APPROVED MINUTES

VIRGINIA BOARD OF DENTISTRY
OPEN FORUM ON
POLICY STRATEGIES TO ADDRESS TELEDENTISTRY

Friday, August 14, 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 9:00 a.m. to receive views on the need for policies on the use of teledentistry in Virginia.
PRESIDING:	Melanie C. Swain, R.D.H., President
MEMBERS PRESENT:	John M. Alexander, D.D.S. Charles E. Gaskins, III., D.D.S. Tammy K. Swecker, R.D.H. James D. Watkins, D.D.S.
STAFF PRESENT:	Sandra K. Reen, Executive Director Kelley W. Palmatier, Deputy Director Huong Vu, Operations Manager
OTHERS PRESENT:	David E. Brown, D.C., DHP Director
COURT REPORTER:	Earlina King, Court Reporter, Crane-Snead & Associates, Inc.
QUORUM:	Not required.
FORUM COMMENTS:	**Antoinett Kahan, RDH**, Dental Assisting Program Director at Virginia Beach Technical & Career Education Center and President of the Oral Health Improvement Coalition of South Hampton Roads, stated that teledentistry is used on dental access days to give patients their x-rays. She said Emergency Departments (ED) should do this to reduce the number of subsequent ED visits and added that the equipment needed to do this is a NOMAD handheld x-ray unit, digital sensors, laptop, and intraoral camera. She suggested that x-ray technicians should be certified to take dental x-rays, ED physicians should be allowed to approve dental x-rays, and that the telemedicine protocol for the Health Insurance Portability and Accountability Act (HIPAA) should be followed. She asked the Board to amend regulation 18 VAC 60-20-195 to address her recommendations.

Susan Reid Carr, RDH, Virginia Dental Hygienists' Association (VDHA), said that VDHA supports all delivery models of oral health care services which are safe and cost-effective. She said the concepts for teledentistry which VDHA supports are:

- A dentist-patient relationship should be established through an in-person visit to a dentist to establish a dental home, and
- Use of the HIPPA approved communications equipment.

She noted that the initial investment in equipment would improve access and reduce travel costs for patients.

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 said that teledentistry would allow greater flexibility in expanding access to dental care to all parts of Virginia.

David Sarrett, DDS, Dean of VCU School of Dentistry, said the School uses teledentistry for education and research purposes as well as patient treatment. He asked the Board to allow for these uses in any policy action.

Benita Miller, DDS, Virginia Dental Association (VDA), said that the VDA supports a collaborative pilot project for teledentistry with a Community Dental Health Coordinator (CDHC) as a vital part.

Nicole Pugar read written comment from Sarah Bedard Holland, Executive Director of Virginia Oral Health Coalition (VaOHC). Ms. Holland reported that VaOHC is in support of teledentistry and has convened a teledentistry workgroup which determined that "Store and Forward" teledentistry might be an effective way to increase access. She explained that "Store and Forward" may:

- Create more efficiency in the delivery of health care;
- Reduce transportation burden for families; and
- Result in cost savings to the state for Medicaid patients.

She stated that VaOHC recommends that the Board's policies mirror existing telemedicine protocols on a dentist-patient relationship, communications and equipment requirements.

Ms. Swain opened the floor for questions and discussion.

Dr. Adam Wyatt, DDS, Health Services for the Virginia Department of

Corrections (VADOC), explained that VADOC uses telemedicine for inmates. Based on his experience, he recommends policies for:

- A point of accountability in organizations using teledentistry;
- Camera and Monitor Resolution requirements to prevent misdiagnosis;
- acceptable networks for secure transmission of records;
- completing a comprehensive examination with an Intra-Oral camera;
- time-frames for physical exams and oral cancer screenings;
- procedures permitted using teledentistry guidance; and
- teledentistry guidelines for dental education programs.

Discussion followed about billing codes for teledentistry, the need to train ED doctors and nurses to evaluate dental conditions, the work of national organizations, the availability of dental hygienists and using the Board of Medicine's policies as the model for teledentistry in Virginia.

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 10:21 a.m.

Melanie C. Swain, President | Sandra K. Reen, Executive Director

Date | Date

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF HEALTH PROFESSIONS

FORUM FOR THE BOARD OF DENTISTRY

Complete transcript of the Forum in the above-styled matter, when heard on the 14th day of August, 2015.

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PROCEEDING

MS. SWAIN: This is a opem forum to receive your views on policy strategies to address the use of the College of Dentistry of Virginia. Thank you for your participation. 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 as they appear on the sign-up sheet. Each presentation will be timed and will be limited to ten minutes. Speakers will be notified when they have reached the nine minutes so that they may conclude in the allotted time. The forum will close at noon. If time permits, following the presentation attendees will be asked to participate in a question and answer session to allow for explanation and discussion of the recommendations.

At this time, I will call on persons who have signed up to present. As I call your name, please come forward and speak into the microphone. Start by telling us your name and where you're from and if you're presenting an institutional organization.

Let's start with, it looks like Antwanette Kahan.

MS. KAHAN: Good morning, ladies and gentlemen, colleagues, distinguished members of the board. My name is Antwanette Kahan. I've been a Registered Dental

Hygienist in the great Commonwealth of Virginia for over 30 years. I am the Dental Assisting Program Director for the Virginia Beach Technical Career Education Center and the Standing President of the Oral Health Improvement Coalition of South Hampton Roads. As Program Director, I'm in an extremely fortunate position. The Virginia Beach Public City Schools is more than generous when it comes to providing me with state of the art technology to insure my students leave my two-year, 180 hour curriculum with knowledge and skills required to ensure success in subsequent dental employment or continuing with their education at the community college or university level.

While working the coalition to provide access to the area's steadily underserved, we often use tele-dentistry as a tool to link patient with provider. Our dental access days that we do two times a year had filled a peri preprocessor and that took forever. The City of Virginia Beach gave me a nomad to show my students how to use a wireless x-ray unit. We took that instead, and the taking of the x-rays went faster, but once I got sensors and a dedicated laptop, it went even faster. Taking the digital x-rays and emailing them to the patient, the patient was able to keep the image on their personal device for future use at any dental health facility or another outreach. This capability lit up a spark.

How can we use this technology to serve the public at large? I'm sure you all read the cover story in the Journal of the American Dental Association regarding the Trends in Emergency Department to Fake Visits. The research is overwhelming that something must be done to curtail the costly exsurgents that jam up the emergency departments and confound the medical staff. I think down here it says it's doubled from 2014 the number of people that have gone to the emergency room have doubled in that time. A lot of our patients that we see at our dental access days -- we did a survey, and those students did a survey there; and over half of them said that they have used the emergency room as their dental care provider.

I won't use up most of the time here with redundancy so I'll get right to the point of how Tele-Dentistry can reduce the economic imperative facing emergency room departments with a positive inadvertent component. The equipment required and how it works: You'll need a nomad hand-held unit which is quite expensive but if my public education class can have one, then I can send -- for them. The digital sensors, size one and two, were recommended -- the -- sleeves, a dedicated laptop, an inter-oral camera and then a dental emergency referral service.

