.
ESTABLISHMENT OF A QUORUM:	With six members present, a quorum was established.
Michael McQuade, D.D.S. Case No.: 140724 and 150036	Dr. McQuade was present with legal counsel, Joseph D. Morrissey, and Paul Goldman (appearing *pro hac vice*), in accordance with the Notice of the Board dated October 3, 2014. Mr. Halbleib submitted an amended statement of particulars. No objection was made and Ms. Swain accepted the submission.

Mr. Morrissey asked the Board to consider a proposed consent order (CO) in lieu of proceeding with the hearing.

Mr. Halbleib stated that the Commonwealth is not in a position to address the proposed CO because he had just received it.

By consensus, the Board agreed to convene in closed meeting to consult with Board counsel.

Closed Meeting: Dr. Watkins moved that the Board of Dentistry convene in a closed meeting pursuant to section § 2.2-3711(a) (7) of the Code of Virginia for consultation with legal counsel to consider the settlement proposal. Additionally, it was moved that Board staff, Ms. Reen, Ms. Vu, and Board counsel, Mr. Rutkowski, attend the closed meeting because their presence is deemed necessary and their presence will aid the Board in its deliberations. The motion was seconded and passed.

Reconvene: Dr. Watkins 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.

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

Decision: Dr. Watkins moved to reject the proposed CO and proceed with the hearing. The motion was seconded and passed.

Ms. Morrissey raised another preliminary matter. He stated that Dr. McQuade has sold his practice then asked if Dr. Prior could tell the Board about the work Dr. McQuade will be doing at Dr. Prior's practice.

Ms. Swain denied the request and ruled that the hearing will proceed.

Ms. Swain swore in the witnesses.

Mr. Halbleib asked that all witnesses be excused until called to testify. Mr. Morrissey said that Dr. Stoner should stay since he is an expert witness and is assisting in presenting Dr. McQuade's case. Ms. Swain ruled that the witnesses are excused except Dr. Stoner.

Following Mr. Halbleib's opening statement, Ms. Swain admitted into evidence Commonwealth's Exhibits 1 through 4.

Following Mr. Morrissey's opening statement, Ms. Swain admitted into evidence Respondent's Exhibits A through O.

Testifying on behalf of the Commonwealth was Anne L. Hardy, DHP Senior Investigator.

Testifying on behalf of Dr. McQuade were Virginia Van Orman, Dr. McQuade's Office Manager, Kenneth E. Stoner, DDS, Julius Morrison, DDS, and Gordon Prior, DDS.

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 deliberation to reach a decision in the matter of Dr. McQuade. Additionally, he moved that Board staff, Ms. Reen, Ms. Vu, and Board counsel, Mr. Rutkowski 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 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.

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

Decision: Dr. Watkins moved to accept the Findings of Facts and Conclusion of Law as presented by the Commonwealth, amended by the Board, and read by Mr. Rutkowski. The motion was seconded and passed with five (5) votes in favor and one (1) vote against.

Dr. Watkins moved to reprimand Dr. McQuade, impose a $12,000 monetary penalty and require an audit of patient records. The motion was seconded and passed with five (5) votes in favor and one (1) vote against.

Mr. Morrissey moved to set aside the Findings of Facts, Conclusion of Law, and sanctions imposed by the Board.

The Board rejected the motion with five (5) votes against and one (1) vote in favor.

ADJOURNMENT: The Board adjourned at 8:07 p.m.

____
Melanie C. Swain, R.D.H., President

____
Date

____
Sandra K. Reen, Executive Director

____
Date

Commonwealth of Virginia
Office of the Governor

Executive Order

NUMBER TWENTY NINE (2014)

ESTABLISHING THE GOVERNOR'S TASK FORCE ON PRESCRIPTION DRUG AND HEROIN ABUSE

Nationally, prescription drug and heroin abuse has reached epidemic proportions. Since 2000, deaths from prescription drug overdoses in Virginia have more than doubled, while deaths from heroin overdoses have doubled in the past two years. Though prescription drugs are generally safe when used as prescribed, the misuse and abuse of prescription painkillers (opioids) can lead to addiction, and even death. In addition, individuals that are addicted to opioids are shifting to heroin, as prescription drugs become less available.

Prescription opioid and heroin abuse has also led to an increased burden on law enforcement and elevated health care costs from drug-related emergency department visits and treatment admissions. While the numbers of Virginians requiring treatment for addiction to drugs are substantial, resources for treating those who are addicted are limited. It is vital to the Commonwealth's interests to take immediate steps to reverse this dangerous trend of abuse. Therefore, I am directing relevant state and local agencies, health and behavioral health care professionals and organizations, law enforcement, and other stakeholders to work together toward reducing prescription opioid and heroin addiction, curtailing related criminal activity, and enhancing the health, safety, and well-being of all Virginians.

Establishment of the Task Force

Accordingly, by virtue of the authority vested in me as Governor under Article V of the Constitution of Virginia and under the laws of the Commonwealth, including, but not limited to §§ 2.2-134 and 2.2-135 of the *Code of Virginia*, and subject to my continuing and ultimate authority and responsibility to act in such matters, I hereby establish the Governor's Task Force on Prescription Drug and Heroin Abuse ("Task Force").

The Task Force will serve in an advisory role, in accordance with § 2.2-2100 of the *Code of Virginia*, and will be responsible for recommending short-term and long-term measures that can be taken to tackle prescription drug and heroin abuse and addiction, using best practices and evidence-based strategies.

Composition of the Task Force

The Secretary of Health and Human Resources and Secretary of Public Safety and Homeland Security will serve as Co-Chairs. The Task Force will be composed of representatives from the Office of the Attorney General, legislature, and judiciary, as well as relevant state and local agencies, law enforcement, health and behavioral health care professionals, providers, community advocates, and individuals with personal experience, as appointed by the Governor. The Governor may appoint any other person(s) deemed necessary and proper to carry out the assigned functions.

Key Objectives

The Task Force will offer recommendations to meet the Commonwealth's objectives listed under the following five major areas: 1) education, 2) treatment, 3) data and monitoring, 4) drug storage and disposal, and 5) enforcement.

The Task Force will also recommend specific metrics to be used to track progress in each of these five areas, and will suggest a target for each area with a date by which the goals should be met. Overall, the Task Force will seek measures for the reduction in deaths from prescription drug and heroin abuse within 5 years.

1. Education
    - Raise public awareness about the dangers of misuse and abuse of prescription drugs
    - Distribute information about appropriate use, secure storage, and disposal of prescription drugs
    - Train health care providers regarding best practices for opioid prescribing, pain management, the use of the Prescription Monitoring Program (PMP), and identification and treatment of individuals at risk of substance abuse through screening, intervention, and referral tools
    - Train first responders to more effectively respond to calls involving overdose, and use evidence-based interventions to reduce overdose deaths

2. Treatment
    - Improve access to and availability of treatment services
    - Foster best practices and adherence to standards for treatment of individuals addicted to opioids
    - Strengthen and expand the capacity of Virginia's health workforce to respond to substance abuse treatment needs, including encouraging health professions schools and continuing education programs to provide more education about how to identify and treat substance abuse

3. Data and Monitoring
    - Share and integrate data among relevant licensing boards, state and local agencies, law enforcement, courts, health care providers and organizations, and programs such as the PMP, in order to clarify and address public safety

and public health concerns, understand emerging trends, and utilize data-driven decision-making to mitigate harm

4. Storage and Disposal
    - Advance effective solutions that lead to safe storage and proper disposal of potentially dangerous prescription drugs

5. Enforcement
    - Identify and promote evidence-based best practices and strategies across the criminal justice system to address public safety risks and treatment needs of individuals with opioid addiction, training in the use of life saving interventions, expanded alternatives to incarceration, including drug courts, and cross-system collaboration to improve access to and the availability of treatment

Staffing

Staff support for the Task Force will be furnished by the Office of the Secretary of Health and Human Resources and the Office of the Secretary of Public Safety and Homeland Security, and such other agencies and offices as designated by the Governor. The Task Force will meet upon the call of the Chair at least four times per year. The Task Force will provide initial recommendations to the Governor on or before December 31, 2014, a comprehensive implementation plan by June 30, 2015, and any additional reports as necessary.

Effective Date

This Executive Order shall be effective upon its signing and, pursuant to §§ 2.2-134 and 2.2-135 of the *Code of Virginia*, shall remain in full force and effect for a year from its signing or until superseded or rescinded.

Given under my hand and under the Seal of the Commonwealth of Virginia this 26th day of September, 2014.

Terence R. McAuliffe, Governor

Attest: Levar M. Stoney, Secretary of the Commonwealth

prev | next

§ 54.1-2521. Reporting requirements.

A. The failure by any person subject to the reporting requirements set forth in this section and the Department's regulations to report the dispensing of covered substances shall constitute grounds for disciplinary action by the relevant health regulatory board.

B. Upon dispensing a covered substance, a dispenser of such covered substance shall report the following information:

1. The recipient's name and address.

2. The recipient's date of birth.

3. The covered substance that was dispensed to the recipient.

4. The quantity of the covered substance that was dispensed.

5. The date of the dispensing.

6. The prescriber's identifier number.

7. The dispenser's identifier number.

8. The method of payment for the prescription.

9. Any other non-clinical information that is designated by the Director as necessary for the implementation of this chapter in accordance with the Department's regulations.

10. Any other information specified in regulations promulgated by the Director as required in order for the Prescription Monitoring Program to be eligible to receive federal funds.

C. The reports required herein shall be made and transmitted in such manner and format and according to the standards and schedule established in the Department's regulations.

(2002, c. 481; 2006, c. 167; 2012, cc. 21, 71.)

prev | next | new search | table of contents | home

prev | next

§ 54.1-2522. Reporting exemptions.

The dispensing of covered substances under the following circumstances shall be exempt from the reporting requirements set forth in § 54.1-2521:

1. Dispensing of manufacturers' samples of such covered substances or of covered substances dispensed pursuant to an indigent patient program offered by a pharmaceutical manufacturer.

2. Dispensing of covered substances by a practitioner of the healing arts to his patient in a bona fide medical emergency or when pharmaceutical services are not available.

3. Administering of covered substances.

4. Dispensing of covered substances within an appropriately licensed narcotic maintenance treatment program.

5. Dispensing of covered substances to inpatients in hospitals or nursing facilities licensed by the Board of Health or facilities that are otherwise authorized by law to operate as hospitals or nursing homes in the Commonwealth.

6. Dispensing of covered substances to inpatients in hospices licensed by the Board of Health.

7. Dispensing of covered substances by veterinarians to animals within the usual course of their professional practice.

8. Dispensing of covered substances as otherwise provided in the Department's regulations.

(2002, c. 481.)

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prev | next | new search | table of contents | home

2014 SESSION

CHAPTER 178

*An Act to amend the Code of Virginia by adding a section numbered **54.1-2522.1**, relating to Prescription Monitoring Program; requirements of prescribers.*

[S 294]

Approved March 5, 2014

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding a section numbered **54.1-2522.1** as follows:

§ 54.1-2522.1. Requirements of prescribers.

*A. Any prescriber who is licensed in the Commonwealth and is authorized pursuant to §§ **54.1-3303** and **54.1-3408** to issue a prescription for a covered substance shall be registered with the Prescription Monitoring Program by the Department of Health Professions upon filing an application for licensure or renewal of licensure, if the prescriber is not already registered.*

B. Prescribers registered with the Prescription Monitoring Program shall, at the time of initiating a new course of treatment to a human patient that includes the prescribing of benzodiazepine or an opiate anticipated to last more than 90 consecutive days and for which a treatment agreement is entered into, request information from the Director for the purpose of determining what, if any, other covered substances are currently prescribed to the patient. In addition, any prescriber who holds a special identification number from the Drug Enforcement Administration authorizing the prescribing of controlled substances for opioid addiction therapy shall, prior to or as a part of execution of a treatment agreement with the patient, request information from the Director for the purpose of determining what, if any, other covered substances the patient is currently being prescribed. Nothing in this section shall prohibit prescribers from making additional periodic requests for information from the Director as may be required by routine prescribing practices.

C. The Secretary of Health and Human Resources may identify and publish a list of benzodiazepines or opiates that have a low potential for abuse by human patients. Prescribers who prescribe such identified benzodiazepines or opiates shall not be required to meet the provisions of subsection B. In addition, a prescriber shall not be required to meet the provisions of subsection B if the course of treatment arises from pain management relating to dialysis or cancer treatments.

2. That the provisions of this act shall become effective on July 1, 2015.

Virginia's Dental Hygienist Workforce: 2014

Healthcare Workforce Data Center

August 2014

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***

EXPOSURE DRAFT

4,678 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

David E. Brown, D.C.
Director

Jaime H. Hoyle, J.D.
Chief Deputy Director

Healthcare Workforce Data Center Staff:

Elizabeth Carter, Ph.D.	Justin Crow, MPA	Laura Jackson	Christopher Coyle
Director	*Deputy Director*	*Operations Manager*	*Research Assistant*

Virginia Board of Dentistry

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James D. Watkins, DDS

Bruce S. Wyman, DMD

Executive Director

Sandra K. Reen

Contents

Results in Brief 2

Survey Response Rates 3

The Workforce 4

Demographics 5

Background 6

Education 8

Current Employment Situation 9

Employment Quality 10

2013 Labor Market 11

Work Site Distribution 12

Establishment Type 13

Time Allocation 15

Patient Workload 16

Retirement & Future Plans 17

Full-Time Equivalency Units 19

Maps 20
- Council on Virginia's Future Regions 20
- Area Health Education Center Regions 21
- Workforce Investment Areas 22
- Health Services Areas 23
- Planning Districts 24

Appendices 25
- Appendix A: Weights 25

The Dental Hygienist Workforce: At a Glance:

The Workforce

Licensees:	5,563
Virginia's Workforce:	4,585
FTEs:	3,078

Survey Response Rate

All Licensees:	84%
Renewing Practitioners:	88%

Demographics

Female:	99%
Diversity Index:	30%
Median Age:	43

Background

Rural Childhood:	35%
HS Diploma in VA:	57%
Prof. Degree in VA:	64%

Education

Associate:	54%
Baccalaureate:	41%

Finances

Median Inc.:	$50k-$60k
Retirement Benefits:	43%
Under 40 w/ Ed debt:	50%

Current Employment

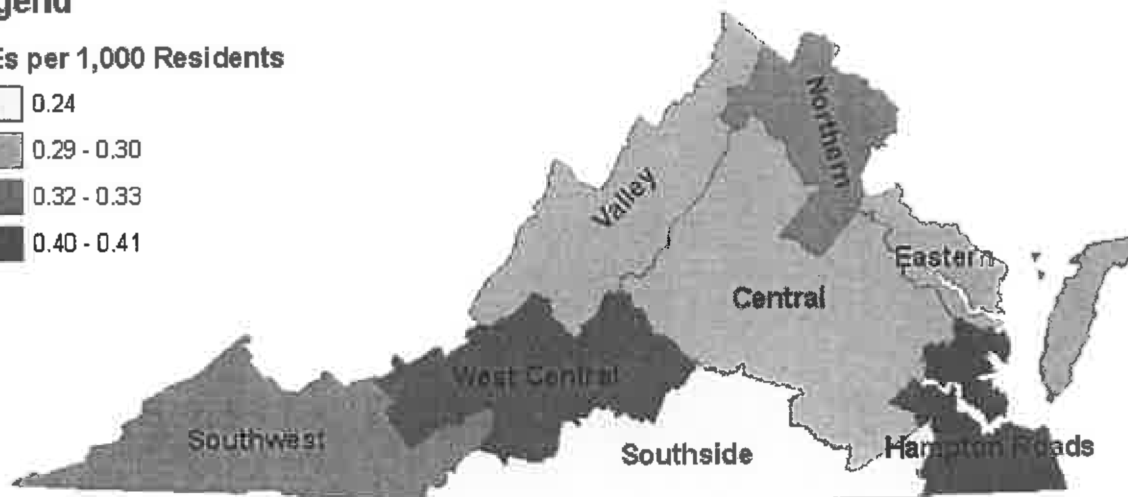
Employed in Prof.:	91%
Hold 1 Full-time Job:	47%
Satisfied?:	93%

Job Turnover

Switched Jobs:	6%
Employed over 2 yrs:	68%

Time Allocation

Patient Care:	90-99%
Administration:	1-9%
Patient Care Role:	92%



Source: Va. Healthcare Workforce Data Center

4,678 dental hygienists voluntarily took part in the 2014 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 84% of the 5,563 dental hygienists who are licensed in the state and 88% of renewing practitioners.

The HWDC estimates that 4,585 dental hygienists participated in Virginia's workforce during the survey period, 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. Between April 2013 and March 2014, Virginia's dental hygienist workforce provided 3,078 "full-time equivalency units", which the HWDC defines simply as working 2,000 hours a year (or 40 hours per week for 50 weeks with 2 weeks off).

99% of dental hygienists are female, while the median age of all dental hygienists is 43. In a random encounter between two dental hygienists, there is a 30% chance that they would be of different races or ethnicities, a measure known as the diversity index. For the Virginia population as a whole, this same probability is 54%. Meanwhile, dental hygienists who are under the age of 40 are somewhat more diverse than the overall dental hygienist workforce, with a diversity index of 39%.

More than one-third of dental hygienists grew up in a rural area, but only 19% of these professionals currently work in non-Metro areas of the state. 57% of Virginia's dental hygienists graduated from high school in Virginia, while 64% received their initial professional degree in the state. Overall, 70% of dental hygienists have some educational background in the state.

More than half of all dental hygienists hold an Associate's degree as their highest professional degree, while 41% have a baccalaureate degree. 28% of dental hygienists currently have educational debt, including half of dental hygienists who are under the age of 40. The median debt burden for those dental hygienists with education debt is between $10,000 and $20,000.

91% of dental hygienists are currently employed in the profession. However, only 47% hold one full-time position, while nearly 30% have just one part-time position. Nearly half of all dental hygienists work between 30 and 39 hours per week, while just 13% work 40 or more hours per week. 2% of dental hygienists are involuntarily unemployed, while another 4% are voluntarily unemployed.

The typical dental hygienist earns between $50,000 and $60,000 per year. Three-quarters of dental hygienists received this income through an hourly wage, with most of the remaining workforce receiving a salary. 72% of dental hygienists receive at least one employer-sponsored benefit, including 44% who have access to some form of retirement plan. 93% of dental hygienists indicate they are satisfied with their current employment situation, including 62% who indicate they are "very satisfied".

More than two-thirds of dental hygienists have worked at their primary work location for at least two years, and only 6% switched jobs in the past year. 72% of dental hygienists work at a solo dental practice, while another 17% work at a group dental practice. Only 5% of Virginia's dental hygienists work for a governmental organization.

A typical dental hygienist spends essentially all of her time treating patients. 92% of all dental hygienists serve in a patient care role, meaning that at least 60% of their time is spent treating patients. On average, a dental hygienist treats between 25 and 49 patients per week at her primary work location.

23% of dental hygienists expect to retire in the next decade, while half the current workforce expects to retire by 2034. Over the next two years, only 5% of dental hygienists plan on leaving either the state or the profession. Meanwhile, 14% of dental hygienists expect to increase patient care activities within the next two years, while 11% expect to pursue additional educational opportunities.

A Closer Look:

Licensees		
License Status	#	%
Renewing Practitioners	5,038	91%
New Licensees	307	6%
Non-Renewals	218	4%
All Licensees	5,563	100%

Source: Va. Healthcare Workforce Data Center

Our surveys tend to achieve very high response rates. 88% of renewing dental hygienists submitted a survey. These represent 84% of dental hygienists who held a license at some point in the past year.

Response Rates			
Statistic	Non Respondents	Respondent	Response Rate
By Age			
Under 30	100	614	86%
30 to 34	102	636	86%
35 to 39	102	596	85%
40 to 44	94	608	87%
45 to 49	101	589	85%
50 to 54	106	606	85%
55 to 59	109	542	83%
60 and Over	171	487	74%
Total	885	4,678	84%
New Licenses			
Issued 4/2013 to 3/2014	81	226	74%
Metro Status			
Non-Metro	73	433	86%
Metro	581	3,530	86%
Not in Virginia	229	695	75%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Licensed Dental Hygienists
Number: 5,563
New: 6%
Not Renewed: 4%

Response Rates
All Licensees: 84%
Renewing Practitioners: 88%

Source: Va. Healthcare Workforce Data Center

Response Rates	
Completed Surveys	4,678
Response Rate, all licensees	84%
Response Rate, Renewals	88%

Source: Va. Healthcare Workforce Data Center

Definitions

1. **The Survey Period:** The survey was conducted in March 2014.
2. **Target Population:** All Dental Hygienists who held a Virginia license at some point between April 2013 and March 2014.
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 2014.

At a Glance:

Workforce

Dental Hygienist Workforce:	4,585
FTEs:	3,078

Utilization Ratios

Licensees in VA Workforce:	82%
Licensees per FTE:	1.81
Workers per FTE:	1.49

Source: Va. Healthcare Workforce Data Center

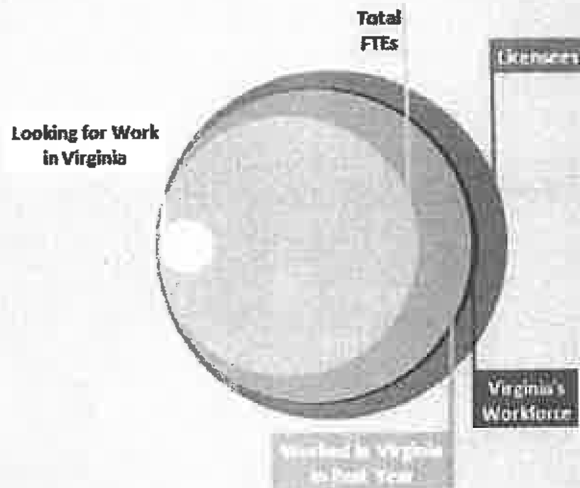
Definitions

1. **Virginia's Workforce:** A licensee with a primary or secondary work site in Virginia at any time between April 2013 and March 2014 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	4,451	97%
Looking for Work in Virginia	134	3%
Virginia's Workforce	4,585	100%
Total FTEs	3,078	
Licensees	5,563	

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	16	3%	584	97%	600	14%
30 to 34	11	2%	571	98%	583	14%
35 to 39	9	2%	543	98%	552	13%
40 to 44	12	2%	535	98%	548	13%
45 to 49	6	1%	503	99%	509	12%
50 to 54	1	0%	532	100%	533	13%
55 to 59	1	0%	472	100%	473	11%
60 +	7	2%	442	99%	448	11%
Total	64	2%	4,184	99%	4,247	100%

Source: Va. Healthcare Workforce Data Center

Race & Ethnicity					
Race/ Ethnicity	Virginia*	Dental Hygienists		Hygienists Under 40	
	%	#	%	#	%
White	64%	3,532	83%	1,349	77%
Black	19%	198	5%	102	6%
Asian	6%	244	6%	146	8%
Other Race	0%	55	1%	27	2%
Two or more races	2%	63	1%	36	2%
Hispanic	8%	165	4%	83	5%
Total	100%	4,257	100%	1,743	100%

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

Source: Va. Healthcare Workforce Data Center

41% of dental hygienists are under the age of 40. Nearly all of these professionals are female, and more than three-quarters are non-Hispanic White.

At a Glance:

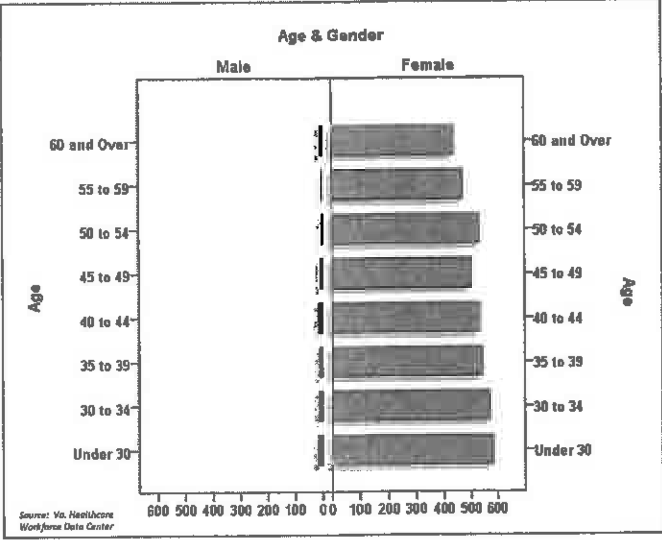
Gender
% Female: 99%
% Under 40 Female: 98%

Age
Median Age: 43
% Under 40: 41%
% 55+: 22%

Diversity
Diversity Index: 30%
Under 40 Div. Index: 39%

Source: Va. Healthcare Workforce Data Center

In a chance encounter between two dental hygienists, there is a 30% 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 as a whole.



At a Glance:

Childhood

Urban Childhood: 13%
Rural Childhood: 35%

Virginia Background

HS in Virginia: 57%
Prof. in VA: 64%
HS or Prof. in VA: 70%

Location Choice

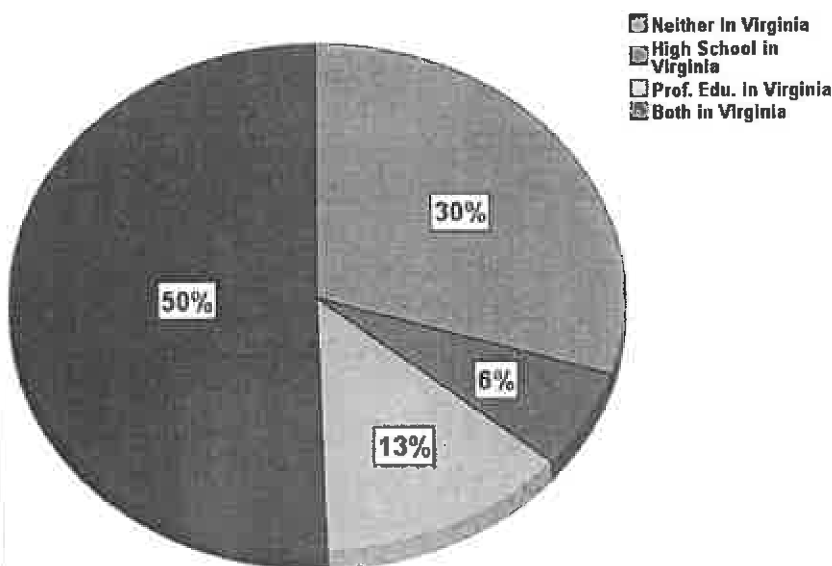
% Rural to Non-Metro: 19%
% Urban/Suburban to Non-Metro: 4%

Source: Va. Healthcare Workforce Data Center

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+	25%	60%	15%
2	Metro, 250,000 to 1 million	50%	40%	11%
3	Metro, 250,000 or less	59%	33%	7%
	Non-Metro Counties			
4	Urban pop 20,000+, Metro adj	58%	28%	14%
6	Urban pop, 2,500-19,999, Metro adj	67%	24%	9%
7	Urban pop, 2,500-19,999, nonadj	91%	8%	1%
8	Rural, Metro adj	66%	32%	3%
9	Rural, nonadj	67%	27%	7%
	Overall	35%	52%	13%

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

Only 13% of dental hygienists grew up in a rural area, and 19% of this group currently works in non-Metro areas of the state. Overall, 9% of dental hygienists currently work in rural areas of Virginia.

Top Ten States for Dental Hygienist Recruitment

Rank	All Dental Hygienists			
	High School	#	Dental School	#
1	Virginia	2,411	Virginia	2,643
2	Outside U.S./Canada	224	North Carolina	199
3	New York	146	West Virginia	123
4	Pennsylvania	144	New York	120
5	North Carolina	141	Maryland	120
6	Maryland	132	Florida	106
7	West Virginia	131	Pennsylvania	101
8	Florida	92	Tennessee	86
9	New Jersey	88	Washington, D.C.	61
10	Michigan	74	Michigan	61

Source: Va. Healthcare Workforce Data Center

57% of all dental hygienists earned their high school degree in Virginia, and 64% received their initial professional degree in the state.

