Virginia Department of
Health Professions

# VIRGINIA BOARD OF DENTISTRY
# BOARD BUSINESS MEETING AGENDA
## JUNE 13, 2025

| TIME | | PAGE |
|---|---|---|
| 9:30 a.m. | **Call to Order – Sultan E. Chaudhry, D.D.S., President** | -- |
| | **Public Comment – Dr. Chaudhry** | -- |
| | **Approval of Minutes** | |
| | • December 13, 2024, Board Business Meeting | 1-5 |
| | • December 13, 2024, Formal Hearing | 6-7 |
| | • January 17, 2025, Telephone Conference Special Session | 8-9 |
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| | **Board Counsel Report – Mr. Rutkowski** | -- |
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**Executive Director's Report – Ms. Sacksteder**

- Update on DDH Compact --
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UNAPPROVED

# VIRGINIA BOARD OF DENTISTRY
## BUSINESS MEETING MINUTES
### December 13, 2024

**TIME AND PLACE:** The meeting of the Virginia Board of Dentistry was called to order at 9:00 a.m., on December 13, 2024, at the Perimeter Center, 9960 Mayland Drive, in Board Room 3, Henrico, Virginia 23233.

**PRESIDING:** Sultan E. Chaudhry, D.D.S., President

**MEMBERS PRESENT:**
Alf Hendricksen, D.D.S., Vice-President
Sidra Butt, D.D.S., Secretary-Treasurer
William C. Bigelow, D.D.S.
Jamiah Dawson, D.D.S.
Surya Dhakar, D.D.S.
J. Michael Martinez de Andino, J.D.
Emelia H. McLennan, R.D.H.
Jennifer Szakaly, D.D.S.

**MEMBERS ABSENT:** Margaret F. Lemaster, R.D.H.

**STAFF PRESENT:**
Jamie C. Sacksteder, Executive Director
Erin Weaver, Deputy Executive Director
Sarah Moore, Executive Assistant
Arne Owens, Agency Director, DHP
Matt Novak, Policy and Economic Analyst

**COUNSEL PRESENT:** N. Brent Saunders, Sr. Assistant Attorney General

**ESTABLISHMENT OF A QUORUM:** With 9 members of the Board present, a quorum was established.

Ms. Sacksteder read the emergency evacuation procedures.

**PUBLIC COMMENT:** Dr. Chaudhry explained the parameters for public comment and opened the public comment period.

Ms. Tracey Martin, Regulatory and Advocacy Chair for the ADHA, read letter on behalf of Ms. Ryan Christine Maphis, President of the Virginia Dental Hygienists' Association, stating their disapproval of the ADA resolutions.

Dr. Chaudhry closed the public comment period.

**APPROVAL OF MINUTES:** Dr. Chaudhry asked if there were any edits or corrections to the September 13, 2024, Board Business Meeting Minutes, the October 2, 2024, Telephone Conference Call Special Session Minutes, the November 1, 2024, Formal Hearing Minutes, the November 1, 2024, Special Session Minutes, or the November 19, 2024, Telephone Conference Call Special Session Minutes. Hearing none, Dr. Hendricksen moved to approve the minutes as presented. The motion was seconded and passed unanimously.

**DHP DIRECTOR'S REPORT** Arne Owens, Agency Director, welcomed the Board and discussed the upcoming General Assembly session. He advised DHP had several agency bills that would be brought forth during this session. He discussed the DHP Agency's Administrative staff and their support of the 13 Agency Boards. He also advised the Bi-Annual Budget was now approved and in place.

**BOARD COUNSEL REPORT:** Mr. Saunders advised the lawsuit against the Board of Dentistry regarding the recently passed Dentist and Dental Hygienist Compact had been dismissed on December 5, 2024.

**LIAISON & COMMITTEE REPORTS:**

**CDCA-WREB-CITA/ AADB, AADA Conferences, September 25-29, 2024, Louisville KY**: Ms. Sacksteder discussed the AADA and AADB portions of the conferences is comprised of executive directors from several states, resulting in sharing of best practices and good contacts for further discussions. Dr. Chaudhry discussed the CWC (CDCA-WREB-CITA) meetings. He advised these meetings went well, ensuing shared highlights of the various national boards. He stated his pride in the Virginia Board of Dentistry.

**ADEX Conference, September 25-29, 2024, Louisville KY:** Dr. Hendricksen highlighted this meeting, which he advised should support better communication with candidates and examiners.

**CODA Site Visit, October 17, 2024:** Dr. Hendricksen advised that his site visit went well. **CODA requires confidentiality therefore; further detail could not be discussed.**

**CDCA Examiner Participation, October 18, 2024, New York, NY:** Dr. Chaudhry shared that he had participated in the examinations, because of confidentiality, details could not be discussed but he stated the test administrators run the exam well.

**DANB Meeting**: Ms. Sacksteder discussed that the details of this meeting are confidential at this time, but it is a group of approximately 20 professionals (educators, DAs, Dentists, Dental Hygienists, and regulators) from across the country working toward a national workgroup model for Dental Assistants. She remarked that the meetings have been very rewarding and enlightening. She stated that she has come away with ideas that would be beneficial to Virginia.

**LEGISLATION, REGULATION, AND GUIDANCE:** **Status Report on Regulatory Actions Chart –** Mr. Novak reviewed the updated Regulatory Actions Chart listing of the ongoing regulatory actions as of November 18, 2024, which was included in the agenda packet. A synopsis of the progress of the bills was provided.

Mr. Novak explained that several guidance documents were being repealed because a purpose of a guidance document is the Board's interpretation of the law or regulations. Several of the proposed guidance documents for repeal were just repeats of code/regulation or they were not actually based on code/regulation. Also, several of the guidance documents are being amended because new regulations went into effect for dentist, dental hygienists, and dental assistants on October 24,2024. The changes to the regulations resulted in the changing of regulations numbers. Several guidance documents (60-1, 60-5, 60-9, 60-10,60-11, and 60-22 were moved last week to policy documents after approval from the AG's office and the Board Chair.

**Adoption of Guidance Document 60-3:** Mr. Novak explained Guidance Document 60-3. This guidance document was necessary because the Board removed the listing of approved CE providers within the regulations (this went into effect October 2024) and this guidance document will allow for the Board to adopt or remove CE providers more easily. This was discussed by the Board. Mr. Martinez made a motion to adopt the Guidance Document 60-3. The motion was seconded and passed unanimously.

**Repeal of Guidance Document 60-4:** Mr. Novak explained that this document does not interpret statue or code, which is the definition of a guidance document and therefore should be repealed This was discussed by the Board. Dr. Martinez made a motion to repeal Guidance Document 60-4. The motion was seconded and passed unanimously.

**Repeal of Guidance Document 60-8:** Mr. Novak explained that this document does not interpret statue or code, which is the definition of a guidance document and therefore should be repealed. This information is a reiteration of regulation. This was discussed by the Board. Ms. McLennan made a motion to repeal Guidance Document 60-8. The motion was seconded and passed unanimously.

**Repeal of Guidance Document 60-23:** Mr. Novak explained that this document was originally created when teledentistry was not addressed in code and is an almost identical copy of a Board of Medicine guidance document that has since been repealed. Teledentistry is now addressed in code and a guidance document is no longer necessary. This was discussed by the Board. Dr. Hendricksen made a motion to repeal Guidance Document 60-23. The motion was seconded and passed unanimously.

**Revision of Guidance Document 60-6:** Mr. Novak explained the changes to Guidance Document 60-6 with regard to changes in regulations effective 10/24/24 and updates to links.. These were discussed by the Board. Dr. Martinez made a motion to adopt the changes in Guidance Document 60-6. The motion was seconded and passed unanimously.

**Revision of Guidance Document 60-12** Mr. Novak explained the changes to Guidance Document 60-12 because there were changes in the regulations that went into effect on 10/24/24, which were discussed by the Board. An edit to add the word 'with' to the wording of the first page section 1B. first bullet, last line, as follows: 'decided on a case by case basis, in accordance ***with*** the regulation'. Dr. Hendricksen made a motion to adopt the changes to Guidance Document 60-12 with the edit. The motion was seconded and passed unanimously.

**Revision of Guidance Document 60-13:** Mr. Novak explained the changes to Guidance Document 60-13 for updated the guidance document to the current Virgina Code and some stylistic edits. This was discussed by the Board. Ms. McLennan made a motion to adopt the changes. The motion was seconded and passed unanimously.

**Revision of Guidance Document 60-27:** Mr. Novak explained the changes to Guidance Document 60-27 updating regulation numbers to the current regulations that were adopted on 10/24/24, which were discussed by the Board. Dr. Dawson made a motion to adopt the changes. The motion was seconded and passed unanimously.

**Petition for Rulemaking from American Medical Technologies:** The Board considered the petition. Dr. Hendricksen made a motion to deny the petition and refer the review of the need of adding more radiological providers to the regulatory committee for further study and review. The Board does not know of any need to add more providers. The motion was seconded and passed unanimously.

**BOARD DISCUSSION TOPICS:**

**Consideration of Public Comments:** The Board discussed the public comment letter from Ms. Ryan Christine Maphis, President of the Virginia Dental Hygienists' Association.

The Board discussed the letter from Dr. Shereef Elnahal of the Department of Veterans Affairs, Federal Register Notice_VA National Standard of Practice. Ms. Sacksteder will respond on behalf of the Board. The Board was in agreement that there were not significant concerns regarding the National Standard of Practice within the Veteran's Affairs for dental hygienists.

The Board discussed the ADA's proposed resolutions to the dental hygiene shortage and the ADHA's response to the ADA's proposed resolutions. The majority of the Board was in favor of creating a pathway for foreign trained dentist to become dental hygienists. However, this would need to be a legislative change, and the Board could not change the current requirements. The Board discussed the increasing of the student ratio for CODA Dental Hygiene Programs, the Board would be in support of this. The Board also discussed dental students being able to work in Dental Hygiene, this was not seen by the Board to be a huge help, since we only have one dental school. Also, Virginia Code does allow some version of this, found in 54.1-2712 for dental and dental hygiene students.

The Board discussed the OPA EFDA Pilot Program in Missouri. There a few factors of concerned by the Board, including allowing dental assistants to scale that are not being taught by a standard curriculum and more of an on-the-job training. The Board could not consider this pilot program since it just begun the first week of December 2024. It would be more beneficial for the Board to review the findings of the pilot program after it has been in process for patient safety factors. Also, some factors would require a legislative change.

The Board discussed the Dental Hygienists Restorative Duties – State Chart regarding creating a pathway for Dental Hygienists to perform restorative functions. The Executive Director would like to create a pathway to allow Dental Hygienists to perform restorative functions without becoming a Dental Assistant II (DA II). Currently the Dental Assistant II regulations are meant for DAIIs and not for dental hygienists. A proposed pathway would be to create language in the dental hygiene

regulations that require a dental hygienist to take a course in restorative training, possible CODA, that the dentist will then review and decide if the dental hygienists can perform restorative functions approved by the dentist. This will eliminate the need for a dental hygienist to hold a separate registration as a DA II and would be more streamlined. This will also address an access to care issue for southwest part of Virginia. The majority of DA IIs are located in Southwest Virginia. There are only 5 DA II's that are licensed as dental hygienist and registered as a DA II. This is thought to only be beneficial for a small amount of dental hygienists. There are only 55 current DA II's that are registered and 4 are outside the state. The Board decided to refer this to the Regulatory Committee for further discussion and consideration.

**DEPUTY EXECUTIVE DIRECTOR'S REPORT:**

**Disciplinary Report -** Ms. Weaver updated the Board on the Disciplinary Report for August 17, 2024 – November 21, 2024, of the number of cases received and cases closed. She advised there were 3 Summary Suspensions, 1 Mandatory Suspension, and 1 Revocation of licenses during this period. She advised that Dr. Ashley Epperly, Dental Review Coordinator, began in September 2024 and is now reviewing cases. She thanked the Board for their case reviews contributing to a more efficient workflow.

**EXECUTIVE DIRECTOR'S REPORT:**

**Disciplinary Cost Recovery**: Ms. Sacksteder reviewed the Disciplinary Cost Recovery Policy and worksheet.

**ADJOURNMENT:**

With all business concluded, the Board adjourned at 11:09 a.m.

| ______________________________ | ______________________________ |
|---|---|
| Sultan E. Chaudhry, D.D.S., President | Jamie C. Sacksteder, Executive Director |
| ______________________________ | ______________________________ |
| Date | Date |

# VIRGINIA BOARD OF DENTISTRY
## FORMAL HEARING MINUTES
## December 13, 2024

**TIME AND PLACE:** The meeting of the Virginia Board of Dentistry was called to order at 1:03 p.m., on December 13, 2024, in Board Room 3 at the Perimeter Center, 9960 Mayland Drive, Suite 201, Henrico, Virginia, 23233.

**PRESIDING:** Sultan E. Chaudhry, D.D.S., President

**MEMBERS PRESENT:**
Alf Hendricksen, D.D.S., Vice-President
Sidra Butt, D.D.S., Secretary-Treasurer
Jamiah Dawson, D.D.S.
Surya Dhakar, D.D.S.
J. Michael Martinez de Andino, J.D.
Emelia H. McLennan, R.D.H.
Jennifer Szakaly, D.D.S.

**MEMBERS ABSENT:**
William C. Bigelow, D.D.S.
Margaret F. Lemaster, R.D.H.

**STAFF PRESENT:**
Jamie C. Sacksteder, Executive Director
Sarah Moore, Executive Assistant

**COUNSEL PRESENT:** N. Brent Saunders, Senior Assistant Attorney General

**OTHERS PRESENT:**
Sean Murphy, Assistant Attorney General
Juan Ortega, Court Reporter
Juliane C. Miller, Esquire
John Zunka, Esquire

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

**Craig A. Zunka, D.D.S.**
**Case No.:229224**

Mr. Zunka was present with counsel in accordance with the notice dated October 3, 2024.

Dr. Chaudhry swore in the witnesses.

Following Mr. Murphy' s opening statement, Dr. Chaudhry admitted into evidence Commonwealth's Exhibits 1-3.

Testifying on behalf of the Commonwealth:

- Julia Turner, DHP Senior Investigator
- Individual 1
- Individual 2
- Individual 3
- Individual 4

Following Ms. Miller's opening statement, Dr. Chaudhry admitted into evidence Exhibit A.

Testifying on behalf of Dr. Zunka:

- Vivian Manual, Dental Assistant
- Michelle Collins, Dental Assistant
- Mr. Zunka testified on his own behalf.
- Jeffrey Brown, D.D.S.
- Marla Mead, D.O.

Mr. Murphy and Ms. Miller provided closing statements.

**Closed Meeting:** Dr. Hendricksen moved that the Board enter into a closed meeting pursuant to §2.1-311(A)(27) and Section 2.2-3712(F) of the Code of Virginia for the purpose of deliberation to reach a decision in the matter Craig A. Zunka, D.D.S. Additionally, he moved that Board staff, Ms. Sacksteder, and Ms. Moore and the Board Counsel, Mr. Saunders attend the closed meeting because their presence in the closed meeting was deemed necessary and would aid the Board in its deliberations. The motion was seconded and passed.

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

**Decision:** Ms. Sacksteder reported that Mr. Zunka's license to practice dentistry in the Commonwealth of Virginia is indefinitely suspended for a period of not less than 2 years, stayed upon compliance of the terms and conditions.

Dr. Hendricksen moved to accept the Board's decision as read by Ms. Sacksteder. The motion was seconded and passed.