So here's your scenario: Dental patients'

1 usually after hours enter the emergency department with oral
2 pain. Interviewer reveals that the patient has been okay
3 for sometime and lacks access to dental care. Perhaps
4 they've tried, unsuccessfully, home remedies. A cursory
5 exam reveals a swollen gum rapid --. The x-ray technician
6 takes a picture of the affected area and emails it to the
7 dentist on call. The doctor, via cell phone, Face Time,
8 Skype, discusses options or referrals with the patient and
9 the emergency room doctor. By the way, should the on-call
10 dentist's finding indicate the need for a medical evaluation
11 due to the oral manifestation that are systemic in nature,
12 not dental, early intervention may save someone's life in
13 the case of leukemia, throat cancer, or osteonecrosis.
14 So the initial obstacles that we can foresee
15 are three: Compliance with 18 VAC 60-20-195 Radiation
16 Certification, the x-ray tech process certification as
17 described in the mentioned regulations right now. There are
18 three ways in which they can do them. They can take the
19 Danby Course. They can take Early View, -- View, at one of
20 the community colleges that offer these courses, or in --
21 radiation, health and safety is built into the X-Ray Tech
22 curriculum as it was with anesthesia dental hygiene.
23 Number two, Compliance with 18 AC 60-20-210
24 Requirements for Directive General Supervision. The
25 emergency room, as it stands, cannot give the okay to take a

1 dental x-ray, so the emergency room doctor calls a dental on
2 call and the doctor can okay it remotely to send an
3 inter-oral picture of the offending tooth, then receives
4 directive for x-ray for the certified x-ray tech to take the
5 x-ray. The second part is the dental board can amend the
6 current regulations to allow, in limited settings such as
7 emergency departments, that emergency room physicians can
8 approve the dental x-ray.
9 Number three is the HIPPA confidentiality.
10 That I minimized to just say see the medical ethics
11 regarding telemedicine because that's what they're already
12 doing.
13 In April, 2015, -- dentistry, Dr. Bruce
14 Donoff, DDS MD, Dean of the Public of School of Dental
15 Medicine writes of his vision to transform dentistry by
16 removing the distinction between oral and systemic health.
17 His persuasive article, The Economic Reform of Poor Health,
18 identifies care as a goal, and states achieving that goal
19 requires a cultural change. The caring medical personnel in
20 the emergency departments would like to be able to offer
21 better treatment to those who seek them out to rid them of
22 their pain and suffering. Yet, they cannot help because so
23 many feel that they are at sea regarding dental treatment.
24 A recent survey found 90 percent of medical doctors think
25 oral health should be addressed, but half of them said that

1 they have little or no training receiving less than two
2 hours of oral health training. Only nine percent of them
3 could answer oral health questions correctly.
4 After collaborating with a radiologist and an
5 emergency room doctor, they both agreed that Tele-Dentistry
6 would not keep patients from using the emergency department
7 as their first stop in their quest for emergency dental
8 care. However, with a proper referral system and follow-up
9 provision in place, it would substantially decrease the
10 number of subsequent visits to the emergency department,
11 providing significant cost-savings to an already
12 heavily-burdened healthcare system.
13 Also the consequence of the medical dental
14 collaboration will eventually improve human health through a
15 more patient-centered model of care. Thank you.
16 MS. SWAIN: Thank you. Sara Holland?
17 MS. DUGAR: She's not here yet. You may want
18 to skip over her?
19 MS. SWAIN: Sure. We can skip over her.
20 MS. DUGAR: That would be great. Thank you.
21 MS. SWAIN: Susan B. Reid.
22 MS. DUGAR: Thanks.
23 MS. REID-CARR: Good morning, ladies and
24 gentlemen. I'm Susan Reid-Carr. I'm the President of --
25 Dental Virginia Hygienist Association, and on behalf of the

1 Virginia Dental Hygienist Association that represents the
2 5,563 licensed dental hygienists in the Commonwealth, we
3 appreciate the opportunity --
4 MS. SWAIN: I'm sorry. Ms. Reid, can you
5 speak up? She can't --
6 MS. REID-CARR: Okay. I'm going to start
7 over.
8 MS. SWAIN: You can pull the mike over.
9 MS. REID-CARR: Okay.
10 MS. SWAIN: Thank you.
11 MS. REID-CARR: You ready?
12 COURT REPORTER: Yes.
13 MS. REID-CARR: On behalf of the Virginia
14 Dental Hygienist Association, that represents the 5,563
15 licensed dental hygienists in the Commonwealth, we
16 appreciate the opportunity to provide comments on
17 Tele-Dentistry in Virginia. The VDHA supports all the
18 delivery modules of oral healthcare services that maintain a
19 safe, cost-effective and high standard of oral healthcare.
20 The discussion that brings us to developing concepts on
21 tele-dentistry is the consistent proven fact that there is
22 an access to oral healthcare issue in the Commonwealth of
23 Virginia.
24 The VDHA believes that tele-dentistry is a
25 critical component in assisting to fulfill that deficit.

1 Using technological methods such as tele-dentistry to
2 provide education, treatment, consultation and necessary
3 referrals can be a vital tool to help solve this problem.
4 In delivering care through tele-dentistry, the VDHA promotes
5 the following concepts that we believe can enhance the safe
6 and effective utilization of dentistry. VDHA supports
7 establishing a dentist-patient relationship through an
8 in-person licensed dental hygienist. To create these
9 opportunities, VDHA supports a collaborative agreement for
10 licensed dental hygienists and dentists. This can create
11 additional opportunities for access to patients and
12 establish a dental home for these patients. HIPAA approved
13 communications equipment seems appropriate as this can
14 maintain the current standard of protective care for
15 patients and providers. VDHA believes that cost may be
16 incurred for equipment, however, the overall investment can
17 provide for far-reaching access to more patients, establish
18 dental homes for more populations, reduce travel cost for
19 patients and potentially reduce costs for payers.
20 As new technology develop, the VDHA
21 encourages the Commonwealth to keep an open mind on ways to
22 adapt safe, cost-effective and quality care. The VDHA is
23 mindful of the fact that while tele-dentistry can benefit
24 various areas of delivery of oral health care, this is a
25 tool that is not the comprehensive solution to the access

1 problem.
2 Thank you.
3 MS. SWAIN: Linda Wilkinson.
4 MS. WILKINSON: Good morning. My name is
5 Linda Wilkinson and I am the CEO of the Virginia Association
6 of Free and Charitable Clinics, and I'm here to remind the
7 Board about the patients that could particularly benefit
8 from these regulations.
9 Our 60-member clinics served 72,000
10 low-income, uninsured adult patients last year. Our clinics
11 are providing medical, behavioral, health, pharmaceutical
12 and/or oral health services. Despite the generosity of time
13 and talent of over 700 volunteer dentists and hygienists,
14 our clinics were only able to serve approximately 15,000 of
15 the 72,000 patient population purely based on the
16 availability of the providers. We're here to support any
17 and all regulations that will expand access to all health
18 services to our patients who are suffering from multiple --
19 exacerbated by their oral health conditions and vice versa.
20 So we ask the Board to please consider again any and all
21 regulations, including and not limited to tele-dentistry
22 regulations that again, will enable our providers to have
23 greater flexibility to provide much needed oral health
24 services to all parts of the Commonwealth and to more than
25 72,000 uninsured low-income patients within the free health

1 system.
2 I thank you for this time, and I thank you
3 for what you do for the Commonwealth.
4 MS. SWAIN: Thank you. David Sarrett.
5 MR. SARRETT: Good morning. Actually, I
6 signed the list. I thought it was attendance but I --
7 I'm the Dean of the School -- certainly we support the
8 use of technology and all forms of the system, patient
9 care, as well as teaching and education and -- I think
10 most people here are addressing, as well as the patient
11 care. I ask that you keep in mind there are
12 educational functions of the search functions --
13 clinical evaluations.
14 They should not fall prey to some -- --
15 consequences of the regulation of the law. I didn't
16 review the document that the Board of Medicine -- I
17 guess it's a guiding document, read carefully, which I
18 thought covered many of the issues that came to my mind
19 quite well. I suggest that's a good starting point so
20 just keep in mind that -- particularly the thorny
21 issues of doctor/patient relationship, establishing the
22 fact that the patient needs to know who the consultant
23 dentist or physician would be in that case, so I found.
24 Thank you.
25 MS. SWAIN: Thank you, Mr. Sarrett. Dr.

