APPROVED

VIRGINIA BOARD OF DENTISTRY
OPEN FORUM ON
POLICY STRATEGIES TO INCREASE ACCESS TO DENTAL TREATMENT

Friday, May 8, 2015

Perimeter Center
9960 Mayland Drive, Suite 201
Richmond, Virginia 23233-1463
Board Room 4

CALL TO ORDER:	The Virginia Board of Dentistry convened an Open Forum at 9:04 a.m. to receive views on policy strategies that will improve access to dental treatment in 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. James D. Watkins, D.D.S. Bruce S. Wyman, D.D.S.
STAFF PRESENT:	Sandra K. Reen, Executive Director Kelley W. Palmatier, Deputy Director Huong Vu, Operations Manager
OTHERS PRESENT:	David E. Brown, D.C., DHP Director Elaine Yeatts, DHP Senior Policy Analyst
COURT REPORTER:	Mary F. Treta, Court Reporter, Crane-Snead & Associates, Inc.
QUORUM:	Not required.
FORUM COMMENTS:	**Lynn Browder, DDS**, Dental Quality Assurance Manager for the Virginia Department of Health (VDH), stated that VDH is in support of ensuring access to care to low income populations. He noted that VDH has only two dentists on staff and is focusing on dental hygiene treatment. He added that VDH has no stake in the DA II topic but is in favor of expanding the use of remote supervision for the practice of dental hygienists. He said that VDH's remote supervision program addresses children and employs 10 dental hygienists who are based in schools. The dental hygienists assess dental conditions and apply topical fluoride varnish and sealants. He noted that the program has some success in partnering with community dentists to establish

dental homes for children.

Michelle McGregor, RDH, Director of the VCU Dental Hygiene Program (VCU), stated that 3.8 million Virginians have no dental insurance according to the Virginia Health Care Foundation's 2015 Dental Statistics and Research Report and added that according to the American Dental Association, 2.1 million Americans visited emergency rooms for dental pain in 2010 and nearly 80 percent of these visits were for preventable conditions. She said that VCU supports expansion of the use of remote supervision of dental hygienists in safety net facilities, nursing homes, community health clinics and other non-traditional settings. She cautioned the Board against using the language "expanded scope of practice" in these discussions since the intent is to address supervision requirements not increasing the duties allowed in the current scope of practice. She provided the following reports for review:

- The June 2014 Journal of Evidence-Based Dental Practice Special Issue-annual Report on Dental Hygiene examined direct access care models across the nation.
- The October 2014 VDH Technical Report on "Remote Supervision Hygienists."

Dr. Alan Dow, a general internist, described his experience with a patient with diabetes who had not received needed dental treatment and is now dependent on Medicare at taxpayers' expense. He said there is increasing evidence of the correlation of poor oral health and chronic disease and inflammation. Noting that it is difficult to locate free clinics to provide oral care, he supported expanding the options for dental hygienists to practice under the remote supervision of dentists.

Mark A. Crabtree, DDS, Chairman of the Virginia Dental Association's Community Dental Health Coordinator (CDHC) Task Force, presented information on the CDHC program being implemented by the VDA. He explained that a CDHC:

- works in a community to address the social barriers to obtaining care by assisting with applying for benefits, arranging transportation and obtaining language translation services;
- serves as a conduit between people in underserved communities and dentists;
- lives in the same community; and

- is trained to perform duties that are not regulated by the Board.

He said a CDHC is a cost effective strategy for addressing access to care that does not require regulatory action. He stated that in the future the VDA might pursue legislation to establish an Advanced CDHC who would be trained to perform duties such as placement of sealants, temporary fillings and teeth cleaning.

Michael J. Link, DDS, VDA President, stated that in 2001 the Board of Dentistry received a petition for establishing a "scaling technician" an option that has been overlooked by the Board. He said the VDA still supports establishing scaling technicians as a way to increase access. He then noted that the CDHC model is more cost effective than the strategies being considered by the Board.

Sheri A. Moore read a letter from Dr. Van Der Sommen, a family physician and Chairman of the Charlottesville-Albemarle Oral Healthcare Committee. He reports that for over 45 years he has seen many seniors battling disorders and diseases that had either a direct or indirect connection to poor oral hygiene. He also stated that the regular presence of dental providers, such as dental hygienists, in Long Term Care Facilities would make a significant difference in decreasing costs for the care of seniors. He asked the Board to support more autonomy for dental hygienists who are very skilled providers of preventive and maintenance care.

Richard D. Shinn spoke on behalf of the Virginia Community Healthcare Association. He urged sustainable change and asked that the VDH model for remote supervision of dental hygienists be expanded to dentally underserved areas, and safety net providers, including but not limited to federally qualified health centers and free clinics. He offered to assist in exploring how best to resolve access to dental services.

Cathy Berard, RDH, Virginia Dental Hygienists' Association (VDHA), thanked the Board for the opportunity to provide comment regarding strategies to increase access to dental treatment. She said that VDHA supports the policy change that would expand the options for dental hygienists to practice under the remote supervision of dentists and reviewed data that there are dental hygienists available to provide some of the needed services. She submitted copies of the following reports:

- The April 2015 The PEW Charitable trusts report card for VA;

- The 2014 Report to the General Assembly provided by VDH on the "Remote Supervision" Protocol; and
- The Joint Commission on Health Care October 8, 2014 report.

Kara Sprouse, RDH, asked the Board to consider allowing dental hygienists to qualify for DA II registration without obtaining Certified Dental Assistant (CDA) certification. She also recommended that the measure for clinical experience be changed from hours to the number of procedures required.

Linda Wilkinson, CEO of Virginia Association of Free and Charitable Clinics, Inc., stated that the clinics serve over 70 thousand people and only 15 thousand receive dental care. She asked the Board to consider the underserved when establishing regs and to allow greater flexibility for retired dentists to volunteer. She then invited Board members to volunteer.

Tina Bailey, President of Virginia Dental Assistants Association, asked the Board to make it easier for underserved populations to get access to oral healthcare.

Sharon C. Stull, RDH, said she lectures at Old Dominion University (ODU) where the classroom is in the community where approximately 66 thousand individuals have received oral health education, screening, and clinical services free of charge. She said that she supports expanding the options for dental hygienists to practice under the remote supervision of dentists. She also provided the "*Community Service Projects provided in 2013-2014 by ODU DH students in DNTH 413 and DHTH 419 Community Oral Health Planning and Practice"* report for review.

Joyce Flores, RDH, ODU faculty, thanked the Board for the opportunity to comment and stated that ODU supports policy change to expand options for dental hygienists to practice under the remote supervisions of dentists in VA. She then explained that graduation from a Dental Hygiene Education Program accredited by CODA prepares hygienists to provide safe care.

Sarah Holland, Virginia Oral Health Coalition, thanked the Board for the time to comment and stated that she supports expanding the options for dental hygienists to practice under the remote supervision of dentists.

Ms. Swain opened the floor for questions and discussion.

Drs. Crabtree and Link responded to questions about what states have CDHCs, where they are employed, the education requirements for basic CDHCs and their role in working with dentists and dental hygienists.

Discussion followed about the economics of remote supervision, the opportunity for dentists to send dental hygienists to community settings, the training provided in restorative procedures in dental hygiene programs, engaging social services agencies in identifying patients, requiring CDA certification for dental assistants I and the limited number of dentists participating in the clinical training of dental assistants I.

Dr. Jennifer Lee, Deputy Secretary of Health and Human Resources, stated that as an emergency room and free clinic physician, she sees many patients with poor oral health. She thanked the Board for addressing the issues and noted that it is an important issue to the Governor and Secretary.

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

Ms. Swain reminded everyone that any policy action the Board decides to take will include the standard comment opportunities required for regulatory action and for advancing a legislative proposal.

She thanked everyone for the wealth of information provided and concluded the forum at 11:39 a.m.

Melanie C. Swain, President

Sandra K. Reen, Executive Director

6/12/15
Date

June 12, 2015
Date

VIRGINIA DEPARTMENT OF HEALTH PROFESSIONS

BOARD OF DENTISTRY

9960 MAYLAND DRIVE

HENRICO, VIRGINIA

OPEN FORUM ON POLICY STRATEGIES TO INCREASE ACCESS TO DENTAL TREATMENT

May 8, 2015

9:00 a.m.

Board Members Present:
Melanie C. Swain, RDH, President
John M. Alexander, DDS
Sharon W. Barnes
Charles E. Gaskins, III, DDS
James D. Watkins, DDS
Bruce S. Wyman, DDS

Staff Members Present:
Sandra K. Reen, Executive Director
Kelley W. Palmatier, Deputy Executive Director
Huong Q. Vu, Operations Manager

DHP Members Present:
David E. Brown, DC, DHP Director
Elaine J. Yeatts, DHP Senior Policy Analyst

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INDEX

MS. SWAIN: Good morning. Before we start, I would like to have Ms. Reen review the emergency evacuation procedure.

MS. REEN: In case of a fire or other emergency in the building, alarms will sound. You should exit this room immediately, going to either of the doors to my right, your left, then turn right, go through the emergency exit door, proceed through the parking lot to the back, where there is a fence, and await instructions from security personnel. If anyone needs assistance evacuating the room, please let myself or Ms. Vu know, and we will make sure that emergency personnel are aware of your needs.

Thank you.

MS. SWAIN: Good morning. I am Melanie Swain, president of the Board of Dentistry. This is an open forum to receive your views on policy strategies to improve access to dental treatment in Virginia. If are you participating, if you wish to speak, please sign up on the sheets available outside the open door to this room. Speakers will be called in the order they appear on the sign-up sheet. Each presentation will be timed and limited to ten minutes. The speaker will be notified when they have reached nine minutes so that they may conclude in the allotted time. The forum will conclude at noon. If time permits following the presentations, attendees will be asked to participate in a

question-and-answer session to explore and discuss the recommendations made.

At this time I will call on persons who have signed up. As I call your name, please come forward and speak into the microphone. Start by telling us your name, where you are from and if you are representing an institutional organization, and to help our court reporter, it would be great if you could please spell out your name.

Thank you.

The first name is Dr. Lynn Browder.

DR. BROWDER: B-R-O-W-D-E-R.

Good morning. Yes, I am a dentist. I have been so for a lot of years here in Virginia. I am here today representing the Virginia Department of Health today. I have been a dentist with the Health Department for many, many years, as I said, and in the capacity known as the dental quality assurance manager for a lot of years. So, as such, I have been involved in a lot of public health roles, and specifically with the remote supervision project that has been underway in the Health Department for a number of years.

What I would like to do today is to start first by just addressing a couple of points the VDH wanted to make in response to the memo that was sent out for the forum. As you have raised the question of pressing needs, we wanted to go on the record recognizing the main thing, of course, is

general improvement of oral health for our residents, and also the reduction in disparities in healthcare for so many people in the state. We realize that one of the things that needs to be done is assuring access to care for our at-risk and low-income population. So I understand, obviously, this forum is addressing those issues indirectly, but we want to be sure that is never lost sight of, as are the ease and utilization of services that are created to provide for people, because we know there are impairments for some folks that are challenged to access to healthcare, and we take this opportunity to share that with you.

Regarding the policy strategies, an increase in the flexibility of delivery models is something we always think is worthwhile to look at, meaning the opportunities to adjust, perhaps, the settings where care is provided, as well as the folks that are able to provide it. We want to, of course, make a priority of quality of care, but at the same time we understand that there may be some room for exploring opportunities in both conventional dental settings and non-dental settings to improve access to care, not forgetting that that is the main point of this discussion today.

We have identified some parameters that we would prioritize for any model that is considered, of course, those being to use the least-costly method to provide safe, quality care to people in the Commonwealth, and to always

provide opportunities for people, again, in shortage areas that are challenged or perhaps under-resourceful. Now, regarding the specific strategies that were identified for discussion today, the Health Department does not have a big position or stake in the DAII discussions. It is not that we are ignoring that, but I will touch a little more on our transition for employment with hygiene, but at this point we are getting to be very small as far as dental practices. The transition over the past few years is more of a hygiene program. So a dental assistant two is not particularly valuable to VDH, but we recognize, again, and support any mode of providing care that might reduce the cost by increased access.