**Adjournment:** The Board adjourned at 10:25 p.m.

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Sultan E. Chaudhry, D.D.S., President

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Jamie C. Sacksteder, Executive Director

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Date

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Date

**UNAPPROVED**

# VIRGINIA BOARD OF DENTISTRY

## MINUTES
## SPECIAL SESSION

| | |
|---|---|
| **CALL TO ORDER:** | Pursuant to Virginia Code § 54.1-2408.1(A), the Board of Dentistry convened by telephone conference call and at the Department of Health Professions, Perimeter Center, 2nd Floor Conference Center, Board Room 4, 9960 Mayland Drive, Henrico, VA 23233 on January 17, 2025 at 11:04 a.m., to consider a possible summary suspension in case number 219990. |
| **MEMBERS PRESENT BY TELEPHONE:** | Sultan E. Chaudhry, D.D.S., President – **Presiding**<br>William C. Bigelow, D.D.S.<br>Sidra Butt, D.D.S.<br>Jamiah Dawson, D.D.S.<br>J. Michael Martinez de Andino, J.D. |
| **MEMBERS PRESENT AT DHP:** | Alf Hendricksen, D.D.S.<br>Emelia H. McLennan, R.D.H.<br>Jennifer Szakaly, D.D.S. |
| **MEMBERS ABSENT:** | Surya Dhaka, D.D.S.<br>Margaret F. Lemaster, R.D.H. |
| **POLLING OF BOARD MEMBERS:** | The Board members were polled prior to scheduling the telephone conference call as to whether they could attend the meeting in Richmond. |
| **QUORUM:** | With eight members present, a quorum was established. |
| **STAFF PRESENT:** | Jamie C. Sacksteder, Executive Director<br>Erin T. Weaver, Deputy Executive Director<br>Donna M. Lee, Discipline Case Manager |
| **OTHERS PRESENT:** | James Rutkowski, Senior Assistant Attorney General, Board Counsel<br>Sean Murphy, Senior Assistant Attorney General<br>Rebecca Smith, Senior Adjudication Specialist |
| **Kevin D. Kiely, D.M.D.<br>Case No.: 219990** | The Board received information from Mr. Murphy to determine if Dr. Kiely's practice of dentistry constituted a substantial danger to public health or safety. Mr. Murphy reviewed the cases and responded to questions. |
| **CLOSED MEETING:** | Dr. Hendricksen moved that the Board convene a closed meeting pursuant to § 2.2-3711(A)(27) of the Code of Virginia for the purpose of deliberation to reach a decision in the matter of Kevin Kiely. Additionally, Dr. Hendricksen moved that Ms. Sacksteder, Ms. Weaver, Ms. Lee, and Mr. Rutkowski attend the closed meeting because their presence in the closed meeting was deemed necessary and their presence would aid the Board in its deliberations. The motion was seconded and passed. |

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

**DECISION:** Mr. Martinez moved that the Board summarily suspend Dr. Kiely's license to practice dentistry in the Commonwealth of Virginia in that his practice of dentistry constituted a substantial danger to public health and safety; and schedule a formal hearing. The motion was seconded and passed unanimously.

**ADJOURNMENT:** With all business concluded, the Board adjourned at 11:30 a.m.

______________________________
Sultan E. Chaudhry, D.D.S., Chair

______________________________
Jamie C. Sacksteder, Executive Director

______________________________
Date

______________________________
Date

UNAPPROVED

# VIRGINIA BOARD OF DENTISTRY
## FORMAL HEARING MINUTES
### March 6-7, 2025

**TIME AND PLACE:** The meeting of the Virginia Board of Dentistry was called to order at 8:45 a.m., on March 6, 2025, in Board Room 1 at the Perimeter Center, 9960 Mayland Drive, Suite 201, Henrico, Virginia, 23233.

**PRESIDING:** Sultan E. Chaudhry, D.D.S., President

**MEMBERS PRESENT:**
Alf Hendricksen, D.D.S., Vice-President
Sidra Butt, D.D.S., Secretary-Treasurer
Jamiah Dawson, D.D.S.
Surya Dhakar, D.D.S.
Margaret F. Lemaster, R.D.H.
J. Michael Martinez de Andino, J.D.
Emelia H. McLennan, R.D.H.

**MEMBERS ABSENT:**
William C. Bigelow, D.D.S.
Jennifer Szakaly, D.D.S.

**STAFF PRESENT:**
Jamie C. Sacksteder, Executive Director
Sarah Moore, Executive Assistant

**COUNSEL PRESENT:** James E. Rutkowski, Senior Assistant Attorney General

**OTHERS PRESENT:**
Sean Murphy, Senior Assistant Attorney General
Rebecca Smith- need her title
Juan Ortega, Court Reporter
Dan J. Alpert, Esquire
Jacques G. Simon, Esquire

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

**Shahrzad Salartash, D.D.S. Case No.:222445 and 225344**

Dr. Salartash was present with counsel, Dan Alpert and Jacques Simon, pursuant to his *pro hac vice* admission in Virginia for this formal conference matter, to discuss the allegations set for the in the Notice of the Board dated October 4, 2024.

Dr. Chaudhry swore in the witnesses.

Following Mr. Murphy' s opening statement, Dr. Chaudhry admitted into evidence Commonwealth's Exhibits 1-5.

Testifying on behalf of the Commonwealth:

- Todd Troutner, DHP Senior Investigator, NOVA
- Umar Alam, M.D., Board Certified Neurologist

- Bhavna Shroff, D.D.S., Director of Orthodontics, VCU

Following Mr. Simon's opening statement, Dr. Chaudhry admitted into evidence Exhibit A-J.

Dr. Salartash testified on her own behalf

**Adjournment:** The meeting was adjourned at 5:15 p.m.

**MEETING CONTINUED TIME AND PLACE:** The meeting of the Virginia Board of Dentistry was called to order at 9:04 a.m., on March 7, 2025, in Board Room 1 at the Perimeter Center, 9960 Mayland Drive, Suite 201, Henrico, Virginia, 23233.

Dr Chaudhry had to swear in the witnesses that weren't present on Thursday, so we need to mention that here

Dr. Salartash continued and testified on her own behalf

Also testifying on behalf of Dr. Salartash:

- Jeffrey Brown, D.D.S.
- Fred Bloem, M.D.

Mr. Murphy and Mr. Simon provided closing statements.

**Closed Meeting:** Dr. Hendricksen moved that the Board enter into a closed meeting pursuant to §2.1-311(A)(27) and Section 2.2-3712(F) of the Code of Virginia for the purpose of deliberation to reach a decision in the matter Shahrzad Salartash, D.D.S. Additionally, he moved that Board staff, Ms. Sacksteder, and Ms. Moore and the Board Counsel, Mr. Rutkowski attend the closed meeting because their presence in the closed meeting was deemed necessary and would aid the Board in its deliberations. The motion was seconded and passed.

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

**Decision:** Mr. Rutkowski reported that Ms. Salartash's license to practice dentistry in the Commonwealth of Virginia is indefinitely suspended for a period of not less than 2 years, stayed upon compliance of terms and conditions.

Dr. Hendricksen moved to accept the Board's decision as read by Mr.

Rutkowski. The motion was seconded and passed.

**Adjournment:** The Board adjourned at 9:58 p.m.

Sultan E. Chaudhry, D.D.S., President

Jamie C. Sacksteder, Executive Director

Date

Date

**UNAPPROVED**

# VIRGINIA BOARD OF DENTISTRY

## MINUTES
## SPECIAL SESSION

| | |
|---|---|
| **CALL TO ORDER:** | Pursuant to Virginia Code § 54.1-2408.1(A), the Board of Dentistry convened by telephone conference call and at the Department of Health Professions, Perimeter Center, 2nd Floor Conference Center, Board Room 4, 9960 Mayland Drive, Henrico, VA 23233 on May 16, 2025, at 9:01 a.m., to consider a possible summary suspension in case numbers 209163, 212202, 212193. |
| **MEMBERS PRESENT AT DHP:** | Sultan E. Chaudhry, D.D.S., President – **Presiding**<br>Sidra Butt, D.D.S., Secretary-Treasurer<br>William C. Bigelow, D.D.S.<br>J. Michael Martinez de Andino, J.D.<br>Margaret F. Lemaster, R.D.H. |
| **MEMBERS PRESENT BY TELEPHONE:** | Alf Hendricksen, D.D.S., Vice-President<br>Jennifer Szakaly, D.D.S. |
| **MEMBERS ABSENT:** | Surya Dhakar, D.D.S.<br>Jamiah Dawson, D.D.S.<br>Emelia H. McLennan, R.D.H. |
| **POLLING OF BOARD MEMBERS:** | The Board members were polled prior to scheduling the telephone conference call as to whether they could attend the meeting in Richmond. |
| **QUORUM:** | With seven members present, a quorum was established. |
| **STAFF PRESENT:** | Jamie C. Sacksteder, Executive Director<br>Erin T. Weaver, Deputy Executive Director<br>Sarah Moore, Executive Assistant |
| **OTHERS PRESENT:** | Sean Murphy, Senior Assistant Attorney General<br>Rebecca Smith, Senior Adjudication Specialist |
| **OTHERS PRESENT BY PHONE:** | James Rutkowski, Senior Assistant Attorney General, Board Counsel |
| **John C. Carter, D.D.S.**<br>**Case No.: 209163, 212202, 212193** | The Board received information from Mr. Murphy to determine if Dr. Carter's practice of dentistry constituted a substantial danger to public health or safety. Mr. Murphy reviewed the case and responded to questions. |

**DECISION:** Mr. Martinez moved that the Board summarily suspend Dr. Carter's license to practice dentistry in the Commonwealth of Virginia in that his practice of dentistry constituted a substantial danger to public health and safety. Following a second, a roll call vote was taken and passed unanimously.

**ADJOURNMENT:** With all business concluded, the Board adjourned at 9:20 a.m.

| | |
|---|---|
| ____________________________ | ____________________________ |
| Sultan E. Chaudhry, D.D.S., President | Jamie C. Sacksteder, Executive Director |
| ____________________________ | ____________________________ |
| Date | Date |

**DRAFT**

# Virginia's Dentistry Workforce: 2024

Healthcare Workforce Data Center

February 2025

Virginia Department of Health Professions
Healthcare Workforce Data Center
Perimeter Center
9960 Mayland Drive, Suite 300
Henrico, VA 23233
804-597-4213, 804-527-4466(fax)
E-mail: *HWDC@dhp.virginia.gov*

Follow us on Tumblr: *www.vahwdc.tumblr.com*
Get a copy of this report from:
*https://www.dhp.virginia.gov/PublicResources/HealthcareWorkforceDataCenter/ProfessionReports/*

***7,000 Dentists voluntarily participated in this survey.*** *Without their efforts the work of the center would not be possible. The Department of Health Professions, the Healthcare Workforce Data Center, and the Board of Dentistry express our sincerest appreciation for their ongoing cooperation.*

***Thank You!***

***Virginia Department of Health Professions***

**Arne W. Owens, MS**
*Director*

*Healthcare Workforce Data Center Staff:*

Yetty Shobo, PhD
*Director*

Barbara Hodgdon, PhD
*Deputy Director*

Rajana Siva, MBA
*Research Analyst*

Christopher Coyle, BA
*Research Assistant*

## Virginia Board of Dentistry

***President***

Sultan E. Chaudhry, DDS
*Falls Church*

***Vice President***

Alf Hendricksen, DDS
*Lynchburg*

***Secretary-Treasurer***

Sidra Butt, DDS
*Midlothian*

***Members***

William C. Bigelow, DDS
*Verona*

Jamiah Dawson, DDS
*Newport News*

Surya Dhakar, DDS
*Glen Allen*

Margaret F. Lemaster RDH
*Chesapeake*

J. Michael Martinez de Andino
*Richmond*

Emelia H. McLennan, RDH
*Virginia Beach*

Jennifer Szakaly, DDS
*Suffolk*

***Executive Director***

Jamie C. Sacksteder

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# The Dentistry Workforce: At a Glance:

### The Workforce
Licensees: 8,394
Virginia's Workforce: 6,283
FTEs: 5,055

### Survey Response Rate
All Licensees: 83%
Renewing Practitioners: 88%

### Demographics
Female: 45%
Diversity Index: 62%
Median Age: 46

### Background
Rural Childhood: 18%
HS Diploma in VA: 40%
Prof. Degree in VA: 33%

### Education
Doctorate/Prof.: 97%
Master's Degree: 1%

### Finances
Median Inc.: $170k-$180k
Retirement Benefits: 41%
Under 40 w/ Ed Debt: 67%

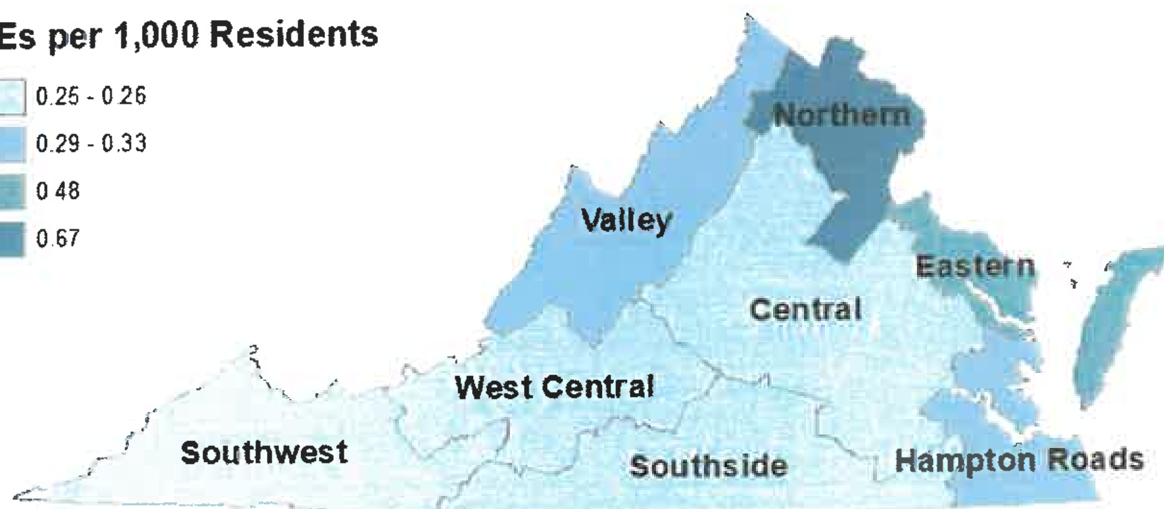
### Current Employment
Employed in Prof.: 96%
Hold 1 Full-time Job: 68%
Satisfied: 96%

### Job Turnover
Switched Jobs: 4%
Employed over 2 yrs.: 68%

### Time Allocation
Patient Care: 80-89%
Administration: 1-9%
Patient Care Role: 91%

**Full Time Equivalency Units Provided by Dentists per 1,000 Residents by Virginia Performs Regions**

Source: Va Healthcare Workforce Data Center




*Annual Estimates of the Resident Population: July 1, 2023*
*Source: U.S. Census Bureau, Population Division*

## Results in Brief

In 2024, 6,283 dentists in Virginia's workforce provided 5,055 "full-time equivalency units", which the HWDC defines as working 2,000 hours a year. The Virginia Department of Health Professions' Healthcare Workforce Data Center (HWDC) administers the 2024 survey during the license renewal process, which takes place annually on an ongoing basis during the birth month of each dentist. The 7,000 survey respondents represent 83% of the 8,394 licensed dentists in the state and 88% of renewing practitioners.

More than two out of every five dentists are female, and the median age of all dentists is 46. In a random encounter between two dentists, there is a 62% chance that they would be of different races or ethnicities, a measure known as the diversity index. The diversity index in Virginia is 60%. Dentists under age 40 have a diversity index of 65%.

Nearly all dentists hold a doctorate or professional degree. About 39% of all dentists have educational debt, including 67% of dentists who are under the age of 40. The median debt for those dentists with educational debt is between $200,000 and $219,000. The median annual income for dentists is also between $170,000 and $180,000, with 58% of wage or salaried dentists receiving at least one employer-sponsored benefit; 96% of dentists indicate that they are satisfied with their current employment situation.

Only 7% of dentists currently work in non-metro areas of the state. Approximately 80% of dentists worked in the Northern Virginia, Central Virginia, and Hampton Roads regions. Dentists spend about 91% of their time treating patients; on average, they treat 50-74 patients per week. Ninety-three percent of dentists work in the private sector, including 89% who work at a for-profit organization. A little over three-fifths of dentists work at a solo dental practice, while another 22% work at a group dental practice. Only 27% of the workforce expect to retire in the next decade, while half of the current workforce expect to retire by 2044.

## Summary of Trends

The Virginia dental workforce has increased by about 3% since 2023 whereas the number of total licensees increased by 2% in the same period; since 2013 both have a 18% and 22% increase, respectively. Alongside these increases, the full time equivalency (FTE) units also increased by approximately 11% over the past year (4,568 in 2023 vs 5,055 in 2024); its increase since 2013 is 13%.