Rank	Licensed in the Past 5 Years			
	High School	#	Dental School	#
1	Virginia	576	Virginia	676
2	Outside U.S./Canada	94	North Carolina	55
3	West Virginia	38	Maryland	38
4	Maryland	34	New York	28
5	North Carolina	34	West Virginia	27
6	Pennsylvania	31	Florida	25
7	New York	30	Pennsylvania	25
8	Michigan	28	Michigan	24
9	California	24	Tennessee	19
10	Florida	20	Ohio	14

Source: Va. Healthcare Workforce Data Center

Among dental hygienists who received their initial license in the past five years, 52% earned their high school degree in Virginia, while 62% received their initial professional degree in the state.

18% of Virginia's licensees were not part of the state's dental hygienist workforce. 80% of these licensees worked at some point in the past year, and 69% currently work as dental hygienists.

At a Glance:

Not in VA Workforce

Total:	979
% of Licensees:	18%
Federal/Military:	5%
Va Border State/DC:	18%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Highest Dental Hygienist Degree		
Degree	#	%
Certificate	91	2%
Associate Degree	2,243	54%
Bachelor Degree	1,686	41%
Post-Graduate Cert.	15	0%
Masters Degree	108	3%
Doctorate	10	0%
Total	4,153	100%

Source: Va. Healthcare Workforce Data Center

At a Glance:

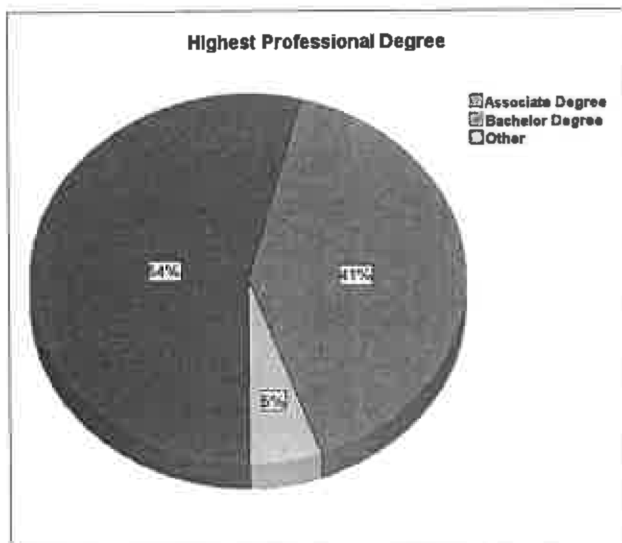
Education

Associate:	54%
Baccalaureate:	41%

Educational Debt

Carry debt:	28%
Under age 40 w/ debt:	50%
Median debt:	$10k-$20k

More than one-quarter of dental hygienists carry educational debt, including one-half of those under the age of 40. For those in debt, their median burden is between $10,000 and $20,000.



Source: Va. Healthcare Workforce Data Center

Educational Debt				
Amount Carried	All Dental Hygienists		Hygienists under 40	
	#	%	#	%
None	2,690	72%	782	50%
Less than $10,000	286	8%	184	12%
$10,000-$19,999	261	7%	192	12%
$20,000-$29,999	198	5%	156	10%
$30,000-$39,999	100	3%	82	5%
$40,000-$49,999	63	2%	48	3%
$50,000-$59,999	52	1%	40	3%
$60,000-$69,999	32	1%	25	2%
$70,000-$79,999	20	1%	15	1%
$80,000-$89,999	12	0%	9	1%
$90,000-$99,999	13	0%	8	1%
$100,000 or more	23	1%	13	1%
Total	3,749	100%	1,554	100%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Employment
Employed in Profession: 91%
Involuntarily Unemployed: 2%

Positions Held
1 Full-time: 47%
2 or More Positions: 17%

Weekly Hours:
40 to 49: 11%
60 or more: 1%
Less than 30: 32%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Current Work Status		
Status	#	%
Employed, capacity unknown	2	0%
Employed in a dentistry related capacity	3,884	91%
Employed, NOT in a dentistry related capacity	97	2%
Not working, reason unknown	0	0%
Involuntarily unemployed	64	2%
Voluntarily unemployed	176	4%
Retired	26	1%
Total	4,250	100%

Source: Va. Healthcare Workforce Data Center

91% of Virginia's dental hygienists are employed in the profession, although less than half currently have one full-time job. Nearly half of dental hygienists currently work between 30 and 39 hours per week, while just 11% work between 40 and 49 hours per week.

Current Positions		
Positions	#	%
No Positions	266	6%
One Part-Time Position	1,216	29%
Two Part-Time Positions	431	10%
One Full-Time Position	1,990	47%
One Full-Time Position & One Part-Time Position	212	5%
Two Full-Time Positions	5	0%
More than Two Positions	76	2%
Total	4,196	100%

Source: Va. Healthcare Workforce Data Center

Current Weekly Hours		
Hours	#	%
0 hours	266	6%
1 to 9 hours	164	4%
10 to 19 hours	366	9%
20 to 29 hours	795	19%
30 to 39 hours	2,033	49%
40 to 49 hours	469	11%
50 to 59 hours	36	1%
60 to 69 hours	15	0%
70 to 79 hours	14	0%
80 or more hours	12	0%
Total	4,170	100%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Income		
Hourly Wage	**#**	**%**
Volunteer Work Only	38	1%
Less than $20,000	247	7%
$20,000-$29,999	232	7%
$30,000-$39,999	359	11%
$40,000-$49,999	541	16%
$50,000-$59,999	633	19%
$60,000-$69,999	634	19%
$70,000-$79,999	400	12%
$80,000-$89,999	184	5%
$90,000-$99,999	77	2%
$100,000 or More	52	2%
Total	3,396	100%

At a Glance:

Earnings
Median Income: $50k-$60k

Benefits
Paid Vacation: 64%
Retirement: 44%

Satisfaction
Satisfied: 93%
Very Satisfied: 62%

Job Satisfaction		
Level	**#**	**%**
Very Satisfied	2,537	62%
Somewhat Satisfied	1,290	31%
Somewhat Dissatisfied	205	5%
Very Dissatisfied	93	2%
Total	4,124	100%

Source: Va. Healthcare Workforce Data Center

The typical dental hygienist made between $50,000 and $60,000 in the past year. Among dental hygienists who were compensated at the primary work location with either a salary or an hourly wage, 63% received paid vacation and 43% had access to a retirement plan.

Employer-Sponsored Benefits			
Benefit	**#**	**%**	**% of Wage/Salary Employees**
Paid Vacation	2,490	64%	63%
Retirement	1,713	44%	43%
Paid Sick Leave	1,388	36%	35%
Dental Insurance	593	15%	15%
Group Life Insurance	415	11%	10%
Signing/Retention Bonus	99	3%	3%
Received At Least One Benefit	2,782	72%	70%

*From any employer at time of survey.

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Employment Instability in Past Year		
In the past year did you . . .?	#	%
Experience involuntary unemployment?	149	3%
Experience voluntary unemployment?	317	7%
Work Part-time or temporary positions, but would have preferred a full-time/permanent position?	508	11%
Work two or more positions at the same time?	860	19%
Switch employers or practices?	278	6%
Experienced at least 1	1,509	33%

Source: Va. Healthcare Workforce Data Center

Only 3% of Virginia's dental hygienists experienced involuntary unemployment at some point in the past year. By comparison, Virginia's average monthly unemployment rate was 5.5% in 2013.[2]

At a Glance:

Unemployment Experience
Involuntarily Unemployed: 3%
Underemployed: 11%

Turnover & Tenure
Switched Jobs: 6%
New Location: 22%
Over 2 years: 68%
Over 2 yrs, 2nd location: 46%

Employment Type
Hourly Wage: 75%
Salary/Commission: 22%

Source: Va. Healthcare Workforce Data Center

Location Tenure				
Tenure	Primary		Secondary	
	#	%	#	%
Not Currently Working at this Location	152	**4%**	111	11%
Less than 6 Months	204	5%	143	14%
6 Months to 1 Year	376	9%	149	14%
1 to 2 Years	557	14%	171	16%
3 to 5 Years	725	18%	181	17%
6 to 10 Years	807	20%	153	14%
More than 10 Years	1,183	30%	149	14%
Subtotal	**4,004**	**100%**	**1,057**	**100%**
Did not have location	167		3,449	
Item Missing	414		79	
Total	4,585		4,585	

Source: Va. Healthcare Workforce Data Center

More than two-thirds of dental hygienists have worked at their primary location for at least two years.

75% of dental hygienists receive an hourly wage at their primary work location, while 22% are salaried employees.

Employment Type		
Primary Work Site	#	%
Salary/ Commission	749	22%
Hourly Wage	2,558	75%
By Contract	45	1%
Business/ Practice Income	20	1%
Unpaid	20	1%
Subtotal	3,392	100%
Did not have location	167	
Item Missing	1,026	

Source: Va. Healthcare Workforce Data Center

[1] As reported by the US Bureau of Labor Statistics. The not seasonally adjusted monthly unemployment rate ranged from 6.3% in January 2013 to 4.8% in December 2013.

At a Glance:

Concentration
Top Region: 33%
Top 3 Regions: 75%
Lowest Region: 2%

Locations
2 or more (Past Year): 25%
2 or more (Now*): 24%

Source: Va. Healthcare Workforce Data Center

33% of all dental hygienists work in Northern Virginia, the most of any region in Virginia. With only 2% of the workforce, Eastern Virginia has the fewest number of dental hygienists of any region in the state.

Number of Work Locations				
Locations	Work Locations in Past Year		Work Locations Now*	
	#	%	#	%
0	167	4%	272	7%
1	3,282	72%	2,889	70%
2	574	13%	556	13%
3	406	9%	375	9%
4	55	1%	18	0%
5	24	1%	6	0%
6 or More	78	2%	22	0%
Total	4,585	100%	4,138	1%

*At the time of survey completion, March 2014.

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Regional Distribution of Work Locations				
COVF Region	Primary Location		Secondary Location	
	#	%	#	%
Central	685	17%	177	16%
Eastern	65	2%	20	2%
Hampton Roads	984	25%	239	21%
Northern	1,328	33%	421	38%
Southside	125	3%	35	3%
Southwest	185	5%	35	3%
Valley	198	5%	38	3%
West Central	394	10%	105	9%
Virginia Border State/DC	20	1%	14	1%
Other US State	14	0%	35	3%
Outside of the US	0	0%	1	0%
Total	3,998	100%	1,120	100%
Item Missing	422		15	

Source: Va. Healthcare Workforce Data Center

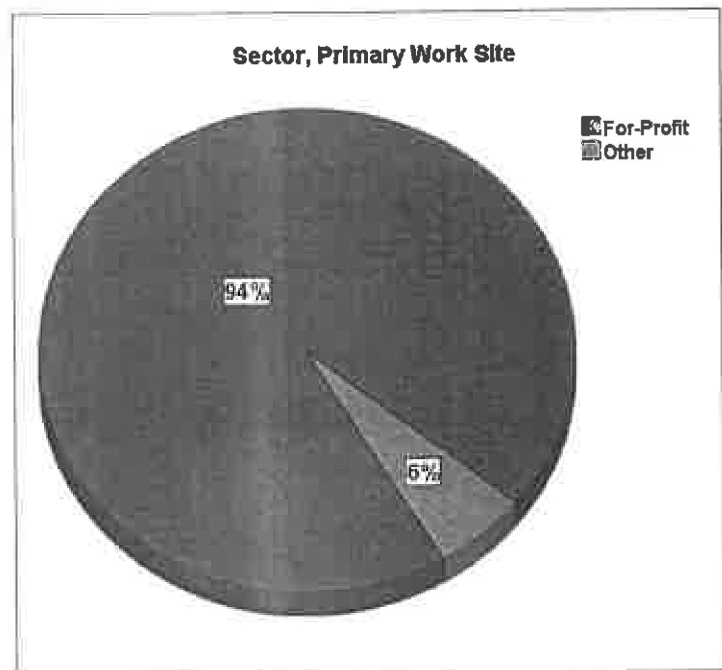
70% of dental hygienists currently have just one work location, while 13% have two separate work locations.

A Closer Look:

Sector	Location Sector: Primary Location #	Primary Location %	Secondary Location #	Secondary Location %
For-profit	3,670	94%	926	90%
Non-profit	44	1%	34	3%
State/local government	107	3%	55	5%
Veterans Administration	7	0%	0	0%
U.S. Military	55	1%	7	1%
Other Federal Government	8	0%	2	0%
Total	**3,891**	**100%**	**1,024**	**100%**
Did not have location	167		3449	
Item missing	527		111	

Source: Va. Healthcare Workforce Data Center

94% of dental hygienists worked in for-profit establishments. Another 5% worked for a government agency, including 1% who worked for the U.S. military.

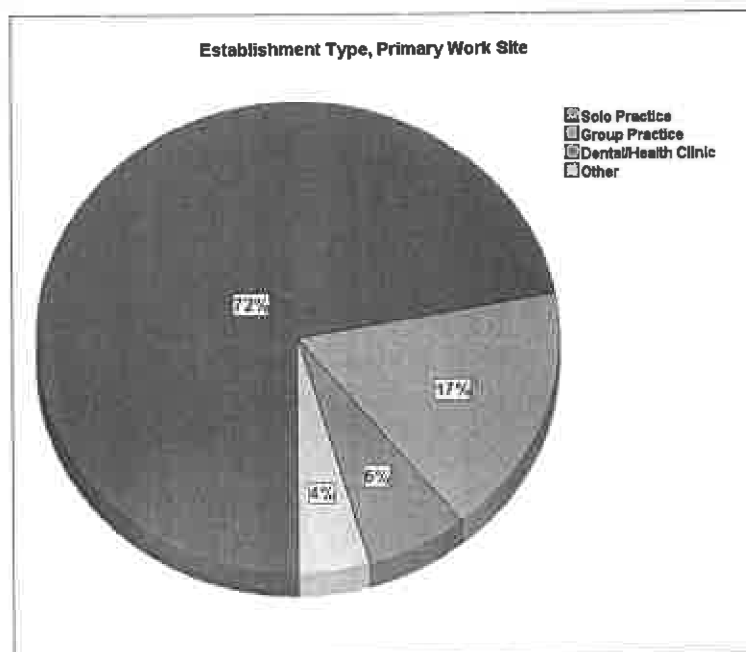


Source: Va. Healthcare Workforce Data Center

Establishment Type	Location Type			
	Primary Location		Secondary Location	
	#	%	#	%
Solo Practice	2,754	72%	725	71%
Group Practice	656	17%	121	12%
Dental/Health Clinic	243	6%	67	7%
Dental School (including Combined Dental/Dental Hygiene)	52	1%	49	5%
Hospital/Health System	22	1%	5	0%
Corrections	15	0%	7	1%
Public Health Program	13	0%	12	1%
Insurance	10	0%	2	0%
K-12 School or Non-Dental College	7	0%	2	0%
Nursing Home/Long-Term Care Facility	6	0%	5	0%
Supplier Organization	3	0%	2	0%
Other	39	1%	21	2%
Total	3,820	100%	1,018	100%
Did Not Have a Location	167		3449	

Nearly three-quarters of dental hygienists worked at a solo dental practice at their primary work location, while another 17% worked at a group dental practice. Dental/health clinics were also significant employers of Virginia's dental hygienist workforce.

Among those dental hygienists who also had a secondary work location, more than four out of five worked at a dental practice, including 71% who worked at a solo dental practice.



Source: Va. Healthcare Workforce Data Center

At a Glance:
(Primary Locations)

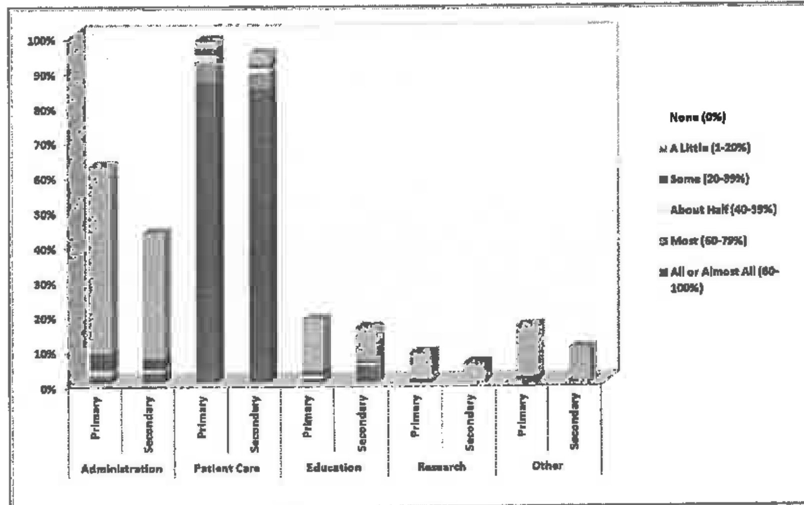
Typical Time Allocation
Patient Care: 90%-99%
Administration: 1%-9%

Roles
Patient Care: 92%
Administrative: 2%
Education: 1%

Patient Care Hygienists
Median Admin Time: 1%-9%
Ave. Admin Time: 1%-9%

Source: Va. Healthcare Workforce Data Center

A Closer Look:



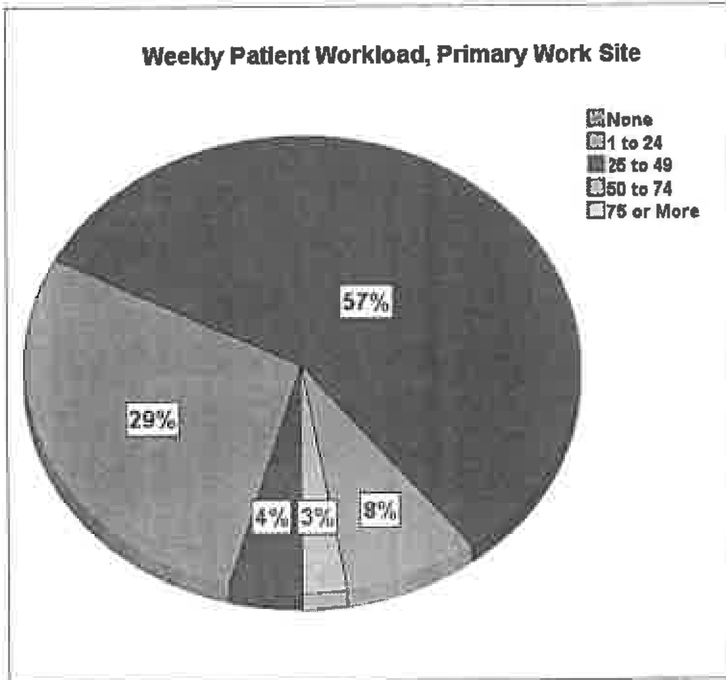
Source: Va. Healthcare Workforce Data Center

A typical dental hygienist spends most of her time caring for patients, with most of the remaining time spent doing administrative tasks. 92% of dental hygienists fill a patient care role, defined as spending 60% or more of their time on patient care activities.

Time Spent	Time Allocation									
	Admin.		Patient Care		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%)	2%	3%	87%	85%	1%	5%	0%	0%	0%	0%
Most (60-79%)	1%	0%	5%	4%	0%	0%	0%	0%	0%	0%
About Half (40-59%)	1%	1%	2%	1%	1%	1%	0%	0%	0%	0%
Some (20-39%)	5%	3%	2%	1%	2%	1%	0%	0%	1%	0%
A Little (1-20%)	53%	36%	2%	3%	15%	10%	8%	5%	14%	9%
None (0%)	38%	57%	2%	5%	82%	84%	91%	94%	84%	90%

Source: Va. Healthcare Workforce Data Center

A Closer Look:



Source: Va. Healthcare Workforce Data Center

At a Glance:

Patient Workload (Median)

Primary Location: 25-49

Secondary Location: 1-24

The typical dental hygienist treated between 25 and 49 patients per week at her primary work location. For those dental hygienists who also had a secondary work location, the median workload was between 1 and 24 patients per week.

# of Patients Per Week	Patient Care Visits			
	Primary		Secondary	
	#	%	#	%
None	166	4%	98	10%
1-24	1,109	29%	713	70%
25-49	2,211	57%	156	15%
50-74	304	8%	35	3%
75-99	50	1%	8	1%
100-124	19	0%	2	0%
125-149	7	0%	2	0%
150-174	8	0%	1	0%
175-199	4	0%	1	0%
200 or More	13	0%	0	0%
Total	3,891	100%	1,016	100%

A Closer Look:

Retirement Expectations				
Expected Retirement Age	All Dental Hygienists		Hygienists over 50	
	#	%	#	%
Under age 50	248	7%	-	-
50 to 54	371	10%	-	-
55 to 59	704	19%	125	10%
60 to 64	1,059	29%	425	35%
65 to 69	821	23%	416	34%
70 to 74	185	5%	115	10%
75 to 79	44	1%	26	2%
80 or over	18	0%	10	1%
I do not intend to retire	198	5%	91	8%
Total	3,648	100%	1,208	100%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Retirement Expectations

All Dental Hygienists
Under 65: 65%
Under 60: 36%
Hygienists 50 and over
Under 65: 46%
Under 60: 10%

Time until Retirement
Within 2 years: 5%
Within 10 years: 23%
Half the workforce: by 2034

Source: Va. Healthcare Workforce Data Center

Nearly two-thirds of dental hygienists expect to retire by the age of 65, while nearly half of dental hygienists who are age 50 or over expect to retire by the same age. Meanwhile, approximately 11% of dental hygienists expect to work until at least age 70, including 5% who do not expect to retire at all.

Within the next two years, only 5% of Virginia's dental hygienists plan on leaving either the profession or the state. Meanwhile, 14% of dental hygienists plan on increasing their patient care activities, and 11% plan on pursuing additional educational opportunities.

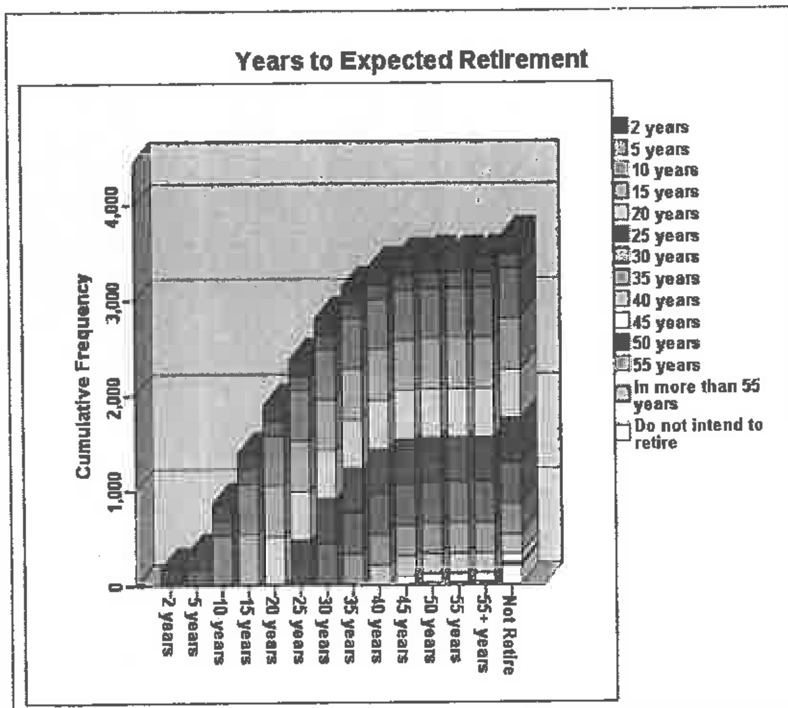
Future Plans		
2 Year Plans:	#	%
Decrease Participation		
Leave Profession	89	2%
Leave Virginia	142	3%
Decrease Patient Care Hours	392	9%
Decrease Teaching Hours	23	1%
Increase Participation		
Increase Patient Care Hours	656	14%
Increase Teaching Hours	147	3%
Pursue Additional Education	491	11%
Return to Virginia's Workforce	55	1%

Source: Va. Healthcare Workforce Data Center

By comparing retirement expectation to age, we can estimate the maximum years to retirement for dental hygienists. Only 5% of dental hygienists expect to retire within the next two years, while nearly one-quarter of dental hygienists expect to retire in the next ten years. More than half of the current dental hygienist workforce expects to retire by 2034.

Time to Retirement			
Expect to retire within...	#	%	Cumulative %
2 years	170	5%	5%
5 years	155	4%	9%
10 years	526	14%	23%
15 years	535	15%	38%
20 years	510	14%	52%
25 years	471	13%	65%
30 years	435	12%	77%
35 years	322	9%	86%
40 years	203	6%	91%
45 years	96	3%	94%
50 years	21	1%	94%
55 years	2	0%	94%
In more than 55 years	4	0%	95%
Do not intend to retire	198	5%	100%
Total	3,648	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 2024. Retirements will peak at 15% of the current workforce around 2029 before declining to under 10% of the current workforce again around 2049.

At a Glance:

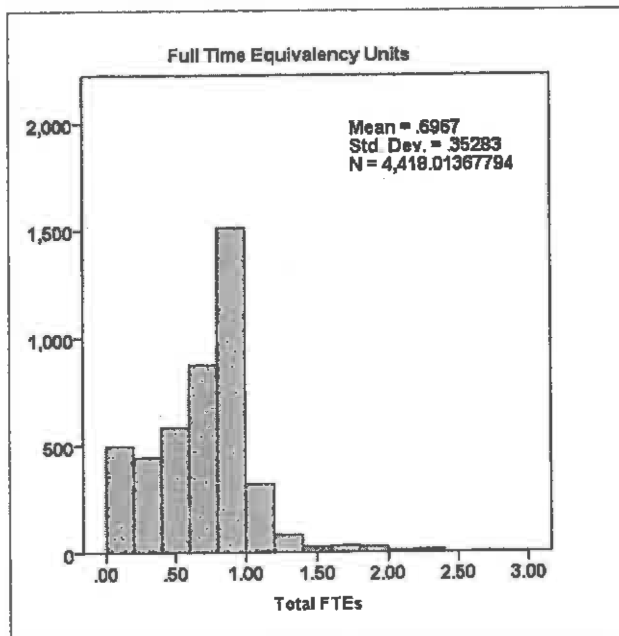
FTEs
Total: 3,078
FTEs/1,000 Residents: 0.373
Average: 0.70

Age & Gender Effect
Age, Partial Eta^2: Negligible
Gender, Partial Eta^2: Negligible

Partial Eta^2 Explained:
Partial Eta^2 is a statistical measure of effect size.