1 Bonita Miller.
2 DR. MILLER: I just want to thank the Board
3 as well for considering this concept because there is
4 certainly a great potential use for tele-dentistry and
5 addressing access to care issues. As you know, the
6 Virginia Dental Association has long been interested
7 and active in programs and initiatives and projects,
8 services and other things to try to address the issue.
9 The Virginia Dental Association is very interested in
10 tele-dentistry. It would be great to have ongoing
11 conversations like this to gather the interested
12 stakeholders. It could certainly be a wonderful
13 collaborative effort among our dental oral stakeholders
14 to develop a pilot project.
15 It is certainly something to consider within
16 the Department of Health maybe as a pilot project, and
17 also the Community Dental Health Coordinator could also
18 be an entity that could be a very vital part of the
19 success of the tele-dentistry program. So I thank you
20 for opening the conversation and hopefully gathering an
21 interested group of stakeholders, developing something
22 that would really have a meaningful long-term aspect of
23 addressing access to care. Thank you.
24 MS. SWAIN: Thank you. I hope I don't mess
25 this up, Tonya Adesh.

1 MS. ADESHA: -- sorry.
2 MS. SWAIN: Oh, that's fine, and referring
3 back to Sara Holland, I'm not sure she's here.
4 MS. DUGAR: She's not here. I can read her
5 comments if you'd like?
6 MS. SWAIN: That would be great. Thank you.
7 MS. DUGAR: I'm not Sara Holland. I'm Nicole
8 Dugar, a little obvious, for the Oral Healthcare.
9 COURT REPORTER: I'm sorry, repeat your name?
10 MS. DUGAR: Nicole Dugar, D-U-G-A-R. Let me
11 just touch briefly on what we had submitted oral -- I'm
12 sorry, we had commented. I can just read through some
13 of the highlights here. First of all, thank you for
14 the opportunity to comment on the use of
15 tele-dentistry. The Virginia -- Hospital Coalition is
16 the highest of several hundred organizational and
17 individual partners trying to integrate World
18 Healthcare and all the aspects of health and wellness.
19 One side of this mission is to improve the process to
20 oral health services.
21 Tele-medicine has proven to be an effective
22 mechanism for improving access and to manage.
23 Tele-dentistry appears to have similar promise in
24 improving access to oral healthcare services. The
25 Virginia Oral Health Plan, a state plan offered by over

1 200 state voters from across the Commonwealth, in 2010
2 recommends the goal of prevalence of dental disease as
3 reviewed in Virginia through prevention and early
4 diagnosis and treatment and that stakeholders explore
5 the use of tele-dentistry and server areas of the
6 Commonwealth analyzing -- its appropriate use,
7 reimbursement models and reimbursement models used by
8 other states for tele-dentistry.
9 To support this objective, the Oral Health
10 Coalition needs a support group, and they included a
11 number of different stakeholders including The
12 Department of Health, The Department of Medical
13 Assistance, Private Practice Dentists, Community
14 Healthcare Center Dentists, The Mid Atlantic --
15 Resource Center for the DCS School of Dentistry of
16 Virginia Dental Health, The Dental Association of
17 Headstart and the Coalition. Sara had provided, I
18 think, an attachment of some of the work that the work
19 group had done.
20 Our group members were particularly
21 interested in how well the tele-dentistry could
22 increase access and decrease the transportation burden
23 of families and -- children's program. We particularly
24 would love to have a store-in-forward -- to
25 tele-dentistry as an effective way to address the

1 access issue, a store-in-forward approach because, as
2 you all know, by -- data, says the state of -- x-rays
3 are captured via secured connection and reviewed by a
4 provider at a later time.
5 The working members felt that this was a
6 favorable way to explore the use of this technology as
7 a first step. We thought that it would create more
8 efficiency in the delivery of healthcare. It would
9 produce transportation burden for families, and it
10 would reduce a cost savings to the state for Medicaid
11 patients. It would decrease reliance on the Medicaid
12 transportation benefit.
13 Additionally we thought that a
14 store-in-forward would not be a change in people's
15 practice as it was already occurring in Virginia
16 Medicaid and Dermatology and Radiology and other areas.
17 We had some questions and concerns from the workgroup
18 about duplicative services and this could drive up
19 costs. Examples in California and other common
20 programs demonstrate reduced costs and no duplication.
21 If a consulting provider using tele-dentistry is also
22 the dentist performing the procedure, regulations
23 created by the Board can address and prevent
24 duplicative consults. Given that tele-medicine is
25 already established in Virginia, we recommend as the

1 Coalition that the issues related to the
2 dentist/patient relationship and communication
3 equipment requirements mirror existing tele-medicine
4 protocol.
5 MS. DUGAR: I just also want to make a comment
6 from the Dental -- Foundation and -- you all should
7 have received this as well. Thank you.
8 MS. SWAIN: Thank you. We have time for
9 discussion and a few recommendations of questions. I
10 want to remind everyone that our policy -- I'm sorry.
11 I'm just reading this dialogue here, but I just want to
12 make sure that since we do have time for discussion,
13 I'd like to open the floor for anybody who'd like to
14 speak in regards to -- and any board members who might
15 have questions regarding to -- Mr. Alexander?
16 QUESTIONS BY THE BOARD
17
18 MR. ALEXANDER: The first speaker, I
19 appreciate that. I understand what's going on. Have you
20 discussed this with any of the ER physicians? What is their
21 take on it?
22 MS. KAHAN: Their take, again, was we started
23 thinking about doing this. A friend of mine, her husband is
24 an emergency room dentist, and my other friend's married to
25 a radiologist. They both agreed that it won't stop the

1 first one. People that don't have insurance or for whatever
2 reason, they don't go to the emergency room that first time,
3 it won't stop the first time, but it would probably cut down
4 on subsequent visits so if there's somewhere in there right
5 now, there isn't a way to get the patient from the emergency
6 room. They leave with pain medicine and antibiotics and
7 that we all know will just be a very short-term fix for
8 them. But if we can provide for them through donated dental
9 care, whatever type of referral service that we have, yes
10 that, but then the dentists can take a look at it, the inter
11 oral picture or the x-ray and they could call the referral,
12 whether it's to an endodontist, and sometimes it might be
13 that the patient just needs a cleaning. The patient needs a
14 filling. It could be a very simple fix. It doesn't
15 necessarily need to be a very big thing so they can make the
16 appropriate referral.
17 They can refer them to their own office. They can
18 refer to any of the clinics that we have, and they would be
19 provided with that information and given an appointment to
20 go to that particular place. The Oral Health Improvement
21 Coalition – also has dental vouchers that can be given to
22 the patient to go to any of the clinics to receive the care
23 that they need so that, that way will keep them from
24 returning to the emergency room. So it won't reduce the
25 first one, but hopefully it will reduce subsequent visits.

1 MR. ALEXANDER: Well I think it's a great
2 idea.
3 MS. KAHAN: We're trying that as a pilot by
4 the way. One of my students is working on her Masters.
5 MR. ALEXANDER: You're trying it in the
6 emergency room?
7 MS. KAHAN: Yeah. That's where she's working
8 on her Masters at Fulton A&M for Community Health. When we
9 started talking about this, she wasn't really quite sure
10 what she was going to do for her project, and this is her
11 project.
12 MR. ALEXANDER: She's gonna have fun, I'll
13 bet.
14 MS. KAHAN: We're going to have fun.
15 MR. ALEXANDER: Have you talked to the
16 emergency room, the people that run it, are they willing to
17 buy this equipment?
18 MS. KAHAN: That is our next step.
19 MR. ALEXANDER: The other thing is, you're
20 going to have to have dentists on call that are willing to,
21 having worked in the emergency room for years, a lot of
22 these patients come in after hours in the middle of the
23 night, so you know, having the dental people available is
24 another thing that you're really going to have to work
25 through.