The main point that we would raise in considering whatever adjustments to the DAII that you are considering is that although something like this may increase capacity in any given practice, which can theoretically improve access and possibly reduce cost to delivery of services, we don't really feel that that type of provider expansion is necessarily going to put care providers in new areas. It may be improve capacity in existing facilities, but it is not going to provide in those areas of the state where we are short of providers, where there are people that are having trouble accessing care for a variety of reasons.

So the main reason that I am here today is to

speak to the remote supervision issue. As you know, this has been going on since 2009. I was involved with it since the inception of it, as many people in this room, as we put together the guidance for it and developed the protocols and regulations. We started it off as a pilot in VDH. We have now moved into expanding this to ten hygienists that are school-based and four hygienists that are Health-Department-based, providing services under remote supervision. So we have literally provided tens of thousands of assessment models where the hygienists are provided supervision, policies and procedures, training, guiding orientation, go into the field and assess, primarily children, although we are not limited to that and we are exploring other segments, and from that point providing better services, as appropriate, and most importantly, working with our partners in the community to try to get specifically children into a dental home.

The first thing we do when we go to any community is contact every dentist there, and at that point, when we go into any school organization, we have a list of willing providers. I am not speaking to the financial commitments that they make, but they are aware of what we are doing and they are willing to take our patients. The reason this has been successful, and the reason that we feel it is a safe way to provide a lot of care to people who otherwise

would not have access, is that we have had the support of dentists in the community and the other community providers serving as our referral. So we feel that we have not only had the opportunity to provide services to children that may not have any, but we also stimulated some care-seeking behavior that may not have happened. If you look at any public health science, you will see that programs such as this have been documented to do just that, to stimulate or facilitate care in the community beyond the initial intake assessment and dental services that are received through hygiene programs such as ours, and that, perhaps, is the greatest thing that we could do, is to get people to access care that they otherwise have just not been able to.

Our hygienists very often function as case managers in trying to get that. Folks, again, I keep saying children, but trying to help parents get these children into care, and particularly when it is a severe issue, they stay with them for quite a long period of time, and then we go back and look for the kids again the next year to make sure that those sealants are still there and maintain the quality standards, but also to see if care has been done, and if not, we start that process again with contacting parents.

So what we have found to be very successful is using a hygienist with lots of training, adequate oversight, to bring care into areas that otherwise would not have

adequate access, or people in areas that would keep them from having full access, making it relatively simple for them to get in, get the kids started, get out in front at a very young age. We have started at the pre-K level with assessments, have the consents and proper paperwork, and as long as we can provide the training and orientation and detailed regulations, we have found this has worked wonderfully. As you can seen in our latest reports, like I said, we have delivered a lot of services, and a lot of services in places that may not otherwise have received them.

I will conclude in my last minute by just saying that we feel like it has been successful and we have accomplished what we hoped to accomplish. We would like to see it continue, of course. The Health Department, having gone through a transition plan and putting some of its funds towards hygiene, is going to try to expand to the extent that it can, but we do feel that it is reasonable to consider the expansion of remote supervision as a way of providing access to more people in the state, as well as those people who are particularly facing barriers because of either where they live or income stress. So I will leave it with you to continue this discussion, but I will remain, and if we do get into a discussion later today, I will be happy to take any questions. Do you want questions at this point?

MS. SWAIN: No. Thank you.

Michelle McGregor.

MS. MCGREGOR: M-C-G-R-E-G-O-R.

Good morning. It is like being on trial, and we can smile. Good morning. My name is Michelle McGregor. I'm a registered dental hygienist, with over thirty years of experience in private practice, group practice and public health and education. Currently, I serve as the Virginia Dental Association president, the program director for the Virginia Commonwealth University Dental Hygiene Program, and I also serve on two national organizations with the American Dental Education Association. So I would like to say I am here representing all of those organizations, but my comments are being brought from VCU's Dental Hygiene Program.

I would like to thank the Board for the opportunity to offer comments on the three concepts outlined during the October 2014 regulatory legislative meeting investigating improving access to dental hygiene care to all Virginians. I would like to provide comment on concept three only, expanded options for dental hygienists to practice under the remote supervision model. I will be brief, and excuse me for reading, but I want to stay on track.

There are many practice models being examined across the nation, but we must focus on the best fit for Virginia. Documentation of need exists and improved access is warranted. I have stated this in previous forums and task

force, but it needs repeating. I strongly caution the Board of Health Professions and the Board of Dentistry in using the language expanded scope of practice in these discussions. It continues to be misleading and confusing, since the intent is to address supervision requirements, not to address increasing duties allowed in the current scope of practice of dental hygiene.

The Virginia Health Care Foundation reported in its 2015 Dental Statistics and Research Report that 3.8 million Virginians have no dental insurance. These individuals often seek care in free or charitable clinics or resort to hospital emergency rooms. According to the American Dental Association, 2.1 million Americans visited emergency rooms for dental pain in 2010, and nearly eighty percent of those were preventable. Dental hygienists, the profession, is rooted in prevention and education. As most of you know, as has been stated earlier, in 2009 the General Assembly enacted legislation that reduces dentist oversight requirements for dental hygienists employed by the Virginia Department of Health in selected underserved areas. This model has already demonstrated success as a safe and effective way to improve access to preventative dental services for those at highest risk. So we have already solved our problem a little bit.

The VDH has documented these outcomes, and I

have provided the 2014 Technical Report on remote supervision as evidence-based support. The June 2014 Journal of Evidence-Based Dental Practice Special Issue Annual Report on dental hygiene examined the direct access model across the nation. I present this document, also, to the Board for reference. Currently, thirty-six states have some type of direct access, and that includes Virginia, due to our Department of Health hygienists. The report acknowledges the adopted models are specific to each state and hygienists must still adhere to federal and state regulations. Some states require additional education or hours of practice, have restrictions on settings for direct access or require formal agreements with a dentist or another supervising entity. The current VDH employed hygienist requires two years of experience and allows hygienists to work collaboratively with a public health dentist who is not physically on site nor has examined these patients. So, again, I say we must think about Virginia.

Schools prepare hygienists to serve in these roles, and the educational process has continued to transform over the years to include course work on public health, research, insurance and tele-dentistry to meet the evolving needs of our communities. This evidence-based practice report concludes that minority populations, such as the elderly, special needs, children and rural populations, have

benefited from care provided directly by dental hygienists. This has also served as an entry point for many into the healthcare system. I receive many calls at the school for people asking students to come to provide care at facilities that have an empty dental chair but no dentist. The 2014 Dental Hygiene Workforce study indicated that there are licensed hygienists in Virginia who are looking for work. The need is there, the workforce is there, and it is time for Virginia to take action.

The VCU Dental Hygiene Program supports the expansion of the remote supervision program to include the utilization of licensed dental hygienists in safety net facilities, nursing homes, community health clinics and non-traditional settings. Again, I emphasize this expands practice settings to reach those in need and does not expand the scope of practice or services provided. Using models of collaborative agreement, such as the Department of Health, between dentists and dental hygienists would allow hygienists to work to their full capacity and us all to better address access-to-care issues.

I thank you for your time.

MS. SWAIN: Dr. Alan Dow.

DR. DOW: Good morning. So my name in Alan Dow. I am a physician. I am in an usual spot here, I guess, and I wanted to talk about sort of the medical prospective.

I am on the faculty at VCU, but I don't represent VCU. However, I think I can speak about sort of the physician perspective on this issue.

So let me tell you a little bit about myself. So I am a general internist. I primarily do hospital work at VCU, and then I also do free clinic work in a primary care setting in Richmond. I wanted to talk to you about a patient that I took care of this February. I am going to call the patient Jesse, not his real name, but Jesse is very typical of the patients that I have taken care of over the past fifteen years at VCU. Jesse was from southern Virginia, a rural area, and he arrived and transferred to our hospital with a diabetic foot ulcer. So Jesse had diabetes that was out of control over years and years, had a large foot ulcer which unfortunately had spread into the bone, the infection, and it required an amputation as part of his care when I was taking care of him.

I talk about Jesse, because when you look at what led him to the condition he was in when I began to take care of him, it was a decade or more of poor access to care, poorly controlled diabetes, and when you ask Jesse about what was going on with him, it wasn't just his foot that was bothering him. It was his poor oral health. He actually had an oral abscess. He was seen by oral surgeons as part of care. We had him on antibiotics for his foot, which also

helped with his abscess. When we sent him home, he was going to get some follow-up care for his oral issues at our clinic at VCU. I think he made the appointments, but I talk about Jesse because we know there is increasing evidence about the link of poor oral health, uncontrolled disease and the manifestations that I see when I take care of patients in the hospital, and our dental colleagues have done a great job of sort of clarifying some of those issues, but when you get chronic inflammation from chronic oral infections, periodontal disease and whatnot, you end up with out-of-control diabetes, which I see in the free clinic setting often, leading to these health outcomes, and Jesse's story is sad for him, and I think we are all sympathetic, but there are broad social implications of Jesse's story as well, because when we think about what happens with Jesse's life after he is in the hospital, what it involves is a lot of cost to our society.

So Jesse was a relatively young man. He was forty-five, and once he gets a foot amputation, he is going to be on disability, he is going to go from being uninsured to being on Medicaid, and all of that is going to cost our state and our society tens of thousands of dollars a year. So, in a sense, our inability to control his chronic diseases to begin with, both oral and medical, has led to a cost of thirty or forty thousand dollars a year for our society for

Jesse's ongoing cost. So if you multiply that times a life expectancy of twenty or thirty years, you are talking about hundreds of thousands of dollars that a patient like Jesse is costing us, the taxpayers.

I also see people like Jesse in the free clinic setting, who come in to get control of their chronic diseases, and I will tell you, as a primary care physician for a lot of these patients, it is very difficult to get their medical problems, particular their diabetes, under control. There is a lot of evidence now linking poor oral health and chronic inflammation to elevated Hemoglobin A1Cs, and this is sort of the midpoint on the path to becoming Jesse.

So how do we sort of think about those patients and try to find them access to care. In the free clinic setting, very, very difficult to find oral health providers for patients. In the City of Richmond we are fortunate we can refer to the VCU dentistry clinic, that helps people on a sliding scale, but a lot of these folks are in rural environments and don't have the ability to come to Richmond and be seen at the VCU clinic.

So hearing what the previous two speakers have said about the pilot study that the Virginia Department of Health has done, and what Ms. McGregor said about 3.8 million people that are uninsured, which is just a shocking number to

me for oral health, I think the question is what can we do to make this better, and it is very clear to me that the Virginia Department of Health's pilot at least provides us a way forward. I don't know much about the first questions. From what I understand, there are eight dental assistants in Virginia right now, so that doesn't seem like an easy number to expand and really increase capacity, but it is very clear that the third strategy, about increasing the practice ability of the dental hygienist, is a viable strategy that is backed up by evidence in terms of moving forward.

I do know from working at VCU that we have a ready workforce for this. We graduate approximately thirty dental hygienists over the year. I know there are other places that are graduating dental hygienists around the state. So we do have a workforce that can provide some of this capacity for some of this preventative care that we need for dental health, and I do see this as a strategy that would work going forward.

It is interesting to me, as a physician, to think about this issue parallel with what I see in the medical profession. So if I think what dental hygienists do in terms of assessments, some procedures that are not particularly invasive, it reminds me of the link between a physician and home health nurse. They both are trained, they are trained to do what their specific role is going to be,

yet our home health nurses function much more autonomously than our dental hygienists do, and it is striking to me that I can have a patient that I discharge from the hospital and I rely on that home health nurse to work relatively autonomously, in terms of making assessments, doing wound care, drawing blood, all that sort of invasive kind of stuff that a home health nurse does, and do that without a lot of concern, yet there seems to be a lot of concern about dental hygienists working, and what I actually see is it is a more narrow scope of intervention than with what a dental hygienist does.

So I want to conclude just by saying that Jesse was a patient that was just one of many patients like that that I have taken care over fifteen years. I think the implications of what we are talking about today goes far beyond oral health. It goes into really the health of the old person and the health of the whole community. If you think about 3.8 million people that do not have access to oral care because they do not have insurance, anything that we can do to sort of start stemming this type of chronic illness early and preventing all those downstream costs and morbidity for our population is really crucial for thinking about building a healthier Virginia.