Source: Va. Healthcare Workforce Data Center

A Closer Look:

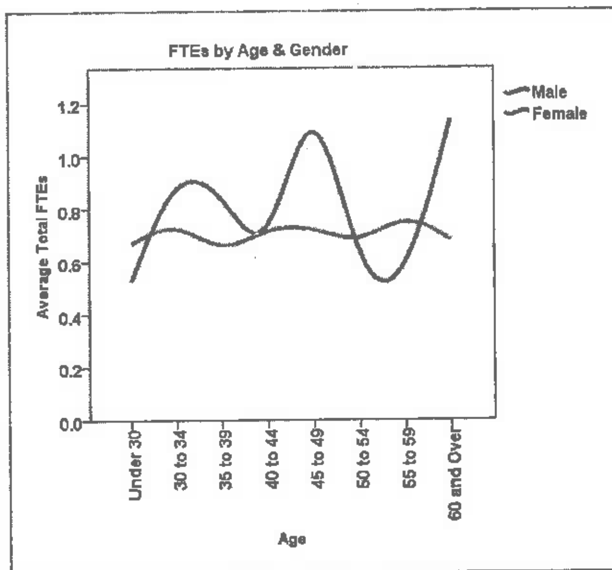


Source: Va. Healthcare Workforce Data Center

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

Full-Time Equivalency Units		
Age	Average	Median
Age		
Under 30	0.66	0.71
30 to 34	0.73	0.78
35 to 39	0.68	0.79
40 to 44	0.71	0.65
45 to 49	0.68	0.75
50 to 54	0.67	0.65
55 to 59	0.76	0.84
60 and Over	0.70	0.79
Gender		
Male	0.79	0.88
Female	0.70	0.75

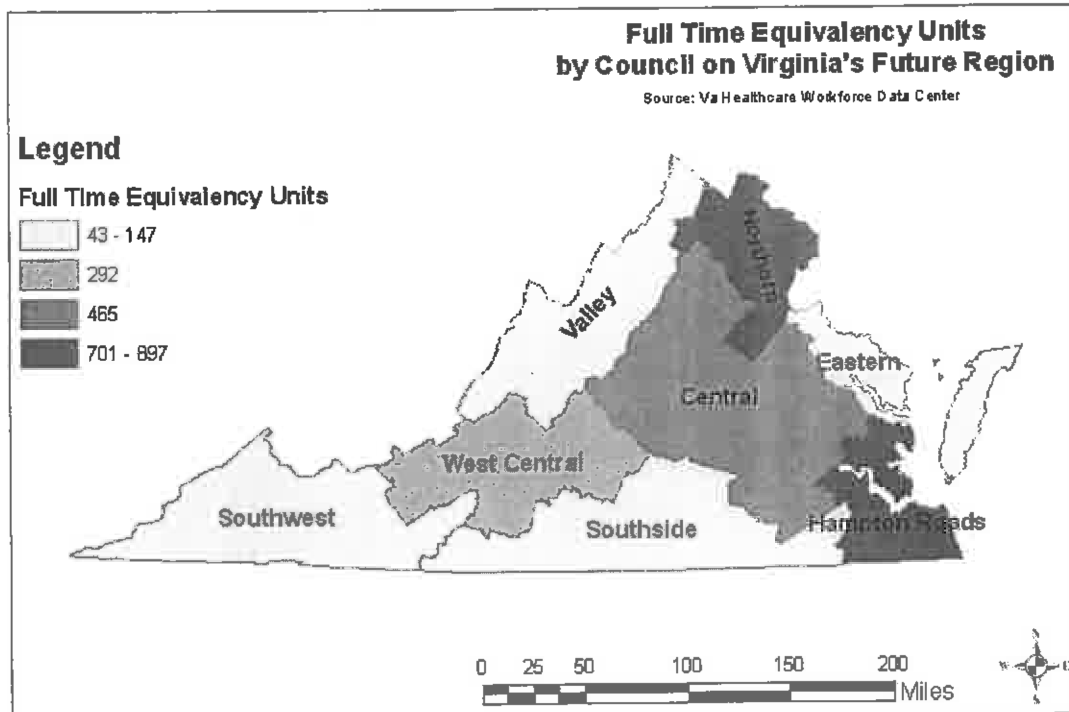
Source: Va. Healthcare Workforce Data Center

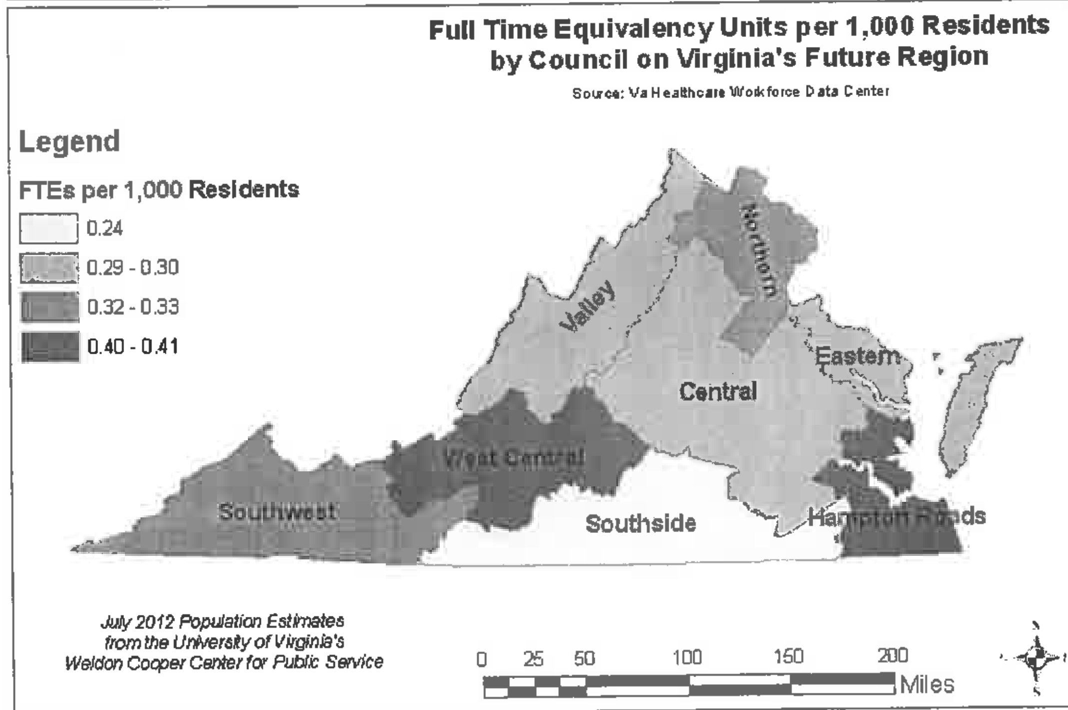


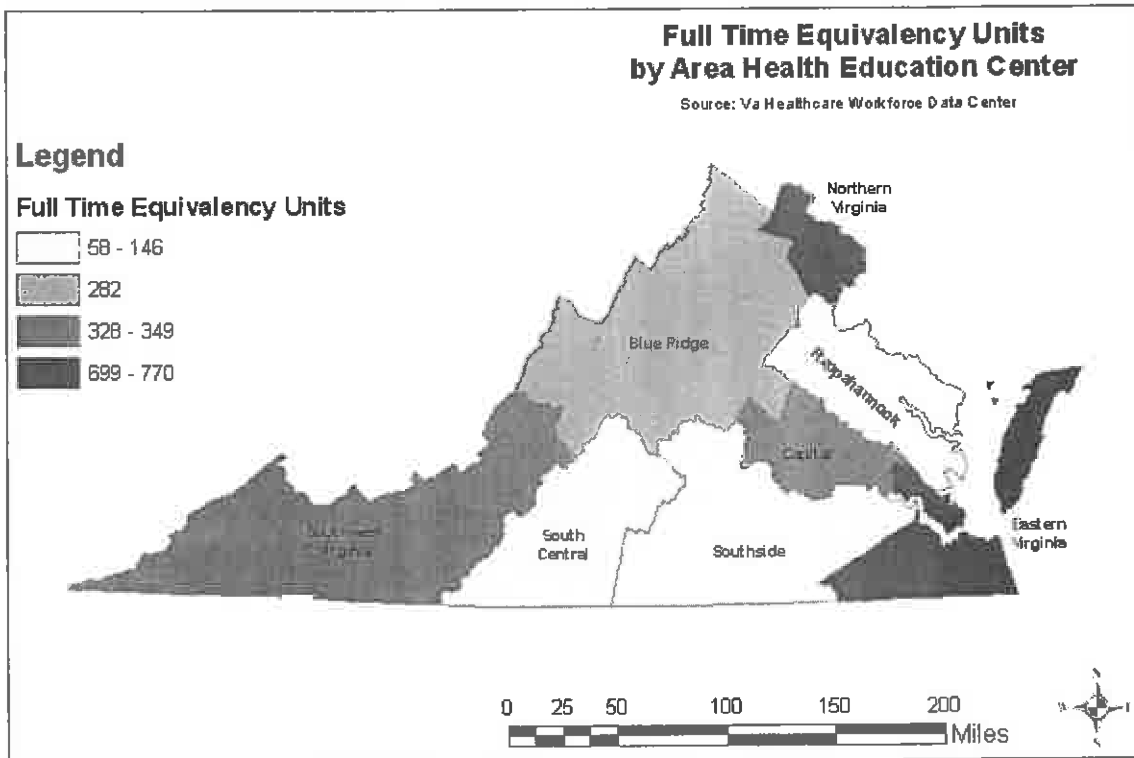
Source: Va. Healthcare Workforce Data Center

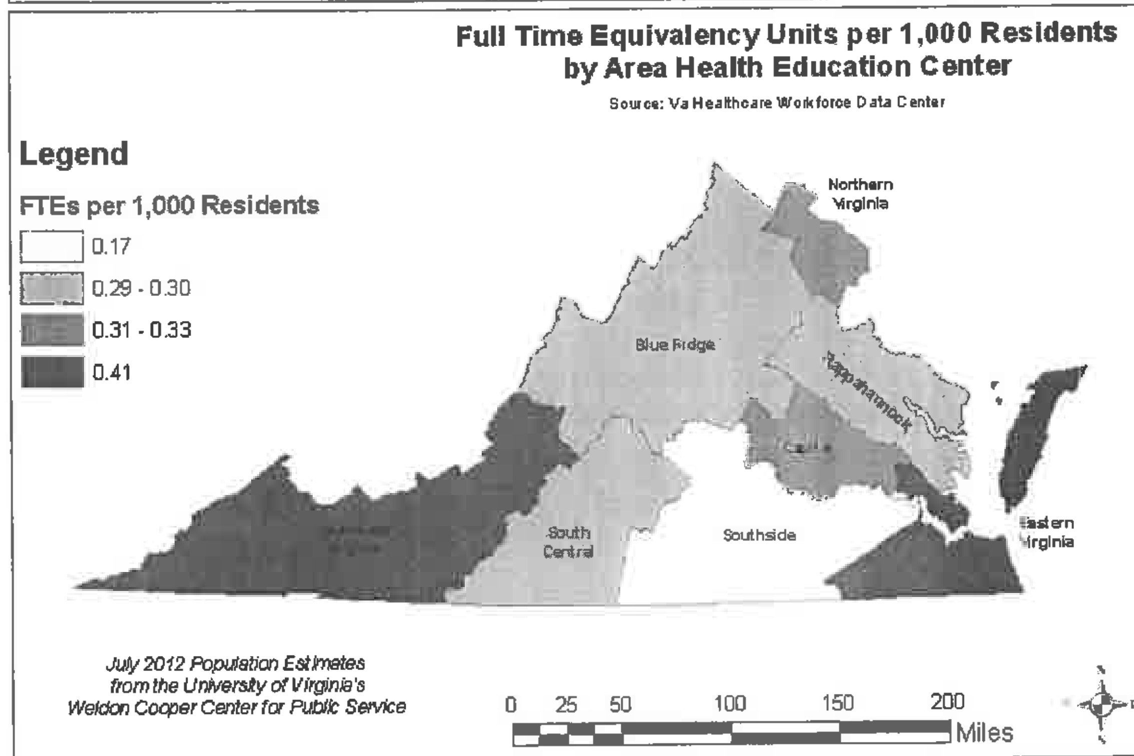
[2] Due to assumption violations in Mixed between-within ANOVA (Levene's Test and interaction effect are significant)

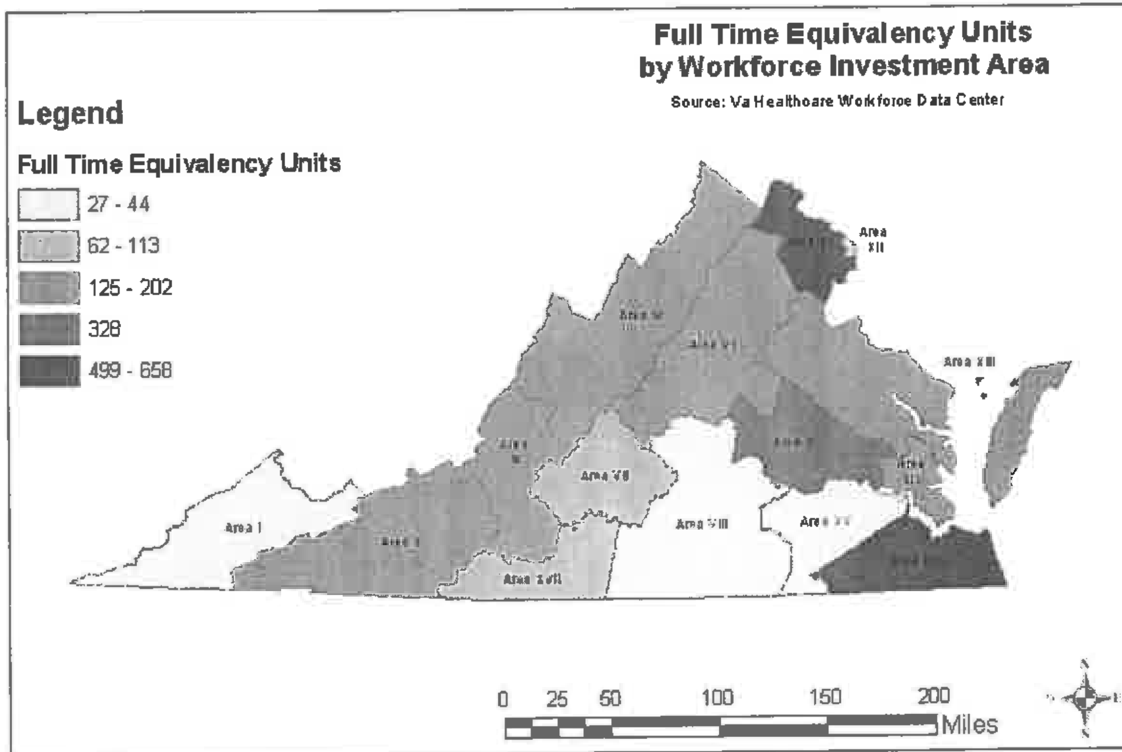
Council on Virginia's Future Regions

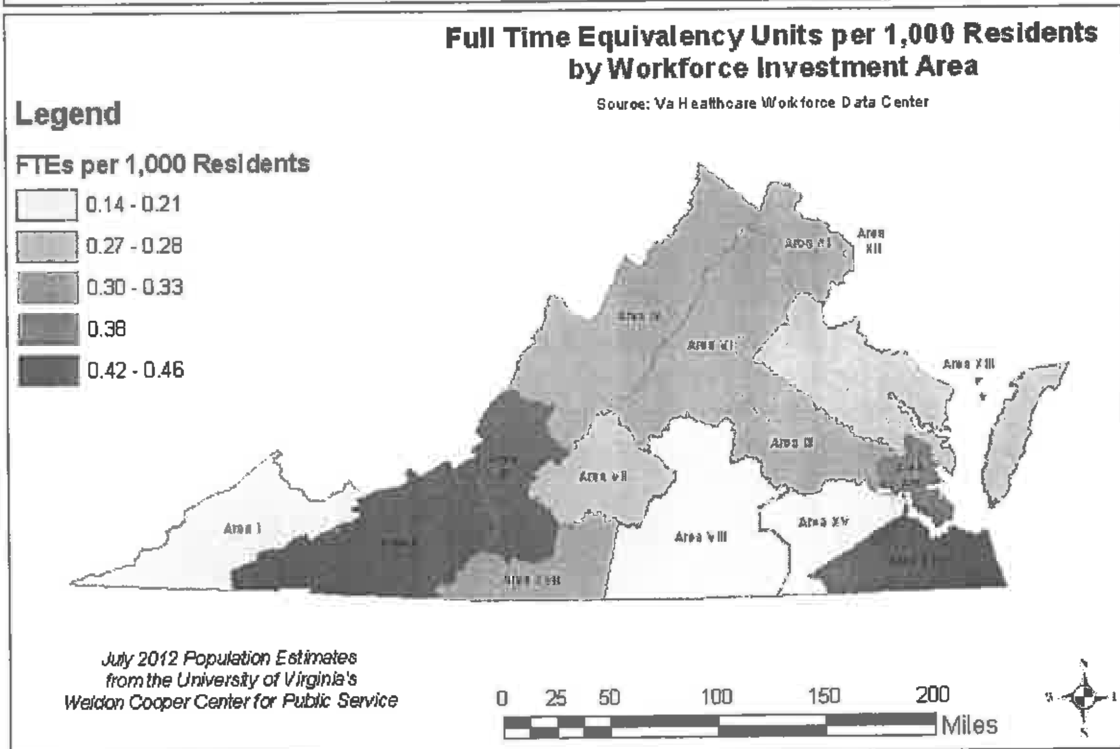


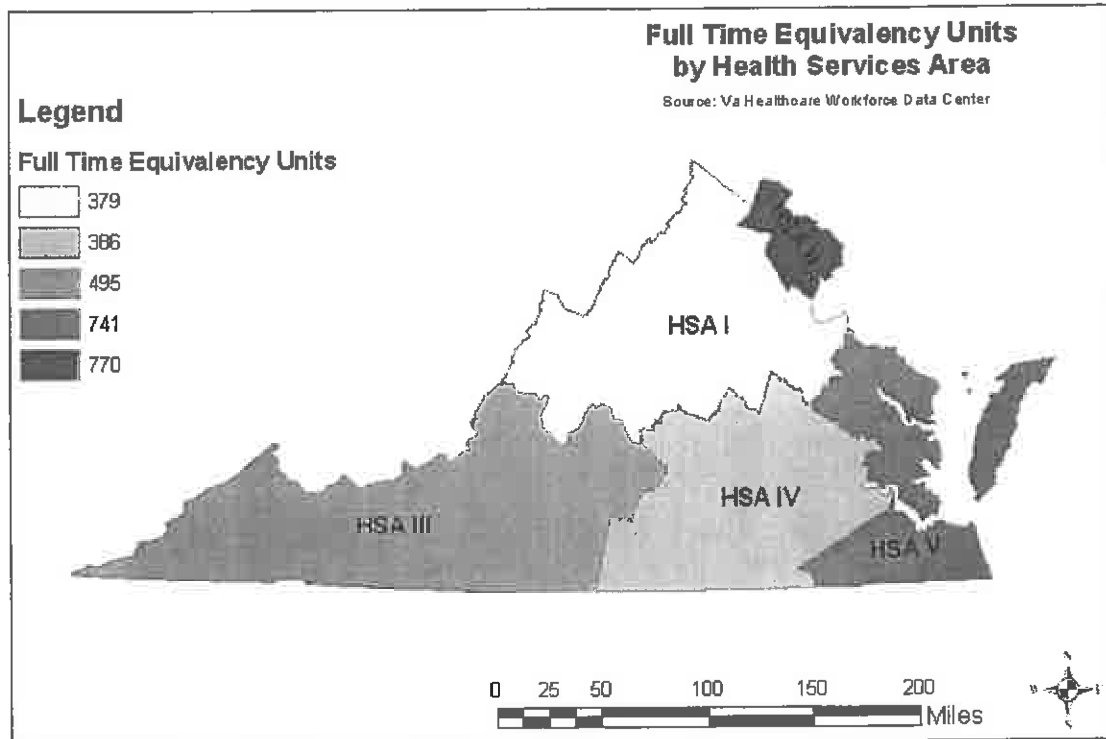


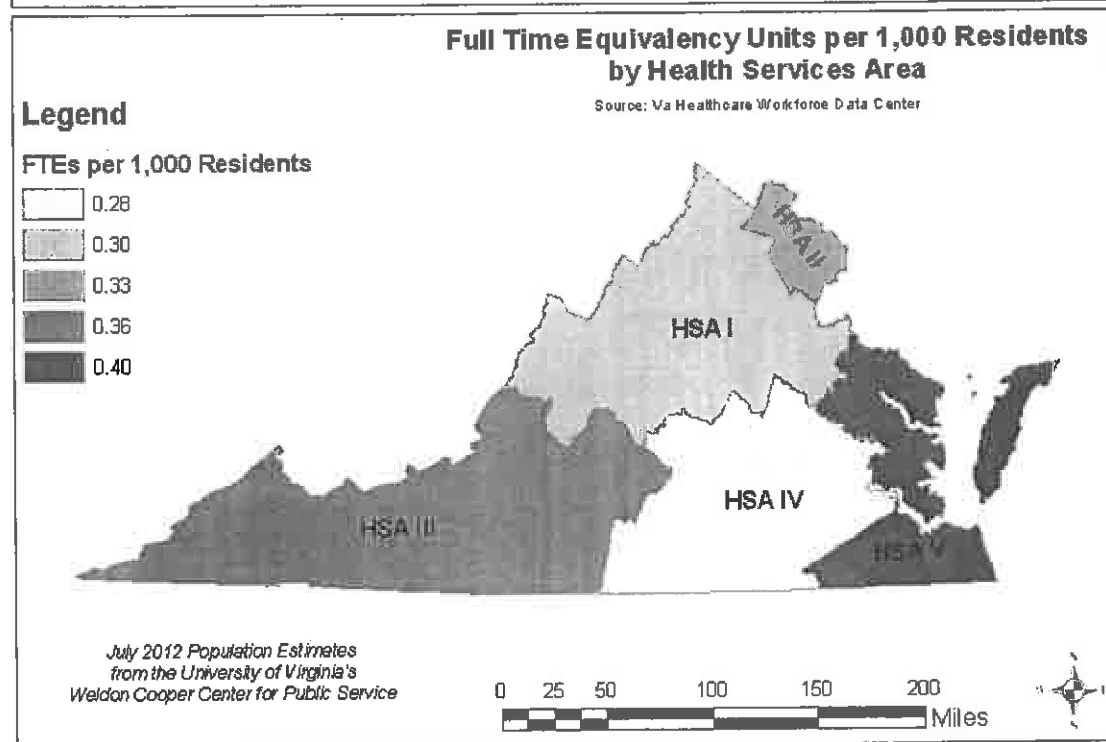

Full Time Equivalency Units
by Area Health Education Center
Source: Va Healthcare Workforce Data Center
Legend
Full Time Equivalency Units
58 - 146
282
328 - 349
699 - 770
Northern Virginia
Blue Ridge
Rappahannock
South Central
Southside
Eastern Virginia
0 25 50 100 150 200
Miles

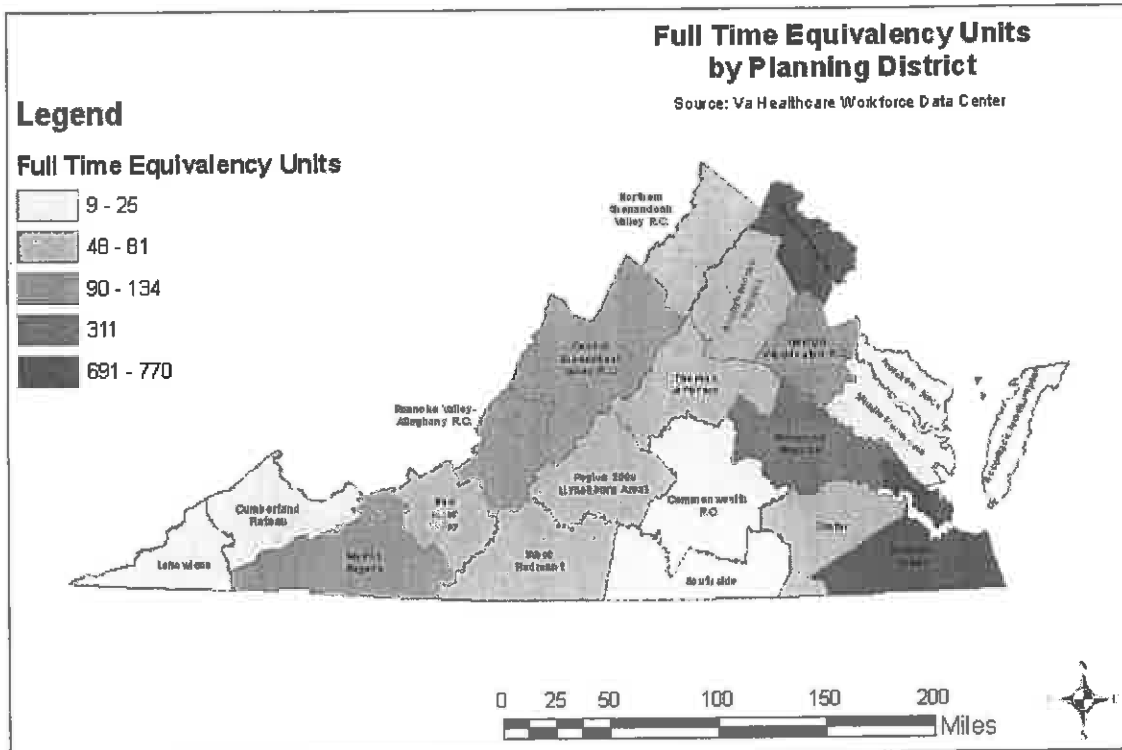

Full Time Equivalency Units per 1,000 Residents
by Area Health Education Center
Source: Va Healthcare Workforce Data Center
Legend
FTEs per 1,000 Residents
0.17
0.29 - 0.30
0.31 - 0.33
0.41
Northern Virginia
Blue Ridge
Rappahannock
South Central
Southside
Eastern Virginia
July 2012 Population Estimates
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
27 - 44
62 - 113
125 - 202
328
499 - 658
Area XII
Area XIII
Area VII
Area VIII
Area I
Area XVII
0 25 50 100 150 200
Miles

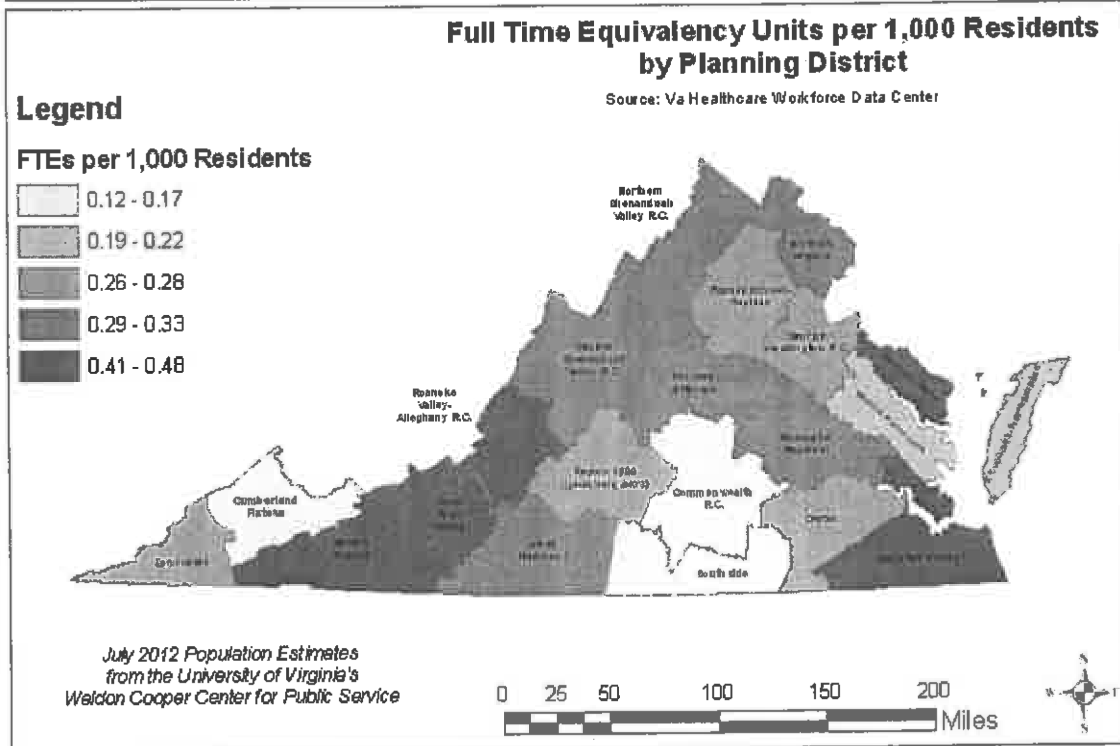

Full Time Equivalency Units per 1,000 Residents
by Workforce Investment Area
Source: Va Healthcare Workforce Data Center
Legend
FTEs per 1,000 Residents
0.14 - 0.21
0.27 - 0.28
0.30 - 0.33
0.38
0.42 - 0.46
Area XII
Area XIII
Area VII
Area VIII
Area XV
Area I
July 2012 Population Estimates
from the University 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
379
386
495
741
770
HSA I
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
0.28
0.30
0.33
0.36
0.40
HSA II
HSA I
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
9 - 25
48 - 81
90 - 134
311
691 - 770
Northern Shenandoah Valley R.C.
Roanoke Valley-Alleghany R.C.
Cumberland Plateau
Commonwealth R.C.
South side
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
0.12 - 0.17
0.19 - 0.22
0.26 - 0.28
0.29 - 0.33
0.41 - 0.48
Northern Shenandoah Valley R.C.
Roanoke Valley-Alleghany R.C.
Cumberland Plateau
Commonwealth R.C.
South side
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 #	Rate	Weight	Total Weight Min	Max
Metro, 1 million+	3349	85.49%	1.169752	1.13554	1.32881
Metro, 250,000 to 1 million	391	86.44%	1.156805	1.12297	1.31411
Metro, 250,000 or less	371	88.68%	1.12766	1.09467	1.281
Urban pop 20,000+, Metro adj	92	88.04%	1.135802	1.10258	1.29025
Urban pop 20,000+, nonadj	0	NA	NA	NA	NA
Urban pop, 2,500-19,999, Metro adj	179	86.59%	1.154839	1.12106	1.31187
Urban pop, 2,500-19,999, nonadj	111	85.59%	1.168421	1.13424	1.3273
Rural, Metro adj	83	81.93%	1.220588	1.18488	1.38656
Rural, nonadj	41	82.93%	1.205882	1.17061	1.36986
Virginia border state/DC	446	78.48%	1.274286	1.23701	1.44756
Other US State	478	72.18%	1.385507	1.34498	1.57391

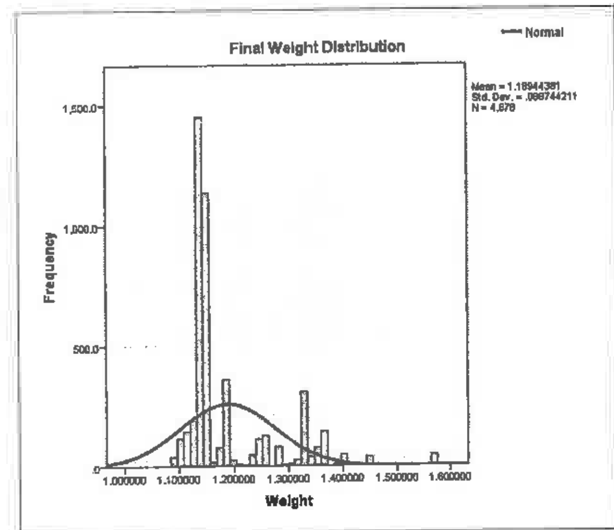
Age	Age Weight #	Rate	Weight	Total Weight Min	Max
Under 30	714	85.99%	1.162866	1.10251	1.3546
30 to 34	738	86.18%	1.160377	1.10015	1.3517
35 to 39	698	85.39%	1.171141	1.11035	1.36424
40 to 44	702	86.61%	1.154605	1.09467	1.34498
45 to 49	690	85.36%	1.171477	1.11067	1.36463
50 to 54	712	85.11%	1.174917	1.11393	1.36864
55 to 59	651	83.26%	1.201107	1.13876	1.39915
60 and Over	658	74.01%	1.351129	1.281	1.57391

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:

Age Weight x Rural Weight x Response Rate = Final Weight.