Compared to 2013, there have been significant changes in the demographic composition of the state's dentistry workforce. Females make up a greater proportion of the dental workforce (30% vs 45%). Further, in 2024, 60% of the dentists under age 40 are female, up from 50% in 2013. Median age has declined from 50 to 46 since 2013, and the percentage of dentists above age 55 years declined from 40% to 30% in the same period. Further, the number of dentists under age 40 has increased from 27% in 2013 to 34% in 2024. The diversity index continues to increase, from 60% in 2023 to 62% in 2024, and has increased significantly since 2013 when it was 48%. Further, the diversity index for dentists under 40 years, increased slightly, from 63% in 2023 to 65% in 2024.

The percentage of dentists in non-metro areas (7%) did not change between 2023 and 2024 after declining from 8% to 7% in 2018. The educational attainment level of dentists also did not change from 2023 to 2024 though the median debt increased from $170,000-$180,000 to $200,000-$220,000; meanwhile, income has held steady since 2023 at $170,000-$180,000. Among all dentists the percent carrying education debt has decreased since 2023, 42% to 39%; the percentage of dentists under the age of 40 who carry education debt also decreased from 70% in 2023 to 67%.

Since the coronavirus pandemic, past year involuntary unemployment recovered to less than 1%, suggesting a which is comparable to pre-pandemic unemployment rates. The proportion receiving at least one employer-sponsored benefit increased from 46% in 2013 to 50% in 2024. The percent of dentists who intend to retire by age 65 increased from 36% in 2013 to 49% in 2024; additionally, half of the dentistry workforce plan to retire within two decades of the survey, which has remained unchanged since 2013.

## A Closer Look:

| Licensees | | |
|---|---|---|
| License Status | # | % |
| Renewing Practitioners | 7,402 | 88% |
| New Licensees | 557 | 7% |
| Non-Renewals | 435 | 5% |
| All Licensees | 8,394 | 100% |

*Source: Va. Healthcare Workforce Data Center*

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

| Response Rates | | | |
|---|---|---|---|
| Statistic | Non Respondents | Respondent | Response Rate |
| **By Age** | | | |
| Under 30 | 218 | 183 | 46% |
| 30 to 34 | 278 | 769 | 73% |
| 35 to 39 | 249 | 1,017 | 80% |
| 40 to 44 | 140 | 993 | 88% |
| 45 to 49 | 94 | 869 | 90% |
| 50 to 54 | 80 | 841 | 91% |
| 55 to 59 | 56 | 655 | 92% |
| 60 and Over | 279 | 1,673 | 86% |
| Total | 1,394 | 7,000 | 83% |
| **New Licenses** | | | |
| Issued in Past Year | 497 | 60 | 11% |
| **Metro Status** | | | |
| Non-Metro | 76 | 341 | 82% |
| Metro | 759 | 4,953 | 87% |
| Not in Virginia | 559 | 1,706 | 75% |

*Source: Va. Healthcare Workforce Data Center*

### Definitions

1. **The Survey Period:** The survey was conducted throughout 2024 on the birth month of each renewing practitioner.
2. **Target Population:** All dentists who held a Virginia license at some point in 2024.
3. **Survey Population:** The survey was available to dentists who renewed their licenses online. It was not available to those who did not renew, including some dentists newly licensed in 2024.

| Response Rates | |
|---|---|
| Completed Surveys | 7,000 |
| Response Rate, All Licensees | 83% |
| Response Rate, Renewals | 88% |

*Source: Va. Healthcare Workforce Data Center*

### At a Glance:

**Licensed Dentists**
Number: 8,394
New: 7%
Not Renewed: 5%

**Response Rates**
All Licensees: 83%
Renewing Practitioners: 88%

## At a Glance:

**Workforce**
Dentistry Workforce: 6,283
FTEs: 5,055

**Utilization Ratios**
Licensees in VA Workforce: 75%
Licensees per FTE: 1.66
Workers per FTE: 1.24

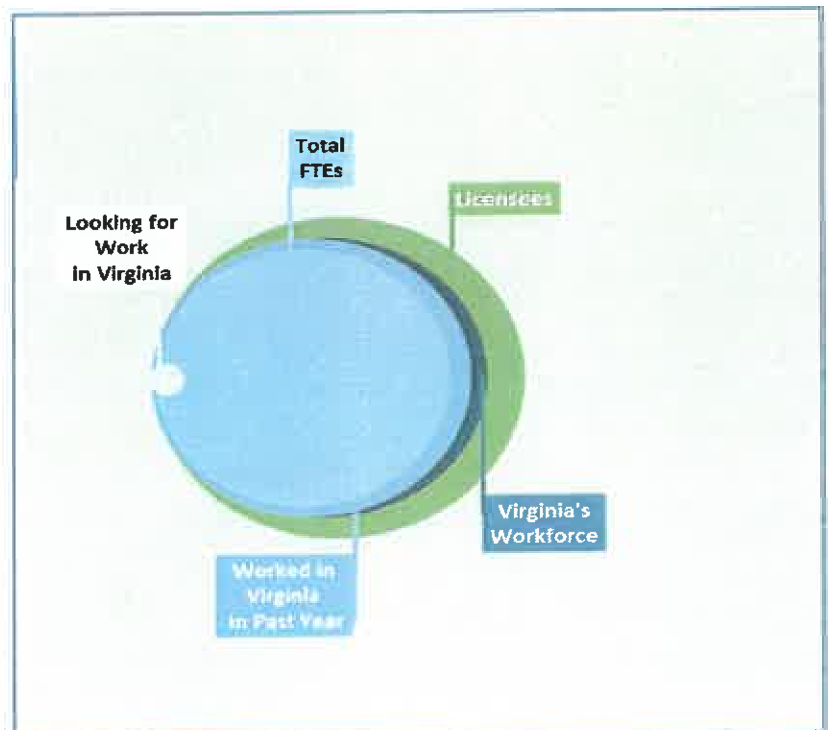
## Definitions

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

| Virginia's Dentistry Workforce | | |
|---|---|---|
| Status | # | % |
| Worked in Virginia in Past Year | 6,211 | 99% |
| Looking for Work in Virginia | 72 | 1% |
| Virginia's Workforce | 6,283 | 100% |
| Total FTEs | 5,055 | |
| Licensees | 8,394 | |

*Source: Va. Healthcare Workforce Data Center*

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




*Source: Va. Healthcare Workforce Data Center*

## A Closer Look:

| Age & Gender | | | | | | |
|---|---|---|---|---|---|---|
| Age | Male | | Female | | Total | |
| | # | % Male | # | % Female | # | % in Age Group |
| **Under 30** | 108 | 39% | 171 | 61% | 279 | 6% |
| **30 to 34** | 251 | 40% | 382 | 60% | 633 | 13% |
| **35 to 39** | 297 | 42% | 413 | 58% | 709 | 15% |
| **40 to 44** | 304 | 49% | 323 | 52% | 627 | 13% |
| **45 to 49** | 288 | 54% | 246 | 46% | 534 | 11% |
| **50 to 54** | 292 | 55% | 235 | 45% | 527 | 11% |
| **55 to 59** | 244 | 63% | 143 | 37% | 387 | 8% |
| **60 +** | 841 | 82% | 188 | 18% | 1,028 | 22% |
| **Total** | **2,624** | **56%** | **2,101** | **45%** | **4,726** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

## At a Glance:

**Gender**
% Female: 45%
% Under 40 Female: 60%

**Age**
Median Age: 46
% Under 40: 34%
% 55+: 30%

**Diversity**
Diversity Index: 62%
Under 40 Div. Index: 65%

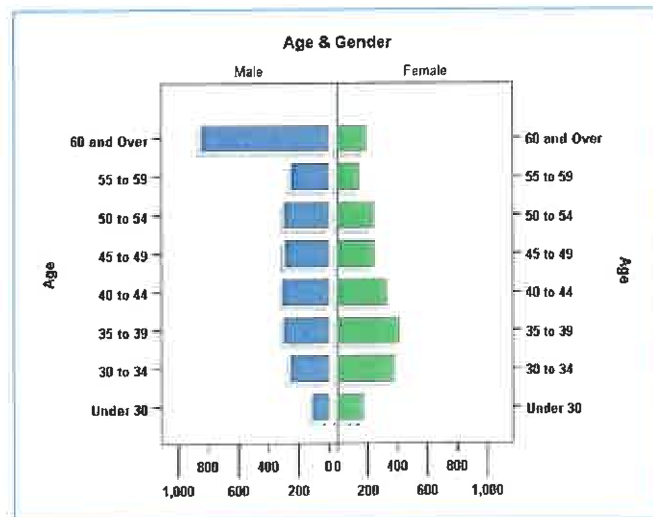
| Race & Ethnicity | | | | | |
|---|---|---|---|---|---|
| Race/ Ethnicity | Virginia* | Dentists | | Dentists Under 40 | |
| | % | # | % | # | % |
| **White** | 59% | 2,623 | 56% | 802 | 50% |
| **Black** | 19% | 295 | 6% | 90 | 6% |
| **Asian** | 7% | 1,179 | 25% | 488 | 30% |
| **Other Race** | 0% | 199 | 4% | 72 | 4% |
| **Two or More Races** | 3% | 111 | 2% | 53 | 3% |
| **Hispanic** | 11% | 300 | 6% | 103 | 6% |
| **Total** | **100%** | **4,707** | **100%** | **1,608** | **100%** |

*Population data in this chart is from the US Census, Annual Estimates of the Resident Population by Sex, Race, and Hispanic Origin for the United States, States, and Counties: July 1, 2023.

*Source: Va. Healthcare Workforce Data Center*

*In a chance encounter between two dentists, there is a 62% chance they would be of a different race/ethnicity (a measure known as the Diversity Index), this is slightly higher than the 60% diversity index for Virginia's population as a whole.*

*One in three dentists are under the age of 40. 60% of dentists under 40 are female, and 30% are non-Hispanic Asian.*



## At a Glance:

**Childhood**

Urban Childhood: 24%
Rural Childhood: 18%

**Virginia Background**

HS in Virginia: 40%
Dental Ed. in VA: 33%
HS or Dental Ed. in VA: 47%

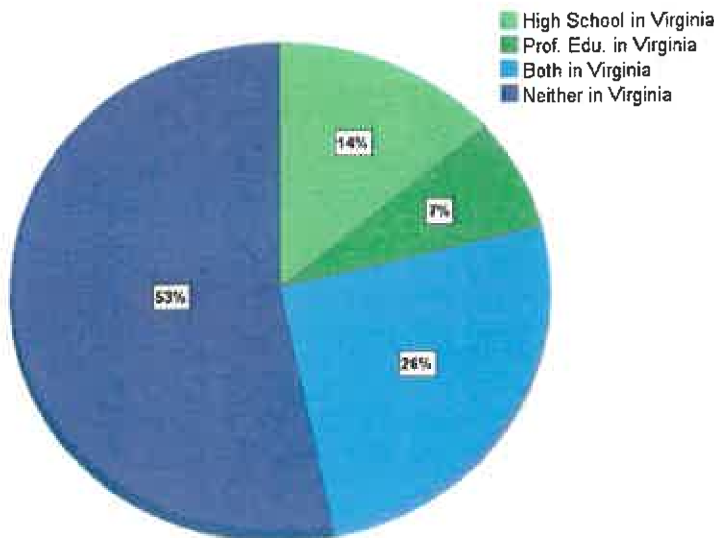
**Location Choice**

% Rural to Non-Metro: 18%
% Urban/Suburban to Non-Metro: 5%

## A Closer Look:

| Primary Location: USDA Rural Urban Continuum | | Rural Status of Childhood Location | | |
|---|---|---|---|---|
| Code | Description | Rural | Suburban | Urban |
| | **Metro Counties** | | | |
| **1** | Metro, 1 million+ | 13% | 61% | 26% |
| **2** | Metro, 250,000 to 1 million | 35% | 55% | 10% |
| **3** | Metro, 250,000 or less | 25% | 58% | 17% |
| | **Non-Metro Counties** | | | |
| **4** | Urban pop 20,000+, metro adjacent (adj) | 46% | 43% | 12% |
| **6** | Urban pop, 5,000-19,999, metro adj | 43% | 39% | 18% |
| **7** | Urban pop, 5,000-19,999, nonadj | 64% | 23% | 13% |
| **8** | Rural, metro adj | 48% | 38% | 14% |
| **9** | Rural, nonadj | 26% | 54% | 20% |
| | **Overall** | **18%** | **58%** | **24%** |

*Source: Va. Healthcare Workforce Data Center*




*Source: Va. Healthcare Workforce Data Center*

*Only 18% of dentists grew up in a rural area, and 18% of this group currently works in non-metro areas of the state. Overall, 7% of dentists currently work in rural areas of Virginia.*

## Top Ten States for Dentist Recruitment

| Rank | All Dentists | | | |
|---|---|---|---|---|
| | High School | # | Dental School | # |
| 1 | Virginia | 1,835 | Virginia | 1,524 |
| 2 | Outside U.S./Canada | 988 | Outside U.S./Canada | 358 |
| 3 | Maryland | 180 | Washington, D.C. | 325 |
| 4 | New York | 169 | Pennsylvania | 320 |
| 5 | Pennsylvania | 168 | New York | 286 |
| 6 | California | 115 | Maryland | 282 |
| 7 | North Carolina | 111 | Massachusetts | 219 |
| 8 | Florida | 100 | California | 114 |
| 9 | New Jersey | 92 | West Virginia | 97 |
| 10 | West Virginia | 65 | Kentucky | 92 |

*Source: Va. Healthcare Workforce Data Center*

*40% of all dentists earned their high school degree in Virginia, and 33% received their initial professional degree in the state.*

| Rank | Licensed in the Past 5 Years | | | |
|---|---|---|---|---|
| | High School | # | Dental School | # |
| 1 | Virginia | 399 | Virginia | 242 |
| 2 | Outside U.S./Canada | 262 | Outside U.S./Canada | 113 |
| 3 | Maryland | 49 | New York | 98 |
| 4 | Pennsylvania | 41 | Pennsylvania | 88 |
| 5 | New York | 36 | Massachusetts | 68 |
| 6 | North Carolina | 33 | Maryland | 61 |
| 7 | Florida | 28 | Washington, D.C. | 61 |
| 8 | Texas | 28 | Illinois | 45 |
| 9 | California | 28 | California | 39 |
| 10 | New Jersey | 25 | Florida | 33 |

*Source: Va. Healthcare Workforce Data Center*

*Among dentists who received their initial license in the past five years, 34% earned their high school degree in Virginia, while 21% received their initial professional degree in the state.*

*One quarter of Virginia's licensees were not part of the state's dental workforce. 89% of these licensees worked at some point in the past year, including 82% who worked as dentists.*

### At a Glance:

**Not in VA Workforce**

| | |
|---|---|
| Total: | 2,113 |
| % of Licensees: | 25% |
| Federal/Military: | 14% |
| VA Border State/DC: | 20% |

## A Closer Look:

| Highest Dental Degree | | |
|---|---|---|
| Degree | # | % |
| Baccalaureate | 55 | 1% |
| Graduate Certificate | 36 | 1% |
| Masters | 57 | 1% |
| Doctorate/Professional | 4,463 | 97% |
| **Total** | **4,611** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

*Approximately 2 out of every 5 of dentists carry educational debt, including 67% of those under the age of 40. For those in debt, their median debt is between $200,000 and $219,999.*

### At a Glance:

**Education**
Doctorate/Professional: 97%
Baccalaureate: 1%

**Educational Debt**
Carry debt: 39%
Under age 40 w/ debt: 67%
Median debt: $200k-$220k

**Residencies**
GPR-1: 12%
AEGD: 11%
Orthodontics: 6%

| Residencies/Special Training Programs | | |
|---|---|---|
| Residency | # | % |
| General Practice Residency -1 (GPR-1) | 785 | 12% |
| Advanced Education in General Dentistry (AEGD) | 671 | 11% |
| Orthodontics | 326 | 6% |
| Pediatric Dentistry | 271 | 4% |
| General Practice Residency -2 (GPR-2) | 166 | 3% |
| Oral and Maxillofacial Surgery | 157 | 2% |
| Endodontics | 155 | 2% |
| Periodontology | 147 | 2% |
| Prosthodontics | 101 | 2% |
| Dental Public Health | 19 | 0% |
| Oral and Maxillofacial Pathology | 11 | 0% |
| Oral and Maxillofacial Radiology | 8 | 0% |
| **At Least One** | **2,442** | **39%** |