Thank you.

MS. SWAIN: Dr. Mark Crabtree.

DR. CRABTREE: Good morning. Just a second to get set up here. As the former mayor of Martinsville, I feel like I am off to the races, since I have got ten minutes, so I want to make sure I get it all in.

I am Mark Crabtree, a private-practicing dentist in Martinsville, Virginia; past president of the Virginia Dental Association; past chairman of the Counsel on Access, Prevention and Interprofessional Relations for the American Dental Association. Presently, I am the chairman of the task force that is set up to get the Community Dental Health Coordinator program started in Virginia, a program that was introduced several years ago by the American Dental Association, studied very thoroughly, and also is spreading across the country. So those of you who are ADA members may have been following a little bit of that discussion in the ADA.

So I want to set the discussion about access to care, and when you look at access to care it is a multi-factorial issue. There are many, many factors that keep people from accessing care. Workforce is one piece of it, but there are many, many other things that limit someone's ability to access to care. The ADA is proposing, and the VDA, the Community Dental Health Coordinator is a piece of that. We can address all those factors with one solution. There have to be multiple solutions that we can

come up with, but we think that the one that we are going to provide is going to be much more cost-effective and actually get people to the care that they need.

So the Community Dental Health Coordinator's focus is on reducing the oral health disparities that target the social determinants of oral disease and improving access to dental care. It is focused on primary prevention. I am also president of the Piedmont Virginia Dental Health Foundation in Martinsville, Virginia, who has a very active program that addresses dental disease in the City of Martinsville, with the highest unemployment rate in the State of Virginia, and we have a thirty-one percent reduction in ED visits to our little hospital because we have attacked dental disease and declared war on gum disease, and we do it by not only doing the primary prevention but also doing the care that people need.

So what is the CDHC. The CDHC is a conduit between underserved communities that are in desperate need of care and the dentists who are trained and licensed to provide that care. What Jesse needs, the gentleman that was described earlier, is a CDHC, who could take him by the hand and help him to navigate the maze of the options that are available to him to get his total health taken care of at a community health center and get him the dental care that he needs. There are resources that are available, chairs that

are empty within the State of Virginia that are not being filled because people are not accessing the care because of the social determinants that are there, and that is why we have the CDHC.

It is based on a community health worker model. It is a model that works. It recruits people from the same communities where they work, and it leverages the existing resources that are available to fund it. In 2005 in the Journal of Public Health Dentistry -- I can give you a more specific citation for that, but I had to whittle everything back, so I am going to zip right along. The Dental Health Care Coordinator intervention significantly increased dental utilization. They compared with similar children who received routine Medicaid member service. Public health programs and communities endeavoring to reduce the oral health disparities may want to consider incorporating a dental health coordinator. We would want Virginia to be a part of that growing effort across the country.

How they do it, they basically assess the needs. Are they in pain, do they need to see a dentist, do they need financing, is that a barrier, is language a barrier, is transportation a barrier. They are going to help in these areas. It is a navigator, someone who can help people get to the care that they need. It is help in registering for Medicaid. They may even be available for

other programs that they don't know about. Help with transportation. They will provide support for other potential personal access barriers. They will try to address those, such as fear and anxiety. There are a lot of things on those whole socioeconomic scales that can affect their ability to access care. They basically coordinate dental care and manage all aspects.

So in a private dental office, a lot of this is done by your front desk person, triaging, but a lot of people who are in need of care can't get to that point through the community health centers. They are out there in the community suffering, and this is a way where we can actually take people from the community and help them to get the care that they need. They will be trained to work under a dentist's supervision in health and community settings, such as community health centers, schools, churches, senior citizen centers, Head Start programs and other public health settings with residents that have ethnic and cultural backgrounds similar to the CDHC. They collect the information to assist in the triage.

They address their social, environmental and health literacy issues facing that community's population. They will assist the community members in developing goals to promote their personal oral health. I lot of people just don't understand that they need to have preventative dental

care to get rid of that plaque and tartar on their teeth, to save their teeth and prevent abscesses and things that go on there, especially if they are a diabetic like Jesse was. Manage the care and navigate the patients through the maze of health and dental care systems. That is a huge thing. There is care available for a lot of folks, and they don't access it because they don't have the skill sets necessary to do that. Just as a dental assistant, they can do anything that a dental assistant would do, providing regulated activity such screening and fluoride treatments under supervision, which is pretty much standard in any dental office.

The curriculum, these are what they will learn in the basic model. This is where there is a lot of confusion. It has evolved over time. There is a basis model and an advanced model. We are only talking about the basic model. The basic model is a community dental health worker, or a community health worker with some dental skills, so they understand how dentistry works and how the dental programs work that are available. I am off to the races, as I said.

Dental health outreach and advocacy, there is a lot of education that goes on in the schools. They can assist with oral health communication, interviewing skills, legal and ethical issues that are in dental health. They have some dental skill modules, which is basically understanding what dentistry is. The textbook is kind of

like that dental assisting textbook that covers screening and classification; prevention of dental carries; prevention of oral cancer; financing and payment options for dental care. Very simple, basic things that nonregulated people do within community health centers and health educators do. They have an internship model based on what a community health center would be able to utilize them for.

That is the basic model, and the advanced model includes all dental details, the regulated pieces that you all will be concerned with, and which we will, too, if we want to take it to another level. We are not talking about that level at this time. We are only concerned with getting the navigation piece and the basic model up and going.

An advanced CDHC would be possibly trained, even if it was in a community health center with a hygienist, placement of sealants, placement of temporary fillings, simple teeth cleanings, class one stuff, removing gross debris, stains, calculus using scalers and all that stuff. Advanced, that will require probably legislative change and lots of changes in the rules and regs. So I want to make sure we separate those two in people's minds, so they understand that the advanced certificate is the one where there will be a lot of discussion.

Now, the task force at the VDA forum determined that this would be a very feasible model in Virginia, and

this has just occurred since September. We think it should be a two-level certificate program. Obviously, you can't introduce the second one. The basic certificate, there are no regulated duties, but this bottom piece is what we would really like for you all to kind of take a look at. The CDHC should be a part of a career path in oral healthcare, and if you look at the far right, you have the DDSMS. That is our specialist. They are the top of the pyramid. They are the guys and gals that have gone out there and are oral surgeons. They are endodontists. They are periodontists. They are public health Ph.D.s. All those folks are on that end. Then you have the dentists, and then you have the bachelor's degree hygienists, you have associates degree hygienists, and then we have the regulated area of advanced CDHC, the dental assistant two and the basic CDA, which are basically the assistance level.

What does this mean economically. You don't want someone at the top end of the deal doing something that someone at the bottom can do. A basic CDHC will be expected to make the same as a community health worker in Virginia, which is about 35,000; the advanced, 40 to 38. Hygienists in Virginia are at 81,000 a year. Dentist are reporting 156. I am sure some of the specialists make a lot more than that. This is the economic issue that is there.

There is not a shortage of dental hygienists in

Virginia. You take someone out of this equation, but you have to fill it back and increase the problem there, and, basically, why would someone at the upper end want to be doing tasks that could be done by someone at a lower level. It is very simple economics. A hygienist can do everything a basic CDHC would do, but why would they not do that when they are able to earn, and up in Northern Virginia it is even more than that, that amount.

I hate that we have to try to get all of this squeezed in, and I hope there is an opportunity to take it further, but this basically is not dental healthcare, and this one is the last slide. I am going to give you this, if that is okay. I understand, without objection of the Board members, that you could be flexible.

MS. SWAIN: We will have time in the end.

Dr. Michael Link.

DR. LINK: Thank you. I am Dr. Michael Link. I am president of the Virginia Board of Dentistry, and I want to give you a little bit of history -- sorry, I am trying to concentrate on too many things. I am a past chairman of the Virginia Board of Dentistry. I am the current president of the VDA. I want to give you a little history on what happened with the DAIIs.

Back when I was president back in 2001, there was a petition for a ruling to make a change to the

regulation to allow scaling technicians, and the reason that this petitioner asked this was because he could not find a hygienist where he lived and because of the cost. So what ended up happening is, over the next few years, we ended up with the expanded duty dental assistant, or DAII. Currently, I believe as of two weeks ago, Sandy told us that there are seven registered in the whole state. Now, I feel like if you only have seven that maybe currently there is too much of a stringent requirement. However, the main reason for the petition was to have a scaling technician, which was totally overlooked by the Board. The Board approved over the next few years a tandem duty functions to help dentists with such as packing cord, you know the duties, but the intent of the petition was for a scaling technician.

The VDA's policy is, in support of scaling technicians, to help address the access to care issue. As I mentioned, the ADA has done extensive research with more open-chair time in dental offices throughout the state and the nation, and we believe the workforce model is more than adequate. The Commonwealth needs the most economical and feasible way to help access to care. Now, we have researched the issue throughly, and through the Virginia Labor Market website and federal data, the breakdown of hygienists' salaries are consistently higher, and as you look at here, you can see this comes right off the Virginia government

website. It tells you the salaries of the hygienists, and we believe that the CDHC model is much more economically effective and feasible than any model that has been suggested.

Lastly, if the Board is considering any changes in the supervision model, then the VDA's policy does not currently permit this. We would encourage and hope to be encouraging any dialogue for charges. This way it will give our organization the time it needs to either adjust its policies or to have input on these policies.

Thank you very much. That is all I have.

MS. SWAIN: Sheri Moore.

MS. MOORE: Moore, M-O-O-R-E.

Thank you, Madam President. Can you hear me?

MS. SWAIN: We can.

MS. MOORE: My name is Sheri Moore, and I hold the position of council chair for policy bylaws for the American Dental Hygienists' Association, and I am also the Board of Dentistry liaison for VDHA, but I am not speaking in either of those capacities. I was asked to come forward to bring testimony and presentation for Dr. Lyn Van Der Sommen, L-Y-N, V-A-N, D-E-R, S-O-M-M-E-N.

Lyn says: Please accept my apologies for not being physically present today. As power of attorney for my mom, it was necessary for me to accompany her to her

healthcare appointments, but I wanted to share my concerns with you regarding the state of oral healthcare of our Virginia seniors.

I have spent over forty-five years in healthcare. As a family physician who practiced in office, emergency and nursing home settings, I witnessed firsthand many a senior battling disorders and disease that had either a direct or indirect connection to poor oral hygiene. There were those who could not manage a proper diet because of oral infections, a painful mouth or inability to chew properly. Sepsis, poorly controlled diabetes, malnutrition and pneumonia all became possible outcomes. I could only refer my patients to emergency rooms, hoping they would receive more care than I could possibly provide. However, more often than not, treatment included pain medications, antibiotics and a trip back home, and the cycle would begin again.

As a very active volunteer with the American Cancer Society for many years, I saw the devastating malignant results of poor oral care. As a community college program manager for healthcare education and training of direct care staff for seniors, I observed how little training aids are provided with regards to oral care. I fought an uphill battle to stress the importance of such care to those running longterm care facilities. From poor supervision and training, time constraints, lack of equipment and materials,

I saw little oral care being provided on any regular basis. Today, as chairman of a Charlottesville-Albemarle oral healthcare committee, I know little has changed. Only those who can privately pay or have dental insurance obtain the needed services, while the condition of the rest of the residents deteriorates.

With certifications in gerontology and geriatric education, I founded the Geriatric Collaborative of Central Virginia, whose mission is to bring evidenced-based best practices of geriatric education and training to healthcare professionals. One of our goals is to bring attention to the poor oral healthcare of our seniors in longterm care facilities and how changing the present culture of care to one that acknowledges the importance of oral healthcare is a battle worth fighting.

Most recently, as a member of the Virginia Dental Association's Task Force, I have been participating in a pilot study to demonstrate how the regular presence of dental providers in longterm care facilities will make a significant difference in decreasing costs for the care of our seniors. These providers, dental hygienists, can offer training to staff, provide preventative and routine maintenance services to residents and timely referrals to dentists for needed procedures. Studies and implementation of such providers and services in other states throughout the

nation have proven to decrease morbidity, mortality and healthcare dollars. The reduction in emergency room visits and hospital admissions alone have been shown to pay for providing seniors with access and dental insurance.