1 MS: KAHAN: Well, I think what they're hoping
2 to do is get -- with larger practices where they might just
3 have some of the doctors -- some of the doctors might take
4 a week so it won't fall on one particular – they'll be a
5 bunch of doctors that they could call.
6 I don't think that it is all that much. It's not like
7 there's ten or 15 a night. It isn't that much, but the few
8 people that do go there really do pose a significant cost
9 increase to emergency rooms, and then, of course, the human
10 cost. While they're in there and they're taking care of
11 somebody who is non-life threatening dental, it's taking the
12 emergency room doctors time away from something that –
13 MR. ALEXANDER: Thank you.
14 MS. SWAIN: Are you okay over there?
15 COURT REPORTER: Just have to speak up?
16 MR. SARRETT: I think it's great that you're
17 working on this. I will refer T there is a publication. I
18 have a doctor and one of his residents, Adam -- the name
19 will come to me. About two years ago, we had a conversion
20 program for dental issues to the -- Health System. -- to
21 the ER for them being registered in the ER and come to
22 dental to help solve these issues.
23 That was fairly successful, very successful. As a
24 hospital, they're worse – of probably undiagnosed is other
25 things like cardiac events so they decided they really

1 needed a triage so now it's kind of snarled up in the back
2 where you walk in the door.
3 Even if they say, "I think I've got a toothache,"
4 they've got to be somewhat triaged so that kind of
5 complicates things. If I recall their publication, actually
6 they indicated most of the visits were Monday through
7 Thursday during the daytime. I guess, to the nature of
8 that, -- the weekend.
9 MR. ALEXANDER: Which means there will be
10 more dentists in their office during the daytime that might
11 take a tele-medicine call and not have to be woke up in the
12 middle of the night so that might help out too?
13 MS. KAHAN: One of the things that they
14 Talked about at Harvard was doing that and to disciplinary
15 because we do know the connection now between dental issues
16 – now, we need to get those physicians –
17 MS. SWAIN: Ms. Kahan, I think, Ms. Rucker
18 has a question.
19 MS. RUCKER: What type of students do you
20 have?
21 MS. KAHAN: I have juniors and seniors in
22 high school.
23 MS. RUCKER: Your dental assistant program
24 that they use – are you going to have one here in
25 Chesterfield?

1 MS. ALEXANDER: Like a technical program.
2 MS. RUCKER: Like a technical program, and so
3 they use it as a stepping stone for hygiene schools?
4 MS. KAHAN: So they're really -- because
5 again, I'm very fortunate that the Virginia T schools,
6 whenever something comes up, the head of technical career
7 education, his wife happens to be a dentist, and the person
8 who funds me, her brother, is a dentist up in Boston and so
9 whenever I say to them, I need a plug.
10 As a matter of fact, I have a first-edition nomad,
11 which now, with their lypo hand gliders, this is like the
12 big one, but it's whenever I ask them for anything, they're
13 behind anything I want to do with the students. When I say
14 hey, let's think about this, I make them read these journal
15 articles which is laid out carefully, a lot of them. They
16 do understand. They do empathize with people, some of their
17 families.
18 Twenty-five percent of my school is on free lunch and
19 Medicaid so we do see students in my clinic. Our public
20 health dentist comes one day a week, and my assistants help
21 her help the kids in my school so it's worked out really
22 well so I'm really very, very fortunate.
23 MS. RUCKER: A number of you spoke to the --
24 you made a comment about physicians having more -- and
25 supervising maybe assistants or possibly hygienists. I just

1 know we speak with remote supervision because they are in
2 these settings. They're in nursing homes or free clinics.
3 They're already there and having a broader supervision
4 of a hygienist, possibly instead of just being under direct
5 supervision of a dentist or an assistant. Maybe you could
6 speak to that because you're seeing that in an ER setting,
7 if you'd like to speak on that?
8 MS. KAHAN: Well, I brought that up because a
9 couple of years ago, it's probably Hampton Roads now, but it
10 was the Chesapeake Care Clinic. They only had a dentist
11 there, I think Tuesday and Thursday nights, but during the
12 day, it was mainly a medical facility. Someone had called
13 me and said I have a patient here and there's a dental
14 assistant here, but the physician wants her to take an
15 x-ray. Can they do it? I said I don't know, and I called
16 Sandra Reen, and she was like absolutely, if you can
17 remember. I called and they were like, no. I was sort of
18 -- 18 VAC 60. I mean she knew it like that. It has to come
19 from a dentist.
20 So I already knew that, that would be one of the
21 obstacles that you would suggest to me. An x-ray tech in a
22 hospital -- when we were first initially thinking about
23 this, we were thinking a nurse could do it, and then my
24 friend who is an RN, she was like, no, we're too heavily
25 burdened.

1 So we were going through the people, and we were like
2 they already have x-ray techs, but there is no dental
3 component to x-ray technology, that particular profession.
4 So we either have to add it to their curriculum or they
5 would have to become dental x-ray certified --. There was
6 no other way to do it, and so that was how I knew about it.
7 MS. RUCKER: Then you would have to --
8 MS. KAHAN: They would have to either call
9 the attending dentist, then he could give the remote thing
10 to that person acting as a dental assistant or to x-ray; or
11 you're going to have to change it, at least in the emergency
12 room. In free clinics or whatever, allow the physician to
13 say, okay, go take my x-rays.
14 MS. RUCKER: And that's why I wanted to say
15 that as we have these discussions as board members, that we
16 may need to look at in these settings to have a physician to
17 say all right, we have a hygienist. He could clean this
18 person's teeth or an assistant, he could take this
19 radiograph so that we could have tele-medicine work.
20 MS. KAHAN: Like I said, sometimes it works
21 the other way, sometimes you'll find out that it isn't a
22 dental thing, that it's more of a medical thing and you
23 write down to see a physician. You're having a heart
24 attack.
25 MS: RUCKER: I work in a hospital setting,

1 too.
2 MS. SWAIN: Dr. Wyatt?
3 MR. WYATT: I was just interested in having a
4 conversation. We always used to have a conversation about
5 what are the regulatory barriers providing access to dental
6 care? What I'm hearing is that it's only just another
7 supervision conversation or at least in part, it's
8 supervision.
9 Can a dental hygienist be in an emergency room and be
10 performing any services without a dentist being present? I
11 think that, to some degree, is some of the conversation.
12 You know, I loved hearing the model of just another way of
13 allowing access to care.
14 People currently -- I know it's appalling when you hear
15 the wait list that the free clinics have simply because of
16 manpower, a lack of workforce to be able to --. I think the
17 more specific we can look at this and identify barriers,
18 regulatory barriers, is what I think the point is here and
19 what are potential solutions? What have other states done
20 to allow -- the reality is that when people with oral pain
21 seek help in emergency rooms on a regular basis, how do we
22 make sure they have the most effective care possible when
23 they go there? That's a great task for this board to see if
24 there are any models, things we can do regulatory-wise to
25 pass such regulation that addresses that without

1 compromising the patient's safety.
2 I think we should encourage more discussion on this so
3 we can leave this with some clarity. What are the problems?
4 How are we not able to use tele-dentistry currently in an
5 effective way, and what are the potential solutions to those
6 problems? I'd like to have that as part of a discussions
7 about that or any comments about that, that would be great.
8 MS. SWAIN: Yes, sir.
9 DR. WYATT: Excuse me for being late. I've
10 been traveling around in circles. I'm Dr. Wyatt. I'm
11 representing the doctor and what we do currently for
12 tele-medicine.
13 MS. SWAIN: Yeah. We need for you to speak
14 into the mic.
15 DR. WYATT: In here, okay. What we do
16 currently with tele-medicine and also the county shed
17 some light.
18 MR. ALEXANDER: Just to be clear to my
19 knowledge, you're a dentist or an assistant?
20 DR. WYATT: Yes, I'm a dentist. I've
21 actually been practicing with the department for about
22 eight years. I practiced clinically in various
23 different situations – I have a Masters in Health
24 Informatics and I've been using tele-dentistry and
25 things of that nature on and off for the past 20 years,