*Source: Va. Healthcare Workforce Data Center*

| Educational Debt | | | | |
|---|---|---|---|---|
| Amount Carried | All Dentists | | Dentists under 40 | |
| | # | % | # | % |
| None | 2,327 | 61% | 405 | 33% |
| Less than $80,000 | 391 | 10% | 116 | 9% |
| $80,000-$119,999 | 198 | 5% | 51 | 4% |
| $120,000-$159,999 | 93 | 2% | 51 | 4% |
| $160,000-$199,999 | 9 | 0% | 4 | 0% |
| $200,000-$239,999 | 177 | 5% | 132 | 11% |
| $240,000-$279,999 | 71 | 2% | 41 | 3% |
| $280,000-$319,999 | 94 | 2% | 71 | 6% |
| $320,000-$359,999 | 98 | 3% | 77 | 6% |
| $360,000-$399,999 | 79 | 2% | 64 | 5% |
| $400,000 or More | 265 | 7% | 210 | 17% |
| **Total** | **3,802** | **100%** | **1,222** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

## At a Glance:

**Employment**
Employed in Profession: 96%
Involuntarily Unemployed: <1%

**Positions Held**
1 Full-time: 68%
2 or More Positions: 15%

**Weekly Hours:**
40 to 49: 29%
60 or more: 3%
Less than 30: 16%

## A Closer Look:

| Current Work Status | | |
|---|---|---|
| Status | # | % |
| Employed, capacity unknown | 3 | <1% |
| Employed in a dentistry related capacity | 4,421 | 96% |
| Employed, NOT in a dentistry related capacity | 11 | <1% |
| Not working, reason unknown | 2 | <1% |
| Involuntarily unemployed | 4 | <1% |
| Voluntarily unemployed | 69 | 2% |
| Retired | 92 | 2% |
| Total | 4,602 | 100% |

*Source: Va. Healthcare Workforce Data Center*

*96% of Virginia's dentists are employed in the profession, and 68% currently have one full-time job. 29% of dentists currently work between 40 and 49 hours per week, while only 3% work 60 hours per week or more.*

| Current Positions | | |
|---|---|---|
| Positions | # | % |
| No Positions | 167 | 4% |
| One Part-Time Position | 611 | 14% |
| Two Part-Time Positions | 284 | 6% |
| One Full-Time Position | 3,051 | 68% |
| One Full-Time Position & One Part-Time Position | 251 | 6% |
| Two Full-Time Positions | 21 | <1% |
| More than Two Positions | 95 | 2% |
| Total | 4,480 | 100% |

*Source: Va. Healthcare Workforce Data Center*

| Current Weekly Hours | | |
|---|---|---|
| Hours | # | % |
| 0 hours | 167 | 4% |
| 1 to 9 hours | 121 | 3% |
| 10 to 19 hours | 216 | 5% |
| 20 to 29 hours | 381 | 9% |
| 30 to 39 hours | 1,918 | 43% |
| 40 to 49 hours | 1,276 | 29% |
| 50 to 59 hours | 237 | 5% |
| 60 to 69 hours | 87 | 2% |
| 70 to 79 hours | 18 | <1% |
| 80 or more hours | 22 | <1% |
| Total | 4,443 | 100% |

*Source: Va. Healthcare Workforce Data Center*

## A Closer Look:

| Annual Income | | |
|---|---|---|
| Income Level | # | % |
| Volunteer Work Only | 40 | 1% |
| Less Than $30,000 | 10 | <1% |
| $30,000-$69,999 | 20 | 1% |
| $70,000-$109,999 | 414 | 15% |
| $110,000-$149,999 | 487 | 17% |
| $150,000-$189,999 | 609 | 22% |
| $190,000-$229,999 | 489 | 17% |
| $230,000-$269,999 | 344 | 12% |
| $270,000-$309,999 | 264 | 9% |
| $310,000-$349,999 | 114 | 4% |
| More than $350,000 | 50 | 2% |
| **Total** | **2,841** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

## At a Glance:

**Earnings**
Median Income: $170k-$180k

**Benefits**
Retirement: 41%
Paid Vacation: 23%

**Satisfaction**
Satisfied: 96%
Very Satisfied: 67%

| Job Satisfaction | | |
|---|---|---|
| Level | # | % |
| Very Satisfied | 2,999 | 67% |
| Somewhat Satisfied | 1,278 | 29% |
| Somewhat Dissatisfied | 147 | 3% |
| Very Dissatisfied | 46 | 1% |
| **Total** | **4,469** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

*The typical dentist made between $170,000 and $180,000 in the past year. Among dentists who were compensated at the primary work location with either a salary or an hourly wage, 46% had access to a retirement plan and 29% received paid vacation leave.*

| Employer-Sponsored Benefits | | | |
|---|---|---|---|
| Benefit | # | % | % of Wage/Salary Employees |
| Retirement | 1,796 | 41% | 46% |
| Paid Vacation | 1,003 | 23% | 29% |
| Paid Sick Leave | 668 | 15% | 19% |
| Group Life Insurance | 624 | 14% | 18% |
| Dental Insurance | 695 | 16% | 20% |
| Signing/Retention Bonus | 260 | 6% | 8% |
| **Receive at least one benefit** | **2,232** | **50%** | **58%** |

*From any employer at time of survey.

*Source: Va. Healthcare Workforce Data Center*

## A Closer Look:

| Employment Instability in Past Year | | |
|---|---|---|
| **In the past year did you . . .?** | **#** | **%** |
| Experience involuntary unemployment? | 24 | <1% |
| Experience voluntary unemployment? | 201 | 3% |
| Work part-time or temporary positions, but would have preferred a full-time/permanent position? | 105 | 2% |
| Work two or more positions at the same time? | 752 | 12% |
| Switch employers or practices? | 261 | 4% |
| **Experienced at least 1** | **1,120** | **18%** |

*Source: Va. Healthcare Workforce Data Center*

*Less than 1% of Virginia's dentists experienced involuntary unemployment at some point during the last year. By comparison, Virginia's average monthly unemployment rate was 2.9% in the same time period.*[1]

### At a Glance:

**Unemployment Experience**
Involuntarily Unemployed: <1%
Underemployed: 2%

**Turnover & Tenure**
Switched Jobs: 4%
New Location: 21%
Over 2 years: 68%
Over 2 yrs., 2nd location: 50%

**Employment Type**
Salary/Commission: 62%
Business/Practice Income: 28%
Hourly Wage: 3%

| Location Tenure | | | | |
|---|---|---|---|---|
| **Tenure** | **Primary** | | **Secondary** | |
| | **#** | **%** | **#** | **%** |
| Not Currently Working at this Location | 105 | 2% | 57 | 6% |
| Less than 6 Months | 246 | 6% | 127 | 12% |
| 6 Months to 1 Year | 403 | 9% | 124 | 12% |
| 1 to 2 Years | 643 | 15% | 206 | 20% |
| 3 to 5 Years | 734 | 17% | 182 | 18% |
| 6 to 10 Years | 623 | 14% | 131 | 13% |
| More than 10 Years | 1,621 | 37% | 198 | 19% |
| **Subtotal** | **4,374** | **100%** | **1,025** | **100%** |
| Did not have location | 74 | | 5,207 | |
| Item Missing | 1,834 | | 51 | |
| **Total** | **6,283** | | **6,283** | |

*Source: Va. Healthcare Workforce Data Center*

*Nearly seven out of ten dentists have worked at their primary location for at least two years.*

*62% of dentists are salary or wage employees, while 28% receive income from their own practice.*

| Employment Type | | |
|---|---|---|
| **Primary Work Site** | **#** | **%** |
| Salary/ Commission | 2,165 | 62% |
| Business/ Practice Income | 987 | 28% |
| By Contract | 161 | 5% |
| Hourly Wage | 112 | 3% |
| Unpaid | 40 | 1% |
| **Subtotal** | **3,465** | **100%** |
| Did not have location | 74 | |
| Item Missing | 2,743 | |

*Source: Va. Healthcare Workforce Data Center*

[1] According to the U.S. Bureau of Labor Statistics, the non-seasonally adjusted monthly unemployment rate over the past year fluctuated between a low of 2.3% and a high of 3.5%. At the time of publication, the unemployment rate from December 2023 was still preliminary.

## At a Glance:

**Concentration**
Top Region: 44%
Top 3 Regions: 80%
Lowest Region: 1%

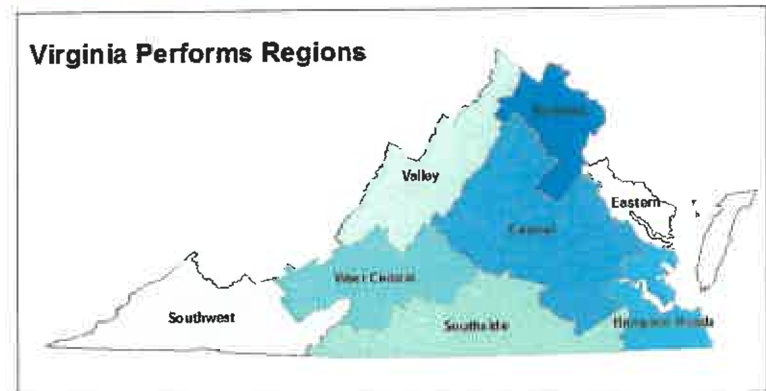
**Locations**
2 or more (Past Year): 17%
2 or more (Now*): 22%

*44% of all dentists work in Northern Virginia, the most of any region in Virginia. With only 1% of the workforce, Eastern Virginia has the fewest number of dentists of any region in the state.*

## A Closer Look:

| Regional Distribution of Work Locations | | | | |
|---|---|---|---|---|
| Virginia Performs Region | Primary Location | | Secondary Location | |
| | # | % | # | % |
| Central | 829 | 19% | 163 | 16% |
| Eastern | 62 | 1% | 17 | 2% |
| Hampton Roads | 732 | 17% | 169 | 16% |
| Northern | 1,925 | 44% | 469 | 45% |
| Southside | 101 | 2% | 15 | 1% |
| Southwest | 109 | 3% | 26 | 2% |
| Valley | 216 | 5% | 37 | 4% |
| West Central | 313 | 7% | 46 | 4% |
| Virginia Border State/DC | 23 | 1% | 46 | 4% |
| Other US State | 33 | 1% | 55 | 5% |
| Outside of the US | 2 | 0% | 4 | 0% |
| **Total** | **4,345** | **100%** | **1,047** | **100%** |
| Item Missing | 1,862 | | 27 | |

*Source: Va. Healthcare Workforce Data Center*




| Number of Work Locations | | | | |
|---|---|---|---|---|
| Locations | Work Locations in Past Year | | Work Locations Now* | |
| | # | % | # | % |
| 0 | 74 | 1% | 158 | 4% |
| 1 | 5,133 | 82% | 3,311 | 75% |
| 2 | 732 | 12% | 661 | 15% |
| 3 | 246 | 4% | 225 | 5% |
| 4 | 46 | 1% | 31 | 1% |
| 5 | 27 | <1% | 26 | 1% |
| 6 or More | 24 | <1% | 26 | 1% |
| **Total** | **6,283** | **100%** | **4,438** | **100%** |

*At the time of survey completion, Jan. 2024-Dec. 2024 (birth month of respondent).

*Source: Va. Healthcare Workforce Data Center*

*75% of dentists currently have just one work location, while 15% have two different work locations.*

## A Closer Look:

| Location Sector | | | | |
|---|---|---|---|---|
| Sector | Primary Location | | Secondary Location | |
| | # | % | # | % |
| For-profit | 3,722 | 89% | 863 | 87% |
| Non-profit | 132 | 3% | 40 | 4% |
| State/local government | 157 | 4% | 66 | 7% |
| Veterans Administration | 20 | <1% | 1 | <1% |
| U.S. Military | 114 | 3% | 19 | 2% |
| Other Federal Government | 15 | <1% | 4 | <1% |
| **Total** | **4,160** | **100%** | **993** | **100%** |
| Did not have location | 74 | | 5,207 | |
| Item missing | 2,049 | | 81 | |

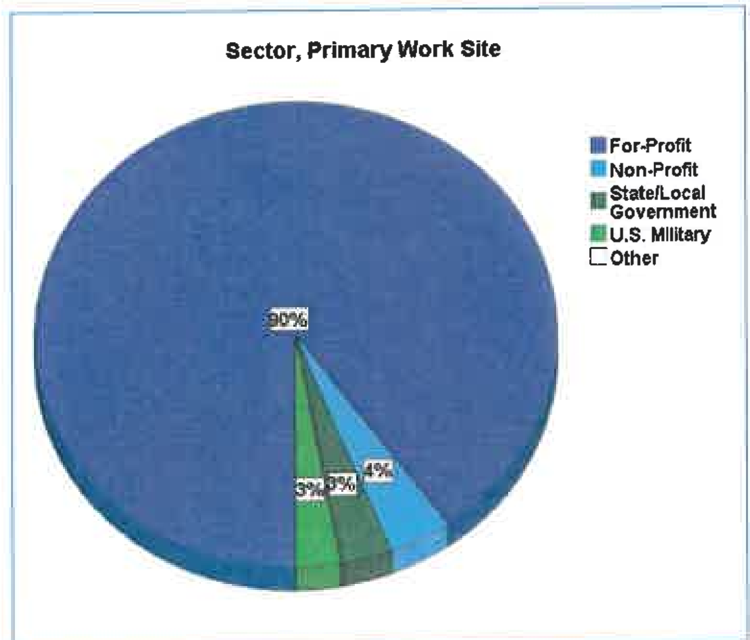
*Source: Va. Healthcare Workforce Data Center*

**At a Glance:**
(Primary Locations)

**Sector**
For Profit: 89%
Federal: 4%

**Top Establishments**
Solo Practice: 62%
Group Practice: 23%

*89% of dentists worked in for-profit establishments. Another 4% worked for a government agency, including 4% who worked for the state government.*




*Source: Va. Healthcare Workforce Data Center*

| Accepted Forms of Payment | | |
|---|---|---|
| Payment | # | % of Workforce |
| Cash/Self-Pay | 3,858 | 61% |
| Private Insurance | 3,748 | 60% |
| Medicaid | 1,441 | 23% |
| Medicare | 1,035 | 16% |
| **At least one** | **4,013** | **64%** |

*Source: Va. Healthcare Workforce Data Center*

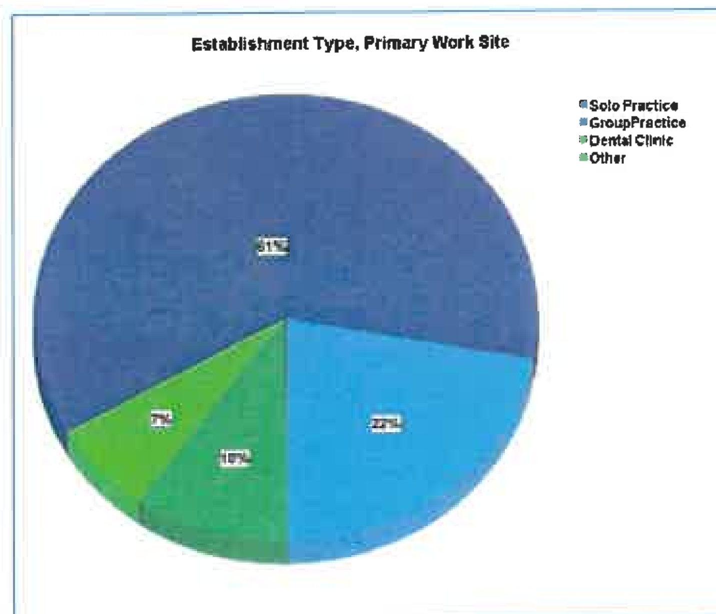
*Cash/self-pay is the most commonly reported form of payment among Virginia's dentistry workforce whereas Medicare is the least commonly accepted form of payment.*

| Establishment Type | Location Type | | | |
|---|---|---|---|---|
| | Primary Location | | Secondary Location | |
| | # | % | # | % |
| Solo Practice | 2,527 | 61% | 502 | 53% |
| Group Practice | 902 | 22% | 265 | 28% |
| Dental Health Clinic | 407 | 10% | 104 | 11% |
| Hospital/Health System | 86 | 2% | 17 | 2% |
| Dental School (including Combined Dental/Dental Hygiene) | 71 | 2% | 17 | 2% |
| Corrections | 23 | 1% | 16 | 2% |
| Public Health Program | 22 | 1% | 1 | 0% |
| Insurance | 13 | 0% | 5 | 1% |
| Nursing Home/Long-Term Care Facility | 8 | 0% | 3 | 0% |
| Dental Hygiene Program (Community College) | 5 | 0% | 5 | 1% |
| K-12 School or Non-Dental College | 2 | 0% | 0 | 0% |
| Dental Hygiene Program (Technical School) | 1 | 0% | 2 | 0% |
| Supplier Organization | 0 | 0% | 0 | 0% |
| Other | 50 | 1% | 19 | 2% |
| **Total** | **4,117** | **100%** | **956** | **100%** |
| Did Not Have a Location | 86 | | 5207 | |