To provide this level of care, it is not necessary to have a dentist physically present in such facilities. Dental hygienists are very skilled providers of preventative and maintenance care. They are able to access if more care is needed and make the necessary, appropriate and cost-effective referrals. We have an epidemic of poor oral healthcare in America, and the cost to America at so many levels is only going to soar. We need to elevate the importance of oral healthcare. We need to change the dialogue of healthcare to always include oral and dental services, to be proactive to provide affordable and accessible dental care services to all seniors.

Please consider taking such measures as advocating for dental insurance for our Virginia seniors and supporting more autonomy for our Virginia dental hygienists. We have in place a well-trained workforce that is being underutilized and who could make a positive difference in the overall healthcare of our seniors.

Thank you very much.

Lyn Van Der Sommen.

MS. SWAIN: Rick Shinn.

MR. SHINN: Good morning. My name is Rick Shinn, S-H-I-N-N. I am the director of public affairs for the Virginia Community Healthcare Association. I do represent the community health centers in Virginia, and I will be speaking for them this morning.

You have my comments. Someone skipped a lot of this. I do want to give you a little bit of a background about who we are and what we do. We are federally-qualified health centers that work in medically underserved areas, serving over 300,000 Virginias at 144 sites, all the way from Chincoteague clear down to–

MS. SWAIN: Mr. Shinn, I think they need to hear you in the back. Can you speak a little louder, please.

MR. SHINN: All our of our sites are located in medically underserved areas or serving medically underserved populations. Most of those also happen to be dentally underserved areas as well. So we have a considerable shortage of dental professionals and services. In addition, a large percentage of the persons that we serve are uninsured or have Medicaid coverage. Access to dental healthcare services is extremely important to these people, yet gaining access is severely impeded due to the lack of adequate financial coverage and lack of providers willing to locate their practices in underserved areas. Obviously, we do not fault the providers, as they must have sufficient populations

and incomes to operate sustainable practices.

We would appreciate your consideration of the following comments I have given to you this morning. Our main concern is the impact on the patients served by the health centers in regards to any proposed options that may be considered. Our concern is that a mechanism that is effective and sustainable over time be developed to provide dental services to those persons who are living in underserved areas. Since many of the persons in these areas are uninsured or on Medicaid -- that is another issue -- their ability to pay for services is limited or practically nonexistent. The remote supervision dental hygienist model developed for the Virginia Department of Health appears to be meeting the mission intended. This could serve as a model for extending this concept to other safety net providers, while maintaining the integrity of dental services being delivered to persons living in underserved areas of the Commonwealth.

Following on the recent Dental Hygienist Scope of Practice Review, we would ask that consideration be given to expanding the options for dental hygienists to practice under remote supervision of dentists in dentally underserved areas and with safety net providers, including but not limited to federally qualified health centers and free clinics, and that roles in the options that were previously

sent out under a different memo, of the remote supervision and restricting the expanse of the practice to serve the areas of populations I just mentioned.

We look forward to working with you. We know there are a lot of issues to discuss here. There are a lot of parties involved in this, and anything that we can do in working with you on these issues, we would appreciate that.

Thank you.

MS. SWAIN: Cathy Berard.

MS. BERARD: B-E-R-A-R-D.

My name is Cathy Berard. Good morning, first of all. My name is Cathy Berard. I am a dental hygienist, a past president of the Virginia Dental Hygienists' Association, and I currently serve as cochair of our Public Health, Education and Professional Affairs Council. I have over forty years of experience as a dental hygienist, in both general practice and multi-specialty group practice. I am an adjunct faculty at Northern Virginia Community College.

On behalf of the Virginia Dental Hygienists' Association, that represents the 5,563 licensed dental hygienists in the Commonwealth, I would like to thank the Board of Dentistry for the opportunity to provide comment regarding strategies to increase access to dental treatment. Through data, research, stakeholder discussions and a successful statewide Virginia Department of Health program,

the VDHA supports the policy change that would expand the options for dental hygienists to practice under the remote supervision of dentists.

Access to oral healthcare is a national issue, and Virginia is no exception. As stated before, 3.8 million Virginians do not have dental insurance. As you know, most Medicare plans do not include a dental benefit, and Virginia Medicaid provides only full dental coverage for children, covers emergency care for some adults, and most recently started providing dental benefits for pregnant women. Due to the lack of affordable access to dental care, many low-income individuals rely on hospital emergency departments and safety net providers, such as free and charitable clinics and community health centers.

During the summer and fall 2013, oral healthcare stakeholders met to discuss how Virginia can improve oral healthcare and examine how to divert patients from emergency departments. In addition, the group looked at ways providers can practice in additional settings to access patient populations that are not being reached. Oral healthcare leaders among the stakeholder group focused on the importance of providing timely preventive dental service rather than waiting until treatment needs arise, which escalates costs. Improving access to preventive dental services can significantly reduce costs for those low-income

individuals.

The overwhelming belief is that providing preventive oral healthcare access is the focus and dental hygienists within the remote supervision model is the solution. As previously pointed out, in 2009 the General Assembly enacted legislation that reduces dental oversight requirements for dental hygienists employed by the Virginia Department of Health in select dentally underserved areas. VDH dental hygienists worked under remote supervision and had periodic communication with a public health dentist. Under that 2009 legislation, dental hygienists were authorized to perform services such as initial examination of teeth and surrounding tissues, charting existing conditions, prophylaxis of natural and restored teeth, application of topical fluorides, providing dental sealants, scaling and educational services. That initial VDH pilot program focused on providing sealants, fluoride varnish, initial examination and education, and as stated by Dr. Browder, was a glowing success throughout the Commonwealth and was expanded in 2012.

From the 2014 Virginia Department of Health Report on remote supervision, just a few statistics: 4,000 children returned a permission form and were screened by a dental hygienist in a school-based setting; 1,746 received sealants; 3,754 received a fluoride varnish application; 1,220 children were identified as having other oral health

needs and referred to community providers.

This effort has improved access to preventive dental service for those at highest risk of dental disease, as well as reducing barriers and costs for dental care for low-income individuals. The report indicates the remote supervision model has been a successful alternative method of delivery for safety net dental program services that have increased access for underserved populations. Increasing the availability of preventive services such as sealants and fluoride has been proven to significantly reduce the dental disease burden, which is a priority need for those populations at highest risk.

The VDHA support for the remote supervision model comes through evidence-based data that demonstrates the dental hygiene workforce needs to be utilized. Recent public comment and dialogue has improperly defined dental hygienists in the workforce and their salary. I want to take a moment to review the facts of the dental hygiene workforce based on a 2014 survey completed by the Virginia Department of Health Professions Workforce Data Center. The dental hygienist workforce survey had responses from 4,678 of the 5,563 licensed hygienists, which represents an 84-percent response rate. Out of those licensed hygienists, approximately only 47 percent hold a full-time position, and nearly 30 percent have just one part-time position. The survey revealed that

there are 3 percent who are looking for work. These are hygienists who are already educated and licensed by this Board. The average median income for a licensed dental hygienist is between $50,000 and $60,000 per year. Provided to you with out comments is the complete 2014 Virginia Dental Hygienist Workforce Survey.

Additional outside entities have scored the Commonwealth of Virginia on our oral healthcare access. The Pew Charitable Trust provided a report card rating for Virginia. Pew gave Virginia a rate of C minus for dental sealants. In 2012 the grade was a C. The stated reason for the grade drop is due to the fact that the only hygienists permitted to place sealants in schools under remote supervision are those employed by the State Health Department, and I believe Dr. Browder said that number was about ten people. The National Governors Associations, which is a bipartisan collective voice on national policy and innovative solutions to improve state government, recently published their paper on the role of dental hygienists in providing access to oral healthcare. The NGA specifically points out the suggestion of placing dental hygienists in underserved areas.

Some experts question the equity of limiting the work of dental hygienists based on practice settings and argue that expanding their practice areas will help

hygienists fulfill oral healthcare needs for underserved populations. More than half the states allow direct-access hygienists to work with underserved populations in some public settings but explicitly bar them from practicing in private settings. The rationale that state dental boards most commonly use for restricting hygienists from practicing in an unserviced setting focuses on concerns about quality and safety, even though no clear evidence exists to support such restrictions.

When it comes to risks associated with the remote supervision model, I, again, ask you to look no further than the Virginia Department of Health program. There have been no patient safety concerns for the dental hygienists providing care to Virginia's most vulnerable over the last six years. Any concerns about safety and efficacy should apply, regardless of the income level of the recipient of care.

Through the data, research and comments we have made today, the Virginia Dental Hygienists' Association, representing over 5,000 licensed dental hygienists, stands by the need for a policy change. We align ourselves with other oral healthcare stakeholders and believe that expanding the options for hygienists to practice under the remote supervision of dentists is the next step for Virginia to reach those who need oral healthcare services.

Thank you.

MS. SWAIN: Kara Sprouse.

MS. SPROUSE: Good morning. My name is Kara Sprouse. It is spelled K-A-R-A, S-P-R-O-U-S-E. I am a dental hygienist, and actually I just became the eighth person to be licensed to be a dental assistant two. I recently completed the DAII program at Fortis College. I am here today to speak in response to the open forum on policy strategies to increase access to dental treatment and the three strategies under consideration by the Board.

The first thing I would like to comment on is adjusting education endorsement requirements for DAII registration to increase the number of registrants. I am aware that currently there are eight licensed in the State of Virginia. I believe that there are a few different reasons as to why there aren't more. First, many people are probably unaware that there are only two programs in the State of Virginia, one being Fortis College and the other being Germanna. I believe that not everyone who is a dental assistant holds a current CDA. In order to be accepted into this program, a dental assistant must hold a current CDA.

Being a dental hygienist, I have already taken a national board. I felt that taking the CDA to get into the DAII program was a bit redundant. A dental hygienist should be able to enter a DAII program and take the clinical

components to obtain DAII without obtaining CDA status. For dental assistants, the education requirements within the DAII program probably are necessary. Some components of the program are a review for dental hygienists. However, I found them to be a good review. The Virginia Board of Dentistry DAII requirement for didactic and laboratory training hours are necessary.

The clinical hours in a dental office under the direct and immediate supervision of a dentist, however, are difficult to track. For example, it is necessary to complete 120 hours of placement in shaping composite restorations. I feel having hours isn't very measurable. There is no guarantee that within those 120 hours that a student has experienced every class of restoration, such as class one, two, three, et cetera. Also, two clinicians won't perform at the same rate. For example, within one hour clinician A may complete six composites versus clinician B may only complete four. I think the change in the regulations from hours to number of clinical procedures completed should be something to consider. I suggest to the Virginia Board of Dentistry to reach out to the DAII program to decide the amount of procedures that students should complete.

The last point I want to touch on is creating a pathway for dental hygienists to perform these duties delegated to DAIIs. I think this will allow hygienists and

assistants to work together better and closer. Dental offices require teamwork. With the skill I have acquired as a dental hygienist and a DAII, I am able to review the patient's medical history, anesthetize the patient, a DDS will cup the wrap and I return to restore the tooth. I enjoy performing these duties and helping return my patients back to health. I also would like to add that both dental hygienists and DAIIs are regulated under two different boards. However, I feel like this DAII program can bridge the gap between the two professions, because they would be under the same regulatory guidelines.

That is all I have to say, and thank you for the opportunity for me to speak today and I hope you will consider my suggestions.

MS. SWAIN: Linda Wilkinson.

MS. WILKINSON: Good morning. My name is Linda Wilkinson. I hope you can hear me. I am a victim of Virginia's pollen, so hopefully you can hear me.

Good morning, again. My name is Linda Wilkinson, and it is a privilege and pleasure to be the CEO of the Virginia Association of Free and Charitable Clinics. We have sixty member clinics throughout the Commonwealth who serve adult uninsured patients, literally at or below 200 percent of the federal poverty level. To give you an idea of what that looks like, for a family of four, we are talking

about a family of four living at 100 percent of the federal poverty level, we are talking about an annual household income of a little over $24,000.