1 either to ripen myself or try to incorporate the
2 methods into wherever I've practiced.
3 What I was wanting to do was give some
4 recommendations based on that experience. I did review
5 the materials that you all gave me. Most of the things
6 that I saw that had been said, I guess that's going to
7 be precedent that you all are going to be looking; I
8 just wanted to add a few things that might be
9 considered that I did not find in that material.
10 Some of those things may have been addressed.
11 I'm not sure, in the board and in different areas, but
12 based on what you all have provided, I just wanted to
13 bring certain things to your attention so that you
14 might want to debate whether they would be an issue or
15 whether they wouldn't be. Did I have enough copies?
16 Did everybody get one of these?
17 MS. SWAIN: Yes, we did.
18 MR. WYATT: Well, currently the Virginia
19 Department of Corrections, if you look on the first
20 page. I've given an example of what we're doing, and
21 we usually communicate with VCU. This is how we get
22 all of our referrals.
23 The materials that you see here on the front
24 of the pictures, these are video conferencing devices
25 that are used. The problem I foresee is that they have

1 taken administrative type of areas in offices, and they
2 have incorporated this pretty well but they're for
3 screening of the papers or the documentation that you
4 provided me. You were interested in seeing how far we
5 could go with tele-dentistry, whether we could do
6 comprehensive examinations and things of that nature.
7 Currently, most of their consultations are
8 for external general review. That's fine for
9 screenings. That's fine for writing prescriptions,
10 things of that nature, but for comprehensive
11 examinations, I think that there are some parameters
12 that should be set through the technology, the use of
13 interval cameras.
14 I didn't see any of that documented as a
15 requirement, specified requirements in the amendments
16 that allow for the tele-dentistry in the other states.
17 I think it's important that Virginia start out that
18 way. The reason I'm saying this is I can see a problem
19 with accountability and whether it's fraud, whether
20 it's misdiagnosis based on the fact that no specifics
21 were set with respect to resolution. Of course, high
22 definition is pretty common, but it's not actually
23 specified in the documentation. You don't want someone
24 snapping a picture and then end up in a case or I end
25 up in a case trying to defend something and the

1 resolution be an issue because it hasn't been – things
2 like that.
3 We, for instance, the Virginia Department of
4 Corrections, we do everything on a secure network.
5 It's an isolated network. Well, if you allow doctors
6 to pursue this and you haven't defined that that needs
7 to be a parameter, you wouldn't want things being
8 transmitted, not that they would think about that, but
9 being transmitted over unsecured networks because they
10 don't have a list, because they would be doing things
11 like they would normally do, hot-mailing procedures or
12 pictures or images or things like that. So I tried to
13 make a list of certain things that I would think the
14 Board may want to define.
15 It doesn't have to be exhaustive, but at
16 least it gives doctors a framework so everybody's
17 playing on the same rulebook using the same specs, and
18 also you all are provided with the information to where
19 they could resource materials that they need so that
20 everyone is pretty consistent and standardized. Did I
21 make myself clear?
22 MS. SWAIN: Thank you. Does anyone have any
23 questions to Dr. Wyatt's information?
24 MS. REEN: You talked a little bit about what
25 a defined tele-dental liaison would? What is that?

1 DR. WYATT: At the DOC, we actually have a
2 medical tele-medicine liaison. She is the one who is
3 responsible for communicating with the physician and they
4 can either request or fill in the request, communicate with
5 VCU to actually set up the consult. Because we know who
6 that is, if there's any issue with the transmission, if
7 there's any issue with privacy, if there's any issue with
8 whether or not providers were given the health history and
9 that sort of thing, we know who to go to because she set up
10 the appointment.
11 So if the Board ever had to review an issue in
12 tele-dentistry, if you have a liaison and you have one
13 person in the organization responsible for it, you know who
14 to point to, who would have that material, and I just think
15 it would be easier to regulate if you know you have one
16 contact person.
17 MR. ALEXANDER: You said that you are using
18 it? Explain how you document them.
19 DR. WYATT: Right now for us, it's in the
20 dental clinic. We're not using it as far as tele-dentistry
21 with respect to exams and things of that nature. I assume
22 this is what you'd like to expand to. I think it's good,
23 but for instance, if I refer a patient for oral surgery,
24 which I do a lot. I do some surgery, and there are some
25 cases I can't do, I refer to DMVC. Those consultations are

1 set up using the on-site medical liaison who's responsible
2 for that.
3 All the documentation you have here on the first page,
4 she coordinates that document. She sets it up, and then
5 there's a direct coordination with the oral surgery
6 department. Now, I don't have the ability in my clinic to
7 do that, which is what I think would be a good idea, but
8 they're set up like a medical referral. In other words, it
9 just falls in line with the other medical consultations that
10 are in the form at this point.
11 MR. ALEXANDER: So it's not a face-to-face
12 thing?
13 DR. WYATT: Yeah, it's face-to-face, but it's
14 face-to-face with the physician at this point, not with the
15 dentist.
16 I write the consults when I refer to medical and
17 medical sets up the consultation and does the communication,
18 and I assume we want to expand to the point where the
19 dentist can do the same thing, but right now we're set up
20 with tele-medicine, not tele-dental, so I was just trying to
21 see how organizations who are already practicing it, how it
22 could be expanded and regulated?
23 MR. GASKIN: What do you perceive the model
24 MR. WYATT: Well, as with any fields in
25 healthcare, cost is always an issue. So if you want

1 widespread acceptance, I think that there should be some
2 evidence-based practice based on what the resolutions are,
3 what type of networks and what the states are already using.
4 If you have a predominance of equipment that's out there, we
5 should be able to expand with that. The only major
6 barriers, other than what is included in what I've listed
7 here, inter-oral cameras and the areas that the actual
8 examinations are being performed, currently the medical
9 department is able to do there in administrative office
10 settings.
11 It's just an administrative office because they're
12 pretty much teleconferencing and that's because they're not
13 performing exams. What they're doing is consulting and it's
14 fine for screenings or writing prescriptions, but if you
15 want to do actual exams, you would obviously need to either
16 lay a patient back in the clinical chair in the same setting
17 that he or she is comfortable with and be able to do it
18 there. Now, I don't see that as being a huge barrier, but
19 what you don't want is to put the regulations out there and
20 then people reading them the way that they want. If that's
21 not defined, then someone may start doing it in their
22 office. Well, now you see a whole can of worms opening up
23 for things that are not listed, the same thing for the
24 training, the same thing for every aspect of this. I don't
25 think it's complicated. I just think that we --

1 MS. SWAIN: Mr. Gaskin.
2 MR. GASKIN: The liaison that you're speaking
3 of is within your facility or centrally here in Richmond?
4 DR. WYATT: No. It's in my facility, but the
5 way that the correctional facility is, it's similar to a VA.
6 MR. GASKIN: Now, does every correctional
7 facility in the state that has a dental facility have this
8 capability or just you at Suffolk?
9 DR. WYATT: Well, I'm at Deerfield, but I'm
10 not exactly sure. She is a tele-medicine liaison. She is
11 located right there at that facility. Now, I'm not sure if
12 she is a tele-medicine liaison for different facilities
13 because it's common practice with the "now" culture. If a
14 patient needs something and we can't provide it at the
15 facility, we have direct communication with another facility
16 that will. Dental is pretty much in-house. I'm not very
17 familiar with how they're handling their patients. I just
18 know what they're capable of doing. They could very well be
19 shipping in medical patients that either tele-medicine comes
20 from another facility that's close and having that
21 consultation at their facility. I'm not sure.
22 I do know that video conferencing is available at all
23 the facilities because we have medical quarterly meetings
24 with all the providers. But as far as doing consults with
25 VCU and --, I'm not sure what facility has the capability

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1 but it's not an issue with us because we move our people to
2 where we will be moving, but expanding to that is probably
3 pretty simple, especially if they're –
4 MR. GASKIN: I'm just trying to sort through
5 in my mind listening to you, how much -- or are you speaking
6 for the Department of Corrections and how they intend to
7 manage all of their dental clinics with these technicians
8 and then trying to overlay that in private practice or any
9 other nursing home or other situation? As far as each one
10 maybe having a liaison or something?
11 MS. SWEEKER: Dr. Wyatt, I used to work for
12 DSA too but this was a million years ago. We had
13 tele-dentistry in 1994 and that dentist actually talked to
14 DCU and they didn't do it. They did it face-to-face. They
15 talked to the oral surgeons ┬ your facility did, but we did
16 that then so I'm familiar with tele-dentistry. The dentist
17 actually talked to the oral surgeon and talked about the
18 wisdom teeth, and they had the radiographs and everything.
19 That was at –
20 It's closed now, or it's getting ready to close, but
21 they did that then. Anyway, now I know why dentists
22 actually talked to the oral surgeon. So I guess each
23 facility -- and we had a coordinator so I'm very familiar
24 with what you're talking about.
25 DR. WYATT: Right, right.