Overall Response Rate: 0.840762



Source: Va. Healthcare Workforce Data Center

Virginia's Dentistry Workforce: 2014

Exposure Draft

Healthcare Workforce Data Center

August 2014

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 5,500 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!

EXPOSURE

Virginia Department of Health Professions

David E. Brown, D.C.
Director

Jaime H. Hoyle, J.D.
Chief Deputy Director

Healthcare Workforce Data Center Staff:

Elizabeth Carter, Ph.D.	Justin Crow, MPA	Laura Jackson	Christopher Coyle
Director	*Deputy Director*	*Operations Manager*	*Research Assistant*

Virginia Board of Dentistry

President

Melanie C. Swain, RDH

Vice-President

Charles E. Gaskins, III, DDS

Secretary-Treasurer

A. Rizkalla, DDS

Members

John M. Alexander, DDS

Surya P. Dhakar, DDS

Evelyn M. Rolon, DMD

Tammy K. Swecker, RDH

James D. Watkins, DDS

Bruce S. Wyman, DMD

Executive Director

Sandra K. Reen

Exposure Draft

Contents

Results in Brief 2

Survey Response Rates 3

The Workforce 4

Demographics 5

Background 6

Education 8

Current Employment Situation 9

Employment Quality 10

2013 Labor Market 11

Work Site Distribution 12

Establishment Type 13

Time Allocation 15

Patient Workload 16

Retirement & Future Plans 17

Full-Time Equivalency Units 19

Maps 20
- Council on Virginia's Future Regions 20
- Area Health Education Center Regions 21
- Workforce Investment Areas 22
- Health Services Areas 23
- Planning Districts 24

Appendices 25
- Appendix A: Weights 25

The Dentistry Workforce: At a Glance:

The Workforce		Background		Current Employment	
Licensees:	7,106	Rural Childhood:	19%	Employed in Prof.:	97%
Virginia's Workforce:	5,393	HS Diploma in VA:	41%	Hold 1 Full-time Job:	70%
FTEs:	4,589	Prof. Degree in VA:	40%	Satisfied?:	95%
Survey Response Rate		**Education**		**Job Turnover**	
All Licensees:	77%	Doctorate/Prof.:	95%	Switched Jobs:	4%
Renewing Practitioners:	83%	Masters Degree:	1%	Employed over 2 yrs:	75%
Demographics		**Finances**		**Time Allocation**	
Female:	31%	Median Inc.:	$140k-$150k	Patient Care:	80-89%
Diversity Index:	50%	Retirement Benefits:	31%	Administration:	1-9%
Median Age:	49	Under 40 w/ Ed debt:	79%	Patient Care Role:	93%

Source: Va. Healthcare Workforce Data Center

Source: Va. Healthcare Workforce Data Center

5,489 dentists voluntarily took part in the 2014 Dentist 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 77% of the 7,106 dentists who are licensed in the state and 83% of renewing practitioners.

The HWDC estimates that 5,393 dentists participated in Virginia's workforce during the survey period, 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. Between April 2013 and March 2014, Virginia's dentist workforce provided 4,589 "full-time equivalency units", which the HWDC defines simply as working 2,000 hours a year (or 40 hours per week for 50 weeks with 2 weeks off).

Nearly one-third of dentists are female, while the median age of all dentists is 49. In a random encounter between two dentists, there is a 50% chance that they would be of different races or ethnicities, a measure known as the diversity index. For the Virginia population as a whole, this same probability is 54%. Meanwhile, with a diversity index of 63%, dentists who are under the age of 40 are actually more diverse than the state's overall population.

Only 19% of dentists grew up in a rural area, and one out of five of these professionals currently work in non-Metro areas of the state. Meanwhile, 41% of Virginia's dentists graduated from high school in Virginia, and 40% received their initial professional degree in the state. In total, 49% of dentists have some educational background in the state.

Nearly all dentists hold a doctorate or professional degree, with most of the remaining dentists holding a baccalaureate degree as their highest professional degree. More than one-third of all dentists currently have educational debt, including 79% of dentists who are under the age of 40. The median debt burden for those dentists with educational debt is between $120,000 and $130,000.

97% of dentists are currently employed in the profession. 70% hold one full-time position, while another 14% hold at least two separate positions. 30% of all dentists work between 40 and 49 hours per week, while just 3% work at least 60 hours per week. Less than 1% of dentists are involuntarily unemployed, while just 1% are voluntarily unemployed.

The median annual income for dentists is between $140,000 and $150,000. In addition, 41% of dentists receive at least one employer-sponsored benefit, including 31% who have access to some form of retirement plan. 95% of dentists indicate they are satisfied with their current employment situation, including 73% who indicate they are "very satisfied".

Nearly 80% of dentists worked in the regions of Northern Virginia, Central Virginia, and Hampton Roads. 93% of dentists work in the private sector, including 90% who work at a for-profit company. Two-thirds of dentists work at a solo dental practice, while another 20% work at a group dental practice.

A typical dentist spends between 80% and 90% of his time treating patients. 93% of all dentists serve in a patient care role, meaning that at least 60% of their time is spent treating patients. On average, a dentist treats between 50 and 75 patients per week at his primary work location.

36% of dentists expect to retire by the age of 65. Only 8% of the workforce expects to retire in the next decade, while half the current workforce expects to retire by 2034. Over the next two years, only 3% of dentists plan on leaving either the state or the profession. Meanwhile, 13% of dentists expect to pursue additional educational opportunities in the next two years, and 16% expect to increase their patient care activities.

A Closer Look:

Licensees		
License Status	#	%
Renewing Practitioners	6,272	88%
New Licensees	488	7%
Non-Renewals	346	5%
All Licensees	7,106	100%

Source: Va. Healthcare Workforce Data Center

Our surveys tend to achieve very high response rates. 83% of renewing dentists submitted a survey. These represent 77% of dentists who held a license at some point in the past year.

Response Rates			
Statistic	Non Respondents	Respondent	Response Rate
By Age			
Under 30	67	168	72%
30 to 34	199	637	76%
35 to 39	170	707	81%
40 to 44	175	736	81%
45 to 49	126	588	82%
50 to 54	136	547	80%
55 to 59	156	606	80%
60 and Over	588	1,500	72%
Total	1,617	5,489	77%
New Licenses			
Issued 4/2013 to 3/2014	205	283	58%
Metro Status			
Non-Metro	111	304	73%
Metro	1,040	4,040	80%
Not in Virginia	460	1,101	71%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Licensed Dentists

Number: 7,106
New: 7%
Not Renewed: 5%

Response Rates

All Licensees: 77%
Renewing Practitioners: 83%

Source: Va. Healthcare Workforce Data Center

Response Rates	
Completed Surveys	5,489
Response Rate, All Licensees	77%
Response Rate, Renewals	83%

Source: Va. Healthcare Workforce Data Center

Definitions

1. **The Survey Period:** The survey was conducted in March 2014.
2. **Target Population:** All Dentists who held a Virginia license at some point between April 2013 and March 2014.
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 2014.

At a Glance:

Workforce

Dentistry Workforce:	5,393
FTEs:	4,589

Utilization Ratios

Licensees in VA Workforce:	76%
Licensees per FTE:	1.55
Workers per FTE:	1.18

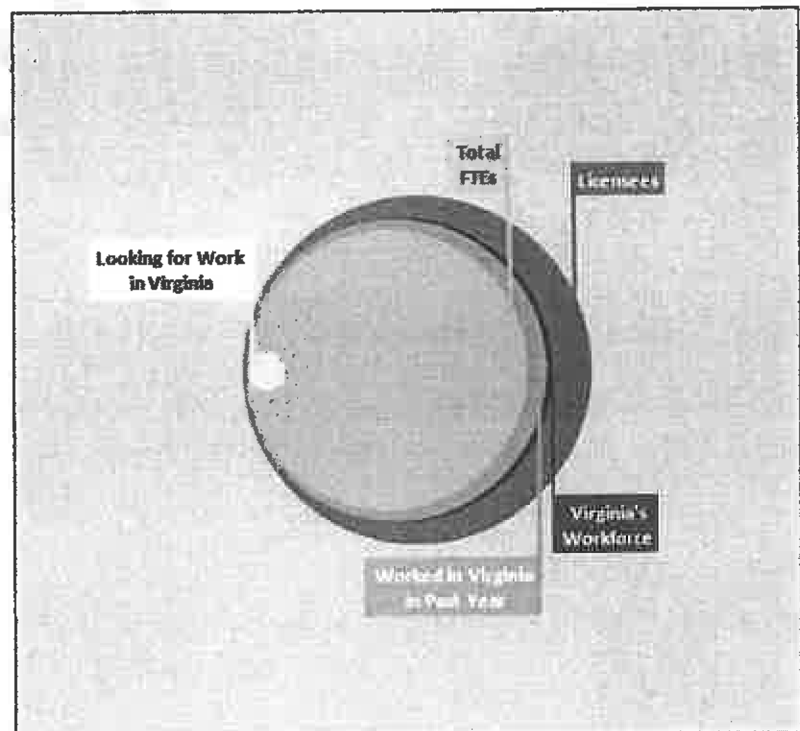
Definitions

1. **Virginia's Workforce:** A licensee with a primary or secondary work site in Virginia at any time between April 2013 and March 2014 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 Dentistry Workforce		
Status	**#**	**%**
Worked in Virginia in Past Year	5,307	98%
Looking for Work in Virginia	86	2%
Virginia's Workforce	5,393	100%
Total FTEs	4,589	
Licensees	7,106	

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	Male #	Male % Male	Female #	Female % Female	Total #	Total % in Age Group
Under 30	71	45%	85	55%	157	3%
30 to 34	246	44%	311	56%	557	11%
35 to 39	314	54%	263	46%	577	12%
40 to 44	349	53%	308	47%	657	14%
45 to 49	316	64%	179	36%	495	10%
50 to 54	333	69%	149	31%	482	10%
55 to 59	408	80%	103	20%	511	11%
60 +	1,303	91%	122	9%	1,425	29%
Total	3,340	69%	1,521	31%	4,861	100%

Age & Gender

Source: Va. Healthcare Workforce Data Center

At a Glance:

Gender
% Female: 31%
% Under 40 Female: 51%

Age
Median Age: 49
% Under 40: 27%
% 55+: 40%

Diversity
Diversity Index: 50%
Under 40 Div. Index: 63%

Source: Va. Healthcare Workforce Data Center

Race & Ethnicity

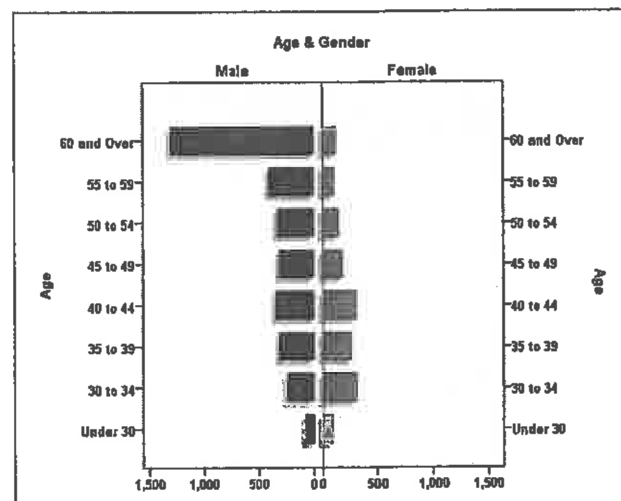
Race/ Ethnicity	Virginia* %	Dentists #	Dentists %	Dentists Under 40 #	Dentists Under 40 %
White	64%	3,326	68%	689	54%
Black	19%	297	6%	83	6%
Asian	6%	792	16%	349	27%
Other Race	0%	164	3%	54	4%
Two or More Races	2%	92	2%	39	3%
Hispanic	8%	191	4%	68	5%
Total	100%	4,862	100%	1,282	100%

*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 50% 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 as a whole.

More than one-quarter of dentists are under the age of 40. 51% of these professionals are female, and 27% are non-Hispanic Asian.



Source: Va. Healthcare Workforce Data Center

At a Glance:

Childhood
Urban Childhood: 24%
Rural Childhood: 19%

Virginia Background
HS in Virginia: 41%
Dental Ed. in VA: 40%
HS or Dental Ed. in VA: 49%

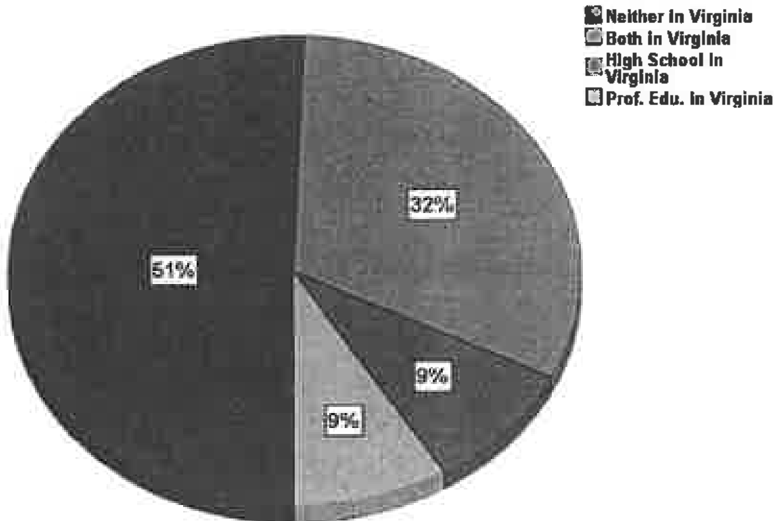
Location Choice
% Rural to Non-Metro: 20%
% Urban/Suburban to Non-Metro: 5%

Source: Va. Healthcare Workforce Data Center

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+	14%	60%	26%
2	Metro, 250,000 to 1 million	33%	49%	17%
3	Metro, 250,000 or less	25%	55%	20%
	Non-Metro Counties			
4	Urban pop 20,000+, Metro adj	39%	47%	15%
6	Urban pop, 2,500-19,999, Metro adj	50%	38%	12%
7	Urban pop, 2,500-19,999, nonadj	64%	29%	7%
8	Rural, Metro adj	43%	45%	12%
9	Rural, nonadj	32%	41%	27%
	Overall	19%	57%	24%

Source: Va. Healthcare Workforce Data Center



Source: Va. Healthcare Workforce Data Center

Only 19% of dentists grew up in a rural area, and 20% of this group currently works in non-Metro areas of the state. Overall, 8% of dentists currently work in rural areas of Virginia.

Top Ten States for Dentist Recruitment

Rank	All Dentists			
	High School	#	Dental School	#
1	Virginia	1,964	Virginia	1,916
2	Outside U.S./Canada	737	Washington, D.C.	441
3	New York	249	Pennsylvania	320
4	Maryland	194	Maryland	263
5	Pennsylvania	181	New York	220
6	West Virginia	109	Outside U.S./Canada	199
7	New Jersey	109	Massachusetts	163
8	California	106	West Virginia	127
9	Florida	102	Tennessee	118
10	North Carolina	98	Kentucky	114

Source: Va. Healthcare Workforce Data Center

41% of all dentists earned their high school degree in Virginia, and 40% received their initial professional degree in the state.

Rank	Licensed in the Past 5 Years			
	High School	#	Dental School	#
1	Outside U.S./Canada	308	Virginia	218
2	Virginia	256	Outside U.S./Canada	107
3	Pennsylvania	35	Pennsylvania	102
4	California	34	New York	95
5	Maryland	33	Washington, D.C.	60
6	New York	27	Massachusetts	55
7	North Carolina	25	Maryland	51
8	Canada	23	California	38
9	Georgia	22	West Virginia	30
10	West Virginia	21	Kentucky	26

Source: Va. Healthcare Workforce Data Center

Among dentists who received their initial license in the past five years, 25% earned their high school degree in Virginia, while 22% received their initial professional degree in the state.

Nearly one quarter of Virginia's licensees were not part of the state's dental workforce. 88% of these licensees worked at some point in the past year, including 85% who worked as dentists.

At a Glance:

Not in VA Workforce

Total:	1,721
% of Licensees:	24%
Federal/Military:	18%
Va Border State/DC:	18%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Highest Dental Degree		
Degree	#	%
Baccalaureate	127	3%
Graduate Certificate	54	1%
Masters	40	1%
Doctorate/Professional	4,581	95%
Total	4,801	100%

Source: Va. Healthcare Workforce Data Center

More than one-third of dentists carry educational debt, including nearly 80% of those under the age of 40. For those in debt, their median burden is between $120,000 and $130,000.

At a Glance:

Education
Doctorate/Professional: 95%
Baccalaureate: 3%

Educational Debt
Carry debt: 36%
Under age 40 w/ debt: 79%
Median debt: $120k-$130k

Residencies
GPR-1: 13%
AEGD: 10%
Orthodontics: 7%

Source: Va. Healthcare Workforce Data Center

Residencies/Special Training Programs		
Residency	#	%
General Practice Residency -1 (GPR-1)	683	13%
Advanced Education in General Dentistry (AEGD)	522	10%
Orthodontics	355	7%
Pediatric Dentisty	202	4%
Oral and Maxillofacial Surgery	198	4%
Periodontology	184	3%
Endodontics	171	3%
General Practice Residency -2 (GPR-2)	169	3%
Prosthodontics	141	3%
Dental Public Health	23	0%
Oral and Maxillofacial Pathology	12	0%
Oral and Maxillofacial Radiology	4	0%
At Least One	2,286	42%

Educational Debt				
Amount Carried	All Dentists		Dentists under 40	
	#	%	#	%
None	2,575	64%	225	21%
Less than $40,000	201	5%	49	5%
$40,000-$59,999	110	3%	41	4%
$60,000-$79,999	117	3%	40	4%
$80,000-$99,999	120	3%	63	6%
$100,000-$119,999	146	4%	84	8%
$120,000-$139,999	95	2%	55	5%
$140,000-$159,999	90	2%	58	5%
$160,000-$179,999	102	3%	76	7%
$180,000-$199,999	80	2%	66	6%
$200,000 or More	383	10%	301	28%
Total	4,017	100%	1,060	100%

At a Glance:

Employment
Employed in Profession: 97%
Involuntarily Unemployed: 0%

Positions Held
1 Full-time: 70%
2 or More Positions: 14%

Weekly Hours:
40 to 49: 30%
60 or more: 3%
Less than 30: 14%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Current Work Status		
Status	#	%
Employed, capacity unknown	5	0%
Employed in a dentistry related capacity	4,639	97%
Employed, NOT in a dentistry related capacity	10	0%
Not working, reason unknown	2	0%
Involuntarily unemployed	17	0%
Voluntarily unemployed	44	1%
Retired	91	2%
Total	4,808	100%

Source: Va. Healthcare Workforce Data Center

97% of Virginia's dentists are employed in the profession, and 70% currently have one full-time job. 30% of dentists currently work between 40 and 49 hours per week, while only 3% work at least 60 hours per week.

Current Positions		
Positions	#	%
No Positions	154	3%
One Part-Time Position	571	12%
Two Part-Time Positions	204	4%
One Full-Time Position	3,249	70%
One Full-Time Position & One Part-Time Position	342	7%
Two Full-Time Positions	15	0%
More than Two Positions	99	2%
Total	4,634	100%

Source: Va. Healthcare Workforce Data Center

Current Weekly Hours		
Hours	#	%
0 hours	154	3%
1 to 9 hours	74	2%
10 to 19 hours	189	4%
20 to 29 hours	381	8%
30 to 39 hours	2,094	45%
40 to 49 hours	1,400	30%
50 to 59 hours	256	5%
60 to 69 hours	71	2%
70 to 79 hours	25	1%
80 or more hours	24	1%
Total	4,668	100%

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Income		
Hourly Wage	#	%
Volunteer Work Only	34	1%
Less Than $30,000	147	4%
$30,000-$69,999	317	9%
$70,000-$109,999	684	19%
$110,000-$149,999	650	18%
$150,000-$189,999	498	14%
$190,000-$229,999	403	11%
$230,000-$269,999	289	8%
$270,000-$309,999	158	4%
$310,000-$349,999	90	2%
More than $350,000	336	9%
Total	3,604	100%

Source: Va. Healthcare Workforce Data Center

At a Glance:

Earnings
Median Income: $140k-$150k

Benefits
Retirement: 31%
Paid Vacation: 22%

Satisfaction
Satisfied: 95%
Very Satisfied: 73%

Source: Va. Healthcare Workforce Data Center

Job Satisfaction		
Level	#	%
Very Satisfied	3,396	73%
Somewhat Satisfied	1,049	23%
Somewhat Dissatisfied	155	3%
Very Dissatisfied	56	1%
Total	4,656	100%

Source: Va. Healthcare Workforce Data Center

The typical dentist made between $140,000 and $150,000 in the past year. Among dentists who were compensated at the primary work location with either a salary or an hourly wage, 35% had access to a retirement plan and 31% received paid vacation.

Employer-Sponsored Benefits			
Benefit	#	%	% of Wage/Salary Employees
Retirement	1,429	31%	35%
Paid Vacation	1,041	22%	31%
Paid Sick Leave	662	14%	20%
Group Life Insurance	585	13%	16%
Dental Insurance	522	11%	16%
Signing/Retention Bonus	142	3%	5%
Receive at least one benefit	1,921	41%	50%

*From any employer at time of survey.

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Employment Instability in Past Year		
In the past year did you . . .?	#	%
Experience involuntary unemployment?	67	1%
Experience voluntary unemployment?	158	3%
Work Part-time or temporary positions, but would have preferred a full-time/permanent position?	171	3%
Work two or more positions at the same time?	751	14%
Switch employers or practices?	210	4%
Experienced at least 1	1,092	20%

Source: Va. Healthcare Workforce Data Center

Only 1% of Virginia's dentists experienced involuntary unemployment at some point during the renewal cycle. By comparison, Virginia's average monthly unemployment rate was 5.5% in 2013.[2]

At a Glance:

Unemployment Experience 2013
Involuntarily Unemployed: 1%
Underemployed: 3%

Turnover & Tenure
Switched Jobs: 4%
New Location: 18%
Over 2 years: 75%
Over 2 yrs, 2nd location: 59%

Employment Type
Salary/Commission: 52%
Business/Practice Income: 40%

Source: Va. Healthcare Workforce Data Center

Location Tenure				
Tenure	Primary		Secondary	
	#	%	#	%
Not Currently Working at this Location	69	2%	54	5%
Less than 6 Months	219	5%	123	10%
6 Months to 1 Year	330	7%	138	12%
1 to 2 Years	523	11%	162	14%
3 to 5 Years	662	14%	226	19%
6 to 10 Years	711	16%	169	14%
More than 10 Years	2,070	45%	302	26%
Subtotal	4,584	100%	1,174	100%
Did not have location	88		4,127	
Item Missing	720		92	
Total	5,393		5,393	

Source: Va. Healthcare Workforce Data Center

Three-quarters of dentists have worked at their primary location for at least two years.

More than half of dentists are salary or wage employees, while 40% receive income from their own practice.

Employment Type		
Primary Work Site	#	%
Salary/ Commission	1,978	52%
Hourly Wage	135	4%
By Contract	122	3%
Business/ Practice Income	1,526	40%
Unpaid	37	1%
Subtotal	3,797	100%
Did not have location	88	
Item Missing	1,507	

Source: Va. Healthcare Workforce Data Center

[1] As reported by the US Bureau of Labor Statistics. The not seasonally adjusted monthly unemployment rate ranged from 6.3% in January 2013 to 4.8% in December 2013.

At a Glance:

Concentration

Top Region:	40%
Top 3 Regions:	78%
Lowest Region:	2%

Locations

2 or more (Past Year):	23%
2 or more (Now*):	24%

Source: Va. Healthcare Workforce Data Center

40% of all dentists work in Northern Virginia, the most of any region in Virginia. With only 2% of the workforce, Eastern Virginia had the fewest number of dentists of any region in the state.

Number of Work Locations				
Locations	Work Locations in Past Year		Work Locations Now*	
	#	%	#	%
0	88	2%	137	3%
1	4,039	75%	3,412	73%
2	797	15%	732	16%
3	372	7%	317	7%
4	44	1%	39	0%
5	25	1%	23	1%
6 or More	28	1%	11	1%
Total	5,393	100%	4,670	0%

*At the time of survey completion, March 2014.

Source: Va. Healthcare Workforce Data Center

A Closer Look:

Regional Distribution of Work Locations				
COVF Region	Primary Location		Secondary Location	
	#	%	#	%
Central	879	19%	220	18%
Eastern	69	2%	27	2%
Hampton Roads	825	18%	188	15%
Northern	1,850	40%	475	39%
Southside	143	3%	30	2%
Southwest	119	3%	28	2%
Valley	214	5%	51	4%
West Central	406	9%	82	7%
Virginia Border State/DC	23	1%	48	4%
Other US State	42	1%	79	6%
Outside of the US	1	0%	1	0%
Total	4,571	100%	1,229	100%
Item Missing	735		35	

Source: Va. Healthcare Workforce Data Center

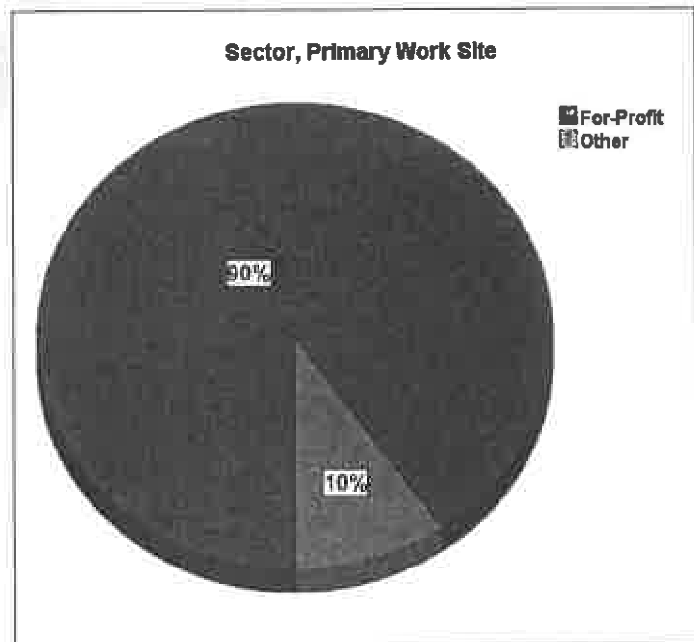
Nearly three out of four dentists currently have just one work location, while 16% have two different work locations.