Free and Charitable Clinics provide uncompensated care, including preventive and chronic care for illnesses such as diabetes, COPD and hypertension. Our services include medical, pharmaceutical, behavioral and/or dental healthcare services. Last year our clinics served over 70,000 unduplicated patients, but only 15,000 of whom received dental care, despite the generous donation of time and talent of 462 volunteer dentists and 142 volunteer hygienists.

I am here today to encourage the Board of Dentistry to consider three simple things:

1.) When developing regulations, please consider Virginia's uninsured population who have very limited access to much needed dental services, despite their significant oral health issues which are complicated by chronic illnesses. I believe you have heard now from two, maybe even three, other speakers that there are 3.8 million residents in Virginia without dental coverage.

2.) Many of our volunteer dentists are retiring, and younger dentists are not replacing them at the same rate. Thus we encourage the Board to consider regulations that allow the greatest flexibility for all

dental providers, including dental hygienists, by expanding remote supervision models such as those that exist with the public health departments; and

3.) I would be remiss and not performing my functions as the CEO of this association if I did not invite every member to this distinguished panel to volunteer at one of our Free and Charitable Clinics.

Thank you, and I am very grateful for this opportunity to address you today, and thank you very much for what you do for the Commonwealth of Virginia.

MS. SWAIN: Tina Bailey.

MS. BAILEY: Hi. Good morning. I am Tina Bailey. I am the current president of the Virginia Dental Assistants' Association and a long-time dental care advocate. Through the dental assisting national board, I currently, and have held since 1982, my certification in dental assisting, and since 1986 my certificate in dental practice administration. I have worked in private practice at the VCU School of Dentistry, in both free clinic settings and in community outreach programs. Specifically, those programs, along with the Mission of Mercy projects through the VDA, I was fortunate to be involved with a program where we provided access and education to children.

Throughout my career I have had the honor of serving along with many other, numerous other, dental

professionals who share a passion for dentistry, and I just ask you -- today I am not here for me or for the other dental professionals – I am here to ask you to make it more accessible for those folks in the community who need that dental care, and just as you do that, I don't want to say make it easier for us to get to them, but make it easier for them to get to us and have us there in the community.

Thank you.

MS. SWAIN: Sharon Stull.

MS. STULL: Good morning. I am Sharon Stull, and I am coming to you by two organizations. One is Old Dominion University's School of Dental Hygiene, and two, Chesapeake Care, Inc., a charitable clinic in the Hampton Roads area. So I have made the ride up from Hampton Roads today with not too many issues, and I am probably, as all of you, very acutely aware of access needs in oral healthcare service, but I am probably one of the luckiest people in this room, I feel personally, because I teach students, our future oral health providers, that actually our classroom is out in community, and just this last year we have treated, and I have shared that document with you, in 2013/2014 my students at the School of Dental Hygiene have served the underserved, the vulnerable, the at-risk patients in our community with nearly 71,000 donated dental hygiene services. That is impactful, and that is about 6,600 individual. So that is an

enormous amount of data on that sheet.

That sheet also includes the ability that the students provide our community with oral health literacy, increasing that, which is a huge need. They are amazed by how low the oral health literacy is. I want to look at my teeth, and we always tell them look at your gums, they tell the story. I feel that we already have a perspective model in place in the Hampton Roads area. So I hope you would consider that expansion for the remote supervision under a remote dentist for dental hygienists, because we already have that model in place in the Hampton Roads area.

Our students go to seven of the safety net providers to provide clinical services, and then they go into the schools and provide oral health education. So they are making an impact on our community, and they are not licensed yet but they are wanting to be licensed, and it is really a frustration for me as a licensed dental hygienist over thirty years that I see and hear, after the students are in their classroom and learning the skills and the education needed to become a licensed dental hygienist in the State of Virginia, that they come back from their community-service learning experience and say: How do we solve this issue. They are confounded as well, as all of we are.

So I attempt to share, as Professor Flores shares, be political and advocate for your profession and

volunteer. That is such an asset to our community. We all need volunteers. Speaking of volunteering, I have been a member of Chesapeake Care, at the time free clinic, since 1991. I was a volunteer licensed dental hygienist. Since then, seven years now, I have been an executive board member and instrumental in helping the expansion of our dental clinic at Chesapeake Care, which is now called Hampton Roads Dental Center, and I was instrumental in getting the preceptorship program from VCU, bringing the dental students down there so our waitlist could go down at this clinic, and I also have my students go there and serve that public, and they are all at risk. Fifteen years, they have never been to the dentist.

I am imploring you to consider, not only for me when I advocate in the classroom and in community for my thirty-nine students that are graduating this May, next week, is that they, as future oral health providers, are able to not see their only employment opportunities as the private practice model but they see that Virginia has chosen to work in public health. Like Representative Commen said, a strong America has to be a well America.

Thank you for your time.

MS. SWAIN: Joyce Flores.

MS. FLORES: On behalf of the Old Dominion University faculty, staff, undergraduate and graduate

students, RDH candidates and licensees practicing in the Commonwealth, I would like to thank the Board of Dentistry for the opportunity to provide comment regarding strategies to increase access to dental treatment. I am a professor of research methods at Old Dominion, Ph.D. candidate, licensed RDH in three states for over twenty years, and I serve as liaison for the Virginia Dental Hygienists' Association to the Board for people with disabilities. I would like to, again, thank the Board for letting me comment.

We support policy change to expand options for dental hygienists to practice under the remote supervision of dentists in Virginia, after reviewing current evidence-based research on the topics of safe oral healthcare delivery, risk of harm posed by remote supervision collaborative care, less restrictive regulation of dental hygienists and effective outcomes of the statewide Virginia Department of Health Program.

Dental hygienists are providers of safe oral healthcare, regardless of level of supervision. Dental hygienists are educated on the delivery of safe patient care and risk management, guided by our high educational standards required by the American Dental Association's Commission on Dental Accreditation, or CODA. To complete licensure requirements to practice as a registered dental hygienist in Virginia, candidates must graduate from a dental hygiene

education program accredited by CODA and maintain these standards for the continuance of licensure, according to the Virginia Practice Act. The Commission on Dental Accreditation serves the oral healthcare needs of the public through the development and administration of standards that foster continuous quality improvement of dental and dental-related educational programs. In order for us to graduate our students, programs must demonstrate effectiveness in these six standards, which include institutional effectiveness; educational programs; administration, faculty and staff; educational support services; health and safety provisions; patient care services.

Specifically, the intention of standard five, health and safety, that provision is that all individuals who provide patient care or have contact with patients should follow all standards of risk management, thus ensuring a safe and healthy environment. All dental hygiene patients should receive appropriate care that assures their right as a patient is protected. Patients should be advised of their treatment needs and scope of care available at the facility and appropriately referred for procedures that cannot be provided. All individuals who provide care or have contact with patients should follow all standards of risk management, thus ensuring a safe and healthy environment.

Old Dominion University and all other institutions providing dental hygiene programs throughout Virginia must comply with those CODA standards in order for us to graduate students. In turn, only graduates of CODA accredited programs can obtain a license to practice dental hygiene in Virginia, in addition to everything else they go through, including passage of an eight-hour written national board examination and a hands-on clinical board examination. Dental hygiene is one of the only remaining health professions that requires the use of a human patient acquired by the student to demonstrate safe and effective dental treatment skills.

As demonstrated in the outcomes of the statewide Virginia Department of Health program, patient safety, risk or harm were not threatened nor resulted in the revocation, suspension or reprimand against the license of any registered dental hygienist practicing under the remote supervision program. All evidence of my references are provided. The program increased the number of patients seen by registered dental hygienists in Virginia and demonstrated the effect of least restrictive regulations.

Remote supervision for dental hygienists does not introduce harm to the citizens of Virginia. By not adopting policy changes, however, the current restrictive supervision of registered dental hygienists could be further

contributing to debilitating fatal disease rates, as stated in numerous published epidemiology studies, and as was referred in earlier testimony today. Retention of the dentition in advanced age, for example, extends the reach of oral and dental diseases into a life state in which professional oral care is critical, especially for those institutionalized in longterm care facilities and nursing homes. Aspiration of bacteria, colonizing on the teeth, calculus deposits and other oral tissues have been found to play a key role in pneumonia. Nursing home acquired pneumonia is the leading case of death in the nursing home population, and is the second most common infection in longterm care facilities, yet there is abundant documentation of inadequate provision of oral care among Virginia institutions.

Our current students want to have opportunities to practice in these kinds of settings, particularly, our bachelor's degree completion and graduate students who have demonstrated desire to seek extensive education in administrative leadership, professional development and research. However, they cannot clinically implement their advanced education due to restrictive practices in Virginia. Please don't let us lose these great providers of care to states with least restrictive supervision. Our citizens of Virginia need and deserve the safe care our students are

educated and skilled to provide.

Thank you for your time.

MS. SWAIN: Sarah Holland.

MS. HOLLAND: Good morning. I am Sarah Holland. I am with the Virginia Oral Health Coalition. The Coalition is a statewide nonprofit organization that works with partners from all parts of the state to integrate oral health into all aspects of healthcare, recognizing the connections between oral health and diabetes, potential connections with pre-term birth. Thank you for your time.

I am here today really just to reiterate the Coalition's position, which is based on our guiding principles. We have a twenty-three member legislative committee, as well as an eighteen member board of directors, which is how we funnel through our legislative positions, and we long stated our support for dental hygienists being able to work under remote supervision in safety net settings as a mechanism for improving access to particularly preventative services throughout the state of Virginia. We recognize that this is not the only path, or this particular path will not solve the problem. Other access options are needed in terms of increasing access to comprehensive dental benefits and other things like that for individuals in the state. We believe it is a good start.

MS. SWAIN: Thank you.

Before we continue with the discussion, I would like to give the Board members a ten-minute break. We will resume at 10:30.

NOTE: The forum stands in recess; whereupon it reconvenes as follows:

MS. SWAIN: We have time to discuss recommendations or questions. Please raise your hand to be recognized before speaking, and I invite you to speak through the microphone so everybody in the room can hear your. Please note that any policy action that the Board eventually decides to take will include the standard for comment, opportunities required for regulatory action and for advancing a legislative proposal. If you would like to notice a Board meeting and comment opportunities, please add your name and email address on the sign-up sheet outside the door. Thank you for the wealth of information provided.

Any questions ready now from anybody?

Dr. Gaskins.

DR. GASKINS: This question is for Dr. Crabtree and all. In speaking of the CDHC option, I would like to hear a little more. Is this group on the ground in the country at this point? What is the status, more specifically in Virginia, with this? Also, I noted that you made the

comment that this would be an unregulated basic procedure of basic entry level at this point. If it is unregulated, what would be your wish list or what is your concern and desire that this Board do, action or inaction, either way at this point? If you can comment on that a little further for us.

DR. CRABTREE: Well, the first question, where the status is across the country, New Mexico, I think Oklahoma and I believe Pennsylvania were the pilot states where they already have it. New Mexico is probably the strongest. Right now the ADA is giving presentations all over the country. Florida, I think, has been involved, and there is a list actually in the last ADA news, a list of several of the states that are actually moving ahead and going forward.

The regulatory levels, the wish list, I guess, is first of all we just think that we need to get people in to the care that they need to get, and the navigation piece, the social worker piece, the community health worker piece of the CDHC is going to be a very good start, and if we can get that going in the State of Virginia, have a community college to provide the educational component with the curriculum that has been developed, and then we have been working with the Eastern Shore right now to actually have a CDHC come in to show how it works within the system, to get these people navigated to the care they need to get.

At some time in the future, we would like to have a rollout of a discussion that will invite all interested parties to come in and talk about how that worked in Virginia, how does that fit into our system of rules and regs, but the big thing is that as a screening and health education thing, it is a like a dental front desk person crossed with a dental assistant type, with added skills as they go along. I think they are cross walking it on the educational piece, where they can become a dental assistant, just a basic dental assistant, and the curriculum, of course, includes the didactic portion of the radiation, which they can take the exam to get a radiation certificate.