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1 MS. SWEEKER: Candy was her name, and she
2 transported everything that went along with tele-medicine,
3 tele-dentistry so that the inmates were transported, because
4 it's different when you're transporting an inmate than when
5 you're transporting someone who can get themselves there on
6 their own accord.
7 MR. GASKIN: So through the Chair, my
8 question still stands, are you speaking for yourself or are
9 you speaking for DSUV? Who are you speaking for today as I
10 read your comments and listen? Could you define that for
11 us?
12 DR. WYATT: I'm speaking for me as a
13 clinician within DOC and I'm also speaking on behalf of DOC
14 because if this is something that's going to be made
15 available, we need to be able to make sure that it works.
16 Now, for clarification, I'm not sure whether it's a contract
17 to state issue. Most of this is administrative, so in order
18 to get approval, there's an approval process that we have
19 now. They don't approval every tele-medicine or every
20 tele-dental consultation. I'm not in that loop, okay.
21 I do refer to oral surgery. We do refer the
22 radiographs, but I haven't found the need to have to consult
23 face-to-face with the surgeon. Usually, they contact me on
24 the phone because it's separate from my dental clinic so I
25 don't have the ability to go in right now and to use that

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1 office space for tele-dentistry so I have been locked out.
2 MS. SWEEKER: You used to do it though?
3 DR. WYATT: Right. If that's something that
4 was going on then, I don't see why it can't return to
5 that.
6 MS. SWEEKER: Right.
7 DR. WYATT: Now, it's been eight years. Now,
8 I could request a time and I'm sure that I would be
9 given access but it's common practice in medical to be
10 able to walk into the office and do that. That's not
11 me. I have to go through. Did that answer your
12 question, sir?
13 MS. SWAIN: Thank you. Do you have any
14 questions?
15 MS. DUGAR: I do have a -- I guess in
16 reading all this information, I am realizing that there's a
17 crossover with medicine and dentistry and I didn't know if
18 anybody might have any input on coding or how that's done
19 with filing. I think -┬ indicated that there's issues with
20 no duplication and cost. Can you speak to that?
21 MS. SWEEKER: I can't speak specifically to
22 that, but what I can speak to is I know that -- had done
23 tele-dentistry in other states. They are working on
24 establishing codes to ┬ - dentistry. I can't prove it, of
25 course, but –

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1 MS. DUGAR: I was just curious because
2 obviously that's going to be something that's going to be
3 something we'll have to look at.
4 MS. SWEEKER: In terms of duplication, what
5 the workgroup preferred was making sure that the same
6 dentist who's doing the consultation isn't providing the
7 service so that you're not getting a patient who has a
8 consult done by one dentist, goes back and has another
9 procedure or has the procedure done by another dentist, so
10 you're getting a double charge.
11 MS. DUGAR: Right. Because the standard is,
12 like in private practice, you can only fee out an exam once
13 or twice a year.
14 MS. SWEEKER: Right.
15 MS. DUGAR: Yes.
16 MS. SWAIN: This is an opportunity for
17 everybody to discuss. Does the audience have any
18 questions to ask of each other to get the forum carried
19 over, the information presented to us. Any other
20 comments? Really this is an informational scenario for
21 us, and it would be great for us to have all of the
22 input laid out because we're going out blindly and it
23 would be nice to have as much information to help us
24 review the policies. Ma'am?
25 MS. KAHAN: I don't have a question so much as

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1 a comment. Inside dentistry, the Dean of Dental
2 Medicine, this year I think is starting, and again,
3 there's so much research out there. Just to put in
4 emergency room dentistry, whatever it is, there's just
5 so much research. In their clinic, they are now
6 bringing in physicians, dentists, medical students,
7 dental students and nursing.
8 To do this and be disciplinary, starting now,
9 the way that our current system is, that might be a
10 little difficult to change, but starting with medical
11 schools, dental schools, combining and adding more
12 dental curriculum to the medical school and
13 administering -- we don't have a lot of medicine built
14 into our curriculum. I used to tell everybody how over
15 qualified I am to be – I mean, I'm glad that I'm over
16 qualified but just in dental hygiene, what we have to
17 know about the human body, but then it doesn't transfer
18 over.
19 We take blood pressures, but I've never ever
20 gone – and my husband's a dentist. I've never ever
21 gotten from the medical practice, although I do know
22 some of them do it, where my neighbors are OBGYN and
23 orthopedists, and I always say to them, do you make
24 sure that your patient has their teeth cleaned before
25 you do the joint replacement.

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1 It's always after, so I think maybe where we
2 need to start is intergrating with, and I'm reaching
3 out to our medical, our nursing program, the Virginia
4 Health and Medical Educators Association to try to get
5 more dentists into the nursing programs. At EVMS we
6 had talked about that, coming in and just giving some
7 sort of semester on dentistry because they get so
8 little of it, and so I think once we start
9 incorporating that, there won't be that barrier where,
10 okay, who do we charge for the fee because we're still
11 doing that.
12 We still think the mouth is here, and we have
13 separate fees, and then we have the body here that has
14 its separate fees and he does address that so I know
15 that there -- so we don't have to reinvent the wheel
16 that other – about putting them both together. It
17 might be a place for discussion.
18 MS. SWAIN: Sir, in the back?
19 MR. BLACK: I'm from Roanoke, and – Virginia
20 Tech Medical School – young and he's five years old
21 now. The dental clinic at the Korean Hospital decided
22 they needed to have studies there, and so if you want
23 to look to a model to teach medical students more about
24 dentistry, they have a 25-hour curriculum in the
25 medical school on dentistry. That is Dr.

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1 I don't know if you know Dr. – who is head
2 of that program. So if you want to look to a model for
3 teaching physicians more about this, you don't have to
4 go to Harvard, you can go right here.
5 MS. KAHAN: Sorry to --. It's just from the
6 article.
7 MS. SWAIN: Any other comments? This is
8 really a good time. Dr. Sarrett?
9 DR. SARRETT: I'll just give you a piece of
10 information that may help in the future, and when I
11 tell you this, you're going to think how could this be
12 fixed? There's another organization called the
13 American Association of Medical Colleges, the AAMC,
14 who's kind of the educational oversight for medical
15 education. They're in Washington, DC. There's also an
16 organization called the American Dental Education
17 Association which is the comparable dental education
18 association for US members and Canada.
19 AAMC purchased a large building in Washington
20 DC and moved into it. The American Association is now
21 in the same building as the American Association of
22 Medical Colleges. They have moved from their location
23 and have space right next to the AAMC so I predict that
24 will be the single most important thing that's going to
25 change this entire situation, because you've got

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1 everything now.
2 You've got the Dental Education Association
3 people running into and talking to the people at the
4 AAMC, and finally that message will start to trickle
5 through them. Something needs to happen in medical
6 education in order to bring an understanding. I had a
7 personal experience recently with this whole thing
8 which kind of got me interested in what they're doing
9 down there.
10 We frequent a restaurant on Wednesday
11 evenings, -- because it's half price burger night on
12 Wednesday nights, and I've gotten very familiar with a
13 server there, and about a month and a half ago, I could
14 tell she wasn't feeling well.
15 She had this mass swelling under her T right
16 here (pointing). I said, "Any of your teeth bothering
17 you?" She said, "Well, I don't know. I haven't been
18 to a dentist in ten years." So I said, "You have to be
19 very careful because if that's an infection under
20 there, that could be very dangerous and you could die
21 from that."
22 So she called her husband. She said, "I
23 think I'm going to go to the hospital when I get off
24 work." I took a napkin and I wrote a note on the
25 napkin and said, "A dentist has talked to you and