A Closer Look:

Location Sector				
Sector	Primary Location		Secondary Location	
	#	%	#	%
For-profit	3,965	90%	946	83%
Non-profit	103	2%	68	6%
State/local government	147	3%	93	8%
Veterans Administration	22	1%	3	0%
U.S. Military	134	3%	22	2%
Other Federal Government	11	0%	6	1%
Total	**4,382**	**100%**	**1,138**	**100%**
Did not have location	88		4127	
Item missing	922		127	

Source: Va. Healthcare Workforce Data Center

90% of dentists worked in for-profit establishments. Another 7% worked for a government agency, including 3% who worked for the U.S. military.



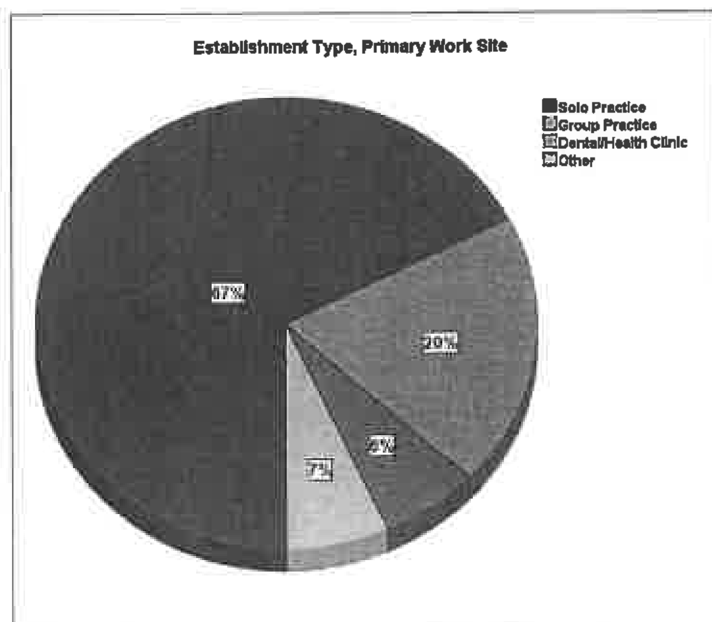
Source: Va. Healthcare Workforce Data Center

Establishment Type	Location Type			
	Primary Location		Secondary Location	
	#	%	#	%
Solo Practice	2,930	67%	562	50%
Group Practice	850	20%	295	26%
Dental/Health Clinic	278	6%	93	8%
Dental School (including Combined Dental/Dental Hygiene)	78	2%	69	6%
Hospital/Health System	72	2%	17	2%
Corrections	28	1%	17	2%
Public Health Program	27	1%	9	1%
Dental Hygiene Program (Community College)	8	0%	6	1%
Nursing Home/Long-Term Care Facility	8	0%	4	0%
Insurance	4	0%	3	0%
Supplier Organization	3	0%	3	0%
K-12 School or Non-Dental College	1	0%	8	1%
Dental Hygiene Program (Technical School)	0	0%	1	0%
Other	60	1%	29	3%
Total	4,347	100%	1,116	100%
Did Not Have a Location	88		4,127	

Source: Va. Healthcare Workforce Data Center

Two-thirds of dentists work at a solo dental practice at their primary work location, while another 20% work at a group dental practice. Dental/health clinics were also significant employers of Virginia's dental workforce.

Among those dentists who also have a secondary work location, approximately three-quarters work at a dental practice, including one-half who work at a solo dental practice.



Source: Va. Healthcare Workforce Data Center

At a Glance:
(Primary Locations)

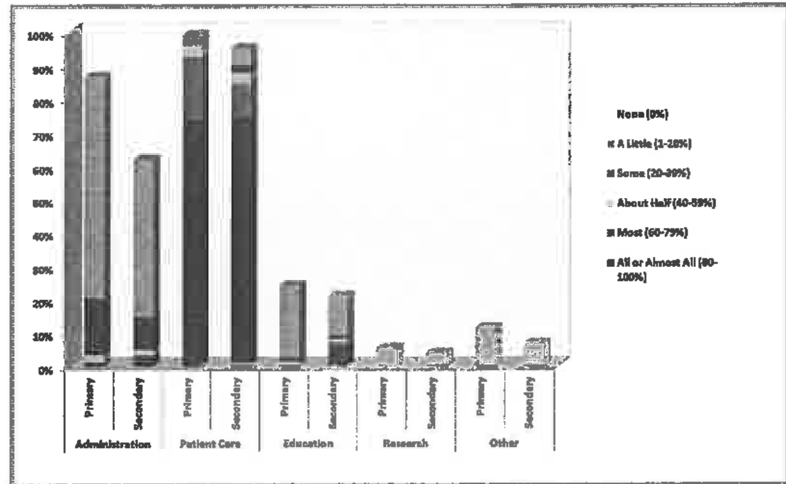
Typical Time Allocation
Patient Care: 80%-89%
Administration: 1%-9%

Roles
Patient Care: 93%
Administrative: 1%
Education: 1%

Patient Care Dentists
Median Admin Time: 1%-9%
Ave. Admin Time: 10%-19%

Source: Va. Healthcare Workforce Data Center

A Closer Look:



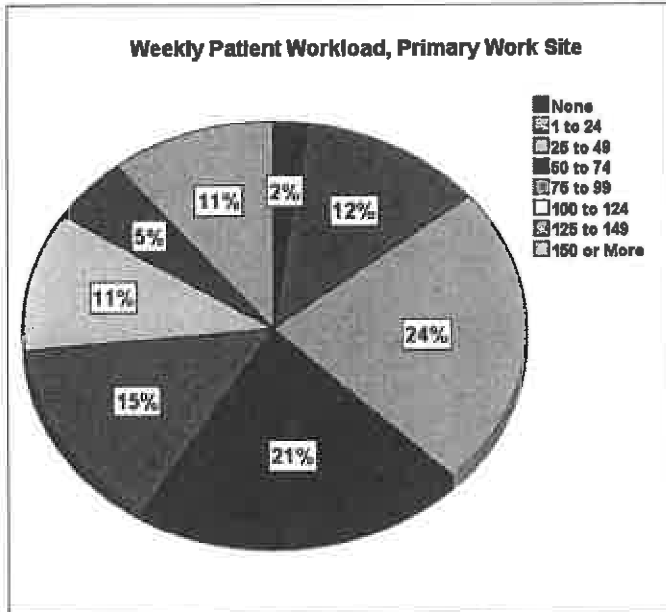
Source: Va. Healthcare Workforce Data Center

A typical dentist spends most of his time caring for patients, with most of the remaining time spent doing administrative tasks. 93% of dentists fill a patient care role, defined as spending 60% or more of their time on patient care activities.

Time Spent	Admin.		Patient Care		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%)	1%	3%	74%	75%	1%	6%	0%	0%	0%	0%
Most (60-79%)	0%	1%	19%	10%	0%	1%	0%	0%	0%	0%
About Half (40-59%)	2%	1%	4%	3%	0%	1%	0%	0%	0%	0%
Some (20-39%)	17%	10%	1%	2%	1%	1%	0%	0%	1%	1%
A Little (1-20%)	66%	47%	1%	5%	22%	12%	5%	4%	10%	5%
None (0%)	13%	38%	1%	5%	76%	79%	95%	96%	89%	93%

Source: Va. Healthcare Workforce Data Center

A Closer Look:



Source: Va. Healthcare Workforce Data Center

At a Glance:

Patient Workload (Median)

Total

Primary Location: 50-74
Secondary Location: 1-24

Hygiene Checks by Support Personnel

Primary Location: 1-24
Secondary Location: None

Source: Va. Healthcare Workforce Data Center

The typical dentist treated between 50 and 74 patients per week at his primary work location. Approximately one-third of those visits were hygiene checks by support personnel.

# of Patients Per Week	Primary Work Location				Secondary Work Location			
	Total		Hygiene Checks*		Total		Hygiene Checks*	
	#	%	#	%	#	%	#	%
None	102	2%	2,052	**48%**	86	8%	700	62%
1-24	526	12%	920	21%	541	48%	307	27%
25-49	1,049	24%	731	17%	244	22%	66	6%
50-74	934	21%	298	7%	118	10%	25	2%
75-99	662	15%	166	4%	50	4%	10	1%
100-124	486	11%	68	2%	39	3%	7	1%
125-149	231	5%	24	1%	15	1%	2	0%
150-174	159	4%	16	0%	20	2%	3	0%
175-199	69	2%	2	0%	6	1%	0	0%
200-224	68	2%	3	0%	5	0%	0	0%
225-249	30	1%	2	0%	3	0%	0	0%
250-274	18	0%	1	0%	0	0%	1	0%
275-299	2	0%	1	0%	0	0%	0	0%
300 or more	39	1%	7	0%	5	0%	4	0%
Total	4,374	100%	4,293	100%	1,132	100%	1,125	100%

*Performed by Support Personnel

A Closer Look:

Retirement Expectations				
Expected Retirement Age	All Dentists		Dentists over 50	
	#	%	#	%
Under age 50	49	1%	-	-
50 to 54	142	4%	-	-
55 to 59	373	9%	80	4%
60 to 64	856	22%	294	15%
65 to 69	1,243	32%	693	36%
70 to 74	679	17%	465	24%
75 to 79	190	5%	148	8%
80 or over	99	3%	65	3%
I do not intend to retire	306	8%	199	10%
Total	**3,937**	**100%**	**1,944**	**100%**

Source: Va. Healthcare Workforce Data Center

At a Glance:

Retirement Expectations

All Dentists

Under 65:	36%
Under 60:	14%

Dentists 50 and over

Under 65:	19%
Under 60:	4%

Time until Retirement

Within 2 years:	8%
Within 10 years:	28%
Half the workforce:	by 2034

Source: Va. Healthcare Workforce Data Center

More than one-third of dentists expect to retire by the age of 65, but only 19% of those dentists who are age 50 or over expect to retire by the same age. Meanwhile, one-third of all dentists expect to work until at least age 70, including 8% who do not expect to retire at all.

Within the next two years, only 3% of Virginia's dentists plan on leaving either the profession or the state. Meanwhile, 16% of dentists plan on increasing their patient care activities, and 13% plan on pursuing additional educational opportunities.

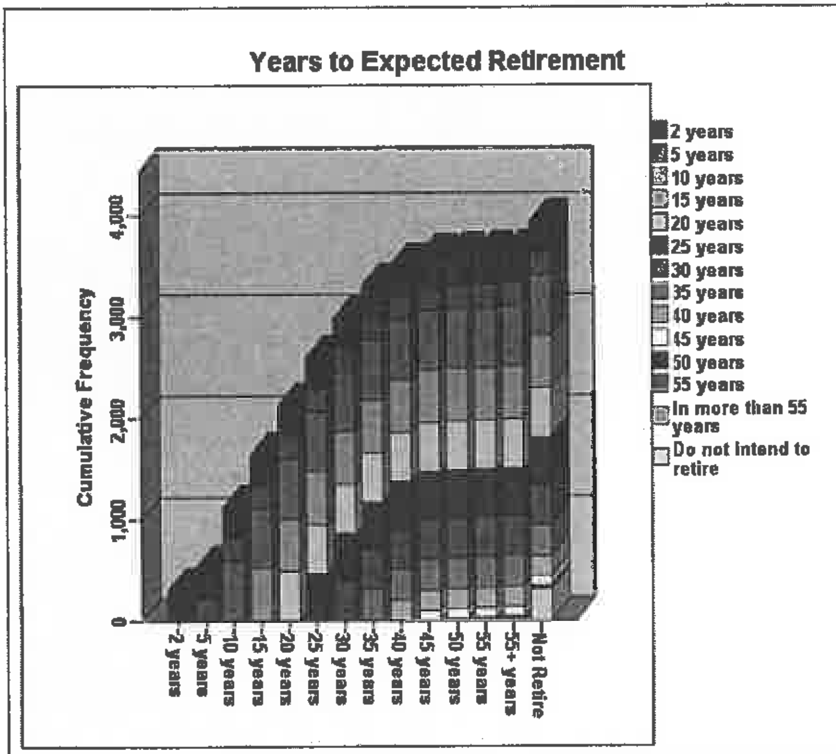
Future Plans		
2 Year Plans:	#	%
Decrease Participation		
Leave Profession	67	1%
Leave Virginia	106	2%
Decrease Patient Care Hours	506	9%
Decrease Teaching Hours	28	1%
Increase Participation		
Increase Patient Care Hours	879	16%
Increase Teaching Hours	268	5%
Pursue Additional Education	726	13%
Return to Virginia's Workforce	35	1%

Source: Va. Healthcare Workforce Data Center

By comparing retirement expectation to age, we can estimate the maximum years to retirement for dentists. 8% of dentists expect to retire within the next two years, while 28% expect to retire in the next ten years. More than half of the current dentistry workforce expects to retire by 2034.

Time to Retirement			
Expect to retire within. . .	#	%	Cumulative %
2 years	299	8%	8%
5 years	227	6%	13%
10 years	595	15%	28%
15 years	519	13%	42%
20 years	486	12%	54%
25 years	466	12%	66%
30 years	396	10%	76%
35 years	312	8%	84%
40 years	197	5%	89%
45 years	95	2%	91%
50 years	17	0%	92%
55 years	6	0%	92%
In more than 55 years	15	0%	92%
Do not intend to retire	306	8%	100%
Total	3,937	100%	

Source: Va. Healthcare Workforce Data Center



Using these estimates, retirements will begin to reach over 10% of the current workforce every 5 years by 2024. Retirements will peak at 15% of the current workforce around the same time period before declining to under 10% of the current workforce again around 2049.

At a Glance:

FTEs

Total:	4,589
FTEs/1,000 Residents:	0.556
Average:	0.87

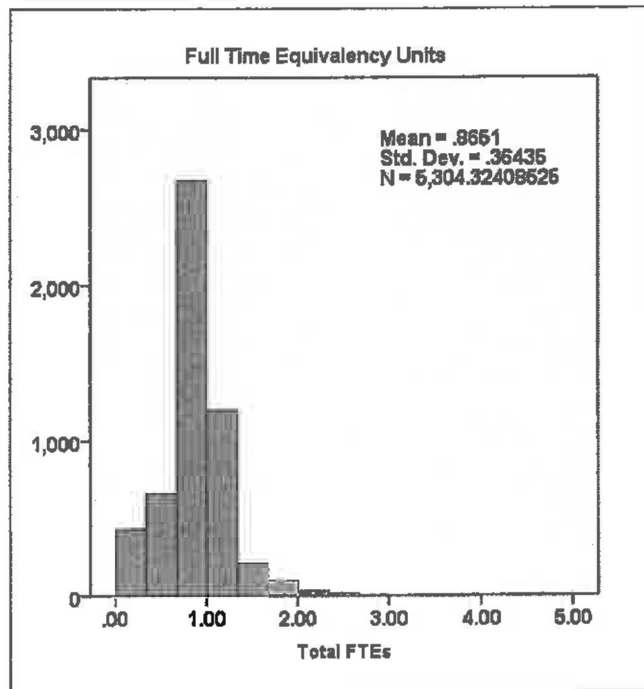
Age & Gender Effect

Age, Partial Eta²:	Small
Gender, Partial Eta²:	Small

Partial Eta² Explained:
Partial Eta² is a statistical measure of effect size.

Source: Va. Healthcare Workforce Data Center

A Closer Look:

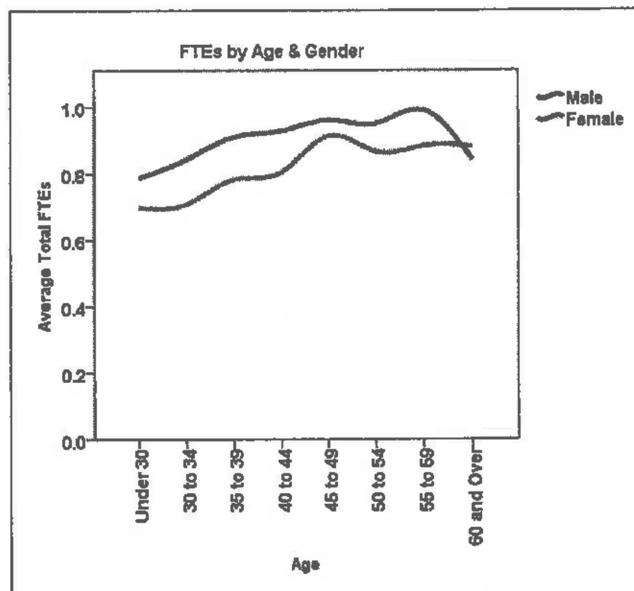


Source: Va. Healthcare Workforce Data Center

The typical (median) dentist provided 0.86 FTEs during the past year, or approximately 33 hours per week for 52 weeks. Although FTEs appear to vary by age and gender, statistical tests did not verify that a difference exists.[2]

Full-Time Equivalency Units		
Age	Average	Median
Age		
Under 30	0.74	0.74
30 to 34	0.76	0.77
35 to 39	0.88	0.88
40 to 44	0.86	0.86
45 to 49	0.93	0.88
50 to 54	0.91	0.88
55 to 59	0.96	0.88
60 and Over	0.84	0.84
Gender		
Male	0.90	0.88
Female	0.81	0.84

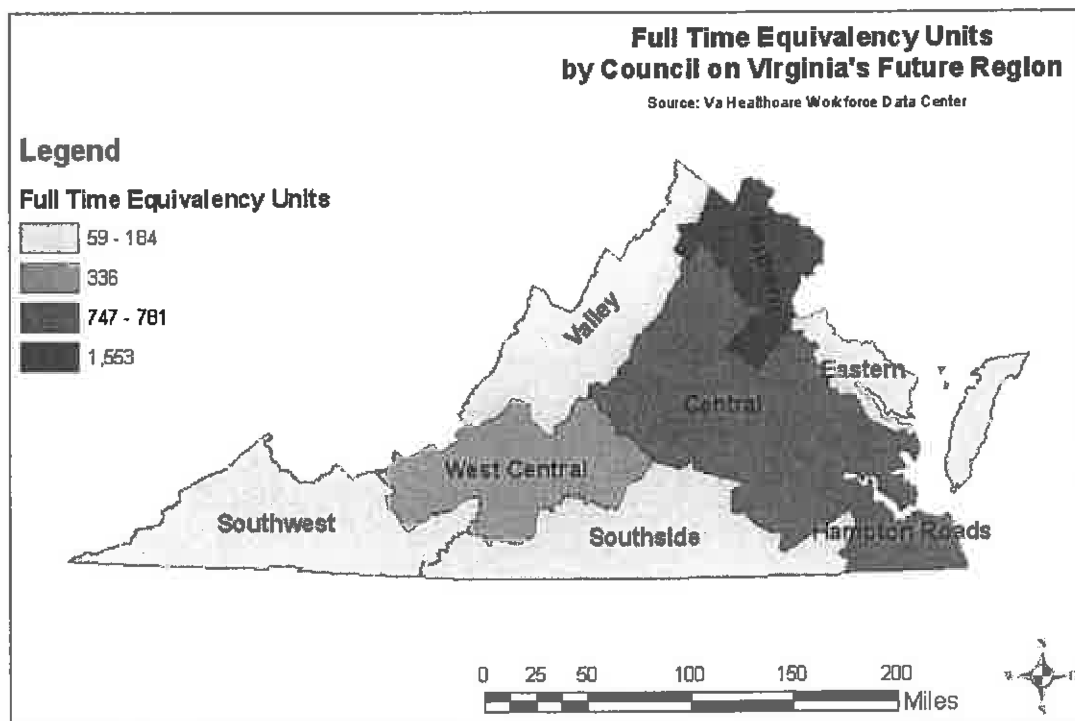
Source: Va. Healthcare Workforce Data Center

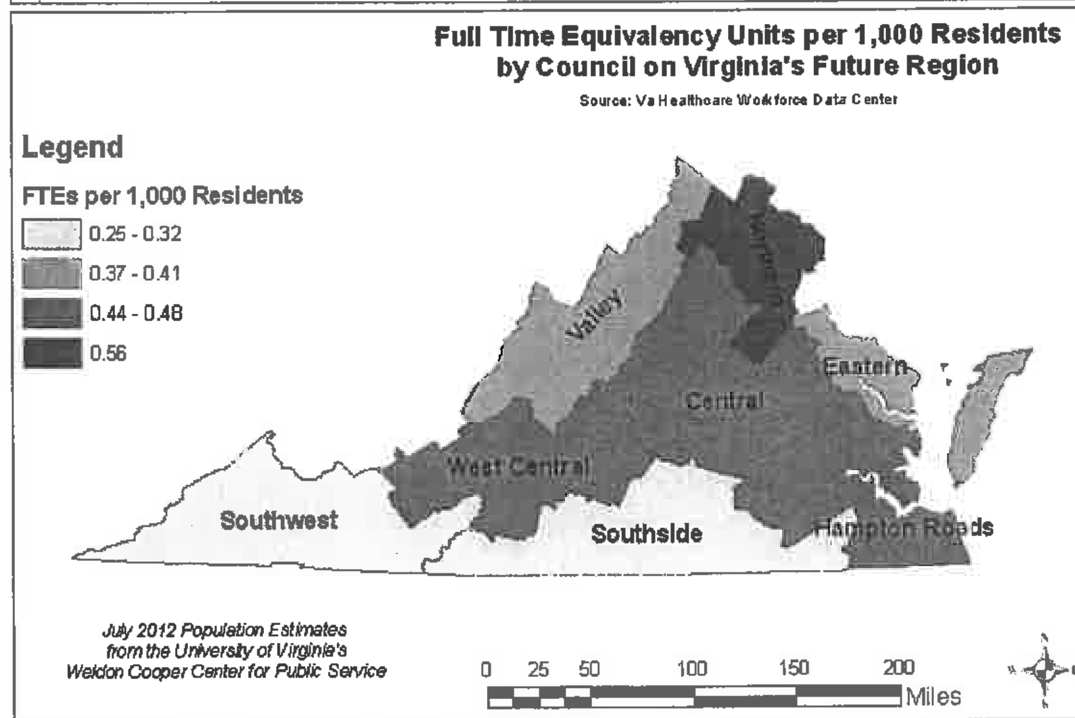


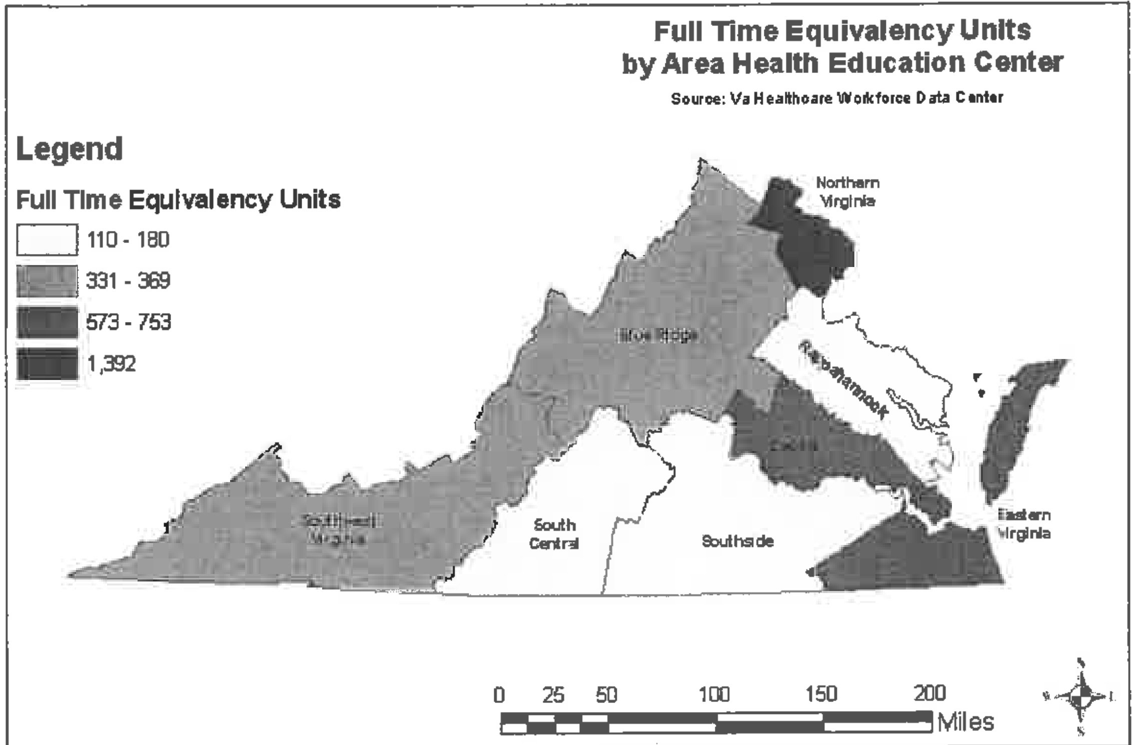
Source: Va. Healthcare Workforce Data Center

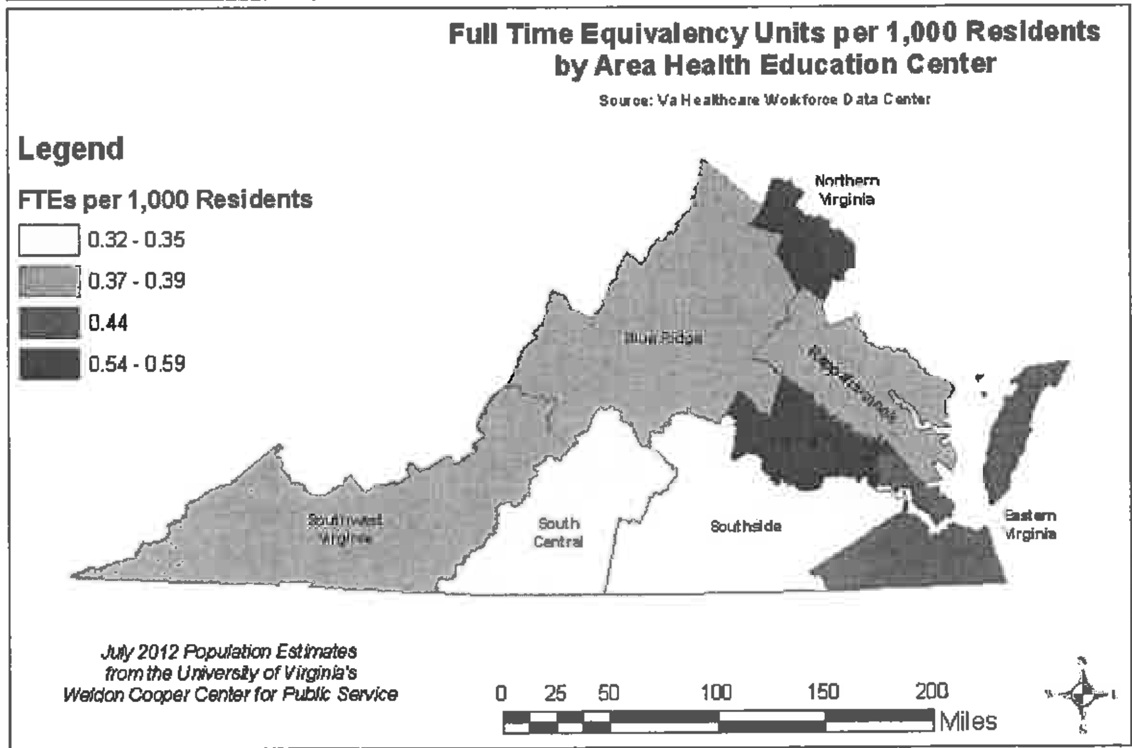
[2] Due to assumption violations in Mixed between-within ANOVA (Interaction effect is significant)