So they would actually eventually within the curriculum be able to apply for that. So they could come out of their program when it is done with their CDHC certificate, which would also probably be a dental assisting one. We don't have any of those skill sets that are included with DAII, and then you have the ability to do the radiation. So it could actually be integrated very closely with an understanding of how a patient needs to get involved to see the dentist. To use the example of the gentleman that has the debilitating condition, he is in desperate need of someone to help him navigate the system, and that is really what the CDHC does. It really helps them to get to the care that they need.

Was there a third part to that question?

DR. GASKINS: Regulatory-wise, I am not hearing that there is any direct request–

DR. CRABTREE: None yet. I have already taken down the piece, but in the little arrow, what we are talking about is the basic certificate. The second level would take the same sort of regulatory action that you would have with the DAIIs. Now, I know you all are working closely to try to figure out a way to make that work. It, obviously, is broken and needs to be fixed, and I think the only speaker that actually spoke to it really, what needs to be done, is to address the regulatory requirements of getting those people placed and to show people how it can help relieve access to care, but there are certain skill sets that people have to have to be able to do that.

That is just regulated activity, the scaling of teeth, that stuff is regulated, hygiene and activities and things, dental office routines. Those would be down the road. There will be a lot of dialogue going on. It will be a totally different discussion, because you will probably have to have changes in the code. There will probably have to be code changes to authorize it, and then also you have to have, of course, regulatory things that follow that. So that is a whole bigger ball of wax, because it actually involves patient care, but that is where you will get some bigger bang

for your buck.

The next two levels in that, the social hygiene and the RDH program, the B.A. or B.S. program, they are basically equal, economically speaking. There is no distinction in the marketplace for those two degrees. Dental offices generally don't pay more for one or the other. It is basically the same, and it is reflective of the marketplace.

DR. LINK: If I could add one more thing, when we did our presentation over at the Eastern Shore, one of the things they realized is that the no-show rate will go down dramatically, because these people will be in those communities helping them understand what their problems are, and I think Dr. Crabtree hit it really well about social determinants. They don't understand. They are going to explain the issues to them in a language they understand. Then they are going to transport these people, find navigation to the offices, and before we even finished our presentation, they were on board one hundred percent to do a pilot program.

MS. SWAIN: Dr. Wyman.

DR. WYMAN: I would like to ask Dr. Crabtree, in Northern Virginia we obviously have an abundance of population. We also have a huge need. I cofounded and was president for ten years of the Northern Virginia Dental Clinic. We now have two facilities with nine dental chairs,

with well over two million dollars in dentistry. We don't have an access to care problem in Northern Virginia, but you do in your area. How would the coordinator model work in an area where there are very few dentists, where patients have to go many miles to get to the dentist, if we had any type of role model to refer these patients and identify some of their basic needs?

DR. CRABTREE: It has been reported to us that there are within the federally qualified retail centers across the state, like the Eastern Shore, they have very high no-show rates, very high rates where they are not being utilized. In other words, we have the resources there being paid for with no patients. So the goal is to have the folks in a very widespread region that come from that area to help people identify the resources. They can help them get where they are. They have transportation issues that they can coordinate.

In our area is the seniors. I think every locality has their own way of trying to help people get to their doctors' appointments and the social services departments and the others. So that person is a social worker type navigator and helps them navigate that to get to the places where they can actually receive care. There are a lot of social determinants that keep a lot of folks in the cities. Whether it is a language barrier, huge, that keeps

people from accessing care. This a way to help bridge that, and there is even interest within the private practices of having folks that are culturally competent helping people to get to the care that they need before they end up in the emergency room, because by the time you get to the emergency room, it is way past where it needs to be.

So you want to get them at the front end, so that you can get them in to see the hygienist, you can get them in to see the dentist if they are in pain or if they are abscessing, or the hospital if they need to go that far, but the goal is to constantly reduce the disease burden in the population before they get to the ED, and they will have an overall improvement in their health outlook. So it is starting at the individual level and having someone there as a resource that can help them, and we have discovered, especially with mothers of small children, once you kind of get the mom understanding what needs to be done, the first child may be the one who has had suffering and pain, but the second child she has figured out that the baby doesn't need to suffer the way the first one did, and then all of a sudden you turn around a family.

Someone there has to help them in their own understanding, in their own language, how to prevent the problems that they have, to get them once they are already in that situation to the care that they need, and also, some of

them haven't even applied for Medicaid and they need to do that. That is a very basic thing. The resource are there. Money is not an issue in some cases, but they are not accessing care because they don't think they have the money, but then their child is eligible for Medicaid and they just don't know that.

DR. LINK: One other thing I want to add, the reason we brought this before you today, because this was the only forum that the VDA could talk to the Board about access of care, so we felt like it was extremely important to tell y'all what the VDA is doing to help with access to care. This pilot program has been going on not even year, and the strives that we have encountered right now are huge, and I believe this is really the true answer to access to care and the most economical way to do it.

DR. WYMAN: The question is to everybody here. I certainly thank you all from coming. One of the keys to success in our clinic in Northern Virginia was the social service agencies in the area were trying to help us. They each have contracts with their respective social service agency. Those social service agencies are the only people that can refer patients to our clinic. They cannot come off the street. I cannot, as a president of the organization, cannot refer a patient. They have to go through the screen, and they all have to pay a nominal fee. I believe it is $35

per visit, plus any lab costs that we have. Some of those costs are subsidized by the agencies, but the system that was developed in conjunction with helping us sort of works as a coordinator at the same time, because the social service agencies perform most, if not all, of the coordinator functions, and the key was showing the local governments that they were getting a huge bang for their bucks, I think it was ten to one. As many of you have eloquently represented this morning, the cost of emergency care and the cost of continuing medical care, as a periodontist preaching to the choir in terms of diabetes and chronic inflammatory diseases.

So my question is, are there any of you here who have social service agencies that might be able to be coordinating a situation where we may be able to get both the ADA model and existing local service agencies and local governments, contributing very little if almost nothing, to existing clinics and unutilized chairs that are already there, as opposed to developing new regulations? The only thing we contacted the Board of Dentistry for twenty years ago is when you have, I think we have probably fifty or sixty volunteers per month, plus we have paid staff members, but how do you put sixty names on the front door of the clinic to comply with state law. Is there anybody here that has any suggestions in terms of social service agencies that are affiliated?

MS. SWAIN: Dr. Brown has a question.
DR. BROWN: I don't mean to interrupt your question, but I have a couple follow-up questions. Who would the dental health coordinator work for?
DR. CRABTREE: There is a list on the presentation of federally qualified community health centers. They could be in health departments. My dream would be to have one in every health department.
DR. BROWN: So those type of entities would be paying the salaries?
DR. CRABTREE: Yes, and there are different ways to go about doing that. For instance, in a community health center that has vacancies, they are very interested in filling those chairs. They get reimbursed. Just like in a dental office you don't really have a fee to charge for your receptionist and the people on down the line. The doctor generates the fee, and then the total cost of the program. So if you increase the profitability by decreasing the vacant chairs, then that pays for itself, if that makes sense. So that is why it is important to have the lowest cost individual that they can have. It is very difficult when you have a very expensive auxillary person versus someone who is less expensive.
DR. BROWN: My second question is, since you worked on this as a pilot, it requires developing curriculum.

So if everything goes well for you with the program you started, when could we see people trained to be coordinators?
DR. CRABTREE: Once the community college system has the curriculum, and they have to evaluate it, I don't really know how the educators do that, but I understand it is a cross walking of trying to determine how it overlays with the dental system program and things like that, they could kick it off very quickly, within a year, because it is just like a community health worker, a social worker type program. It is a certificate. There is a lower threshold. It is actually done through their workforce. The community colleges have degree programs, education programs, and they have workforce programs. So, like, if you want to have someone who is certified in Word, you can have a Word certificate that does that. If you want a dental assistant, you have a dental assistant program. It is already established in Virginia that you get your dental assisting certificate, and there are credentials that help the employers determine who has a basic level of didactic knowledge to be able to do what they need to do. The curriculum is developed by the American Dental Association and is licensed. So it is thoroughly there.
DR. BROWN: Thank you.
MS. SWAIN: Does anyone else in the audience have a specific question regarding this model?

Come up and speak at the microphone, and state your name, please.
MS. BRAD: Hi. I am Vicki Brad (phonetic), and I am a registered dental hygienist and a CDA, certified dental assistant, myself. My question is, I actually am a director of a dental assisting program, ECPI University in Virginia Beach. So I am trying to figure what is the difference between what you are proposing in your curriculum as to what a dental assistant already has. It just seems very similar.
DR. CRABTREE: It is cross walking. If we had a lot of time to go through this, but I cut this way back so that we could have some information, but the health promotion modules are probably a little more, so that reaction of they have that working with the departments of social services, the community mental health agencies and the nursing homes and all that type of health system stuff, is not really included.
MS. BRAD: Well, I am just speaking for my school, and I don't want to speak for someone else, but I know at my school we actually have a course called community health. So we actually have a certain amount of hours we have to volunteer at different facilities. So I do believe that is incorporated in most. I can't speak for any other school, but I do believe it is incorporated in some dental

assisting schools.
DR. CRABTREE: And that is why I was talking about the cross walking, how they match up. So there is going to be a social worker piece that you are not really getting, but then you will also have the dental assisting piece. It very likely they will have both, which will be a very marketable skill for someone graduating to have.
MS. BRAD: So the question is, you would become a dental assistant first and then be given an extra certification?
DR. CRABTREE: They cross walk a great deal. It would be great for a partnership. You would get people with a little more skill set and get more job opportunities, targeting the level of care, targeting the people in need.
MS. BRAD: In my personal opinion, I just believe that education is very important to give to the underserved, that it definitely needs to be someone educated.
DR. CRABTREE: When you talk about health education, dealing with that patient, in my office, I will tell you, my assistants are the ones that are doing a lot of that, in terms of health education, to help us get patients to understand what their needs are.
MS. BRAD: I agree. Thank you.
MS. SWAIN: I believe there was another hand raised.

State your name.
MS. BERARD: Cathy Berard, hygienist. I am curious how the CDHC, would it compliment how the hygienist would already work, because we have hygienists who can provide services and also educate in navigating the system and guiding patients to get the care with the doctors. So I am just curious how that would work. How would the procedures compliment each other?
DR. CRABTREE: It is an excellent question, because I think it is a part of the teamwork. If they are in the community and they are working with a family and they are trying to get them over to get the care that they need, well, if they are not having abscessed pain, where are they going to go first. You don't want to take someone who is highly skilled and carved out in the rules and regulations to the only person in the world that can scale teeth, other than this, because there is a huge economic value there. It shows up in the later statistics. There is an economic value to that. You don't want to take that person and have them doing and spending their time at a lower level of services.
So how they work as a team is what it is all about, and attacking disease, I like to call it declaring war on dental disease. That is the only way we are going to do it. So do those two things, and you are going to reduce your ED business. If you don't do that, you sit around and piddle

around the edges, you are going to have the same thing you have got for years. If we change that model and get a team that is going to focus in on the people that need care, get them to the care that they need, then you are going to make a difference, but until we get to that point, we are just kind of spinning our wheels left and right, and then money is always an issue, and I agree one hundred percent. Money is the issue.
They have cut Medicaid rates once again, the State of Virginia. How do you keep anything sustainable in this state when you continue to do what you don't need, decimating the public health department. When I came to Martinsville, we had three public health dentists. No program now. You expect to have a difference in your oral health outcomes, what can you expect. More dental disease in the community, that is what you are going to get, because you are not attacking the problem. We are all out here worrying about all this other stuff, and we need to declare war on dental disease and find the most cost effective way to do it, and we are providing an opportunity to do that in a way that is less of a burden on the population.
DR. LINK: If I may add one thing, I think the task force under Dr. Crabtree, he was also the chairman through the ADA that got to see the project through the ADA, I think it is this type of thinking outside the box that is

really going to help our dental access issues, and that is why the VDA firmly believes that this is the model that we should all be looking at.
MS. SWAIN: Are there other additional questions?
Ms. Barnes.
MS. BARNES: I am Sharon Barnes, a citizen member of the Virginia Board of Dentistry, and my question goes right to the heart of what you are saying about dollars. What kind of source can be utilized to help this issue? Even in Northern Virginia, we have some very diverse populations, diverse economic situations and some great needs, and I just wonder what kind of funding sources, because since we do not have Medicaid expansion and those things, and particularly nursing home facilities, longterm things. I have had people actually come to me and express the need that they can't get care for that patient who is no longer mobile. Are there different kinds of sources you are looking at in utilizing?
DR. CRABTREE: That is the billion dollar question, and in the State of Virginia Medicaid dollars are available from the federal government and they are given back to the state to provide the dental care required by law. Now, what happens in Virginia, unfortunately, is that you talk about Medicaid expansion, they are cutting the reimbursement rates that they have today. So if you expand

it, then you are going to actually spread the resources even thinner, to the point where you are not going to have anybody taken care of, because it is to the point now that they haven't been doing anything in seven years or more. It is getting to the point now where it becomes charitable care, and in the business model it is the government.
In a business model a doctor will do it, as long as he is able to at least break even. When he has to start subsidizing because the reimbursement rates are so low, it ends, because if you don't, you end up bankrupt. Doing something for free in business, you can only do so much, so you are going to decrease even more that settlement. If you expand it to an even greater number, you have given a greater number of people there, but you are not even taking care of the ones at the bottom, and even hurting them more because you are spreading it so thin.
Let's step up to the plate and fund it. States would have to do that. The federal government would have to do that, and I wish we could figure it out. To do the expansion, you have got to tie it to increasing funding. So if you are going to double the number of people that can do it, which is you raise those rates, it will actually more than double the people because of the curve, and then you are going to have to increase the funds just to keep it where it is. So I think the possibilities, if you are going to

improve the oral health, you need to target the people who need it the most, and we need to look at how we are spending our money. This is a totally different discussion, and I will get off that, but you have to look at how we are spending our Medicaid dollars also.