*Source: Va. Healthcare Workforce Data Center*

*Close to two-thirds of dentists work at a solo dental practice as their primary work location, while another 22% work at a group dental practice. Dental health clinics were also significant employers of Virginia's dental workforce.*

*Among those dentists who also have a secondary work location, more than three-quarters work at a private dental practice, including 53% who work at a solo dental practice.*




*Source: Va. Healthcare Workforce Data Center*

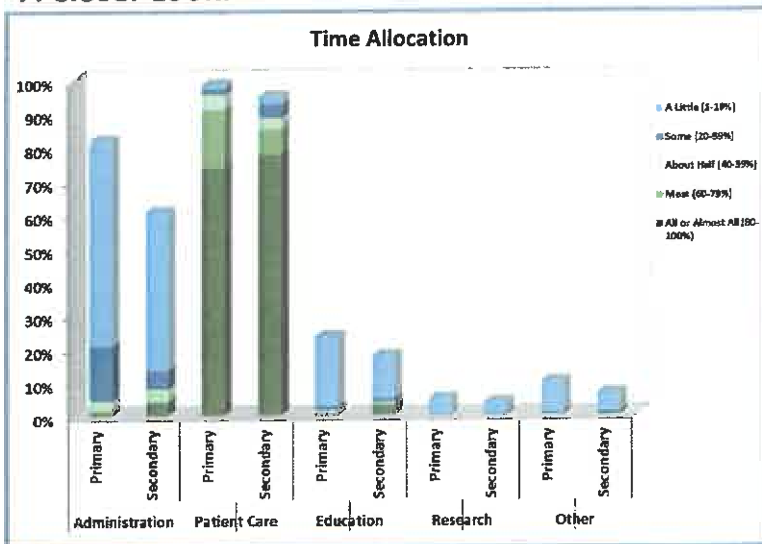
## At a Glance:
(Primary Locations)

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

**Roles**
Patient Care: 91%
Administrative: 2%
Education: 1%

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

## A Closer Look:



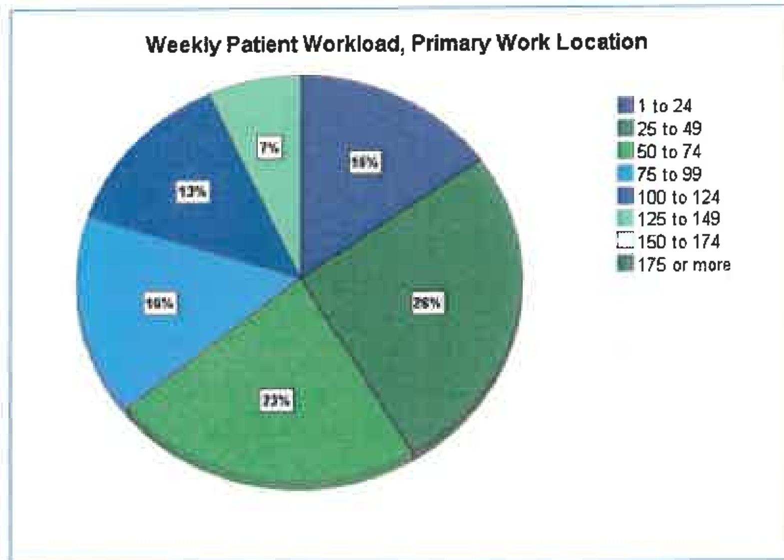

*Source: Va. Healthcare Workforce Data Center*

*A typical dentist spends most of his time caring for patients, with most of the remaining time spent doing administrative and education tasks. 92% of dentists fill a patient care role, defined as spending 60% or more of their time on patient care activities.*

| Time Allocation | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Time Spent | Admin. | | Patient Care | | Education | | Research | | Other | |
| | Prim. Site | Sec. Site | Prim. Site | Sec. Site | Prim. Site | Sec. Site | Prim. Site | Sec. Site | Prim. Site | Sec. Site |
| All or Almost All (80-100%) | 1% | 4% | 74% | 78% | 1% | 3% | 0% | 0% | 0% | 0% |
| Most (60-79%) | 1% | 1% | 18% | 8% | 0% | 1% | 0% | 0% | 0% | 0% |
| About Half (40-59%) | 3% | 3% | 4% | 3% | 1% | 0% | 0% | 0% | 0% | 0% |
| Some (20-39%) | 16% | 6% | 2% | 4% | 1% | 1% | 0% | 0% | 1% | 1% |
| A Little (1-20%) | 61% | 47% | 1% | 2% | 21% | 13% | 5% | 4% | 9% | 6% |
| None (0%) | 18% | 39% | 1% | 5% | 76% | 82% | 95% | 96% | 90% | 93% |

*Source: Va. Healthcare Workforce Data Center*

## A Closer Look:




Source: Va. Healthcare Workforce Data Center

## At a Glance:

**Patient Workload (Median)**
**Total**
Primary Location: 50-74
Secondary Location: 1-24

**Hygiene Checks by Support Personnel (Median)**
Primary Location: 1-24
Secondary Location: None

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

| # of Patients Per Week | Primary Work Location | | | | Secondary Work Location | | | |
|---|---|---|---|---|---|---|---|---|
| | Total | | Hygiene Checks* | | Total | | Hygiene Checks* | |
| | # | % | # | % | # | % | # | % |
| None | 117 | 3% | 1,718 | 41% | 73 | 7% | 504 | 51% |
| 1-24 | 553 | 13% | 1,012 | 24% | 437 | 44% | 349 | 35% |
| 25-49 | 963 | 23% | 696 | 17% | 229 | 23% | 74 | 7% |
| 50-74 | 820 | 20% | 370 | 9% | 119 | 12% | 39 | 4% |
| 75-99 | 582 | 14% | 166 | 4% | 56 | 6% | 9 | 1% |
| 100-124 | 480 | 11% | 91 | 2% | 40 | 4% | 6 | 1% |
| 125-149 | 248 | 6% | 33 | 1% | 15 | 2% | 7 | 1% |
| 150-174 | 159 | 4% | 20 | 0% | 5 | 1% | 1 | 0% |
| 175-199 | 67 | 2% | 23 | 1% | 3 | 0% | 0 | 0% |
| 200-224 | 78 | 2% | 10 | 0% | 4 | 0% | 2 | 0% |
| 225-249 | 29 | 1% | 1 | 0% | 2 | 0% | 1 | 0% |
| 250-274 | 22 | 1% | 0 | 0% | 1 | 0% | 0 | 0% |
| 275-299 | 9 | 0% | 0 | 0% | 2 | 0% | 0 | 0% |
| 300 or more | 56 | 1% | 10 | 0% | 9 | 1% | 2 | 0% |
| **Total** | **4,183** | **100%** | **4,150** | **100%** | **995** | **100%** | **994** | **100%** |

*Performed by Support Personnel

Source: Va. Healthcare Workforce Data Center

## A Closer Look:

| Retirement Expectations | | | | |
|---|---|---|---|---|
| Expected Retirement Age | All Dentists | | Dentists over 50 | |
| | # | % | # | % |
| **Under age 50** | 108 | 3% | - | - |
| **50 to 54** | 243 | 7% | 14 | 1% |
| **55 to 59** | 565 | 15% | 105 | 7% |
| **60 to 64** | 906 | 25% | 288 | 19% |
| **65 to 69** | 949 | 26% | 501 | 32% |
| **70 to 74** | 436 | 12% | 300 | 19% |
| **75 to 79** | 193 | 5% | 158 | 10% |
| **80 or over** | 107 | 3% | 82 | 5% |
| **I do not intend to retire** | 183 | 5% | 94 | 6% |
| **Total** | **3,690** | **100%** | **1,542** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

### At a Glance:

**Retirement Expectations**

**All Dentists**

Under 65: 49%

Under 60: 25%

**Dentists 50 and over**

Under 65: 26%

Under 60: 8%

**Time until Retirement**

Within 2 years: 8%

Within 10 years: 27%

Half the workforce: By 2043

*Approximately 49% of dentists expect to retire by the age of 65, but only 26% of those dentists who are age 50 or over expect to retire by the same age. Meanwhile, about 25% of all dentists expect to work until at least age 70, including 5% who do not expect to retire at all.*

*Within the next two years, only 2% of Virginia's dentists plan on leaving the state and 1% plan on leaving the profession. Meanwhile, 10% of dentists plan on increasing their patient care activities, and 10% plan on pursuing additional educational opportunities.*

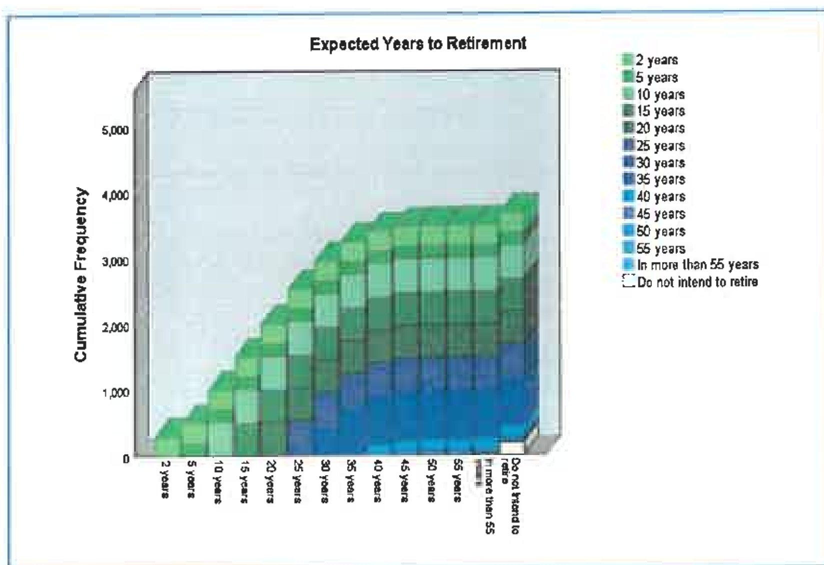
| Future Plans | | |
|---|---|---|
| 2 Year Plans: | # | % |
| **Decrease Participation** | | |
| **Leave Profession** | 84 | 1% |
| **Leave Virginia** | 124 | 2% |
| **Decrease Patient Care Hours** | 585 | 9% |
| **Decrease Teaching Hours** | 18 | <1% |
| **Increase Participation** | | |
| **Increase Patient Care Hours** | 657 | 10% |
| **Increase Teaching Hours** | 256 | 4% |
| **Pursue Additional Education** | 636 | 10% |
| **Return to Virginia's Workforce** | 32 | 1% |

*Source: Va. Healthcare Workforce Data Center*

| Time to Retirement | | | |
|---|---|---|---|
| Expect to retire within. . . | # | % | Cumulative % |
| **2 years** | 299 | 8% | 8% |
| **5 years** | 197 | 5% | 13% |
| **10 years** | 515 | 14% | 27% |
| **15 years** | 496 | 13% | 41% |
| **20 years** | 503 | 14% | 54% |
| **25 years** | 526 | 14% | 69% |
| **30 years** | 424 | 11% | 80% |
| **35 years** | 288 | 8% | 88% |
| **40 years** | 165 | 4% | 92% |
| **45 years** | 66 | 2% | 94% |
| **50 years** | 15 | 0% | 95% |
| **55 years** | 3 | 0% | 95% |
| **In more than 55 years** | 10 | 0% | 95% |
| **Do not intend to retire** | 183 | 5% | 100% |
| **Total** | **3,690** | **100%** | |

*Source: Va. Healthcare Workforce Data Center*

*By comparing retirement expectation to age, we can estimate the maximum years to retirement for dentists. 8% of dentists expect to retire within the next two years, while 27% expect to retire in the next ten years. More than half of the current dentistry workforce expect to retire by 2044.*




*Source: Va. Healthcare Workforce Data Center*

*Using these estimates, retirement will begin to reach over 10% of the current workforce every 5 years by 2034. Retirement will peak at 15% of the current workforce around 2044, before declining to under 10% of the current workforce again around 2059.*

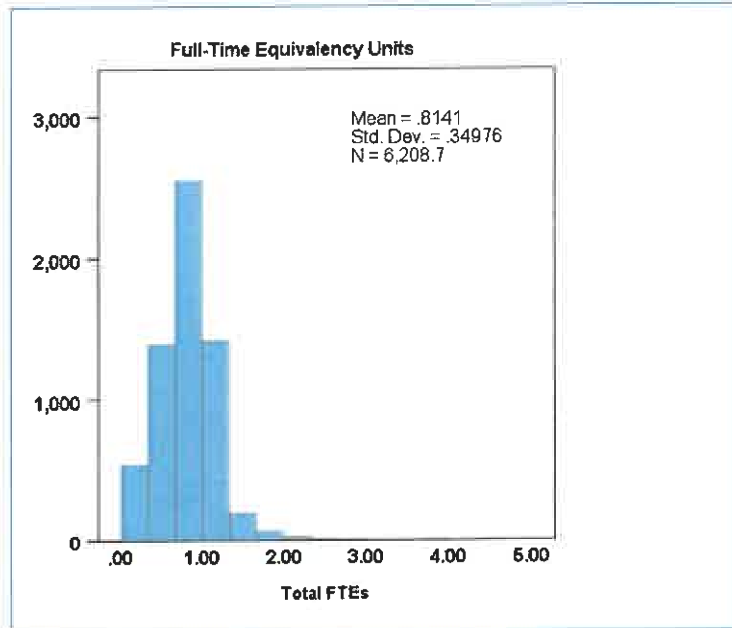
## At a Glance:

**FTEs**
Total: 5,055
FTEs/1,000 Residents[2]: 0.5799
Average: 0.81

**Age & Gender Effect**[3]
Age, Partial Eta$^2$: Small
Gender, Partial Eta$^2$: Small

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

## A Closer Look:

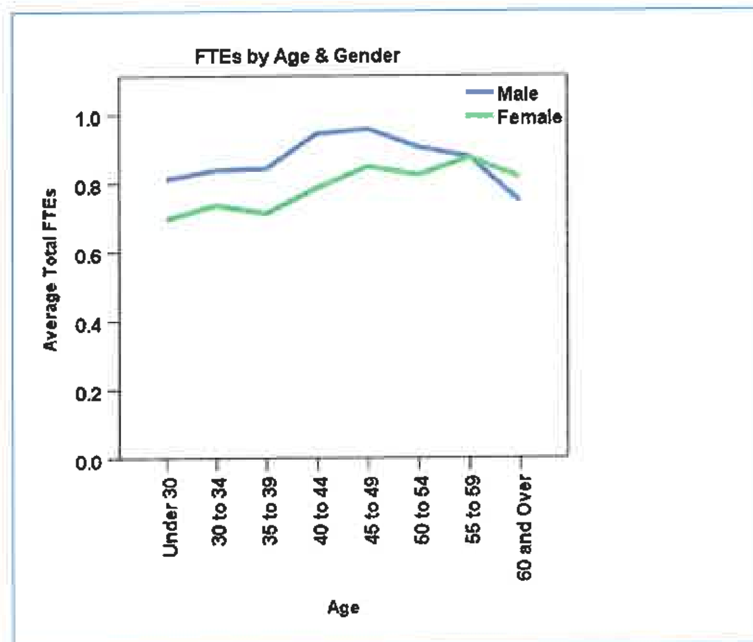



Source: Va. Healthcare Workforce Data Center

*The typical (median) dentist provided 0.81 FTEs during the past year, or approximately 31 hours per week for 52 weeks. Although FTEs appear to vary by age and gender, statistical tests did not verify that a difference exists.[3]*

| Full-Time Equivalency Units | | |
|---|---|---|
| **Age** | **Average** | **Median** |
| Under 30 | 0.74 | 0.75 |
| 30 to 34 | 0.73 | 0.67 |
| 35 to 39 | 0.72 | 0.66 |
| 40 to 44 | 0.83 | 0.77 |
| 45 to 49 | 0.93 | 0.99 |
| 50 to 54 | 0.85 | 0.79 |
| 55 to 59 | 0.80 | 0.79 |
| 60 and Over | 0.85 | 0.91 |
| **Gender** | | |
| Male | 0.85 | 0.88 |
| Female | 0.78 | 0.84 |