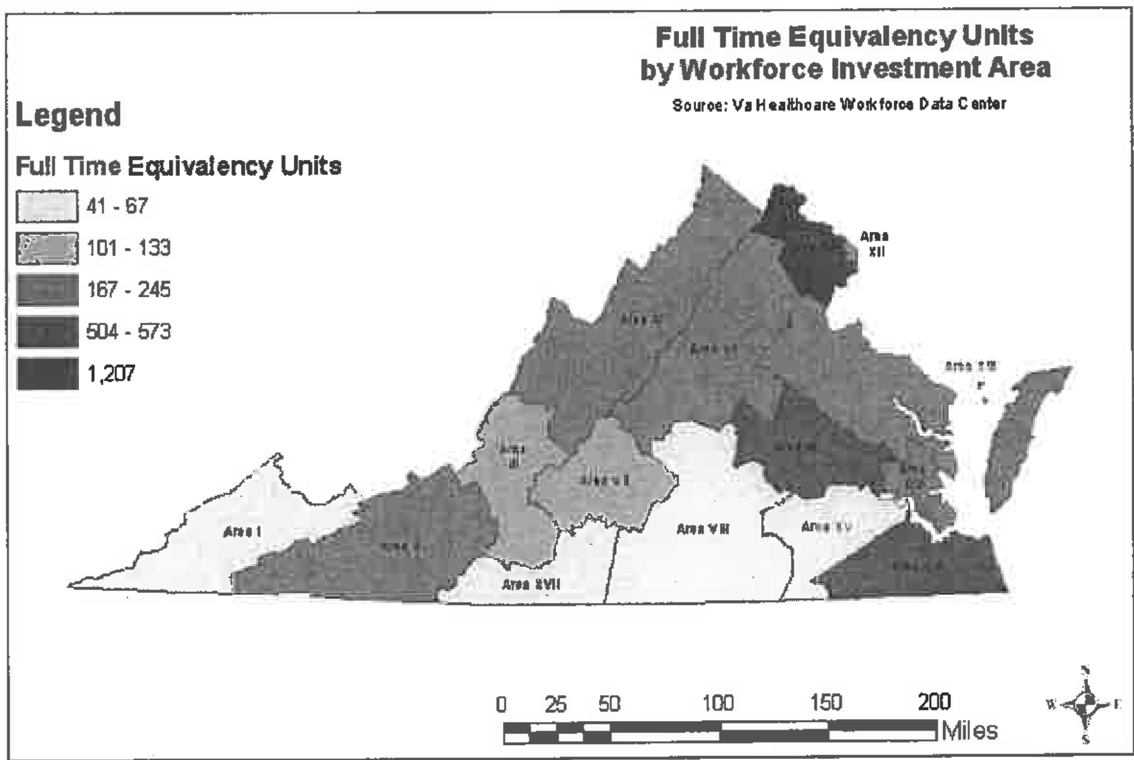
Council on Virginia's Future Regions

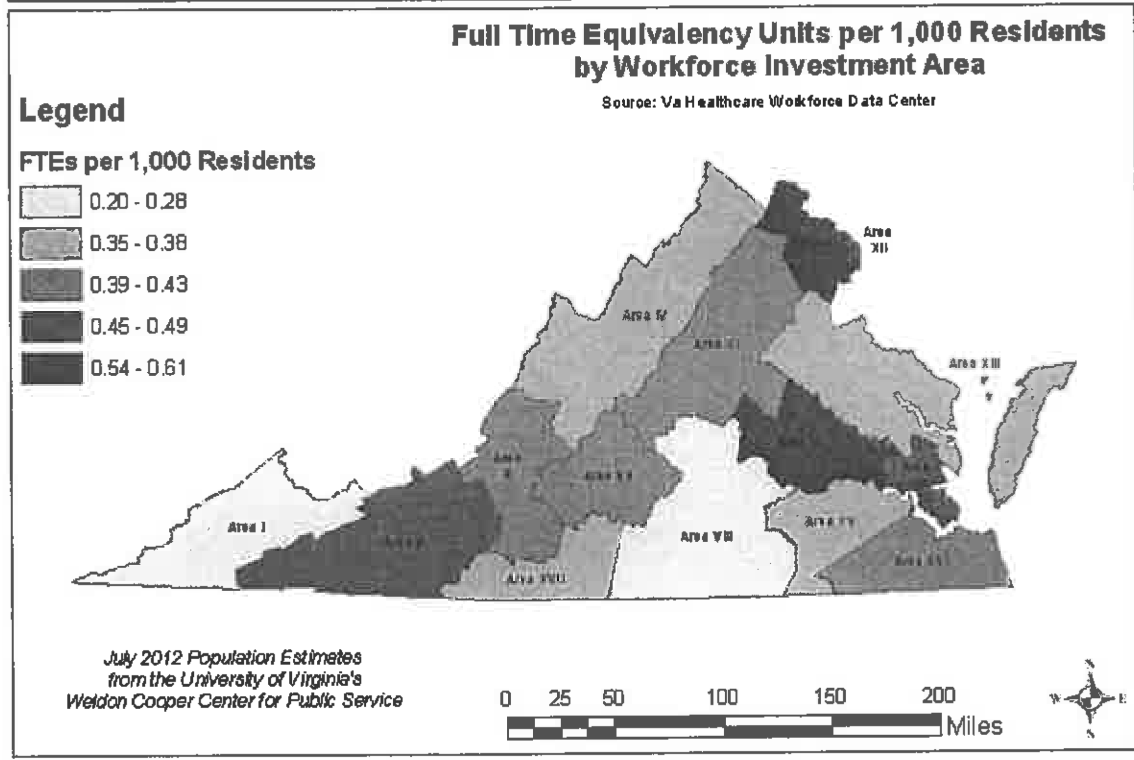


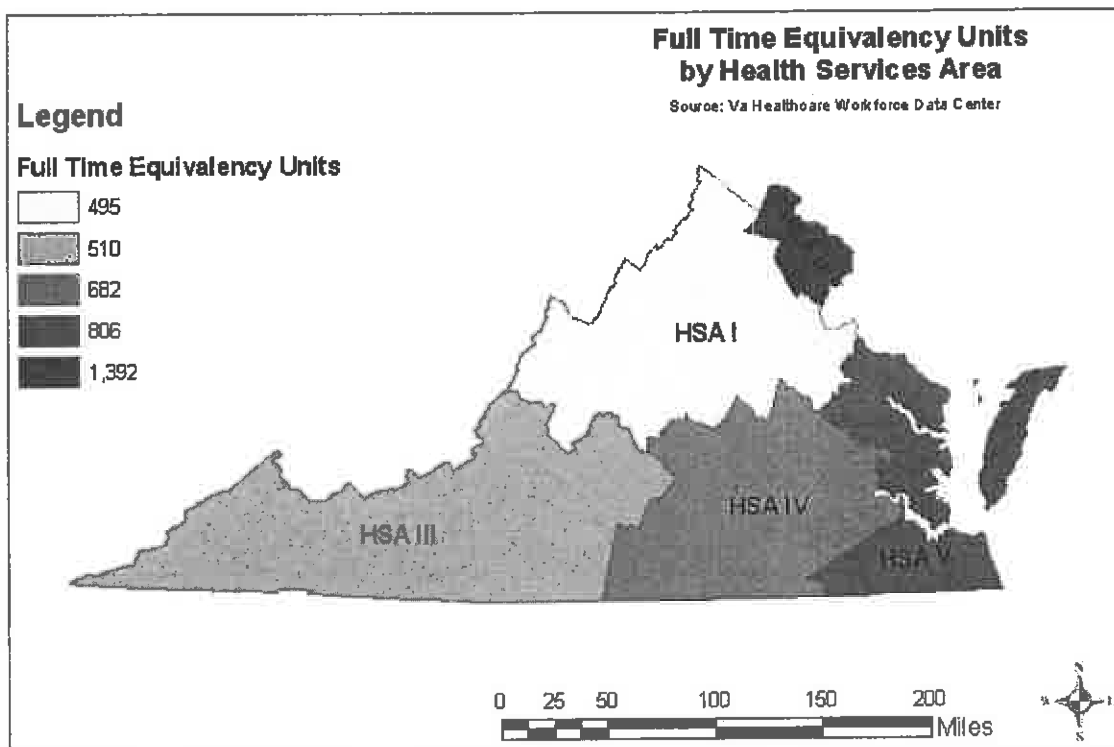


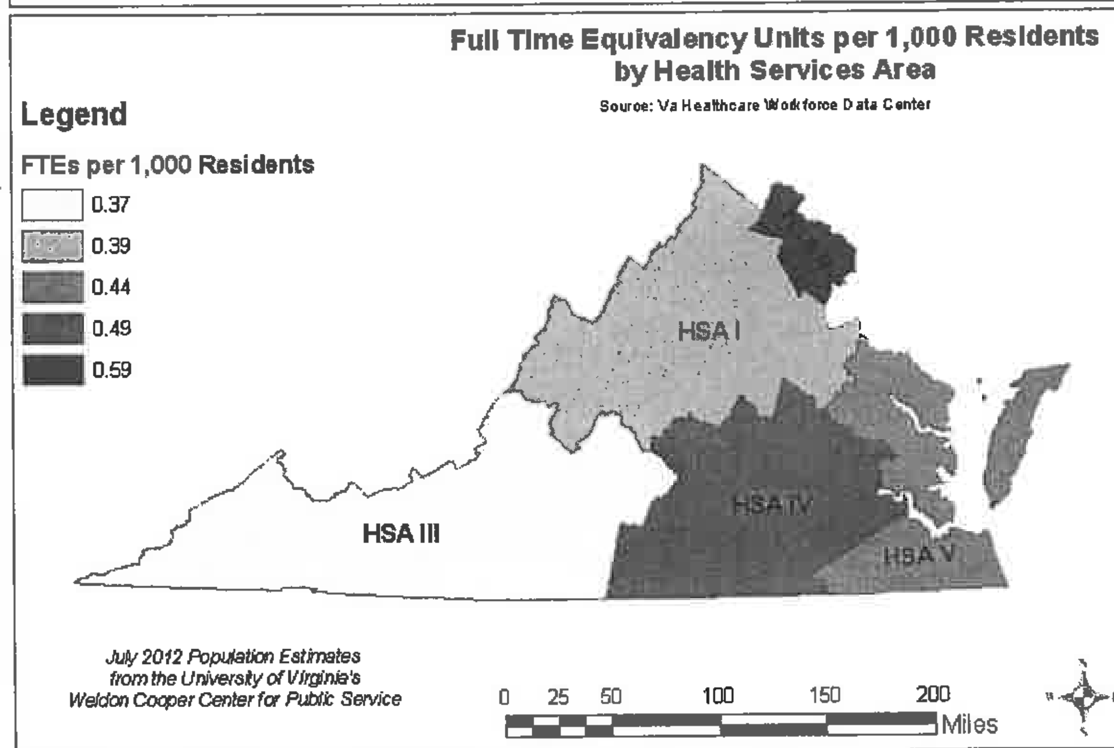

Full Time Equivalency Units
by Area Health Education Center
Source: Va Healthcare Workforce Data Center
Legend
Full Time Equivalency Units
110 - 180
331 - 369
573 - 753
1,392
Northern Virginia
Blue Ridge
Rappahannock
Southwest Virginia
South Central
Southside
Eastern Virginia
0 25 50 100 150 200
Miles


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
0.32 - 0.35
0.37 - 0.39
0.44
0.54 - 0.59
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
41 - 67
101 - 133
167 - 245
504 - 573
1,207
Area XII
Area I
Area VIII
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
0.20 - 0.28
0.35 - 0.38
0.39 - 0.43
0.45 - 0.49
0.54 - 0.61
Area XII
Area IV
Area XIII
Area I
Area VIII
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
495
510
682
806
1,392
HSA I
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
0.37
0.39
0.44
0.49
0.59
HSA I
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

- 19 - 44
- 61 - 81
- 101 - 128
- 547 - 733
- 1,392

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

- 0.19 - 0.26
- 0.31 - 0.33
- 0.37 - 0.41
- 0.44 - 0.47
- 0.52 - 0.59

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+	4,255	79.58%	1.256645	1.1787	1.35781
Metro, 250,000 to 1 million	373	77.21%	1.295139	1.2148	1.3994
Metro, 250,000 or less	452	80.97%	1.234973	1.15837	1.33439
Urban pop 20,000+, Metro adj	73	76.71%	1.303571	1.22271	1.40166
Urban pop 20,000+, nonadj	0	NA	NA	NA	NA
Urban pop, 2,500-19,999, Metro adj	149	70.47%	1.419048	1.33102	1.53329
Urban pop, 2,500-19,999, nonadj	73	82.19%	1.216667	1.1412	1.31461
Rural, Metro adj	88	67.05%	1.491525	1.39901	1.60376
Rural, nonadj	32	75.00%	1.333333	1.25063	1.43366
Virginia border state/DC	734	74.39%	1.344322	1.26093	1.45255
Other US State	827	67.11%	1.49009	1.39766	1.61005

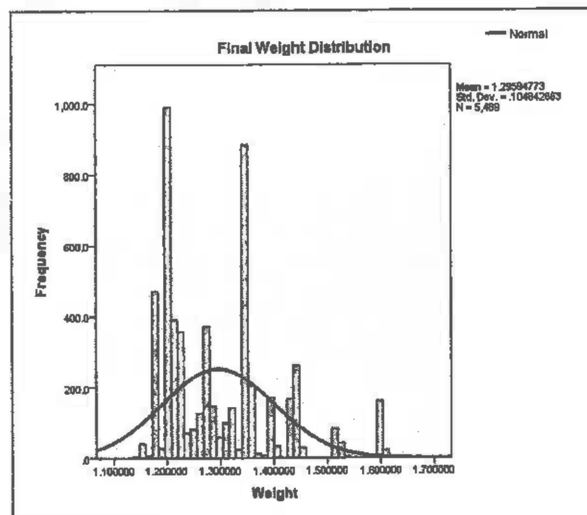
Age	Age Weight			Total Weight	
	#	Rate	Weight	Min	Max
Under 30	235	71.49%	1.39881	1.31461	1.61005
30 to 34	836	76.20%	1.312402	1.23341	1.51205
35 to 39	877	80.62%	1.240453	1.16579	1.42915
40 to 44	911	80.79%	1.237772	1.16327	1.42607
45 to 49	714	82.35%	1.214286	1.1412	1.39901
50 to 54	683	80.09%	1.248629	1.17347	1.43857
55 to 59	762	79.53%	1.257426	1.18174	1.44871
60 and Over	2,088	71.84%	1.392	1.30821	1.60376

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:

Age Weight x Rural Weight x Response Rate = Final Weight.

Overall Response Rate: 0.772446



Source: Va. Healthcare Workforce Data Center

Chapter 25 of Title 54.1 of the Code of Virginia

§ 54.1-2507. Board of Health Professions; membership, appointments, and terms of office.

The Board of Health Professions shall consist of one member from each health regulatory board appointed by the Governor, and five members to be appointed by the Governor from the Commonwealth at large. No member of the Board of Health Professions who represents a health regulatory board shall serve as such after he ceases to be a member of a board. The members appointed by the Governor shall be subject to confirmation by the General Assembly and shall serve for four-year terms.

(1977, c. 579, § 54-951; 1985, c. 448; 1986, c. 564; 1988, c. 765.)

§ 54.1-2508. Chairman; meetings of Board; quorum.

The chairman of the Board of Health Professions shall be elected by the Board from its members. The Board shall meet at least annually and may hold additional meetings as necessary to perform its duties. A majority of the Board shall constitute a quorum for the conduct of business.

(1977, c. 579, § 54-953; 1980, c. 678; 1986, c. 564; 1988, c. 765; 2012, c. 361.)

§ 54.1-2509. Reimbursement of Board members for expenses.

All members of the Board shall be compensated in accordance with § 2.2-2813 from the funds of the Department.

(1977, c. 579, § 54-954; 1980, cc. 678, 728; 1986, c. 564; 1988, c. 765.)

§ 54.1-2510. Powers and duties of Board of Health Professions.

The Board of Health Professions shall have the following powers and duties:

1. To evaluate the need for coordination among the health regulatory boards and their staffs and report its findings and recommendations to the Director and the boards;

2. To evaluate all health care professions and occupations in the Commonwealth, including those regulated and those not regulated by other provisions of this title, to consider whether each such profession or occupation should be regulated and the degree of regulation to be imposed. Whenever the Board determines that the public interest requires that a health care profession or occupation which is not regulated by law should be regulated, the Board shall recommend to the General Assembly a regulatory system to establish the appropriate degree of regulation;

3. To review and comment on the budget for the Department;

4. To provide a means of citizen access to the Department;

5. To provide a means of publicizing the policies and programs of the Department in order to educate the public and elicit public support for Department activities;

6. To monitor the policies and activities of the Department, serve as a forum for resolving conflicts among the health regulatory boards and between the health regulatory boards and the Department and have access to departmental information;

7. To advise the Governor, the General Assembly and the Director on matters relating to the regulation or deregulation of health care professions and occupations;

8. To make bylaws for the government of the Board of Health Professions and the proper fulfillment of its duties under this chapter;

9. To promote the development of standards to evaluate the competency of the professions and occupations represented on the Board;

10. To review and comment, as it deems appropriate, on all regulations promulgated or proposed for issuance by the health regulatory boards under the auspices of the Department. At least one member of the relevant board shall be invited to be present during any comments by the Board on proposed board regulations;

11. To review periodically the investigatory, disciplinary and enforcement processes of the Department and the individual boards to ensure the protection of the public and the fair and equitable treatment of health professionals;

12. To examine scope of practice conflicts involving regulated and unregulated professions and advise the health regulatory boards and the General Assembly of the nature and degree of such conflicts;

13. To receive, review, and forward to the appropriate health regulatory board any departmental investigative reports relating to complaints of violations by practitioners of Chapter 24.1 (§ 54.1-2410 et seq.) of this subtitle;

14. To determine compliance with and violations of and grant exceptions to the prohibitions set forth in Chapter 24.1 of this subtitle; and

15. To take appropriate actions against entities, other than practitioners, for violations of Chapter 24.1 of this subtitle.

(1977, c. 579, § 54-955.1; 1980, c. 678; 1984, cc. 447, 720, 734; 1986, c. 564; 1988, c. 765; 1993, c. 869.)

Draft
Virginia Board of Health Professions
Department of Health Professions
FULL BOARD MEETING
November 6, 2014

TIME AND PLACE:	The meeting was called to order at 9:59 a.m. on Thursday, November 6, 2014 at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, 2nd Floor, Board Room 2, Henrico, VA, 23233
PRESIDING OFFICER:	Virginia Van de Water, appointed today
MEMBERS PRESENT:	James Watkins, Dentistry J. Paul Welch II, Funeral Directors & Embalmers Frazier Frantz, Medicine Trula Minton, Nursing Helene Clayton-Jeter, Optometry Allen Jones Jr, Physical Therapy Virginia Van de Water, Psychology Yvonne Haynes, Social Work Robert Catron, Citizen Robert Logan III, Citizen Martha Perry, Citizen Jacquelyn Tyler, Citizen James Wells, Citizen
MEMBERS NOT PRESENT:	Vacant-ASLP Vacant-Counseling Vacant-Veterinary Medicine Ellen Shinaberry, Pharmacy Amanda Gannon, Long-Term Care Administrators
STAFF PRESENT:	Elizabeth A. Carter, Ph.D., Executive Director for the Board David Brown, DC, DHP Director Elaine Yeatts, DHP Senior Policy Analyst Charles Giles, DHP Budget Manager Jason Brown, Deputy Director for Administration Lisa Hahn, Executive Director Funeral Directors and Embalmers Jay Douglas, Executive Director Board of Nursing Leslie Knachel, Executive Director Board of Veterinary Medicine Justin Crow, Deputy Executive Director for the Board Laura Jackson, Operations Manager
BOARD COUNSEL:	Not present
OTHERS PRESENT:	Tyler Cox, MSV Paul Speidell, Sentara

QUORUM: With 13 members present a quorum was established.

EMERGENCY EGRESS: Dr. Carter read aloud the Emergency Evacuation instructions.

AGENDA: No changes or additions were made to the agenda.

PUBLIC COMMENT: There was no public comment.

BOARD MEMBER INTRODUCTION & WELCOME All Board members introduced themselves for the benefit of newly appointed Board members.

APPROVAL OF MINUTES: Meeting minutes from September 25, 2014 were approved with an edit on page 3, paragraph 2, it should read "Dr. Van de Water." On properly seconded motion by Mr. Catron, the revised minutes were unanimously approved.

DEPARTMENT DIRECTOR'S REPORT: Ms. Hoyle presented the Directors Report.

Governor's Task Force
September 26, 2014 Governor McAuliffe signed Executive Order 29 establishing the Governor's Task Force on Prescription Drug and Heroin Abuse. The task force will recommend immediate steps to address a growing and dangerous epidemic of prescription opioid and heroin abuse in the Commonwealth at a meeting to be held Wednesday, November 12, 2014. Dr. Brown is coordinating the work on this project and the Prescription Monitoring Program is heavily involved.

At the first meeting of the **Mid Level Provider Licensing** invited stakeholders in September, the group determined that there is no current need for a separate form of licensure in Virginia. DHP's report to the Joint Commission on Health Care is being drafted and will be submitted to them shortly.

LEGISLATIVE/REGULATORY UPDATE: Ms. Yeatts provided handouts regarding the Departments regulatory actions, stating that DHP has several regulations in process along with 14 pieces of legislation. She is currently following 85 pieces of legislation that could affect DHP. (See Attachment 1.)

FINANCE DEPARTMENT: Mr. Brown and Mr. Giles provided a thorough overview of the DHP budget development process. They noted that DHP employs internal and external processes to project and manage budget revenues and expenditures. (See Attachment 2.)

EXECUTIVE DIRECTOR'S REPORT:

Board Budget
Dr. Carter reviewed the FY 2015 Board of Health Professions budget and noted that the first quarter results were on target.

Bylaws Revision
Dr. Carter noted that Article III of the the Board's Bylaws Article VIII relating to meetings require amendment to reflect the statutory amendment which shifted from a mandatory quarterly meeting schedule to once a year and at other times deemed appropriate by the Board to accomplish its work. The revised draft will be on the agenda for final vote at the next full Board meeting.

Regulatory Research Committee Update (Mr. Crow)
Mr. Crow provided an update to the Board regarding the recent Joint Commission on Health Care meeting regarding their Dental Safety Net Capacity and Opportunities for Improving Oral Health study. JCHC did not take action.

On properly seconded motion by Mr. Catron, the Board of Health Professions voted unanimously to continue its **Dental Hygienist Scope of Practice Review** with a public hearing to be held in January 2015.

Study on Funeral Licensure Categories
Mr. Crow provided an overview of the workplan developed in response to Senator Kenneth Alexander's request. Appendix 3 provides the workplan.

On properly seconded motion by Mr. Catron, the Board voted unanimously to proceed with the workplan as presented.

2014-2015 Work Plan & Calendar
Dr. Carter reviewed the overall 2014-2105 workplan and advised that the plan will likely evolve if additional studies are requested in response to General Assembly action or other requests.

The 2015 meeting calendar dates were discussed and several board members expressed concern that they would be unable to attend due to scheduling conflicts. Alternative dates will be researched and shared with the members to establish the formal calendar.

Military Credentialing & NGA Grant
Dr. Carter provided the Board with an overview of the Military Credentialing Review's progress. Virginia's participation in the National Governors' Association Veterans' Licensure and Certification Demonstration Policy Academy's has been focusing on the Commonwealth's existing veterans-related data sources and on improvements that could be made to better inform policies across agencies and states. DHP is hosting a meeting scheduled for November 7, 2014 with Tidewater

Community College and NGA to review the military to LPN bridge program. Requested DMDC data has been received and reviewed to assist in this process.

The Board will be updated as progress is made.

HWDC-Healthcare Workforce Data Center
Dr. Carter updated the Board and advised that the HWDC currently has 26 surveys developed and collecting data, with more to come this fall. Dr. Carter and Mr. Crow participated in a HRSA Technical Assistance webinar on October 28, 2014 and another is scheduled for November 19, 2014 with SUNY-Albany. With our population aging and many set to retire, it is imperative that we know who is going to retire, and when. At this time, the federal government is not collecting workforce data on healthcare practitioners who are, themselves, employers. DHP HWDC surveys provide a standard means to gather and analyze key workforce information from all licensees for surveyed professions.

PRACTITIONER SELF REFERRAL:

The Board reviewed the Practitioner Self-Referral Advisory Opinion for the Center for Weight Loss Success.

On properly seconded motion by Dr. Clayton-Jeter, the Advisory Opinion was ratified by the Board unanimously.

ELECTION OF OFFICERS:

The following individuals were nominated from the floor for the vacant positions of Board Chair, and Board Vice Chair. Dr. Virginia Van de Water for Board Chair; Mr. Catron for Board Vice Chair and Dr. Clayton-Jeter for Board Vice Chair.

A motion was made by Mr. Catron and properly seconded by Mr. Jones to accept the nomination of Dr. Virginia Van de Water as Board Chair.

Voting for Vice Chair was through paper ballot. With the majority of votes in favor of Mr. Catron, on properly seconded motion by Ms. Minton, Mr. Catron was accepted as Board Vice Chair.

BOARD REPORTS

Board of Optometry
Dr. Clayton-Jeter stated that the Virginia Board of Optometry is working to amplify the US Food and Drug Administration (FDA) efforts to raise public awareness regarding the hazards of non-corrective, decorative contact lenses sold without prescription. Since many people dressing up for Halloween purchase the non-corrective decorative lenses, the FDA has partnered with the American Optometric Association and the Entertainment Industry Council to provide consumer education materials to people nationwide.

Board of Medicine
Dr. Frantz informed the Board that telemedicine is an area that is being reviewed by the Board of Medicine as it is a national issue. The Board is reviewing regulations, licensing criteria and the doctor/patient relationship. Dr. Frantz stated that developing a coalition for multi-state licensure would change the landscape of our states borders. He offered that telehealth and telemedicine will affect not just the Board of Medicine but many of the Boards here at DHP.

Board of Psychology
Dr. Van de Water stated that the Board of Psychology is also addressing teletherapy concerns. Current issues under consideration relate to state jurisdiction and privacy, especially the confidentiality of messages that could be overheard.

Board of Nursing
Ms. Minton stated that the Board of Nursing is discussing conscious sedation and updating the guidance documents that pertain to it. This affects both CRNAs and nurses.

Board of Funeral Directors and Embalmers
Mr. Welch stated that there are many areas of concern in regards to "virtual" funeral homes. He stated that many are not licensed and that there is very little authority to be able to stop this harmful act against consumers.

NEW BUSINESS There was no new business.

ADJOURNMENT The meeting adjourned at 1:58 p.m.

Virginia Van de Water
Board Chair

Elizabeth A. Carter, Ph.D.
Executive Director for the Board

AADB Annual Session
October 7-8, 2014
San Antonio, Texas

General Assembly I: October 7,2014

ADA update by Dr. Charles H. Norman III

- ADA supporting the NC Board with their case before the U.S. Supreme Court
- Scope of practice use and changes
- Increase of sedation dentistry
- Recent DDS concerns—jobs, increased student debt, mobility for DDS to practice anywhere in the US, use of live patients, increase acceptance of regional exams

Sleep Apnea/ Sleep Disordered Breathing-Saving lives in the Dental Office by Dr. Lamb (??)