MS. SWAIN: Any other questions?

Speak to the mike and state your name.

MS. FLORES: Joyce Flores. I have a couple of statements, just to remind everyone to make sure we are on the same page, and then a question for you. In regard to the level of reimbursement rates and the acceptable decision to take in lower reimbursement rates, it would only be able to be made by the dentist, because currently the restricted practice of dental hygienists in Virginia doesn't allow dental hygienists, even when we want to, it doesn't allow us to make the decision to see the Medicaid recipients, and that is very problematic, because so many dental hygienists in the State of Virginia want to see that population and we are not able to. We are not able to even see them in the same practice where Monday through Thursday perhaps we see traditional private practice payment, and if the practice is open on Friday, we are not even able to see Medicaid patients. They are in need, and we can't because of restricted practice. We can't even have a decision to say we want to see them.

And in regard to economic value, that cost traditionally in the private practice model for services, dental hygienists in the State of Virginia have never had the chance to say what we would want to charge for service. We have never had that chance, and we would love that chance. Maybe we don't want the same charges that would be the fees for services in the private practice model. If we are able to go into the community and do what we do best, maybe we don't want those same salaries, but we have never been asked. We have never had the opportunity to go outside of the private practice model.

When my students get ready to graduate, after having gone through with Ms. Stull and into the community, they are able to see the needs, but it is disheartening when I have to tell them: Your only employment options are in a private practice model, because you are restricted to practice in certain settings. It is restrictive, and they are not able to see the people most in need. So I am not sure why we would want to use a reduced educational model when we already have an existing provider who is able, willing, ready, licensed and capable of providing services. We just don't have the chance.

So my question to you for the CDHC program is, how inter-orally would disease be treated by the CDHC to treat the disease that we have problems with in the State of Virginia?

DR. CRABTREE: That would be under licensed activity, and that would be something that if you really like for the CDHC to take it to the next level, that would be a discussion for level advanced. If you did that, then you would actually do some more treatment sort of things, how they did things. So we have agreed that a lot of people would like to treat them to serve. The dentists would like to see treatment to serve. It is not economically feasible. It is very expensive procedures to do, just the set up of the operatories, the turnover of the operatories, and it becomes a certain level based on the cost, no matter who is doing the care, and of course, to have all of the freedoms that were mentioned there would be an independent practice, and that is certainly a totally different discussion.

In an independent practice model, which gives you total freedom and flexibility, and in the case of Colorado which had granted that, has proven the studies show that economically the cost structure is not enough with Medicaid reimbursements to even sustain them, so they end up being placed in communities that are not in the highest areas of need, and there is a study for that, and I don't think that is what you all want to talk about.

MS. MCGREGOR: I have a question and comment, I guess more of a statement.

MS. SWAIN: Name.

MS. MCGREGOR: I am sorry. Michelle McGregor, Virginia Commonwealth University. I feel like we went a little off tangent. I think the CDHC is a great idea. If there is room for that and there is a need and they are going to serve as a social worker and bring more patients into care for the dental hygienist and the dentists, who are really the only two providers that are providing actual care and treatment, I think that is great. My understanding is the purpose of this forum, though, was to discuss the three concepts that were listed for the dental assistants and the remote supervision expansion. There are other models that could have been discussed today besides the CDHC. There are a lot of models that other states are using that are addressing access to care issues, but I don't think that was the purpose of this, but I do think the CDHC, there may be a place for that, and I think that is great.

One other comment going back to economic feasibility, because that seems to be what we are all talking about, I am having trouble understanding why using the remote supervision dental hygienist is not economically feasible. So if I am working for Dr. Link, let's say, but I go to a nursing home one day a week where there are patients that need care, there is not a dentist there, I am still working under the supervision of Dr. Link, I am providing care for

these patients, I will segway those patients to his office if they need more treatment, and he is still getting the income from me seeing those patients. I get calls every day from patients in a nursing home that have insurance. They are not all Medicaid patients. They are just not getting the care because there is nobody there. I know remote supervision doesn't solve the entire issue, but the fact that we have this model in place and you already have the statistics and the evidence showing what it has done, to move that forward is such a great thing, to have people in collaborative agreements, and I know it won't maybe hit all the rural areas, but there is a lot of need right here in our backyards that isn't being addressed, and if we were working collaboratively with a dentist, I think that would be addressed, and that is economically feasible. Thank you.

MS. SWAIN: Are there any other questions regarding this?

MS. MOORE: I have a question. I just wanted to ask if you could tell me the difference between independent practice and remote supervision, because remote supervision is what we were discussing. We weren't discussing anything about independent practice.

DR. CRABTREE: I am sorry. I thought you were talking about the choice to practice and choose reimbursement. I misunderstood that.

MS. SWAIN: I understand there is room for debate on this subject, but we just want to get to the point.

DR. CRABTREE: Exactly. What I heard was different.

MS. SWAIN: Are there any other comments?

Moving on, are there any other questions outside of the CDHC from anybody in the room?

Dr. Gaskins.

DR. GASKINS: I haven't heard anyone directly address the expanded duties part for RDH. I am hearing a lot about remote supervision, given existing duties at this point without regulations. Dr. Crabtree is talking about varying levels of mid-care providers and low-end providers, if you will, and the high-end providers. Taking the other segment of this, if restorative procedures are eventually an outcome for RDHs, since we have got different institutional folks here arguing institutional things, I believe Old Dominion is the only school that has a master's level of training, how does the community feel about changing the curriculum in order to affect producing these expanded duties? We have to go from where we are now to there, and then the marketplace may take care of some of that. Would anybody just like to expand that for me and for the Board?

MS. BERARD: Cathy Berard. Cathy may be the older hygienist in the room. I was actually trained at the

University of Michigan. We had education on placing out. That is all they had then. We learned it then, and I know that it was even taught most recently at VCU. We did have education in placing restorative materials. I would defer to the educators, but I know that hygienists already exist who know how to do that, because that was included in our original education.

DR. GASKINS: Besides the anecdotal side, every time you do a restorative procedure, periodontal, whatever, how does that fit in your thinking?

MS. BERARD: I will just speak for my practice, my group practice, that even with a large group practice I still have open-chair time. I had a cancellation and had two hours open yesterday. So I got to see the dentist swipe, and I had an hour with no patient in my chair. So that even happens in private practice, not just in federally qualified healthcare or free clinics. That is still going to happen.

DR. GASKINS: What about changing the curriculum?

MS. BERARD: That part I will defer to the educators.

MS. MCGREGOR: I will be brief. Michelle, VCU. Our curriculum already contains all that. We have students graduating with all skill sets, pretty much a DAII for the most part, maybe not the amount of hours that is required for

the DAII program, but our students, legally they cannot do those things in this state, but it is a skill set that they have. So that would not be something that is difficult to change, if that is the wishes of the Commonwealth to expand the duties of our RDHs and expanding their skill set, or what is legally permissible in the State of Virginia. I think more immediately we were looking at expanding our settings, because I can provide those services right now. So to be able to go to work in remote supervision, those services are being met. What you are talking about is a completely different avenue of providing more care, and Kara Sprouse, who spoke earlier, she is a dental hygienist and her employer did want her to have the skill sets to do the DAII, because they wanted her to do both things in the office, even though she is still employed as a hygienist, but the curriculum does have these items. That is already there.

DR. BROWN: Is that because your curriculum prepares dental hygienists to be able to practice in other states which have a broader scope?

MS. MCGREGOR: Absolutely, and we wouldn't be doing our duty if we didn't prepare our students for the evolving trends that are happening across the nation. So that is our duty as educators.

MS. SWAIN: Dr. Watkins.

DR. WATKINS: I will ask you, and maybe I will

ask Kara, the dental hygienist that has the DAII, how does that work in a practice model? Because why would a dentist want to have a dental hygienist do both of those things. I heard somebody say something about having an hour of freedom. Well, dentists get cancellations, too. You have an hour free, and there are other things you can be doing, but having these restorative duties, the six things which are indicated, which I wanted to ask, are you qualified for all six?

MS. SPROUSE: No. I am qualified in two of them, composite restorations and the final crown.

DR. WATKINS: So in the whole scheme of a practice model, where would that come into play, and why would I want a dental hygienist to help? I just want to see in the scheme of a practice model how that would work.

MS. SPROUSE: Well, I work for a solo dentist. We have three chairs. We have a hygiene operatory and two for the dentist to work. Sometimes when my schedule frees up, say for a cancellation or a no show, and my dentist has two patients in the chairs and each are doing composites or crowns, he can sit down and prep the two for composites. Then when he is done, he will get up and walk to the next patient and I can sit down and go ahead and place that composite, finish and polish it.

DR. WATKINS: But it is because you had a no show.

MS. SPROUSE: And also on days that my schedule is free, I also assist my dentist. So I do a little bit of everything in my office.

MS. MCGREGOR: I would think that you would want somebody. A dental hygienist is going to primarily do dental hygiene procedures. I think we can't all do everything, just like you don't want me drilling teeth and hygienists supposedly don't want assistants scaling. I mean, everybody has their little territory of what they do, but I think we kind of work to our full scope. So I think every practitioner should do what they do, to the full extent of what they can do legally in that state. I can tell you when I lived in New York and I did have a broader scope of practice of what I could do, and I worked in a very large practice with three dentists, several hygienists, several assistants, and legally I could do some procedures that I cannot do in the State of Virginia. Primarily, ninety percent of my job was working as a dental hygienist, but we worked as a team, so everybody was able to pitch in. So the fact that I did have some of these other skill sets, I could pitch in. It usually wasn't because of cancellations. It was just because we were all working together to help do the best thing for our patients and the productivity of the office.

MS. SWAIN: Yes, ma'am.

MS. BRAD: Vicki Brad, ECPI University. I have so much to say, but I get so nervous. I believe that the short term for the DAII, hygiene would be the quickest way to get more DAIIs in the State of Virginia, obviously. Also, the second thing I believe is that if we created a DAII in Virginia, which is wonderful, but we are having a hard time in getting them, so I believe that if we increase the education of a DAI to be a CDA, very, very quickly would the DAII be filled in the State of Virginia.

There are so many dental assisting schools, every corner, four weeks, four months, six weeks, that sort of thing. When we started our school six years ago in Virginia Beach, we asked the advisory board, dentists in the area, what do you want different about your dental assistant, and they said more educated, more knowledgable. So that is what we are trying to do, but I truly, in the State of Virginia, if the DAI was required to be a CDA, because that is the issue of getting the requirements for the DAII, we only have, I believe it was three dental schools in the area, and now there is one more, so there are four in the State of Virginia that are CODA accredited, that you can get your CDA right after graduation. Otherwise, you have to work for two years or 3,500 hours to get your CDA.