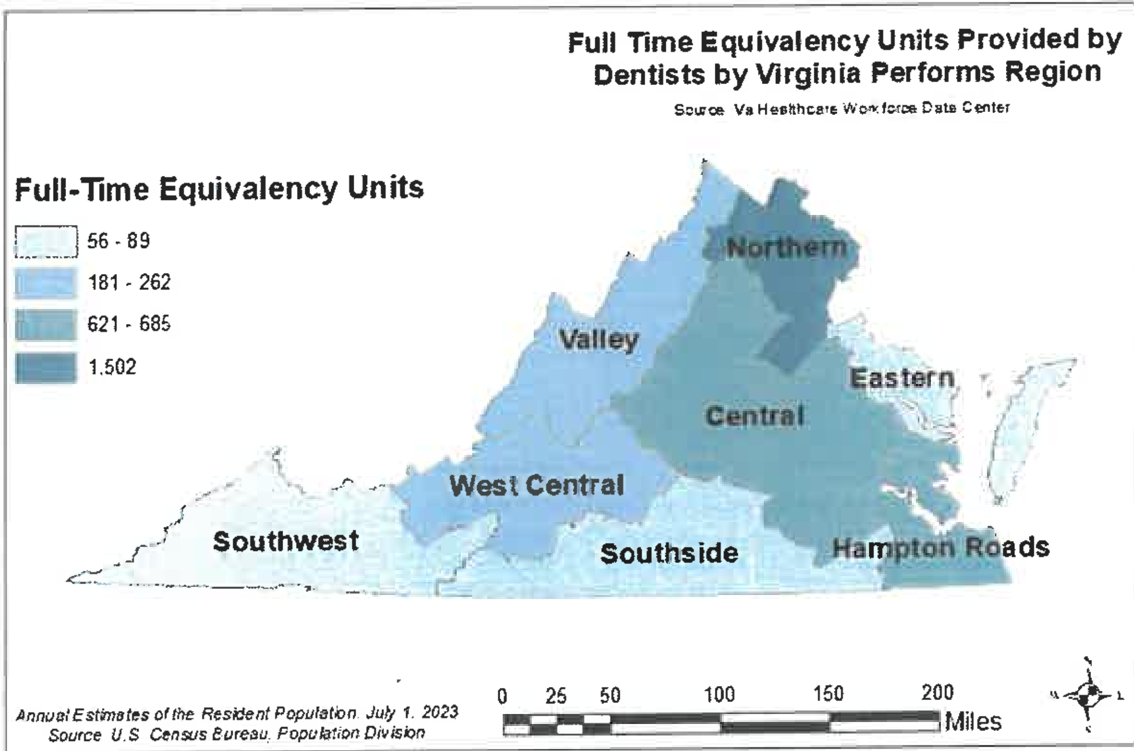
Source: Va. Healthcare Workforce Data Center

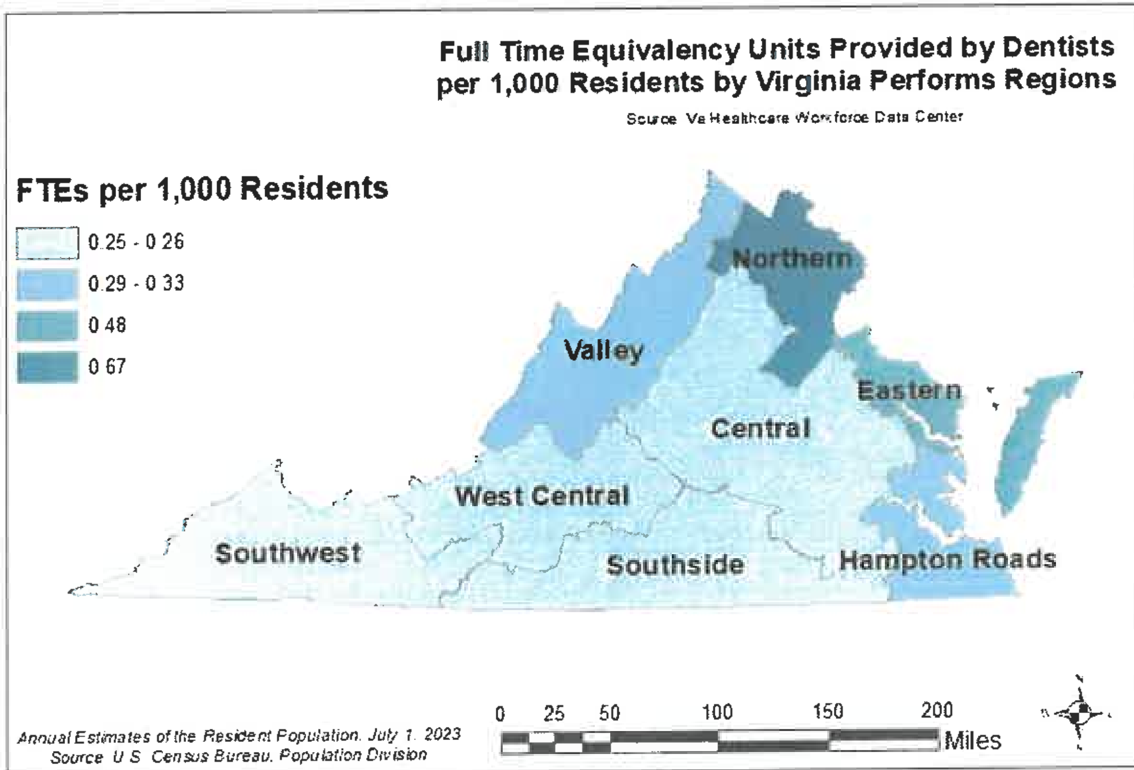


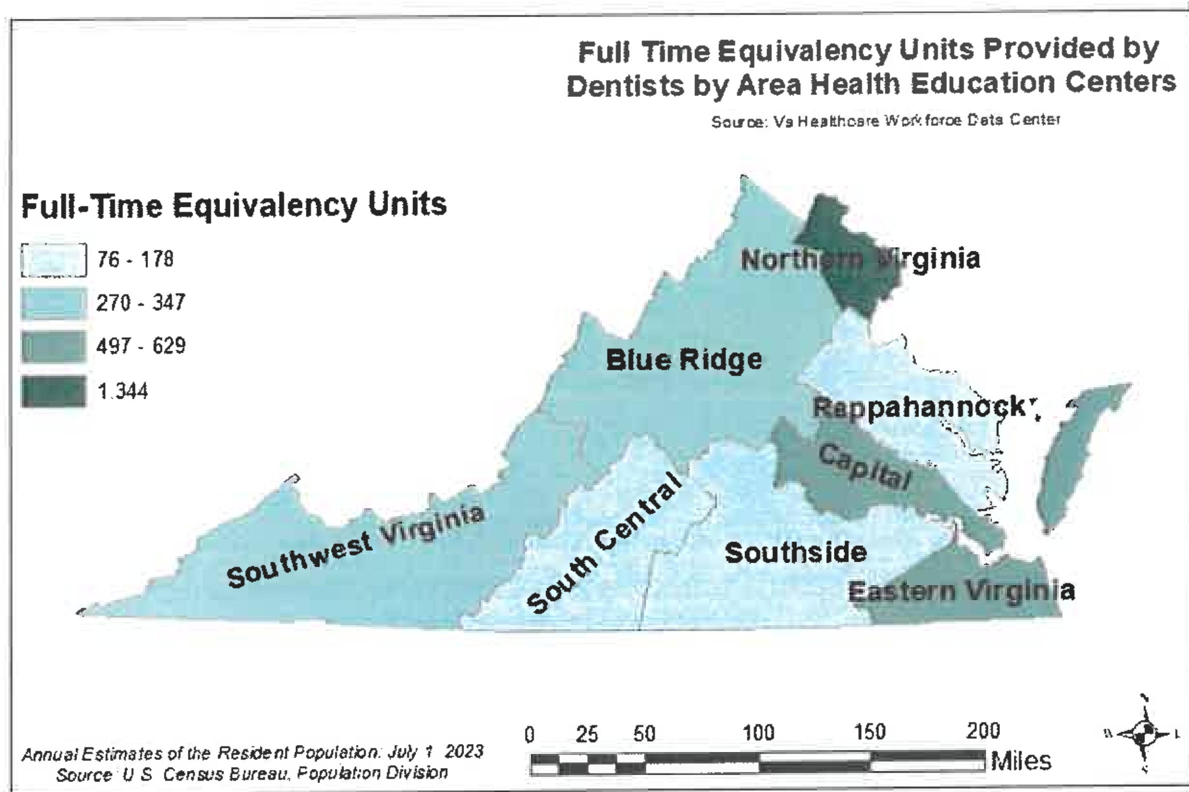

Source: Va. Healthcare Workforce Data Center

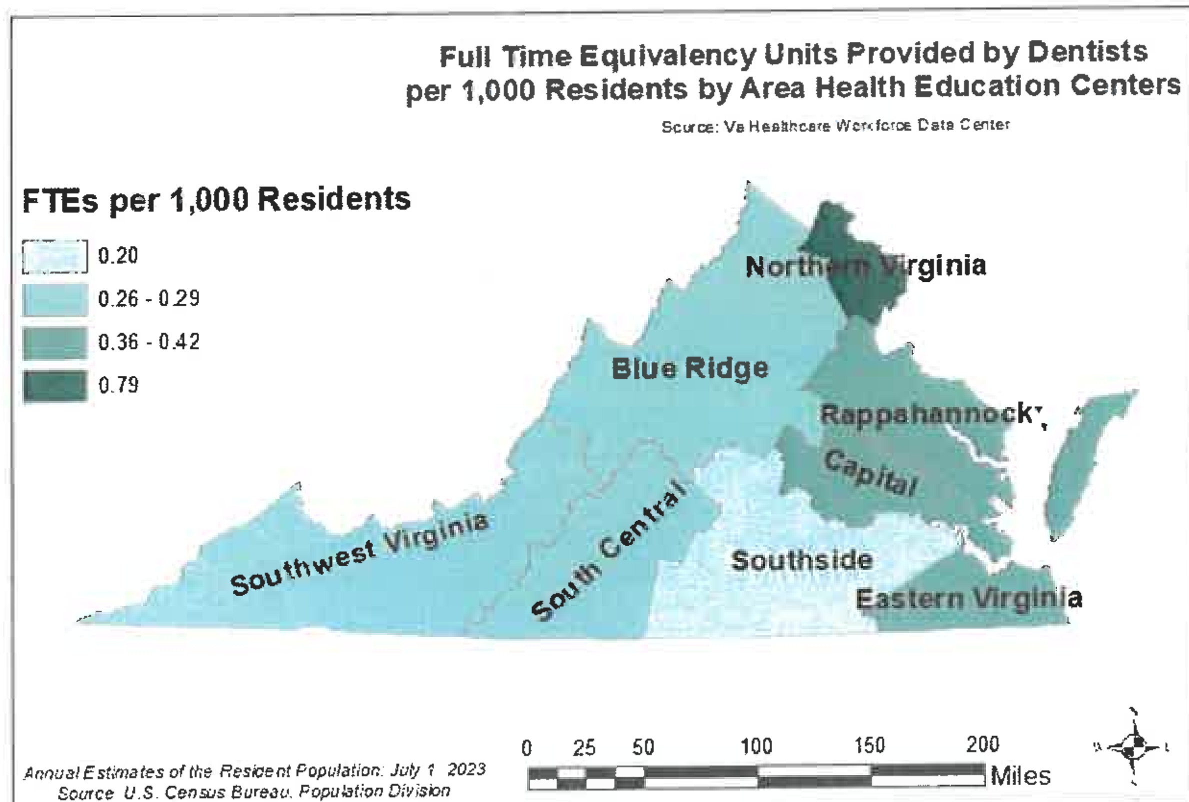
[2] Number of residents in 2023 was used as the denominator.
[3] Due to assumption violations in Mixed between-within ANOVA (Interaction effect is significant).