- CPAP industry has increased recently
- 13-17% of adults have Obstructive Sleep Apnea (OSA) linked to obesity
- Neck circumference greater than 17" for men increases risk factor and neck circumference greater than 15" for women increases risk factor
- American Academy of Sleep Medicine Practice in 2006 parameters—oral appliances are indicated for patients with mild to moderate OSA and cannot use CPAP therapy
- Treatment should be completed by a DDS with advanced in sleep medicine
- CPAP appliance is the most common type of treatment but patient's are not as compliant
- Other treatment options are oral appliances (i.e. Silent Night, Snore Rx, Pure Sleep), surgery and weight loss
- 70% of snoring is indicative of some type of OSA
- Respiratory Disturbance Index (RERA) –is a formula used in reporting sleep study findings
- Apnea Hypopnea Index (AHI)—"gold standard" to diagnose sleep apnea
- Hypopnea—30% decrease of oxygen
- Possible OSA related to TMD, fibromyalgia, bruxism, GERD, headaches/migraines

DH Caucus

- DH position will open up for Executive Council and submit to nominating committee by April 2015
- Seeking RDH representation
- Seeking a slot in the program for RDHs to meet

General Assembly II: October 8, 2014

Sleep Apnea and How Dental Boards Incorporate a New Standard of Care by Dr. George Conrad, WV

- Screen patients adequately—be concerned with possibility of law suits
- Standard of Care—CPAP and/or appliances but must ensure they were used accordingly
- Refer out patients who have OSA to appropriate providers—DDS should "screen" patients and refer to ENT or physician if diagnosed
- There's over 100 oral appliances available in the market but only about 24 are FDA approved---know the products you are promoting/using on patients
- Medicare only pays for 2 types of appliances—mandibular positioning and tongue restraining
- Sample appliance types: Elastic Mandibular Advancement (EMA); SomnoDent/ G2; Moses Appliance; Narval CL; Aveo TSD (tongue stabilizing device)

Attorney Update by Board Attorneys (Oklahoma, Washington DC, Wyoming, Nevada, North Carolina, South Dakota, Maryland, Minnesota, Texas, West Virginia and Ohio):

- Drug laws update—background check on employees
- Forged prescription by staff using digital scripts
- Lack of safeguards on ordering and stocking of prescription meds
- Poor record keeping of distribution cabinets and incomplete drug logs
- Inadequate new patient background information—DDS shoppers, drug seekers (hydrocodone)
- DEA Diversion—check: deadiversion.usdog.gov
  Legend drugs---FDA; scheduled drugs—DEA must maintain log book
- Be careful when ordering drugs since they can come from a foreign country
- "Duty to guard against drug diversion"—texting prescription information which are HIPPAA protected; having friends pick-up prescription prior to real patient; audit prescriptions written by you (DDS) and monitor staff etc.
- Oct. 6, 2014-DEA rescheduling hydrocodone products to schedule II; refills may be filled until April 8, 2015; cannot transfer prescriptions
- What rescheduling means for Ddds:
  1. Patient who call for pain needs written prescription (no call ins or fax Rx)
  2. No mid-level provider can write prescription
  3. Drug logs
- Zohydro is the same as hydrocodone
- Arcos—list of DEA information on drugs sold

- Brief updates on relevant cases
  1. Phoebe Putney Case: http://www.ftc.gov/enforcement/cases-proceedings/111-0067/phoebe-putney-health-system-inc-phoebe-putney-memorial
  2. Klein vs. Flaney Case: http://law.justia.com/cases/kentucky/supreme-court/2014/2012-sc-000071-dg.html
  3. Office of Lawyers Disciplinary Counsel vs. Plant Case: http://www.courtswv.gov/supreme-court/docs/spring2014/14-0348.pdf
  4. NC Dental Board case: http://online.wsj.com/articles/supreme-court-struggles-with-teeth-whitening-case-1413319508

Quality Control by Dr. Rob Compton:
- Quality control after the fact
- Quality assurance is done on the front end i.e. Spore test, sterilize instruments
- CMS. Gov.—physicians quality reporting system
- Health grades—these "measures" are unknown because the "standards" isn't defined
- Government needs to regulate "quality control measurement"
- Members of Dental Quality Alliance
- Used by consumers without complete knowledge of source of information

Open Forum:
- Arizona- mandate 12 hours of training from all health care regulatory boards
- Florida- dental records task force on written records, armed forced may be granted a license
- Hawaii- issues with anesthesia
- Louisiana- advertising new rule; DDS is given 30 days on advertising violations and can be used twice in career
- Massachusetts- registering dental assistants; hydrocodone regulations
- North Carolina- revamping sedation guidelines; eliminate "minimal" sedation—same level
- Minnesota- 43 ADHP licensees to date
- Maine- DH therapist created
- Nebraska- sponsored legislation for dental assistants
- Nevada- PMP-an annual check before renewal
- Ohio- new investigation software system
- Oregon- DDS must have weekly spore testing but legislature rescinded; took away prescription rights; refund civil fees
- South Carolina- sedation dentistry law change, 1-2 years before implementation
- Washington- expanded function dental assistants and RDH
- New York- RDH collaborative practice agreement; electronic prescriptions-issues with schedule II

- Maryland- 2012 fungal meningitis outbreak; issues with pharmacy act; cannot use compound prescription multi-use because of federal mandate for "sterile compound drugs"; pharmacy permit for DDS because of "mixing" drugs
- Testing agency updates:
  ADEX-has now CITA and SRTA; recognized in 43 states; Virgin Islands signed on; revamped hygiene exam to be administered by NERB and SRTA in 2015

Respectfully submitted by,

Melanie C. Swain BSDH RDH
President and AADB Liaison
Virginia Board of Dentistry

Importance: Low

-----Original Message-----
From: Bruce Wyman
Sent: Saturday, October 11, 2014 11:11 PM
To: Reen, Sandra (DHP)
Cc: Swain Melanie
Subject: AADB Wed. PM lectures

Dr Sam Shames: dental support organizations. They can be partnered with the private equity firms to Finance future enhancements. They will support electronic records, CT scans, cost of education, debt.

The values of the new generation of dentists includes not wanting to manage a practice. Dental support organizations will also cover the overhead of the practice, get a handle on labor laws, regulations, techniques and will help with litigation as needed.

Dr. Shames went into a history of failures in the 1980s and 1990s do to a lack of need for DSO's. He indicated that the American dental Association shows that adult dental visits have declined since 2002 and no one knows why. Private employer demand PPO's and HMO's to save money.

He indicated that the dental groups are also less busy today. Solo practitioners incomes have decreased income of the practitioners and group practice dentists income increased due to cost savings.

Approximately 10% of dentists today go into DSO's. DSO's provide non-clinical services including strength in numbers for reimbursements and support from lawmakers, vendor negotiations, financial expertise and bookkeeping, marketing, physical office maintenance, IT support in that old technical support.

He maintains that the association of dental some support organizations has a code of ethics which is very important and includes not interfering in clinical decisions. He believes that there is a myth that increase pressure to produce in lower quality are present. In fact, peer review from fellow practitioners will increase quality.

However, please note that the lecturer is the creator and managing partner of a very large group of offices in Massachusetts and has been quite successful. He also teaches management at Tufts School of Dental Medicine.

Corporate owned group dental practices: Ms. Lile Reitz, attorney for the Ohio BOD.
> The public's perception is that corporate offices are cheaper and better with quicker treatment then small practices. Models for corporate dentistry today include franchise rights, larger corporation ownership, branding etc. There are easier cashed out values in a corporation. If a franchise model is carried out, they must comply with state regulations and laws even if the dentist is not present in the facility. They must support the dental office even though they may not have control over what goes on. Ultimately the licensed dentist controls patent decisions. The ownership of the office must have a commitment to mentor new dentists and promote the highest of standards.

During A question and answer session following the above talks, the staff attorney for the Nevada BOD indicated that Nevada holds the corporations in compliance with state laws because all of the corporations are registered with the state and there is good cooperation between the BOD and other state agencies.

Respectfully submitted,

Bruce Wyman
Sent from my iPhone

Highlights of the American Board of Dental Examiners, Inc (ADEX)

10th House of Representatives

November 9, 2014 , Rosemont, Il

32 out of 33 member states were represented and there were 49 out of 54 State Board , District Hygiene and District Consumer Representatives present.

The President of ADEX, Dr. Bruce Barrette, addressed us with a summary of his fourth and last year as president. He mention that this year to be more effective, the meeting was divided in subcommittees to discuss changes to the exam. Also he informed that the Perio and Restorative part of the exam has being tested recently at NYU. A recognition was given to him in the form of a plaque and he received a standing ovation for a job well done during his presidency.

We heard presentations by:

Dr. Chad Buckendahl, "Update on Psychometric Issues"

Ms. Sarina Butler representing The Butler Group, "ADEX Business Plan"

Dr. Howard Strassler, DMD , Calibration Consultant, "ADEX Calibration Update"

He described the exam experience and changes in grading. Also he addressed the fact that they are trying to make the format friendlier for the Examiners, these changes will be seen in 2015-2016.

Elections were held for Districts 6, 8,10 and 12.

The Officers elected :

Dr. Stanwood Kanna , HI, President , Dr. William Pappas, NV, Vice-President,

Dr. Robert Jolly, AR, Secretary and Dr. Jeffrey D. Hartsog , MS, Treasurer

The 11th ADEX House of Representatives Meeting is scheduled for Sunday, November 15, 2015 at the Doubletree Hotel, Rosemont, IL

RECEIVED
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Board of Dentistry

Minutes
of the
American Board of Dental Examiners (ADEX)
Dental Examination Subcommittee
On Periodontics
November 7, 2014
Rosemont, IL
8:30 am to Noon

Call to Order: The Meeting of the American Board of Dental Examiners (ADEX) Dental Examination Subcommittee on Periodontics was called to order by Dr. Augusto Cesar Garcia-Aguirre, Chair, 8:30 a.m., Friday, November 7, 2014, the Leander room of the DoubleTree Hotel, Rosemont, IL.

Those Members present were: Dr. Augusto Cesar Garcia-Aguirre, PR, Dr. Al Rizkalla, VA; Dr. Robert Carter, AR; Dr. Renee McCoy-Collins, DC; Dr. Arthur "Andy" McKibbin, Jr, NH; Dr. Stephen DuLong, MA; Dr. Uri Hangorski, PA;

Ex-Officio Members present for part of the Meeting: Dr. Bruce Barrette, President ADEX, WI; Dr. Scott Houfek, Chair ADEX Dental Examination Committee, WY.

No Guest present.

Adoption of Agenda

Motion by Dr. DuLong moved, seconded by Dr. McCoy-Collins to adopt the agenda with the proviso that the Chair could reorder items if necessary. The motion passed by general consent.

Review on Teleconference Minutes of Monday, September 11, 2014:

Dr. McCoy-Collins moved motion for approval, seconded by Dr. DuLong. The motion was approved the Teleconference Minutes of Monday, September 11, 2014 as presented. The motion passed by general consent.

Reaffirm and recommend to the ADEX Dental Examination Committee action items reviewed from the Teleconference Meeting of September 11, 2014:

Dr. McKibbin presented a motion to retire the first motion approved at the teleconference of September 11, 2014, it was seconded by Dr. McCoy. Motion approved, and the previous motion will be removed from the motions to be presented to the ADEX Dental Examination Committee.

Dr. McCoy-Collins moved, seconded by Dr. DuLong to charge the Periodontics Ad Hoc Committee to develop a more relevant and simplified periodontal clinical examination. Motion approved unanimously.

Dr. McKibbin moved to make mandatory the periodontal examination in the all the ADEX sites.

Motion withdrawn by Dr. McKibbin

Dr. McKibbin moved and seconded by Dr. DuLong to include a more relevant and simplified periodontal component to the ADEX clinical examination. Motion passed by general consent.

Dr. Dulong moved, and seconded by Dr. Rizkalla.to allow a candidate a second periodontal treatment selection if the first treatment selection is rejected. This second treatment selection can be in the same patient or in a new one. If the second treatment selection is rejected that is then considered a failure. Motion passed unanimously.

Dr. Rizkalla moved and seconded by Dr. McCoy-Collins to charge the periodontal Ad Hoc committee to investigate the feasibility of including a periodontal assessment on the candidate's restorative patients.

Other issues discussed about the periodontal examination modification, but not voted on: possible suggestion to the Periodontal Ad Hoc Committee:

1. Reduction of the number of surfaces for calculus detection and removal

2. Selection of two contiguous teeth for the candidate to do a 6 points pocket depth probing, instead of selecting 3 teeth with one area of 4mm or more.

3, Provide some metric where the candidate can indicate a diagnose or possible diagnosis of the periodontal condition and the recommendation that should be done.

<u>Adjournment</u>

The meeting was adjourned at 12:15 p.m. CST

Dr. Augusto Cesar Garcia-Aguirre, Chair
ADEX Dental Examination Subcommittee on Periodontics

Regulatory/Legislative Committee Report

At its October 24, 2014 meeting, the Committee reviewed the pending topics on its agenda and adopted the following recommendations for Board consideration:

- The Board create a task force to look at the DA II requirements. (*p.49)

- The task force established to address the DA II requirements should also address the Joint Commission on Health Care's inquiry about allowing dental hygienists to take continuing education classes to qualify to perform the duties delegable to DAsII and to consider the recommendation for expansion of remote supervision to community clinics. (*p. 62)

- The Board's president be authorized to appoint an ad hoc committee to address teledentistry. (*p. 118)

*Supporting information related to each of these recommendations is available online in the posted agenda package for the October 24, 2014 Committee meeting at: http://www.dhp.virginia.gov/dentistry/minutes/2014/AgendaRegLeg10242014.pdf.

Unapproved

VIRGINIA BOARD OF DENTISTRY
MINUTES OF REGULATORY-LEGISLATIVE COMMITTEE
October 24, 2014

TIME AND PLACE:	The meeting of the Regulatory-Legislative Committee of the Board of Dentistry was called to order at 1:00 p.m., on October 24, 2014, Department of Health Professions, 9960 Mayland Drive, Suite 201, Board Room 4, Henrico, Virginia.
PRESIDING:	Bruce S. Wyman, D.M.D., Chair
MEMBERS PRESENT:	Charles E. Gaskins, III, D.D.S. Melanie C. Swain, R.D.H.
MEMBERS ABSENT:	Evelyn M. Rolon, D.M.D.
OTHER BOARD MEMBERS:	Al Rizkalla, D.D.S. Tammy K. Swecker, R.D.H. James D. Watkins, D.D.S
STAFF PRESENT:	Sandra K. Reen, Executive Director Kelley W. Palmatier, Deputy Executive Director Huong Q. Vu, Operations Manager
OTHERS PRESENT:	David E. Brown, D.C., Director, Department of Health Professions Elaine Yeatts, Senior Policy Analyst, Department of Health Professions James E. Rutkowski, Assistant Attorney General
ESTABLISHMENT OF A QUORUM:	With three members present, a quorum was established.
PUBLIC COMMENT:	Christopher Nolen, Senior Vice-President of McGuireWoods Consulting introduced himself as representing the Association of Dental Support Organizations (ADSO). He stated that ADSO is interested in the discussion of practice ownership and would like to participate in any Regulatory Advisory Panel formed to address practice ownership. Martin Guy Rohling of Albers & Company introduced himself as representing Kool Smiles which operates 14 dental clinics in Virginia. He said he would like to participate in any Regulatory Advisory Panel (RAP) addressing practice ownership. Trudy Levitin, R.D.H., stated that she recalled the Board's decision to not address charging for examinations performed by dental hygienists when practice under general supervision was permitted. She noted her experience and said billing using the CDT Code D0120 is appropriate. She questioned why the Board would choose to address this billing practice now. David C. Sarrett, D.D.S., Dean of VCU School of Dentistry, stated that the General Practice Residency and the Advanced Education in General Dentistry

residency program are designed to provide training beyond the level of a pre-doctoral dental education program and are not remedial education programs. He provided a handout which listed the goals of these programs. He added that successful completion of an accredited post-doctoral general dentistry program, demonstrates the candidate has met, and surpassed, the entry level for licensure.

APPROVAL OF MINUTES:

Dr. Wyman asked if Committee members had reviewed the May 2, 2014 minutes. Dr. Gaskins moved to accept the minutes. The motion was seconded and passed.

STATUS REPORT ON REGULATORY ACTIONS:

Ms. Yeatts reported that the Periodic Review of proposed regulations to establish four chapters is pending administrative review at the office of the Secretary of Health and Human Resources.

BILLING FOR A PERIODIC EXAM PERORMED BY RDH:

Ms. Reen stated that the Board assigned this topic to the Committee. She added that the Committee is to consider proposing a position on the practice of billing for periodic exams performed by dental hygienists and possibly developing a guidance document on the subject.

Dr. Watkins stated that he brought this matter to the Board's attention because in a case he reviewed, the dentist billed the insurance company CDT Code D0120 for the exam performed by the hygienist under general supervision. He said clarification is needed because he cited it as a violation but was told by staff that it is permissible.

Information on current billing practices in Virginia and on the provisions in the CDT Code was discussed. Following discussion, Dr. Gaskins moved to take this as information and to take no action at this time. The motion was seconded and passed.

CHANGING THE EDUCATION REQUIREMETN FOR DENTAL LICENSURE:

Dr. Wyman stated that there is no uniform standard for foreign trained dentists to become licensed in the United States. He noted his concern is that the 12-month post-doctoral advanced general dentistry program is not sufficient training to prove competency for licensure in Virginia.

Dr. Sarrett stated that foreign trained dentists without competitive skills are not accepted into the advanced programs. Those dentists must complete DDS or DMD programs from a CODA accredited program before being accepted in an advanced program. He added that the VCU School of Dentistry does not offer non-CODA accredited dental training programs.

Dr. Wyman moved to recommend amending the regulations to require foreign trained dentists to complete at least a 24-month post-doctoral advanced general dentistry program. The motion was seconded and failed.

PRACTICE OWNERSHIP:

Ms. Reen reported that she discussed forming a Regulatory Advisory Panel (RAP) with Dr. Brown who recommended having focused conversations with the other state agencies that may have a role or interest in practice ownership before establishing a RAP. She added that Dr. Brown was facilitating these meetings and that a meeting with the Department of Medical Assistance Services' (DMAS) has taken place. Ms. Reen noted that DMAS has agreed to facilitate earlier communication about action taken against providers and DHP agreed to explore conducting joint investigations.

She said Committee discussion of the materials in the agenda package would help her explain the Board's interests and goals. The Committee took no action.

DAII REGISTRATION OPTIONS FOR QUALIFYING:

Ms. Reen stated that very few people qualified for Dental Assistant II (DAII) registration either by education or by endorsement. She explained that many of the duties classified as "expanded" in other states are duties any dental assistant can perform in Virginia. She said that she has included the Minnesota Board of Dentistry provisions for restorative functions to facilitate discussion. She added that the Minnesota Board is working with be CODA to establish standards for dental therapy programs.

Ms. Yeatts noted that the Board has not reviewed this regulation since its implementation. She suggested bringing back dental assistant educators for discussion and feedback on the requirements for registration.

Discussion followed about dental hygienists being allowed to take coursework that is similar to the coursework required by the DAII regulations and about the requirements being too strict that no one will be able to qualify for a DAII registration.

Dr. Gaskin moved to recommend to the full Board that a task force be created to look at the DAII requirements. The motion was seconded and passed.

ADVANCED DENTAL HYGIENE PRACTICE:

Ms. Reen stated that the Committee was asked to consider the Joint Commission on Health Care's (JCHC) request to allow licensed dental hygienists to take continuing education classes to qualify to perform the duties delegable to DAIIs.

She added that the JCHC is also interested in expanding the Remote Supervision model in use in the Virginia Department of Health (VDH) to

include community clinics. She noted that this model allows dental hygienists who are employed by the VDH to see patients who have been seen by a dentist.

It was agreed by consensus that the task force established to address the DAII requirements should also address the Joint Commission recommendations.

ELECTRONIC DENTAL RECORDS:

Dr. Wyman asked Dr. Rizkalla to address his concern. Dr. Rizkalla stated that, through an informal conference, he learned that licensees can modify electronic treatment records after their initial entry.

Dr. Brown stated that this issue transcends the Board of Dentistry and is an agency issue. He asked whether electronic record alteration is a significant enough issue to have separate policy for electronic records. He suggested looking at other states' regulations.

No action was taken following discussion.

TELEDENTISTRY:

Dr. Wyman asked Dr. Brown for guidance. Dr. Brown stated that it is an area of interest of Secretary Hazel for addressing unmet need for services. He added that the Board of Medicine convened an ad hoc committee on this and a guidance document is being drafted. He suggested the need for a broad based workgroup which includes the private sector and educational institutions to study this matter.

Dr. Wyman moved to ask the Board President to appoint an ad hoc committee to address this matter. The motion was seconded and passed.

DENTAL ROLE IN TREATING SLEEP APNEA:

Ms. Reen stated the Board requested consideration of having a policy addressing sleep apnea because it is not currently addressed in the law or regulations. She added that the position of the Board in disciplinary cases is that sleep apnea must first be diagnosed by a physician who can then make a referral to a dentist to provide treatment or a dentist may observe symptoms of sleep apnea and refer to a physician for an evaluation. She referred the Committee to the October 23, 1024 letter from the Virginia Academy of Dental Sleep Medicine (VADSM) and the American Academy of Dental Sleep Medicine (AADSM) Treatment Protocol: Oral Appliance Therapy for Sleep Disordered Breathing for review and discussion.

Discussion followed about when and how sleep apnea is taught dental programs. A member of the audience stated that doctoral level dental students at the VCU School of Dentistry are taught the basics of recognizing sleep apnea and the screening process. He added that once the diagnosis is done by a physician, it is an airway issue that can be treated by a dentist. A member of the Virginia Society of Oral & Maxillofacial Surgeons (VSOMS), suggested that the Committee review VASOMS's position paper before recommending a guidance document.

By consensus, the Committee decided it wanted to review additional information at its next meeting.

ADJOURNMENT: With all business concluded, Dr. Wyman adjourned the meeting at 2:55 p.m.

______________________________	______________________________
Bruce S. Wyman, D.M.D., Chair	Sandra K. Reen, Executive Director
______________________________	______________________________
Date	Date

Agenda Item: Regulatory Actions - Chart of Regulatory Actions (As of December 1, 2014)

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] Final - *At Secretary's Office for 245 days*

November 20, 2014

Ms. Sandra Reen
Executive Director
Virginia Board of Dentistry
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

Dear Ms. Reen,

Thank you for the opportunity to allow Dr. Rob Strauss and me to speak to the Board of Dentistry Regulatory-Legislative Committee members on behalf of the Virginia Society of Oral and Maxillofacial Surgeons (VSOMS) regarding the management of Obstructive Sleep Apnea (OSA) patients from a dental provider standpoint.

As Dr. Strauss and I pointed out, we need as a profession to think of the patient's wellbeing first and foremost. The treatment of OSA must be recognized as a continuum, beginning with proper diagnosis followed by the proper referral to the treating doctor, formally trained in the management of OSA patients. If the first line of treatment fails or is resistant to this treatment, then the patient needs referral to the specialist qualified to provide the next level of care.

I will echo Dr. Strauss' comments made to the Committee:

1. A dentist is a doctor and a professional colleague to a physician. Requiring a "prescription" or a lab chit from a physician lowers the dentist to technician status. At the least, the verbage should be mödified to " ...after referral for consultation to the dentist by a licensed physician." The treating dentist then will decide on the proper method of managing that specific OSA patient. It should be noted that the term "sleep medicine- trained physician" would preclude treatment for many rural patients who have no access to such sub-specialists. Many OSA patients are managed by their primary care provider and it is not in the patient's best interest to limit their access to care.

2. Obstructive sleep apnea is an oro-pharyngeal disease that has systemic consequences, not a systemic disease with oral manifestations. The management decisions should be within the discretion of the treating practitioner or oral and facial surgeon with appropriate referral for the management of the systemic manifestations to the appropriate physician(s). The analogy to this is periodontal disease. As we now know that cardiac disease can result from periodontal issues, should periodontal surgery only be done on the prescription of a physician, or should the periodontist refer the patient to the cardiologist for consultation?

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3. OMS residents are well trained in the recognition and management, both surgically and non-surgically, of OSA patients including recognizing the need for consultation with sleep physicians when indicated. This training is part of the CODA Standards for OMS residency and is an integral section of the American Board of Oral and Maxillofacial Surgery certification examination. Requiring a prescription for management will in some cases cause a delay in the patient's treatment (e.g. the patient has had a previous diagnosis of OSA and needs treatment, but no current sleep doc). While few general dentists may have extensive knowledge of the diagnosis and management of OSA, this is a required part of OMS training. Again, restricting or delaying appropriate access to care to board-certified OMSs (by requiring physician input in EVERY case) is not in the patient's best interest.

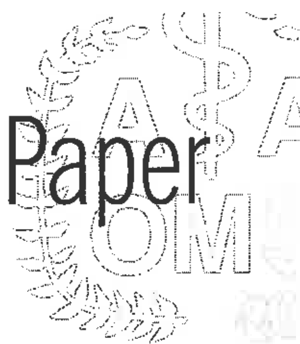
4. Consider the use of at home testing in the workup for OSA. The use of home testing studies has now been validated as a screening tool for OSA. Having the study interpreted by a sleep doc provided by the home PSG is a cost effective process that can save both time and money to get the OSA patient into treatment. This is especially true when considering the instance where the patient's insurance company will not cover a formal lab PSG.

I have enclosed a Position Paper sent out by the American Association of Oral and Maxillofacial Surgeons, I encourage the Board to please read and understand it. It provides insight to the multidisciplinary team approach necessary to manage OSA patients. As this paper indicates, oral appliances have been shown to be effective in some patients, but not all. We ask that the Board recognize that there must be an understanding that, as a treating doctor, a protocol is necessary to then refer the patient to the next level of surgical care when level one treatment modalities such as CPAP and/or oral appliances have failed to provide successful management of the OSA patient. Surgical procedures such as bimaxillary advancement must be considered as a second line of treatment for the patient resistant to oral appliance therapy or CPAP.

The VSOMS is fully committed to providing the best care to our patients. We are also committed to providing input to the Board of Dentistry for guidance regarding the treatment of Obstructive Sleep Apnea patients. Please feel free to contact the VSOMS if additional information is required.

Respectfully,

James M. Solomon, DDS
President, Virginia Society of Oral and Maxillofacial Surgeons
Diplomate, American Board of Oral and Maxillofacial Surgeons



Position Paper

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American Association of Oral and Maxillofacial Surgeons

Evaluation and Management of Obstructive Sleep Apnea – Overview

Obstructive Sleep Apnea (OSA) is a common disorder involving collapse of the upper airway during sleep. This repetitive collapse results in sleep fragmentation, hypoxemia, hypercapnia, and increased sympathetic activity, leading to a host of detrimental systemic medical conditions including hypertension, stroke, congestive heart failure, excessive daytime sleepiness, diminished cognitive function and impaired quality of life. It is estimated that upwards of 18-20 million adults in the US require treatment for this disorder; thereby making it a significant public health problem.

OSA occurs over a wide continuum of airway narrowing. Patients with milder forms of apnea may require less intensive intervention when compared to patients with more severe obstructive pathology. As the upper airway anatomy is in intimate relation to (and in function with) the facial region, oral and maxillofacial surgeons possess unique knowledge and training in upper airway and facial anatomy, physiology and surgery. As such, they are uniquely qualified to provide important diagnostic input—through physical examination and imaging studies—into the evaluation of patients suspected of having OSA. Using all available data, the diagnosis of OSA is ultimately made by a qualified physician who is trained in sleep medicine.

In most adult patients with moderate to severe OSA, continuous positive airway pressure (CPAP) is the first line treatment. Successful long-term treatment of OSA with CPAP is difficult to achieve, however, and fewer than 50% of patients on CPAP are adequately treated (as defined by 4 hours of use 70% of nights [Weaver, TE, Level 2 evidence and Kribbs, NB, Level 2 evidence]). It is therefore important that other treatment options are available to patients with OSA.

Oral appliances have been shown to be an effective therapy in a significant percentage of patients with mild to moderate OSA. While not considered a first-line treatment in patients with severe OSA, custom-made oral appliances may be indicated for use in patients with severe OSA who have failed first-line treatment with CPAP. Oral appliances should be fitted by qualified dental personnel who are trained and experienced in the overall care of oral health, the temporomandibular joint, dental occlusion and associated oral structures (Kushida et al 2006). Oral and maxillofacial surgeons who have received the requisite experience and training to provide oral appliance therapy are qualified to provide this therapy to patients with OSA.

Surgical procedures may be considered as secondary treatment for OSA when the outcome of non-surgical therapy is inadequate, such as when the patient is intolerant of CPAP, or CPAP therapy is unable to eliminate OSA. Surgery may also be considered as a secondary therapy when there is an inadequate treatment outcome with an oral appliance (OA), when the patient is intolerant of the OA, or the OA therapy provides unacceptable improvement of clinical outcomes of OSA. Surgery may also be considered as an adjunct therapy when obstructive anatomy or functional deficiencies compromise other therapies or to improve tolerance of other OSA treatments [Epstein, EJ]. Surgery for OSA has been shown to improve sleep disordered breathing, as well as important clinical outcomes, including improvement in sleepiness and quality of life. Oral and maxillofacial surgeons utilize a variety of hard and soft tissue surgical treatments in the management of OSA. Outside of tracheostomy, maxillomandibular (Jaw) advancement surgery is considered to be the most effective (and often the most well-accepted) therapy for severe obstructive sleep apnea.