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1 thinks you might have a dental infection causing that
2 swelling under the midline of your jaw." I said give
3 this to the -- I said to the MCV emergency department
4 because they will have dentists there.
5 I didn't say -- but I knew they would have
6 somebody with dental, give them this note. So we left.
7 I didn't catch back up with her until the following
8 Wednesday night until the next -- hamburger night, and
9 I said, "What happened?" She said, "Well, I went to
10 the hospital, and I spent the night in the hospital and
11 they called in an ENT. They weren't sure what it was.
12 They took me into the operating room and they drained
13 it.
14 They weren't really sure what it was, thought
15 it might be a cyst. I said, "What did they say about
16 your teeth?" She said, "Well, they didn't think it was
17 a ⊤ they didn't really know." I said, "Where did you
18 go?" She said she went to another hospital in the
19 city, not MCV. I won't say the name of it. I said,
20 "So a dentist never looked at you?" She said, "No".
21 I'm feeling much better.
22 I'm going to go back and they want to do some
23 scans and figure out what's wrong." So I said, "Okay".
24 So a week and a half later, she texted me. My face is
25 all swollen up on one side, and I'm really hurting and

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1 my mouth is hurting terribly. So I got her in the next
2 morning to the AB Williams Clinic, and it turned out
3 she had two bad teeth. They took those teeth out.
4 I saw her last night, Thursday night. It's
5 not -- burger night. I saw her last night. She's
6 feeling fine so the assumption is she had a dental
7 infection this whole time that had crossed the
8 mid-line. I think the medical community needs to
9 really start learning about this stuff because she's
10 got this huge hospital bill. She doesn't have health
11 insurance over at this hospital, and they totally
12 misdiagnosed her because they didn't have the expertise
13 to do it. You have to have provided care. Huge
14 implications, I think, for professional liability. So
15 I think these things are going to change relative to
16 the understanding and a better appreciation for what's
17 between the lips and the tonsils, once people start
18 seeing these issues.
19 MS. SWAIN: Ms. Wilkinson, I believe you had
20 your hand up?
21 MS. WILKINSON: Thank you. I wanted to
22 elaborate on some of that about what Dr. Brown
23 mentioned earlier about wait lists at clinics.
24 Unfortunately, three of our -- in larger practices.
25 That is in Charlottesville, here in Richmond, and the

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1 Fredericksburg Clinic known as the Moss Free Clinic.
2 Each of those free clinics has well over a million
3 dollar operating budget.
4 Crossover here has a $3 million budget with
5 two sites here serving over 70,000 unduplicated
6 patients. The Charlottesville Clinic has a $1.5
7 million operating budget, and the Crossover Free Clinic
8 in Fredericksburg has a $1.8 million operating budget.
9 I mentioned their operating budget to give you an idea
10 of the scope of these particular clinics and their
11 practices. They are serving thousands of unduplicated,
12 uninsured adult patients. Each of those three clinics
13 has a dental practice. The Moss Free Clinic, if you've
14 never visited the Moss Free Clinic in Fredericksburg, I
15 encourage you to do so. They have a state of art
16 dental practice. They have six dental operatories that
17 on any given day of the week sits empty because they do
18 not have dentists and dental hygienists who can
19 practice during the day.
20 They cannot afford to hire a dentist at
21 whatever dentists make in the Fredericksburg market.
22 They can afford to hire some dental hygienist who could
23 benefit from remote supervision and/or tele-dentistry.
24 So I mentioned these three specific communities because
25 these are three communities that are known as resource

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1 wealthy areas of our state, and imagine the problem
2 that's in Wise, Virginia. You've seen the news.
3 You've probably seen 60 Minutes and you're
4 familiar with the RAM Place that takes place every
5 year. They serve thousands of patients and to the
6 generosity of the VDA and VCU and other providers,
7 they're pulling thousands of teeth from patients every
8 summer that could have otherwise been saved if they had
9 the necessary oral healthcare. There's going to be
10 another RAM Clinic down in Kilmart in November and the
11 same thing is going to happen. They will pull
12 thousands of teeth because we don't have the necessary
13 providers who have the flexibility to serve these
14 patients despite the fact that we know, because the
15 providers tell us, they very much want to volunteer at
16 the free clinics, but they just can't be there during
17 the day when the patients can be there. So I mentioned
18 all of that to follow up with Dr. Brown's comment about
19 the wait list and unfortunately, the Charlottesville
20 free clinic has a wait list that is two years long, and
21 it's 500 hundred patients.
22 I just wanted to share that little extra
23 tidbit and again, I remind you, I know it is a focus
24 for you because it is a focus for us that patients need
25 to be at the center of your conversation. I heard what

1 the other speakers said, and I thank you for having
2 this conversation and for including the patients.
3 MS. SWAIN: Dr. Gaskin.
4 DR. GASKIN: While you're standing, can you
5 tell her whatever medicine -- tele-dentistry because I
6 know Crossover does pay, but here in Richmond. I'm
7 very familiar with that clinic. How do you see
8 tele-dentistry helping with what you're presenting to
9 us as a problem?
10 MS. WILKINSON: Primarily because of the
11 availability of a provider, if I don't have a dentist,
12 I can't afford to hire that dentist, or if I don't have
13 a volunteer dentist who's willing to be onsite during
14 the days that my practice is open, tele-dentistry would
15 expand my practice at all of my free clinics that have
16 onsite dentistry. So it allows greater flexibility.
17 We can serve more patients with more flexible hours.
18 DR. GASKIN: Where do you see having their
19 dentistry done? Do you mean come back after they're
20 screened? I'm not sure logistically what you're
21 telling me.
22 MS. WILKINSON: Oh, I'm sorry. I didn't
23 understand the question. The hygienist could be
24 providing the services onsite.
25 DR. GASKIN: Isn't that the same problem,

1 availability of healthcare, volunteers?
2 MS. WILKINSON: We have 150 volunteer
3 hygienists. Clinics can afford to hire hygienists.
4 They can't afford to hire the dentists. We have in
5 just the past 24 hours, we have had free clinics turn
6 down money from -- because they can't use the money to
7 pay for the dentists. It's not enough money to pay for
8 a dentist. It's great that I hire another hygienist,
9 but if I don't have the dentists to supervise him or
10 her, the hygienists, there's no point. They have
11 actually declined money from the association because
12 it's not enough. It's not enough to hire a dentist,
13 and it doesn't do any good to hire a hygienist when
14 they can't do much without that dentist there.
15 MS. SWAIN: Ms. Wilkinson, do you actually
16 have a list of hygienists who can actually be hired who
17 are willing to volunteer their time?
18 MS. WILKINSON: We do have 150 of them.
19 MS. MILLER: No, no, no, no. I just want to
20 make sure that you actually have hygienists who are
21 willing to work and who are willing to --
22 MS. WILKINSON: We have 150, and they are
23 available on those times that you are asking for, not
24 just -- some of those hygienists are, but there are
25 other hygienists that we would like to hire, but we

1 can't hire them without having a dentist. I believe
2 another speaker mentioned the Chesapeake Dental Clinic.
3 Unfortunately, that dentist that we mentioned heard her
4 hours were just cut in half from full time.
5 I'm probably sure it worked out. Her hours
6 were cut in half so it means that half of the patients
7 who were served prior to her hours being cut, because
8 the clinic just couldn't afford her. They just can't
9 afford that six-digit salary that she's being paid, but
10 she's worth every penny of it, but they can't afford
11 it. So now, the patient population will be cut in
12 half. Half the number of pediatric -- at that
13 particular clinic, they serve pediatrics. Half the
14 number of children and half the adults will be served
15 at the Hampton Roads Dental Clinic.
16 MS. SWAIN: Yes, sir, Dr. Wyatt?
17 DR. WYATT: To further the point, I'd like to
18 understand the dilemma of the free clinic --
19 COURT REPORTER: I'm sorry. I cannot hear.
20 DR. WYATT: I understand the dilemma of the
21 free clinics, but it seems that we can also be opening
22 up another can of worms. Patients would still have to
23 have dentistry performed in addition to preventive
24 services, but I think tele-dentistry could help in that
25 regard. Because I am sure that there are contracts