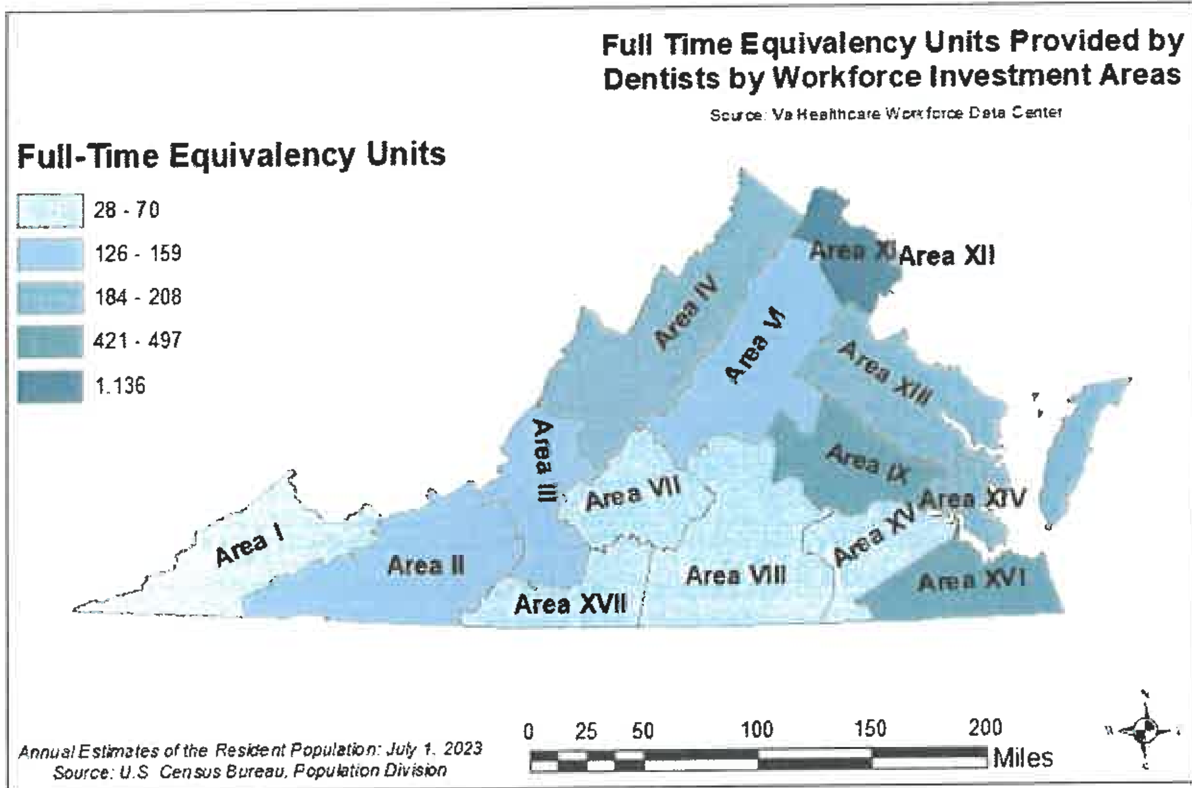
## Virginia Performs Regions

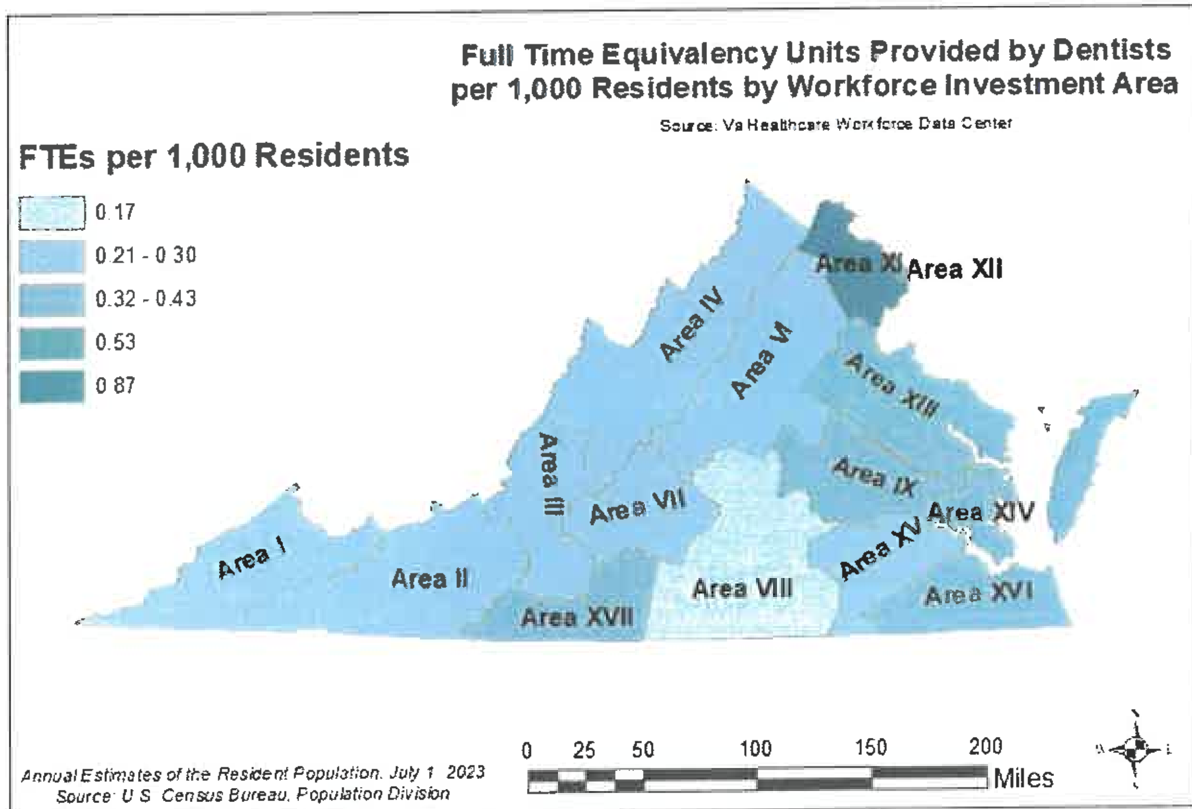


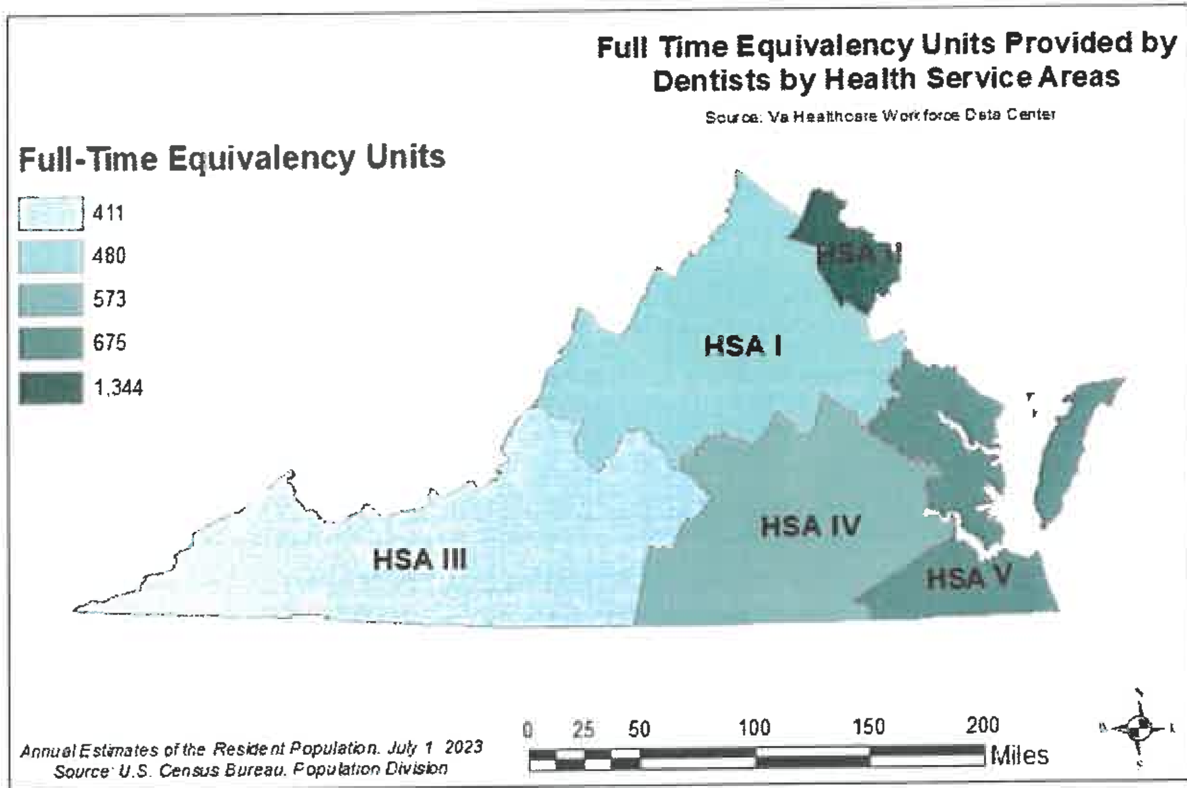



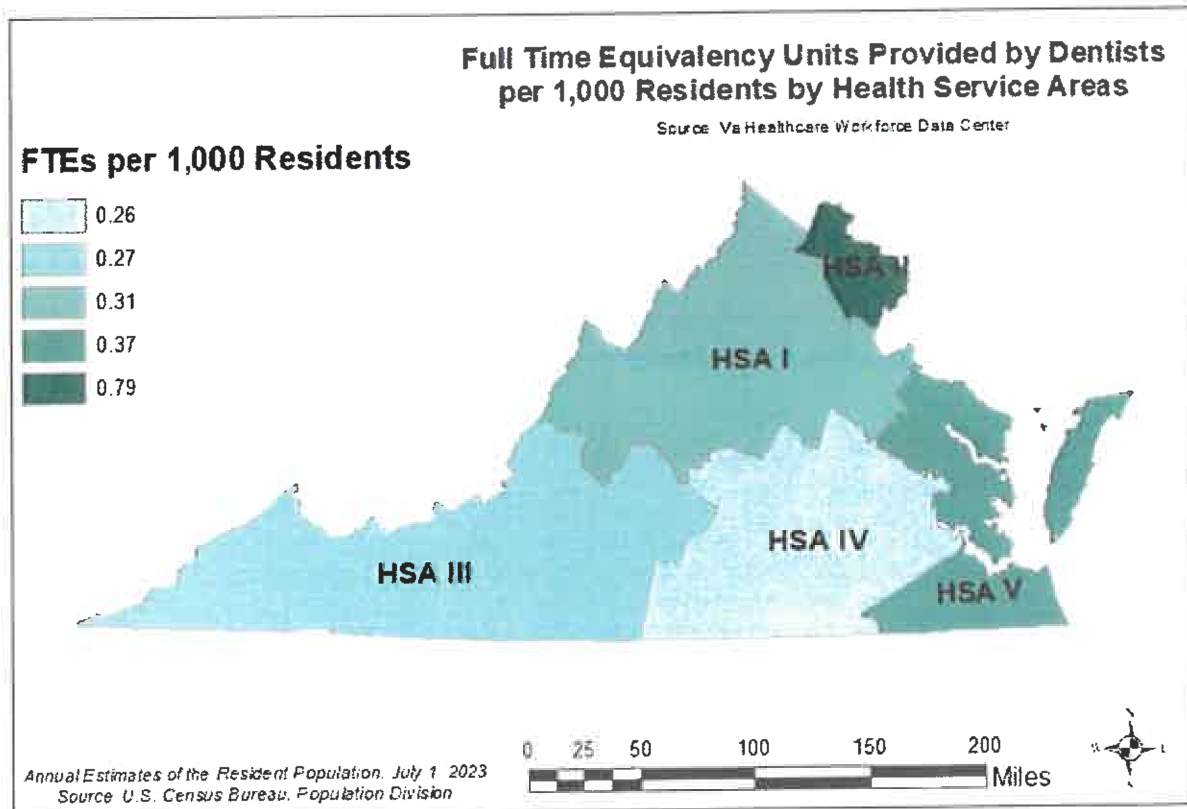

Full Time Equivalency Units Provided by
Dentists by Area Health Education Centers
Source: Va Healthcare Workforce Data Center
Full-Time Equivalency Units
76 - 178
270 - 347
497 - 629
1.344
Northern Virginia
Blue Ridge
Rappahannock
Capital
Southwest Virginia
South Central
Southside
Eastern Virginia
Annual Estimates of the Resident Population: July 1 2023
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles


Full Time Equivalency Units Provided by Dentists
per 1,000 Residents by Area Health Education Centers
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.20
0.26 - 0.29
0.36 - 0.42
0.79
Northern Virginia
Blue Ridge
Rappahannock
Capital
Southwest Virginia
South Central
Southside
Eastern Virginia
Annual Estimates of the Resident Population: July 1 2023
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles


Full Time Equivalency Units Provided by Dentists by Workforce Investment Areas
Source: Va Healthcare Workforce Data Center
Full-Time Equivalency Units
28 - 70
126 - 159
184 - 208
421 - 497
1,136
Area I
Area II
Area III
Area IV
Area VI
Area VII
Area VIII
Area IX
Area XI
Area XII
Area XIII
Area XIV
Area XV
Area XVI
Area XVII
0 25 50 100 150 200 Miles
Annual Estimates of the Resident Population: July 1, 2023
Source: U.S. Census Bureau, Population Division


Full Time Equivalency Units Provided by Dentists per 1,000 Residents by Workforce Investment Area
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.17
0.21 - 0.30
0.32 - 0.43
0.53
0.87
Area I
Area II
Area III
Area IV
Area VI
Area VII
Area VIII
Area IX
Area XI
Area XII
Area XIII
Area XIV
Area XV
Area XVI
Area XVII
0 25 50 100 150 200 Miles
Annual Estimates of the Resident Population: July 1, 2023
Source: U.S. Census Bureau, Population Division


Full Time Equivalency Units Provided by Dentists by Health Service Areas
Source: Va Healthcare Workforce Data Center
Full-Time Equivalency Units
411
480
573
675
1,344
HSA I
HSA III
HSA IV
HSA V
Annual Estimates of the Resident Population. July 1 2023
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles


Full Time Equivalency Units Provided by Dentists per 1,000 Residents by Health Service Areas
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.26
0.27
0.31
0.37
0.79
HSA I
HSA III
HSA IV
HSA V
Annual Estimates of the Resident Population. July 1 2023
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles

## Full Time Equivalency Units Provided by Dentists by Planning Districts

Source: Va Healthcare Workforce Data Center

### Full-Time Equivalency Units

| Legend |
| --- |
| 12 - 25 |
| 43 - 78 |
| 111 - 133 |
| 480 - 613 |
| 1,344 |

Northern Shenandoah Valley R.C.
Northern Virginia
Rappahannock Rapidan
Central Shenandoah Valley R.C.
George Washington R.C.
Northern Neck
Thomas Jefferson
Roanoke Valley-Alleghany R.C.
Region 2000 (Lynchburg Area)
Richmond Regional
Middle Peninsula
Accomack-Northampton
Commonwealth R.C.
Crater
Cumberland Plateau
New River Valley
Lenowisco
Mount Rogers
West Piedmont
Southside
Hampton Roads

*Annual Estimates of the Resident Population: July 1, 2023*
*Source: U.S. Census Bureau, Population Division*

0 25 50 100 150 200 Miles

## Full Time Equivalency Units Provided by Dentists per 1,000 Residents by Planning Districts

Source: Va Healthcare Workforce Data Center

### FTEs per 1,000 Residents

| Legend |
| --- |
| 0.12 - 0.18 |
| 0.20 - 0.26 |
| 0.28 - 0.36 |
| 0.41 - 0.49 |
| 0.66 - 0.79 |

Northern Shenandoah Valley R.C.
Northern Virginia
Rappahannock Rapidan
Central Shenandoah Valley R.C.
George Washington R.C.
Northern Neck
Thomas Jefferson
Roanoke Valley-Alleghany R.C.
Region 2000 (Lynchburg Area)
Richmond Regional
Middle Peninsula
Accomack-Northampton
Commonwealth R.C.
Crater
Cumberland Plateau
New River Valley
Lenowisco
Mount Rogers
West Piedmont
Southside
Hampton Roads

*Annual Estimates of the Resident Population: July 1, 2023*
*Source: U.S. Census Bureau, Population Division*

0 25 50 100 150 200 Miles

## Appendix A: Weights

| Rural Status | Location Weight | | | Total Weight | |
|---|---|---|---|---|---|
| | # | Rate | Weight | Min | Max |
| Metro, 1 million+ | 4861 | 86.57% | 1.155181 | 1.0457 | 2.110922 |
| Metro, 250,000 to 1 million | 373 | 84.99% | 1.176656 | 1.065141 | 2.150166 |
| Metro, 250,000 or less | 478 | 89.54% | 1.116822 | 1.010978 | 2.040828 |
| Urban pop 20,000+, Metro adj | 64 | 79.69% | 1.254902 | 1.135971 | 2.293148 |
| Urban pop 20,000+, nonadj | 0 | NA | NA | NA | NA |
| Urban pop, 2,500-19,999, Metro adj | 159 | 84.28% | 1.186567 | 1.074112 | 2.168277 |
| Urban pop, 2,500-19,999, nonadj | 67 | 86.57% | 1.155172 | 1.045693 | 2.110907 |
| Rural, Metro adj | 103 | 76.70% | 1.303797 | 1.180232 | 2.382498 |
| Rural, nonadj | 24 | 79.17% | 1.263158 | 1.143444 | 1.434191 |
| Virginia border state/DC | 869 | 76.52% | 1.306767 | 1.18292 | 2.387924 |
| Other US State | 1396 | 74.57% | 1.341018 | 1.213926 | 2.450513 |

*Source: Va. Healthcare Workforce Data Center*

| Age | Age Weight | | | Total Weight | |
|---|---|---|---|---|---|
| | # | Rate | Weight | Min | Max |
| Under 30 | 401 | 45.64% | 2.191257 | 2.040828 | 2.450513 |
| 30 to 34 | 1047 | 73.45% | 1.361508 | 1.268042 | 1.522594 |
| 35 to 39 | 1266 | 80.33% | 1.244838 | 1.15938 | 1.392119 |
| 40 to 44 | 1133 | 87.64% | 1.140987 | 1.062659 | 1.275982 |
| 45 to 49 | 963 | 90.24% | 1.10817 | 1.032095 | 1.239282 |
| 50 to 54 | 921 | 91.31% | 1.095125 | 1.019945 | 1.224693 |
| 55 to 59 | 711 | 92.12% | 1.085496 | 1.010978 | 1.213926 |
| 60 and Over | 1952 | 85.71% | 1.166766 | 1.086668 | 1.304811 |

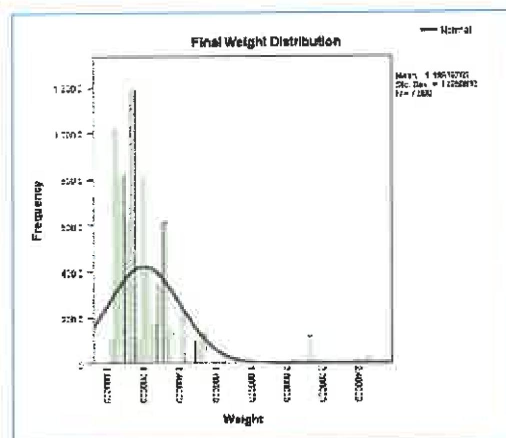
*Source: Va. Healthcare Workforce Data Center*

See the Methods section on the HWDC website for details on HWDC Methods:
www.dhp.virginia.gov/hwdc/

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

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

**Overall Response Rate:** 0.8399




*Source: Va. Healthcare Workforce Data Center*

**DRAFT**

# *Virginia's Dental Hygienist Workforce: 2024*

Healthcare Workforce Data Center

January 2025

Virginia Department of Health Professions
Healthcare Workforce Data Center
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Get a copy of this report from:
*https://www.dhp.virginia.gov/PublicResources/HealthcareWorkforceDataCenter/ProfessionReports/*

***More than 5,500 Dental Hygienists voluntarily participated in this survey.*** *Without their efforts, the work of the center would not be possible. The Department of Health Professions, the Healthcare Workforce Data Center, and the Board of Dentistry express our sincerest appreciation for their ongoing cooperation.*