In the clinical guidelines for evaluation, management and long-term care of OSA in adults, it is recommended that evaluation for primary surgical treatment be considered in select patients who have airway narrowing and anatomy that is surgically correctible, and in patients in whom nonsurgical therapies, including continuous positive airway pressure (CPAP) therapy, are inadequate or not tolerated by the patient. (Epstein, EJ, Evidence Based Clinical Guideline). While coordination of care with other medical specialists is emphasized in both pediatric and adult patients, surgical treatment of severe, life-threatening

pediatric sleep disordered breathing may require facial skeletal (maxillofacial) procedures, such as distraction osteogenesis, in order to affect airway expansion.

Oral and maxillofacial surgeons receive extensive training during their residencies in jaw advancement surgery and techniques, as well as in the medical and perioperative surgical management of these patients. The AAOMS advocates for routine OMS involvement and participation on the sleep apnea treatment team, and supports the development of multidisciplinary comparative effectiveness trials for management of the OSA patient.

References:

1. *Epstein,EJ,(Chair), Kristo,D, Strollo, Jr.PJ, Clinical Guidelines for the Evaluation, Management and Long-term Care of Obstructive Sleep Apnea in Adults. J Clin Sleep Med 5(3):263-79, 2009.*
2. *Weaver TE, Grunstein RR; Adherence to continuous positive airway pressure therapy: the challenge to effective treatment, Proc Am Thorac Soc. 5(2):173-8, 2008*
3. *Kribbs NB, Pack AI, Kline LR, et al. Objective measurement of patterns of nasal CPAP use by patients with obstructive sleep apnea. Am Rev Respir Dis. 147:887-95.1993.*
4. *Kushida et al. Practice parameters for the treatment of snoring and obstructive sleep apnea with with oral appliances: an update for 2005. Sleep 2006; 29: 240-3*
5. *Caples, SM, Rowley, JA, Prinsell, JR, et al: Surgical Modifications of the Upper Airway for Obstructive Sleep Apnea in Adults: A Systematic Review and Meta-Analysis. SLEEP 33 (10): 1396-1407, 2010*
6. *Aurora, RN, Casey, KR, Kristo, D. et al: Practice Parameters for the Surgical Modifications of the Upper Airway for Obstructive Sleep Apnea in Adults. SLEEP 33 (10): 1408- 1413, 2010*

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NOV 06 2014
Board of Dentistry

DHP NOV 06 2014

American Association of Orthodontists®

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Robert E. Varner, DMD
President

1729 W. Harvard Blvd.
Roseburg, OR 97471
541.673.0924 phone
541.673.0925 fax
bobvarner@earthlink.net

Morris N. Poole, DDS
President-Elect

55 Bristol Road
Logan, UT 84341
435.512.4980 phone
435.753.1509 fax
mnpoole@aaortho.org

DeWayne B. McCamish, DDS, MS
Secretary-Treasurer

4610 Brainerd Rd, Suite # 3
Chattanooga, TN 37411
423.622.4173 phone
423.629.9889 fax
dbm@dbmortho.com

Chris P. Vranas, CAE
Executive Director
401 North Lindbergh Boulevard
St. Louis, MO 63141
314.993.1700 phone
314.993.0142 fax
cvranas@aaortho.org

November 3, 2014

Virginia Board of Dentistry
Perimeter Center
9960 Mayland Drive, Ste. 300
Henrico, VA 23233-1463

State Dental Board Commission:

I write to you on behalf of the American Association of Orthodontists (AAO) with concerns about a practice in your state that could negatively affect public health. Apparently, at least one "do it yourself" teeth-straightening company is operating in your state, and the AAO is concerned that it does not meet the standards set by your regulatory authority. The intent of this letter is to make you aware of the practice, and to ask you to review the relevant rules and regulations in order to determine if this practice should be allowed to continue in your state.

The practice model allows patients to take their own dental impressions and then ship them back to the company for evaluation. The company claims that a licensed dental professional reviews the impressions and sets a treatment plan. The company then produces and ships the clear aligners back to the customer. All of this occurs without any doctor-patient interaction or comprehensive diagnostics, which have become standard in the practice of orthodontics and is important for the health of the prospective patient.

The AAO has multiple concerns with this practice, including, but not limited to:

- It is not clear whether the dental professionals who examine the impressions are licensed in your state. If they are not, then they could be in violation of laws and regulations requiring them to be licensed in the state in order to practice dentistry there. If they are licensed, then they may be running afoul of a number of ethical principles as well as failing to comply with regulations they are required to uphold.

- Since there is apparently no contact between the doctor and the patient, it is likely impossible for there to be adequate informed consent of the risks associated with treatment. It is the AAO's position that, regardless of who actually places the clear aligners in the patient, if an orthodontist is involved in directing treatment, the orthodontist should be sure that the patient has been adequately informed of the risks.

- It is impossible for an orthodontist (or any dental professional) to safely suggest a treatment plan from impressions alone—especially when the impressions have been administered by the patient, without supervision of a dental professional. A number of risk factors may be present that are not discernable using an impression, including root resorption, enamel deficiencies, decay, or any number of other problems that would make any type of orthodontic therapy inadvisable. The lack of a physical exam and gathering of patient medical history could also result in a number of unforeseen consequences, such as undiagnosed medical problems that would alter a treatment plan or would be important for the patient to know, such as oral cancer, etc.
- During treatment, if a complication arises, the individual doing the self-directed treatment may not recognize the problem and, there is no existing doctor-patient relationship for the patient to rely upon.
- It is unclear how a company operating in such a manner can verify the age of the patient without any personal contact. For instance, it would apparently be possible for a minor to misrepresent his/her age, order the impressions and receive the aligners.

For these reasons, the AAO believes that residents of your state are in danger of being harmed by this practice. I ask that you review this practice in light of the relevant rules and regulations you have promulgated in order to determine if it should be permitted in your state.

If you have any questions or concerns, please do not hesitate to contact Mr. Kevin Dillard, the AAO's General Counsel, at 314.993.1700.

Sincerely,

Robert E. Varner, DMD
President

REV:krd

DHP NOV 14 2014

Virginia Dental Association

RECEIVED
NOV 14 2014
Board of Dentistry

A Community of Professionals
Advancing Dentistry and Serving the People of Virginia

November 11, 2014

Ms. Melanie Swain
President, Virginia Board of Dentistry
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

Dear Ms. Swain:

The Board of Directors of the Virginia Dental Association would like to invite you and members of the Board of Dentistry to join us for dinner the day prior to your board meeting on March 12th, 2015. The dinner would start at 6:30 and, as soon as we know the place, we will pass that along to you.

A dinner between the two groups used to be an annual event to 'meet and greet' the members of each organization. Obviously, some of our board has not met the new members of the Board of Dentistry and I am sure your board has not met some of our new members. Sharing a common goal of the ethical practice of dentistry certainly is common ground on which to meet. We would look forward to this opportunity to get to know each other better and the roles each of us plays in the profession.

Being aware of the ethical considerations around the 'giving' of gifts, in this case a dinner, we would ask the Board of Dentistry members to each be responsible for paying for the cost of their dinner.

Thank you for sharing this with your fellow board members.

Sincerely,

Michael Link, D.D.S.

Michael Link, D.D.S.
President, Virginia Dental Association

cc/ Secretary HHS, Dr. Bill Hazel
Director, DHP, Dr. David Brown

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Melanie C. Swain, RDH, President and Ms. Sandra Kay Reen
Virginia Board of Dentistry
Perimeter Center, 9960 Mayland Dr., Suite 300
Henrico, VA 23233-1463

November 5, 2014

Dear Ms. Swain and Ms. Reen:

The American Association of Dental Boards (AADB) is pleased the Virginia Board of Dentistry was represented at the Annual Meeting in San Antonio by both of you and Dr. Bruce Wyman. We believe the interaction between dental boards and their respective members have much to gain through the sharing of vital and pertinent information which takes place at both the Mid-Year and Annual AADB meetings. As an active Massachusetts state board member for the past ten years, five of which I served as Chair, I myself can attest to the importance of state board members in attending these meetings. The combination of the formal programming; the ability to interact with other states and their board members; as well as having an access to resources that only AADB can provide, make being a member of this organization an invaluable asset when making sound decisions at the state board level. It is vital all board members have a national and global exposure to issues that are occurring outside of their state in order to make the well informed decisions in protecting the safety of the public in their state.

As I shared with you in person, for the past two years the leadership of AADB has been working diligently to change the culture and function of the organization. AADB has hired a new executive director, reinvigorated our committee structure, conducted a strategic planning process driven by membership participation, taken steps to establish an advocacy component to speak out on issues of importance to the dental regulatory community, begun a restructuring of our meetings to maximize the participants time and expanded the presence of AADB in the dental community seeking collaboration with other organizations.

In addition to the Composite and Clearinghouse, AADB has added to our list of guidelines an Ethics for Dental Boards document and launched the Assessment Services Program (ASP) to assist dental boards with expert review and assessments to give external support and documentation for difficult cases or decisions. The ASP program has proven to be invaluable to states that have utilized it and has begun to gain national recognition and utilization by the majority of state boards.

As President, I personally encourage you to consider rejoining AADB and together advance AADB toward its mission to serve the dental boards. AADB leadership is focused on continuing efforts to move from the past culture to become a strong, relevant representative of dental boards providing a forum for interaction among the licensing and regulatory community.

I would like to open a dialogue with you and your dental board to address any past issues that brought you to discontinuing your Agency participation in AADB. I want your input and suggestions so that together we can customize an organization that will serve all our needs.

I look forward to hearing from you.

Sincerely,

Mina Paul, DMD, MPH
President
drminapaul@comcast.net

211 E. Chicago Avenue • Suite 760 • Chicago, IL 60611 • (312)440-7464 • FAX: (312)440-3525

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AUBREY A. BAUDEAN, JR., D.D.S.
H. O. BLACKWOOD, III, D.D.S.
LEONARD C. BREDA, III, D.D.S.
PATRICIA H. CASSIDY, R.D.H.
CLAUDIA A. CAVALLINO, D.D.S.
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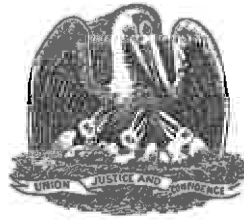

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J. JEROME SMITH, D.D.S.
RICHARD D. WILLIS, D.D.S.
ARTHUR F. HICKHAM, JR.
EXECUTIVE DIRECTOR

Louisiana State Board of Dentistry
ONE CANAL PLACE, 365 CANAL STREET, SUITE 2680
NEW ORLEANS, LOUISIANA 70130
TELEPHONE: (504) 568-8574
TOLL FREE: (877) 467-4488
FAX: (504) 568-8598
www.lsbd.org

September 22, 2014

Received
SEP 2 6 2014
Board of Dentistry

American Board of Dental Examiners, Inc.
Patrick Braatz, Executive Director
P.O. Box 8733
Portland OR 97207-8733

Re: Examination results

Dear Mr. Braatz:

It has come to the attention of the Louisiana State Board of Dentistry that there is an issue with verifying the number of times that an applicant has failed clinical licensing examinations. Most states have a rule that provides that any applicant who fails a clinical examination a certain number of times is either ineligible for licensure or must take remediation prior to licensure. In Louisiana, an applicant who fails any clinical examination three times is not eligible for a license. The difficulty comes in verifying an applicant's attestation that he or she has not failed any clinical examination a total of more than two times.

For example, an applicant could fail CITA once, then fail CRDTS twice, then take CITA a second time and pass it. That applicant would not be eligible for licensure in Louisiana due the three failures prior to the successful second CITA attempt. However, unless the applicant is honest in revealing the two CRDTS failures, the board would not be made aware of the two CRDTS failures. CITA would notify the board of the one CITA failure, but unless the board were to contact every testing agency for every applicant, there would be no way to catch applicants who fail to disclose failures from testing agencies other than the testing agency which eventually passed the applicant.

The Louisiana State Board of Dentistry urges all of the other state boards to push for a clearinghouse to which all testing agencies would report results. This could be done through ADEX, the AADB, or through some other agency. In the absence of such a clearinghouse to which all testing agencies report, ADEX is requested to provide a clearinghouse of its own by

which the results of the ADEX test can be learned, regardless of which testing agency has administered the test.

Should you have any questions regarding this correspondence, please contact me at the board office.

Yours truly,

Arthur F. Hickham, Jr.
Executive Director

Cc: American Association of Dental Boards
state boards of dentistry

Received
SEP 26 2014
Board of Dentistry

Reen, Sandra (DHP)

From: American Dental Association [ADAemail@updates.ada.org]
Sent: Wednesday, November 19, 2014 5:00 PM
To: Reen, Sandra (DHP)
Subject: Comments Requested: ADA Sedation and Anesthesia Guidelines

Comments Requested: ADA Sedation and Anesthesia Guidelines

As you may recall, the Council on Dental Education and Licensure recently considered a proposed change to the ADA Anesthesia Guidelines regarding the use of capnography during moderate sedation in an open airway system. The Council appreciates that many of you provided comment. Based on feedback received, the Council concluded that a more comprehensive review and revision of the *ADA Guidelines for the Use of Sedation and General Anesthesia by Dentists* and the *ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students* should be pursued.

Thus, as the comprehensive review begins, the Council and its Committee on Anesthesiology request your preliminary input. We ask that you carefully review and provide feedback on any part of the Guidelines documents, which may be downloaded from ADA.org.

The Council's Committee on Anesthesiology will consider all comments received by January 7, 2015 and then propose its recommendations to the Council.

Following the Council's April 2015 meeting, any changes proposed will be circulated again for your review and comment.

Comments should reference the line number(s), be specific and offer rationale. Address comments to:

Dr. James M. Boyle, III, Chair
Council on Dental Education and Licensure
American Dental Association
211 East Chicago Avenue
Chicago, IL 60611
Via email, care of: JasekJ@ada.org

If you have any questions or need assistance accessing the document online, please contact CDEL staff member, Ms. Jane Jasek, for assistance.

cc: Karen M. Hart, director, Council on Dental Education and Licensure and Education Operations

Quick Links

- ADA Center for Professional Success
- ADA.org
- Update your ADA Find-a-Dentist profile

- ADA Annual Meeting
- MouthHealthy.org
- Action for Dental Health

This email is being distributed to dental anesthesiology communities of interest on behalf of Dr. James M. Boyle, III, Chair, Council on Dental Education and Licensure (CDEL) and Dr. Daniel Gesek, Chair, CDEL Committee on Anesthesiology.

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Disciplinary Board Report for December 12, 2014

Today's report reviews the 2014 calendar year case activity then addresses the Board's disciplinary case actions for the first quarter of fiscal year 2015 which includes the dates of July 1, 2014 through September 30, 2014.

Calendar Year 2014

The table below includes all cases that have received Board action since January 1, 2014 through November 30, 2014.

Calendar 2014	Cases Received	Cases Closed No/Violation	Cases Closed W/Violation	Total Cases Closed
Jan	36	21	7	28
Feb	37	14	5	19
March	72	29	8	37
April	50	5	4	9
May	31	12	9	21
June	48	24	20	44
July	29	6	6	12
August	46	24	8	32
September	33	55	25	80
October	70	25	11	36
November	18	30	8	38
Totals	**470**	**245**	**111**	**356**

Q1 FY 2015

For the first quarter, the Board received a total of 70 patient care cases. The Board closed a total of 79 patient care cases for a 113% clearance rate, which is up from 62% in Q4. The current pending caseload older than 250 days is 21%, and the Board's goal is 20%. In Q1 of 2015, 67% of the patient care cases were closed within 250 days, as compared to 63% in Q4 of 2014. The Board is again moving in the right direction with its statistics and Board staff does appreciate the hard work that you have been putting in. The Board actually did meet the clearance rate goals for the Agency's Key Performance Measures[1] for the first quarter of 2015.

[1] The Agency's Key Performance Measures.

- We will achieve a 100% clearance rate of allegations of misconduct by the end of FY 2009 and maintain 100% through the end of FY 2010.
- We will ensure that, by the end of FY 2010, no more than 25% of all open patient care cases are older than 250 business days.
- We will investigate and process 90% of patient care cases within 250 work days.

License Suspensions

Between August 26, 2014 and November 30, 2014 the Board summarily suspended the license of one hygienist.

Commonwealth of Virginia
Office of the Governor

Executive Order

NUMBER TWO (2014)

PERSONNEL DIRECTIVE PROHIBITING THE RECEIPT OF CERTAIN GIFTS; ESTABLISHMENT OF EXECUTIVE BRANCH ETHICS COMMISSION

Part I – Importance of the Initiative

Every citizen of the Commonwealth is entitled to have complete confidence and the highest degree of trust in Virginia's government. It is the intent of this Executive Order (the "Order") to ensure that Virginians are governed and represented with integrity. This Order is initiated to establish an ethical framework for state Executive Branch officers and employees with regard to gifts that will enhance the public's trust in the actions of such officers and employees by addressing the receipt of gifts that may result in, or create an appearance of, impropriety.

Therefore, by virtue of the authority vested in me under Article V of the Constitution of Virginia and under the laws of the Commonwealth of Virginia, including but not limited to, Chapters 1, 12, and 29 of Title 2.2 of the Code of Virginia, and as the Governor and Chief Personnel Officer of the Commonwealth, and subject to my continuing and ultimate authority and responsibility to act in such matters, I hereby establish (i) the following personnel policy, banning the solicitation and receipt of certain gifts by officers and employees of the state Executive Branch of the Commonwealth and (ii) an Executive Branch Ethics Commission to perform such duties and responsibilities as are specified below. An officer's or employee's ethical duties and responsibilities under this Executive Order are in addition to those prescribed by law, primarily the State and Local Government Conflict of Interests Act, § 2.2-3100 *et seq.*, and the Virginia Public Procurement Act, § 2.2-4300 *et seq.*, of the Code of Virginia.

Part II – Definitions

As used in this Executive Order, unless the context clearly requires otherwise:
"Advisory agency" means any board, commission, committee or post of the state Executive Branch that does not exercise any sovereign power or duty, but is appointed by a governmental agency or officer or is created by law for the purpose of making studies or recommendations, or advising or consulting with a governmental agency.

21. Any other thing of value that is pecuniary or compensatory in value to a person.

"Anything of value" does not mean a campaign contribution properly received and reported pursuant to Chapter 9 (§ 24.2-900 *et seq.*) and Chapter 9.3 (§ 24.2-945 *et seq.*) of Title 24.2.

"Dependent" means a son, daughter, father, mother, brother, sister or other individual, whether or not related by blood or marriage, if such individual receives from the officer or employee, or provides to the officer or employee, more than one-half of his or her financial support.

"Employee" means, unless otherwise limited by the context of its use, all individuals who are not officers of a component part of the state Executive Branch but are employed by a component part of the state Executive Branch on an at will basis or serve at the pleasure of the Governor, and all individuals who are employed by the component parts of the state Executive Branch and who are covered by the Virginia Personnel Act, Va. Code § 2.2-2900 *et seq.*

"Fair market" value means the price that a good or service would bring between a willing seller and a willing buyer in the open market after negotiations. If the fair market value cannot be determined, the actual price paid for the good or service shall be given consideration.

"Gift" means anything of value to the extent that a consideration of equal or greater value is not received by the donor.

"Gift" does not mean:

1. Printed informational or promotional material;

2. A gift that is not used and, no later than sixty (60) days after receipt, is returned to the donor or delivered to a charitable organization or to a state governmental or advisory agency and is not claimed as a charitable contribution for federal income tax purposes;

3. A gift, devise, or inheritance from an officer's or employee's spouse, child, nephew, niece, aunt, uncle, first cousin, or the officer's or employee's or his or her spouse's parent, grandparent, grandchild, brother, sister, the spouse of any individual covered by this subdivision, or an individual to whom the officer or employee is engaged to be married; provided the donor is not acting as the agent or intermediary for someone other than an individual covered by this subdivision;

4. Anything of value provided by an individual on the basis of a personal friendship unless the officer or employee has reason to believe that, under the circumstances, the gift was provided because of the official position of the officer or employee and not because of the personal friendship. In determining whether a gift is provided on the basis of personal friendship, the circumstances under which the gift was given shall be considered, including: (1) the history of the relationship of the individual receiving the gift with the individual giving the gift, including any previous exchange between them; (2) whether the individual receiving the gift knew that the individual giving the gift personally paid for the gift or sought a tax deduction or business reimbursement for the gift; and (3) whether the individual receiving the gift knew that the individual giving the gift also gave the same or similar gifts to other officers or employees;

employee, whether or not the officer or employee and that individual have been married or have resided together at any time, as long as there is a legally enforceable financial relationship between them, or (iv) any individual who cohabits or who, within the previous 12 months, cohabited with the officer or employee, and any children of either of them then residing in the same household as the officer or employee. With regard to the receipt of gifts, "immediate family" also shall mean an officer's or employee's child, grandchild, parent, grandparent, brother, sister, or brother's or sister's spouse or children, if such individual knew or should have known that the gift was given because of the officer's or employee's position as an officer or employee.

"Legitimate travel and related expenses" include reasonable expenses incurred by the officer or employee in order to engage in an activity that serves a legitimate public purpose, including, but not limited to, air, train, bus, and taxi fare, rental car charges, the cost of meals and lodging, and expenses related to attendance at an event that has a legitimate public purpose, including, but not limited to, costs of registration, admission, tickets, food, refreshments, instruction, and materials.

"Legitimate public purpose" means an activity that is intended to promote the interests of the Commonwealth, a political subdivision of the Commonwealth, an advisory or governmental agency of the Commonwealth, or a component part of a political subdivision of the Commonwealth, including, but not limited to, activities that promote tourism, economic development, charitable, public health, environmental, or educational goals; attendance at training and educational events and conferences designed to improve the efficiencies and effectiveness of public service, or to enhance the knowledge and skills of public officers or employees, or both, relative to their official duties; and any purpose defined as a legitimate public purpose by the Commonwealth, the Governor, the governing body of a political subdivision of the Commonwealth, an advisory or governmental agency, or the Commission established by Part V of this Order.

"Officer" means the Governor, his Cabinet, Deputy Secretaries, and any individual appointed or elected to any governmental or advisory agency who serves at the pleasure of the Governor or whose position may be affected "for cause," whether or not he or she receives compensation or other emolument of office.

"State Executive Branch" means every component part of the government of the Commonwealth of Virginia except any component part of the state Legislative or Judicial Branches, the Office of the Lieutenant Governor, the Office of the Attorney General, the State Corporation Commission, the Virginia Workers' Compensation Commission, the State Lottery Department, local governments and their component parts, and the offices of constitutional officers.

"Value" means the actual cost or fair market value of an item or items, whichever is greater. If the fair market value cannot be determined, the actual amount paid for the item or items shall be given consideration. For food and beverages, "value" includes a proportional amount of any tip, a portion of which was for the food item or beverage.

Part III – Personnel Directive – Prohibited Conduct

No officer or employee of the state Executive Branch or an immediate family member of such officer or employee shall (i) solicit anything of value, or (ii) accept, directly or indirectly, any gift from any lobbyist or from any principal or employee or agent of a principal, as the terms "lobbyist" and "principal" are defined in § 2.2-419 of the Commonwealth's lobbying laws, § 2.2-418 *et seq.* of

(b) Enforce this Order as specified in paragraph (c) of Part VI of this Order.

(c) Recommend to the Governor, at least annually, such revisions to this Executive Order as may appear necessary to ensure the maintenance of high ethical standards within the state Executive Branch.

The Commission may employ a professional staff of up to two (2) individuals to assist the Commission in the exercise of its duties and responsibilities specified in this Order. The necessary staff shall be furnished by the Office of the Governor, the Virginia Department of Human Resources Management, and such other agencies and offices as are designated by the Governor. An estimated 2000 hours of staff time per year will be required to support the Commission's work The Commission shall remain assembled for one full calendar year following the signing of this Executive Order, unless reauthorized by further Executive Order.

Part VI -- Enforcement

(a) The head of each advisory or governmental agency of the state Executive Branch (the "agency head") shall enforce this Executive Order, receive any complaint that an officer or employee of his or her agency has violated this Executive Order, investigate such a complaint, and determine the need for and impose the appropriate discipline, using the normal, then-existing personnel policies, rules, and procedures of the officer's or employee's advisory or governmental agency, including the Virginia Personnel Act, Va. Code § 2.2-2900 *et seq.*, where the officer or employee is covered by that Act. If the officer or employee is not covered by the Virginia Personnel Act, the agency head shall use whatever normal, then-existing personnel policies, rules, and procedures that the agency normally uses for officers and employees who are not covered by the Virginia Personnel Act. Disciplinary action may include any action up to and including suspension or termination.

(b) With regard to an alleged violation by a Deputy Secretary, member of a Secretary's staff, or the head of an advisory or governmental agency of the state Executive Branch within a particular Secretariat, the Secretary shall be the "agency head" for purposes of the enforcement process set forth in paragraph (a) above.

(c) With regard to an alleged violation of this Order by the Governor or a member of the Governor's Cabinet, the Commission shall receive and investigate the complaint, and shall determine whether a violation occurred. The results along with a recommendation for appropriate discipline shall be forwarded to the Governor or his designee.

(d) Each agency head who determines whether or not a violation of this Executive Order by an officer or employee in his or her agency has occurred shall, within thirty (30) days of making that determination, report the facts on which that determination was made, and the discipline, if any, that was imposed, to the Governor's Cabinet Secretary under whose Secretariat that advisory or governmental agency falls. The Secretary shall forward such report, or a report prepared by him or her pursuant to paragraph (b) above, to the Commission within ten (10) days of receipt or completion. The Commission shall report to the Governor, on a quarterly basis, the results of all investigations of officers and employees conducted pursuant to this Executive Order.

Adoption of Revised Guidance Document 60-20

Attached for review and discussion is the vacated guidance document on radiation certification and the proposed revision. The vacated document was removed from the Board's web page because it is outdated as a result of changes made to 18VAC60-20-195 of the Regulations Governing Dental Practice. The proposed draft addresses the Board's prior decision to continue to recognize person who qualified to take x-rays under previous regulatory provisions which were stricken in 2011.

Virginia Board of Dentistry

Guidance for Completion of Radiation Certification

In order for a dental assistant to be qualified to place or expose dental x-ray film, he or she must meet qualifications set forth in Section 195 of regulations of the Board of Dentistry as follows:

18VAC60-20-195. Radiation certification.

No person not otherwise licensed by this board shall place or expose dental x-ray film unless he has (i) satisfactorily completed a course or examination recognized by the Commission on Dental Accreditation of the American Dental Association, (ii) been certified by the American Registry of Radiologic Technologists, or (iii) satisfactorily completed a radiation course and passed an examination given by the Dental Assisting National Board. Any certificate issued pursuant to satisfying the requirements of this section shall be posted in plain view of the patient.

VACATED

The Board interprets satisfactory completion of a "course *or examination recognized by the Commission on Dental Accreditation of the American Dental Association*" to include a course with examination provided by a dental assisting, dental hygiene or dentistry program accredited by the Commission on Dental Accreditation of the American Dental Association.

Any person who was qualified to place or expose dental x-ray film by satisfactorily completing a course and passing an examination in compliance with guidelines provided by the board prior to May 11, 2011 continues to be so qualified.

Virginia Board of Dentistry

Guidance on Radiation Certification

Any person who (1) completed a radiation safety course and examination through a provider previously recognized by the board to offer the course and (2) registered with the board prior to May 11, 2011 by showing satisfactory completion of the course and examination continue to be qualified to expose dental x-ray film.

Beginning on May 11, 2011 the Board amended its regulation on radiation certification section 18VAC60-20-195 to require:

(i) satisfactory completion of a radiation safety course and examination given by an institution that maintains a program in dental assisting, dental hygiene or dentistry accredited by the Commission on Dental Accreditation of the American Dental Association,

(ii) certification by the American Registry of Radiologic Technologists,

or

(iii) satisfactory completion of the Radiation Health and Safety Review Course provided by the Dental Assisting National Board or its affiliate and passage of the Radiation Health and Safety examination given by the Dental Assisting National Board. Any certificate issued pursuant to satisfying the requirements of this section shall be posted in plain view of the patient.