1 that could be written with various businesses
2 throughout the state that would represent
3 tele-dentistry providers.
4 There would be tele-dentistry providers where
5 some of this work could be funneled through their
6 practice if they were willing. Do you follow me? So
7 that you would be sharing resources, and that's what
8 all of this is about; sharing resources, not creating
9 problems off an issue. If you have enough patients who
10 are not being seen, and obviously they're not being
11 treated, then it's great we're being proactive with the
12 preventive, because eventually that will decrease the
13 amount of emergencies and dentistry that needs to be
14 performed, but you also have to make sure that the
15 backend of that is covered because what you create is a
16 scenario where you have a lot of people who need work
17 and then you have a dental shortage. You have to have
18 the foresight in place to fulfill that, and there are a
19 lot of private practitioners I am sure that would be
20 willing to take on that burden if their staff is
21 trained.
22 If that becomes common culture within our
23 profession, then it's just a matter of working together
24 and setting those type of logistics up. Right now, I
25 think we've got gaps. Everybody has these issues, and

1 they figure, well, we can see more patients; but now
2 you've got more procedures. Okay, now, that's not to
3 say ignore the fact that we have these patients out
4 here, they need to be treated. I think we need to make
5 sure that we can address all of these needs.
6 I want to talk about organizations and to
7 include the private practitioners because it would be
8 another source of income for them. They're willing and
9 able, and they're in their own environment so if they
10 know that they're being trained, they might be a pool
11 of private practitioners. That's another source of
12 revenue and treatment. It's a win-win situation for
13 everyone.
14 MS. SWAIN: Yes, sir, Mr. Black?
15 MR. BLACK: David Black again. I'm speaking
16 as a model representative of the UVA party. I started
17 my career in 1971 in Clintwood, Virginia in the
18 Department of Public Health Dental Clinic, a very nice
19 dental clinic that had just opened. We actually had
20 dentist in the Division of Dental Health. I don't know
21 the politics of this, but dentists -- there weren't
22 many dentists who worked for Department of Public
23 Health and they could ask these people to do the
24 dentistry of tele-dentistry.
25 We actually had some dentists who worked for

1 us. I think that's the ultimate rule, as the
2 Department of Dental Health has been obliterated over
3 the last years because of budget concerns because
4 medical Medicaid took up all the money. Like I said,
5 it's too obvious, but maybe we ought to talk to our
6 legislators about getting some dentists to work for the
7 Department of Dental Health.
8 That would be a very obvious place where we
9 could get these people to do the tele-dentistry. I'm
10 for tele-dentistry. I think it's very good, but who
11 are you going to hire to do it? There's a dental
12 clinic in Roanoke that the Department of Health owns,
13 and I think they're trying to sell it at this point.
14 I'm sure there's a bunch of them around the state.
15 Like I said, we need to talk to our legislators about
16 that. The offer was there so I thought I'd make my --
17 MS. KAHAN: In regards to that, again I think
18 it's the separation of the medical. Medicaid takes up
19 most -- again, we keep separating medicine and
20 dentistry. It's always been, you have medical
21 insurance. You have dental insurance. I think we're
22 getting to that part of the discussion where you can't
23 separate the two anymore.
24 The other thing is that in Virginia Beach I
25 can't speak for anyone else, but assuming we have

1 Heartland Dentists who are coming to Virginia. We have
2 a chain of dentistry and a lot of private dentists take
3 on Medicaid now in their practice which is fabulous and
4 great. Because they extend their hours until 9 o'clock
5 at night, our public health in Virginia Beach, when I
6 tried to get that person to come up into our school, we
7 technically don't have funds for public health dental.
8 That had gone away a long time ago, but they
9 found another way so they don't have to keep worrying
10 about budget cuts. They found a way to find money to
11 keep a dental person in public health, although
12 technically not through that particular type of
13 funding. We do have it. They were sort of not doing
14 anything, and their hours were from 8:30 until 4
15 o'clock, exactly the same time when kids were at
16 school. So I would say to them that you either have to
17 go to the school, and I had a full dental health lab,
18 and it took me eight years to get a four-page
19 memorandum of understanding passed by all of the legal
20 stuff. It took eight years.
21 I retired as a director and a dentist in our
22 public health, until I finally got one to come on down,
23 one day a week, and again, you would think it was like,
24 I don't even know what they thought I was asking.
25 She's finally going to do dentistry here. When I said

1 to them, why didn't you just change your hours? Why
2 are you still 8:30 until 4 o'clock? Why don't you
3 change it, and so Heartland -- I got a thing in the
4 mail announcing this new dentist. Guess when she is
5 open? She is open until 9 o'clock at night, seven days
6 a week so they're open on Saturday and Sunday, but of
7 course, that's what I said to public health.
8 Why are you still open? Close on Monday and
9 Tuesday for your weekend and open on Wednesday,
10 Thursday, Friday and come in at 12 and open until 9 and
11 you would make it more easier for patients so the
12 parents would have it more accessible to them. Anyway,
13 public health didn't do it, but Heartland did it and
14 Heartland is getting remunerated through Medicaid for
15 the kids that they see. So sometimes it just takes
16 minor changes.
17 MR. SWAIN: We seemed to be hearing the
18 common lack of providers and economic issues. Does
19 anybody have anything to say about the top three
20 questions: What should the standards for establishing
21 a dentist/patient should be? Should there be
22 requirements for communications equipment at remote
23 sites which I think some of that's been covered, and
24 what are the risks and costs associated with dentistry?
25 Final comments on that?

1 MS. DUGAR: We, specifically, Dental Quest,
2 has specifically addressed each of the questions that
3 were posed, and we just felt like we should hear what
4 is done in tele-medicine in terms of the
5 patient/physician relationship. So if there's an
6 appropriate model and the business that I'm in, when
7 this is discussed in a broader sense in terms of
8 medicine, Virginia has always led, for example, other
9 states in terms of our -- of medical so we felt like it
10 was important to keep -- location and identity of the
11 requesting patient, disclose the validating
12 practitioner's identity credentials to the patient,
13 which I think you touched on, obtain consent from the
14 patient to provide consent to use tele-medicine, that a
15 practitioner has to be licensed in the state. I think
16 the tele-medicine regulations do a nice job of what
17 establishes what constitutes a dentist/patient
18 relationship.
19 MS. SWAIN: Any other comments? Any other
20 questions for the board members?
21 MR. GASKIN: Perhaps for the record, it might
22 be that this is the Department of Health Professions
23 for medicine, it's document 85-12. At this point, I
24 think everyone cited me at this point.
25 MS. SWAIN: I want to remind everyone that

1 any policy action that the Board decides to take will
2 include the standard comment, opportunities require
3 regulatory action and for the legislative of this later
4 proposal. If you would like notice of board meetings
5 and comment opportunities, please add your name and
6 email address on the sign-up sheet outside the door.
7 We appreciate your time this morning, and
8 thank you for the wealth of information provided. This
9 is a big issue, and we appreciate all the input, and
10 this concludes our forum at this time.
11 Thank you.
12 (Proceeding concluded.)
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1 CERTIFICATE OF COURT REPORTER
2
3 I, Earlina O. King, hereby certify that I was the
4 duly sworn Court Reporter in the Board of Dentistry Forum
5 For the City of Richmond, Virginia, on August 14, 2015 at
6 the time of the hearing herein.
7 I further certify that the foregoing transcript,
8 to the best of my ability, is a true and accurate record of
9 the testimony and other incidents of the proceedings.
10 Given under my hand this 27th day of August
11 2015.
12
13
14
15 ____________________
16 Earlina King
17 Court Reporter
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24 COMMISSION EXPIRES October 31, 2015
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