So the majority, I don't know the statistics, but the majority of all the dental assistants working in the

State of Virginia are not CDA, because they are not required to be. The dental assisting schools in Virginia do not require their students to get the CDA either, because it is not a requirement in the State of Virginia. CDA is CODA accredited, which would make the programs, the standards higher, and the curriculum should be included in the CDA program for the DAII. Thank you.

DR. WATKINS: But the CDA is required for the DAII, so the idea behind the process was that first you got the CDA and then you become a dental assistant two. So it would seem that schools that are accredited would be pushing them to do the CDA so that they can approach the DAII. So I don't understand. It seems like what you are saying is actually the way it is supposed to work. The idea behind this process, even when it was first initiated, was first there would be a CDA. Then maybe more schools would come on and produce more CDAs, and then they would have more DAIIs, or so the structure seemed to be. Now, we only have eight. Something is wrong in the process from CDA to DAII. Not that we wouldn't want to have more CDAs, believe me. The whole process was meant to have more CDAs.

MS. BRAD: Exactly. I will tell you, the CDA is a very difficult exam to take if you have not gone to school and been educated. It is very, very difficult. As a matter of fact, I am actually helping five dental assistants

in the area, we just started a week ago, and helping them to review for the CDA, because they have never gone to an education facility. They have been working in the field for ten or fifteen years, and they do want to apply for the CDA -- I'm sorry, for the DAII. So the first process would be to get a CDA, but they are not educated. Radiology, health and safety, infection control, dental materials, it is a lot, and they don't have the education. They don't have the hands-on experience. But to become a CDA is not as easy as you think that it is, but there are a lot of dental assistants in the area, in Virginia, that do want that but are hesitant to get that CDA. So what you said is exactly right.

So, if the schools were required, if the State of Virginia required a dentist assistant one to be a CDA, there would be no issues, but they are not required. A dental assistant doesn't have to have -- we all know this -- a dental assistant doesn't have to have education or any regulations. The only thing they have to have is the radiation/health and safety certification, which they can get in a day and a half. So if the requirements for a DAI were increased, then I think that issue would very quickly be taken care of for the DAII.

MS. SWAIN: Thank you.

I believe there was a question.

MS. JOHNSON-GRAY: Hello. My name is Yolanda

Johnson-Gray. I am the program director of the dental assisting program at Fortis College, and I have five DAIIs out there working as DAII certifications, and I just wanted to say that as far as the CDA component that she is speaking of, no, there is no requirement of the State of Virginia. However, as a certified dental assisting program under CODA, for my program my students are required to sit for all components of the CDA, so that when they graduate they are CDA certified, and I feel, as the program director and a certified dental assistant myself, it is my job to educate my students about that certification and let them know that even though it is not required they should do it.

So we do have them sit, and if you look at the stats for how many CDAs are in the State of Virginia, maybe two years ago and the stats now, it is probably twenty to thirty percent different, and every CDA out there that is certified now comes out of my program. So I think the education and knowledge, and I agree with my other program director, that there are no requirements, but we, as a certified dental assistant association or group, have to actually push that for ourselves.

Can I address the model? I see the model differently. I see the model as we have a DAII to assist the dentist. We have a hygienist to do her or his part in the dental office. The DAII assistant is there to also help the

dentist, also as a producer in the office as well. If there is a schedule befitting and the dentist would be able to see more patients, then the DAII can step into that role of being able to help be a producer in the office. I am not taking anything away from the hygienist component, but I feel that the DAII was made for the dental assistant. The dental assistant should be allowed to practice that. Yes, right now we don't have enough dental assistants able to sit in a DAII class, but we need to work toward that. We need to make dental assistants aware that they can sit for the CDA, educate them and have them become DAIIs. That is a work in progress. That is not something that is going to happen overnight. It is something that I am passionate about and something that I am working toward. So that is all I have.

MS. SWAIN: I do have a question. You indicated your graduates are CDA certified?

MS. JOHNSON-GRAY: Yes, they are.

MS. SWAIN: How many of those graduates indicate to you their interest in pursuing a DAII certification?

MS. JOHNSON-GRAY: Pretty much all of them.

MS. SWAIN: But it doesn't reflect the numbers we are getting.

MS. JOHNSON-GRAY: Well, the problem is the clinical portion component of the DAII, because pretty much

they have to work 300 hours if you total every component that they need to get. So it also falls back on the dentist's side of it. They also have to find a dentist to support them in that to be able to do eighty hours of composites and be able to be right there and direct and attest that they have done those hours. Not every dentist is willing to do that.

MS. SWAIN: Is that a barrier?

MS. JOHNSON-GRAY: That is a big barrier, yes. It is not that we don't have dental assistants who want to do it. The barrier becomes, I can teach them all day long the didactic component, even the laboratory component; however, when you have to do your clinical hours, you have to find a dentist to support you in that. That is the biggest barrier. It is not even that we don't have enough CDAs. We can get the CDAs certified. We need the dentists and the support of being able to provide the clinical aspect of it.

MS. SWAIN: Thank you.

DR. WATKINS: How many per class?

MS. JOHNSON-GRAY: We have had five graduate.

DR. WATKINS: So your class is usually about?

MS. JOHNSON-GRAY: It is usually between five and six, yes.

MS. SWAIN: And that is the cycle every six months?

MS. JOHNSON-GRAY: No, because the DAII program

is twenty-two months long, so it is only maybe twice a year.

MS. SWAIN: Thank you.

Any other questions or comments?

Let's go back to Dr. Wyman's question.

DR. WYMAN: In reference to social service agencies throughout the state, given the Northern Virginia model as one where we utilize social service agencies, they act as coordinators as well as screeners, because the key percentage of what we do is as volunteers, and the last thing you want is a volunteer thinking that they are giving their time for a patient who is trying to take advantage of the system and not pay, or pay very little, are there any social service agencies that you work with in your areas of the state that could be utilized to facilitate more under-privileged patients into existing clinics or private practices that are willing to treat them pro bono?

MS. SPROUSE: Dr. Berard might could help me with this, but in Suffolk they have what is called an oral health navigator. Have you heard of that? She is a navigator, that they have a grant, and she actually reaches out to the community and does exactly what you just asked, but she is funded through a grant, and from what I hear she is doing really great things and getting people into all of the clinics that they have in the Suffolk area, Emporia, Franklin, and she is called an oral health navigator.

DR. WYMAN: A huge percentage of our budget, well over fifty percent, is from foundations and other private sources, including members of the dental society, and also to address Ms. Flores' comment about access to hygienists contributing, we have actively tried to get additional hygienists to volunteer in the clinic for years. There is a core group of hygienists who are volunteering very often, but proportionate to the number of dentists in the area, the hygiene participation is extraordinarily lower than the dentists' participation, and there are some things, socioeconomic factors, involved in that, but there are absences, and I am sure many of the other facilities in the state that have volunteer clinics also would like to have hygienist volunteers in their facilities.

MS. SWAIN: Ma'am, do you want to come up to the microphone, and state your name, please.

DR. BERNHARD: Dr. Elizabeth Bernhard, from the Western Tidewater Health District. I am a public health dentist, and I have been in the system for forty years. So I went all the way back to Joe Dougherty (phonetic), who used to have hygienists go out first, and they assessed all the kids in the school, and then the dentists would come in their dental van to do the procedures that they needed. So I think we are kind of going back in time. I do support the hygiene program that the Health Department currently has. I think it

is a great way for the children to get preventative services. There are other services that need to be provided for the adults, as has already been spoken about, but there is still that group between twenty-two and fifty-five that need to be treated, and I think the community health centers are certainly the avenue for that.

Getting back to what Becky said, we are in a unique situation down in the Tidewater area, that we have what I would consider to be first the first navigator in the state. This woman works with the access partnership program, and this has been a coalition of programs that have been working for years to get something started. We finally have that. They are funded by different healthcare foundations. The navigator is a person who has an MPH, and she is not a dental person or a medical person at all, but she came into the position and immediately her task was to start to get to know the dentists in the area to find out who was there, to get to know who was in charge of the community health centers, and it was kind of like she was just kind of dropped out of nowhere and then had her task to do.

She has done a wonderful job of getting to know people, and through her connections she has been able to help people get out of emergency rooms and into the dental practice, because frequently people go to the emergency room and then they don't have any place else to go. They just go,

okay, now, what do we do now. So they have put people into a couple of the emergency rooms that will connect the person that comes in with a toothache or an infection, connect them to the navigator. She, in turn, does the eligibility determination, and then she can send them to a place where they can get some assistance within a week or so, because frequently it is like here is your antibiotics, here is your pain medicine, go ahead and go to the dentist, but they don't know where to go. So that is why this thing has worked out really well.

Through access partnership they have also developed a voucher program, which enables the person to go a dentist and the dentist is allowed to get paid. So I think that works out really well, but I think that the coordination of where to find services, which dentists are going to do what, is really important in the access issue, but this is treating, I think, the nineteen to fifty-five population that is in great need. The seniors, I think that the remote supervision would be a great idea for getting them taken care of, and with the children, the public health programs, we would go around all those years and see the kids and do the prevention, and at one time we had eighty-five different public health dentists. Now, we have dwindled down to three, and three of us are going to be gone at the end of the year.

But consistency, being there every year, I have

been in Western Tidewater for about twenty years now, and we go to the schools and the children are in great shape. We have been putting sealants on and doing prevention, but once they get out of the grade school levels, then they are kind of off on their own. So I think that a coordinator for the area would be a great thing, whether it is going to be a hygienist or dental assistant, but I think it would be something that would be very important to have.

Thank you.

MS. SWAIN: Any other questions?

Ma'am, yes. Speak through the microphone.

MS. LEE: My name is Jennifer Lee. I am the deputy secretary of health and human resources, and as you begin to close out this forum, I just want to make a couple of quick comments.

So, first of all, on behalf of Secretary Hazel and the Governor's office, I just wanted to thank the whole Board for having this special forum today to look at strategies to enhance access to dental treatment. I am an emergency physician and a free clinic volunteer myself, and I have seen, myself, in my own practice what happens when people don't get access to dental care. I have seen simple dental infections turn into critically complex facial abscesses where patients needed to be admitted and have surgery, get IV antibiotics, and those patients aren't

insured. So, of course, it is not great for the patient, and it is not good for the whole system, because we are all paying for that in the end.

I have also been a volunteer at the RAM clinic last year. I saw thousands of people line up, sleep in their cars overnight to get access to dental treatment. I volunteered in a medical tent down in Wise County, and a lot of patients who I saw down there came and said I need to get my blood pleasure under control so I can be seen by the dentist today. So, to me, it was very striking how urgent and how intense the need is for dental care, for dental treatment, especially in the southwest and rural parts of the state.

So, again, first of all, I just wanted to say thank you for addressing this head-on and for looking for creative strategies to enhance access to treatment. It is something that is very important to us as an administration. We saw it in our Health Virginia Plan, in the fact that we added access to dental care for pregnant moms, for pregnant women, in Famous Moms in the Medicaid program, and we are looking for other ways to do that as well.

So I just ask that you consider the scope of the problem, the urgent need. It is really a crisis situation at this point, and I think whatever you decide to do as you deliberate, or whatever you recommend, that you

really think about the patients that need, and I think the one thing we can't do is nothing. So, again, we just appreciate you taking action, considering various strategies carefully and deliberately, and looking at the data as well to see what the best way forward is.

Thank you.

MS. SWAIN: Thank you.

Any other comments or questions?

Well, as you know, this is obviously an important issue, and it is a matter that we all are passionate about, providing access to care. So I thank you for your time and all the wealth of information that you provided today, and this concludes our forum.

Thank you.

CERTIFICATE OF COURT REPORTER

I, Mary F. Treta, certify that I was the court reporter at the Virginia Department of Health Professions for the Open Forum before the Board of Dentistry on May 8, 2015, at the time of the hearing herein.

I further certify that the foregoing transcript is a true and accurate record of the statements and other incidents taken during the hearing herein, to the best of my ability.

Given under my hand this 19th day of May, 2015.

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Mary F. Treta