***Thank You!***

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## The Dental Hygienist Workforce At a Glance:

**The Workforce**
- Licensees: 6,363
- Virginia's Workforce: 5,306
- FTEs: 3,497

**Survey Response Rate**
- All Licensees: 88%
- Renewing Practitioners: 93%

**Demographics**
- Female: 98%
- Diversity Index: 41%
- Median Age: 43

**Background**
- Rural Childhood: 36%
- HS Diploma in VA: 61%
- Prof. Degree in VA: 67%

**Education**
- Associate: 55%
- Baccalaureate: 40%

**Finances**
- Median Income: $70k-$80k
- Retirement Benefits: 57%
- Under 40 w/ Ed. Debt: 45%

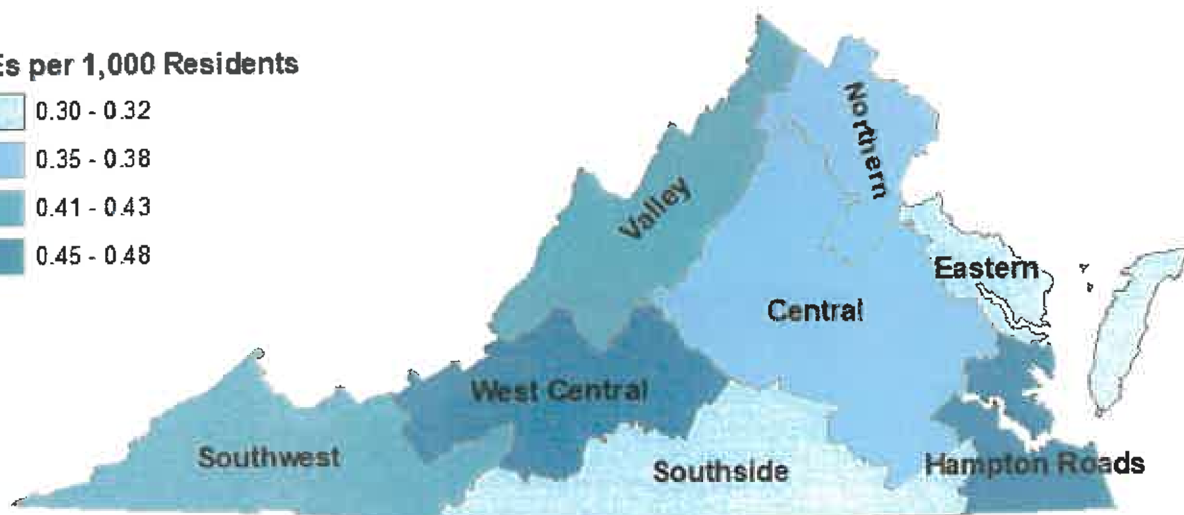
**Current Employment**
- Employed in Prof.: 91%
- Hold 1 Full-Time Job: 56%
- Satisfied?: 95%

**Job Turnover**
- Switched Jobs: 7%
- Employed Over 2 Yrs.: 57%

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

### Full-Time Equivalency Units Provided by Dental Hygienists per 1,000 Residents by Virginia Performs Region

Source: Va Healthcare Workforce Data Center




*Annual Estimates of the Resident Population: July 1, 2023*
*Source: U.S. Census Bureau, Population Division*

## Results in Brief

This report contains the results of the 2024 Dental Hygienist Workforce survey. Among all dental hygienists, 5,594 voluntarily participated in this survey. The Virginia Department of Health Professions' Healthcare Workforce Data Center (HWDC) administers the survey during the license renewal process, which takes place annually on an ongoing basis during the birth month of each dental hygienist. These survey respondents represent 88% of the 6,363 dental hygienists who are licensed in the state and 93% of renewing practitioners.

The HWDC estimates that 5,306 dental hygienists participated in Virginia's workforce during the survey time period, which is defined as those dental hygienists who worked at least a portion of the year in the state or who live in the state and intend to return to work in the profession at some point in the future. Virginia's dental hygienist workforce provided 3,497 "full-time equivalency units," which the HWDC defines simply as working 2,000 hours per year.

The median age of Virginia's dental hygienist workforce is 43, and 98% of all dental hygienists are female. In a random encounter between two dental hygienists, there is a 41% chance that they would be of different races or ethnicities, a measure known as the diversity index. This diversity index increases to 45% for those dental hygienists who are under the age of 40. For Virginia's overall population, the comparable diversity index of 60%. More than one-third of all dental hygienists grew up in a rural area, and 22% of dental hygienists who grew up in a rural area currently work in a non-metro area of Virginia. In total, 10% of all dental hygienists work in a non-metro area of the state.

Among all dental hygienists, 91% are currently employed in the profession, 56% have one full-time position, and 53% work between 30 and 39 hours per week. The typical dental hygienist earns between $70,000 and $80,000 per year. In addition, 77% of dental hygienists receive at least one employer-sponsored benefit, including 57% who have access to a retirement plan. Among all dental hygienists, 95% indicated that they are satisfied with their current work situation, including 62% who indicated that they are "very satisfied."

## Summary of Trends

In this section, all statistics for the current year are compared to the 2014 dental hygienist workforce. The number of licensed dental hygienists in Virginia has increased by 14% (6,363 vs. 5,563). During the same time, the size of the dental hygienist workforce has risen by 16% (5,306 vs. 4,585), and the number of FTEs provided by this workforce has grown by 14% (3,497 vs. 3,078). Virginia's renewing dental hygienists are more likely to respond to this survey (93% vs. 88%).

The diversity index of Virginia's dental hygienist workforce has increased (41% vs. 30%). This trend has also occurred among dental hygienists who are under the age of 40 (45% vs. 39%). Dental hygienists are slightly more likely to have grown up in a rural area (36% vs. 35%), and dental hygienists who grew up in a rural area are more likely to work in a non-metro area of Virginia (22% vs. 19%). In total, the percentage of all dental hygienists who work in a non-metro area of the state has increased slightly (10% vs. 9%).

Dental hygienists are more likely to hold one full-time position (56% vs. 47%) instead of two or more positions simultaneously (12% vs. 17%). In addition, dental hygienists are more likely to work between 30 and 39 hours per week (53% vs. 49%) than between 20 and 29 hours per week (16% vs. 19%). The percentage of dental hygienists who have worked at their primary work location for more than two years has fallen (57% vs. 68%), and the one-year rates of underemployment (3% vs. 11%) and involuntary unemployment (1% vs. 3%) have also declined. Dental hygienists are relatively more likely to work in a dental/health clinic (9% vs. 6%) instead of a solo dental practice (68% vs. 72%).

The median annual income of the dental hygienist workforce has increased ($70k-$80k vs. $50k-$60k), and dental hygienists are more likely to earn this income as an hourly wage (83% vs. 75%) instead of a salary (15% vs. 22%). In addition, dental hygienists are more likely to receive at least one-employer sponsored benefit (77% vs. 72%). At the same time, dental hygienists are slightly more likely to carry education debt (29% vs. 28%), and the median outstanding balance among those dental hygienists with education debt has increased ($20k-$30k vs. $10k-$20k). Dental hygienists are more likely to indicate that they are satisfied with their current work situation (95% vs. 93%).

## A Closer Look:

| Licensees | | |
|---|---|---|
| License Status | # | % |
| Renewing Practitioners | 5,763 | 91% |
| New Licensees | 304 | 5% |
| Non-Renewals | 296 | 5% |
| All Licensees | 6,363 | 100% |

*Source: Va. Healthcare Workforce Data Center*

*HWDC surveys tend to achieve very high response rates. Among all renewing dental hygienists, 93% submitted a survey. These represent 88% of the 6,363 dental hygienists who held a license at some point in the past year.*

| Response Rates | | | |
|---|---|---|---|
| Statistic | Non Respondents | Respondents | Response Rate |
| **By Age** | | | |
| Under 30 | 230 | 585 | 72% |
| 30 to 34 | 99 | 736 | 88% |
| 35 to 39 | 77 | 768 | 91% |
| 40 to 44 | 61 | 790 | 93% |
| 45 to 49 | 63 | 656 | 91% |
| 50 to 54 | 49 | 614 | 93% |
| 55 to 59 | 49 | 558 | 92% |
| 60 and Over | 141 | 887 | 86% |
| Total | 769 | 5,594 | 88% |
| **New Licenses** | | | |
| Issued in Past Year | 259 | 45 | 15% |
| **Metro Status** | | | |
| Non-Metro | 70 | 559 | 89% |
| Metro | 469 | 4,127 | 90% |
| Not in Virginia | 230 | 908 | 80% |

*Source: Va. Healthcare Workforce Data Center*

### Definitions

1. **The Survey Period:** The survey was conducted throughout 2024 on the birth month of each renewing practitioner.
2. **Target Population:** All dental hygienists who held a Virginia license at some point in 2024.
3. **Survey Population:** The survey was available to dental hygienists who renewed their licenses online. It was not available to those who did not renew, including some dental hygienists newly licensed in 2024.

| Response Rates | |
|---|---|
| Completed Surveys | 5,594 |
| Response Rate, All Licensees | 88% |
| Response Rate, Renewals | 93% |

*Source: Va. Healthcare Workforce Data Center*

## At a Glance:

**Licensed Dental Hygienists**
Number: 6,363
New: 5%
Not Renewed: 5%

**Response Rates**
All Licensees: 88%
Renewing Practitioners: 93%

## At a Glance:

**Workforce**
Dental Hygienist Workforce: 5,306
FTEs: 3,497

**Utilization Ratios**
Licensees in VA Workforce: 83%
Licensees per FTE: 1.82
Workers per FTE: 1.52

Source: Va. Healthcare Workforce Data Center

### Definitions

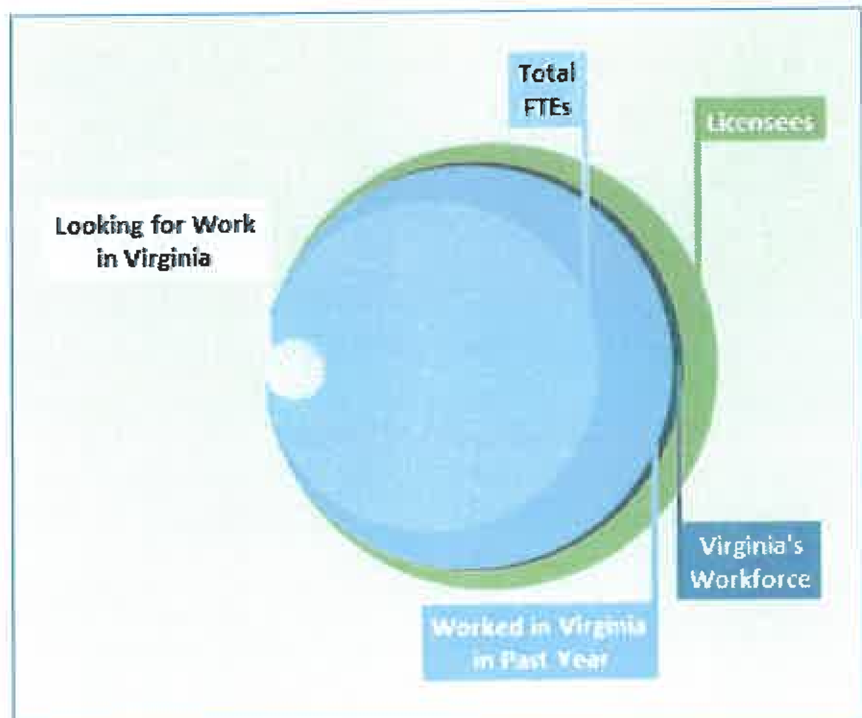
1. **Virginia's Workforce:** A licensee with a primary or secondary work site in Virginia at any time in the past year or who indicated intent to return to Virginia's workforce at any point in the future.
2. **Full-Time Equivalency Unit (FTE):** The HWDC uses 2,000 (40 hours for 50 weeks) as its baseline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

**Dental Hygienist Workforce**

| Status | # | % |
|---|---|---|
| Worked in Virginia in Past Year | 5,182 | 98% |
| Looking for Work in Virginia | 124 | 2% |
| Virginia's Workforce | 5,306 | 100% |
| Total FTEs | 3,497 | |
| Licensees | 6,363 | |

*Source: Va. Healthcare Workforce Data Center*

*Weighting is used to estimate the figures in this report. Unless otherwise noted, figures refer to the Virginia Workforce only. For more information on the HWDC's methodology, visit: https://www.dhp.virginia.gov/PublicResources/HealthcareWorkforceDataCenter/*




*Source: Va. Healthcare Workforce Data Center*

## A Closer Look:

| Age & Gender | | | | | | |
|---|---|---|---|---|---|---|
| Age | Male | | Female | | Total | |
| | # | % Male | # | % Female | # | % in Age Group |
| **Under 30** | 14 | 2% | 642 | 98% | 656 | 15% |
| **30 to 34** | 23 | 4% | 629 | 97% | 652 | 15% |
| **35 to 39** | 20 | 3% | 624 | 97% | 644 | 14% |
| **40 to 44** | 13 | 2% | 566 | 98% | 579 | 13% |
| **45 to 49** | 8 | 2% | 474 | 98% | 482 | 11% |
| **50 to 54** | 10 | 2% | 403 | 98% | 413 | 9% |
| **55 to 59** | 3 | 1% | 388 | 99% | 391 | 9% |
| **60 and Over** | 5 | 1% | 640 | 99% | 645 | 14% |
| **Total** | **94** | **2%** | **4,366** | **98%** | **4,460** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

| Race & Ethnicity | | | | | |
|---|---|---|---|---|---|
| Race/ Ethnicity | Virginia* | Dental Hygienists | | Hygienists Under 40 | |
| | % | # | % | # | % |
| **White** | 59% | 3,403 | 76% | 1,428 | 73% |
| **Black** | 19% | 287 | 6% | 129 | 7% |
| **Asian** | 7% | 366 | 8% | 178 | 9% |
| **Other Race** | 0% | 52 | 1% | 10 | 1% |
| **Two or More Races** | 3% | 123 | 3% | 82 | 4% |
| **Hispanic** | 11% | 268 | 6% | 129 | 7% |
| **Total** | **100%** | **4,499** | **100%** | **1,956** | **100%** |

*Population data in this chart is from the U.S. Census, Annual Estimates of the Resident Population by Sex, Race, and Hispanic Origin for the United States, States, and Counties: July 1, 2023.

*Source: Va. Healthcare Workforce Data Center*

## At a Glance:

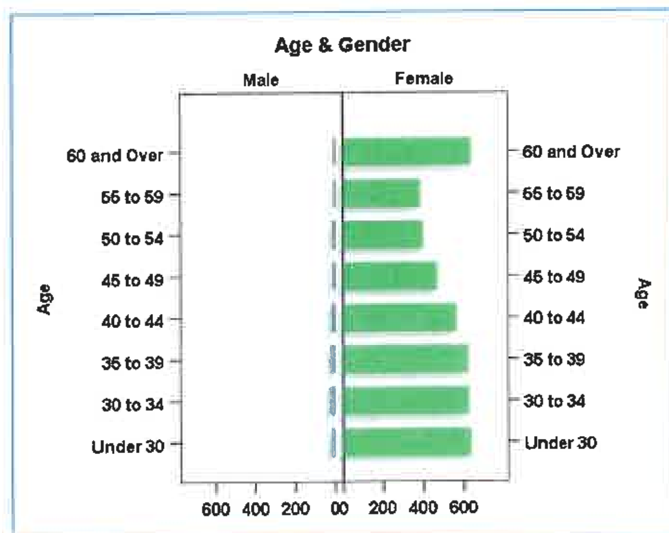
**Gender**
% Female: 98%
% Under 40 Female: 97%

**Age**
Median Age: 43
% Under 40: 44%
% 55 and Over: 23%

**Diversity**
Diversity Index: 41%
Under 40 Div. Index: 45%

*In a chance encounter between two dental hygienists, there is a 41% chance that they would be of different races or ethnicities (a measure known as the diversity index). For Virginia's population as a whole, the comparable diversity index is 60%.*

*Among the 44% of dental hygienists who are under the age of 40, 97% are female. In addition, the diversity index among dental hygienists who are under the age of 40 is 45%.*




*Source: Va. Healthcare Workforce Data Center*

## At a Glance:

**Childhood**
Urban Childhood: 12%
Rural Childhood: 36%

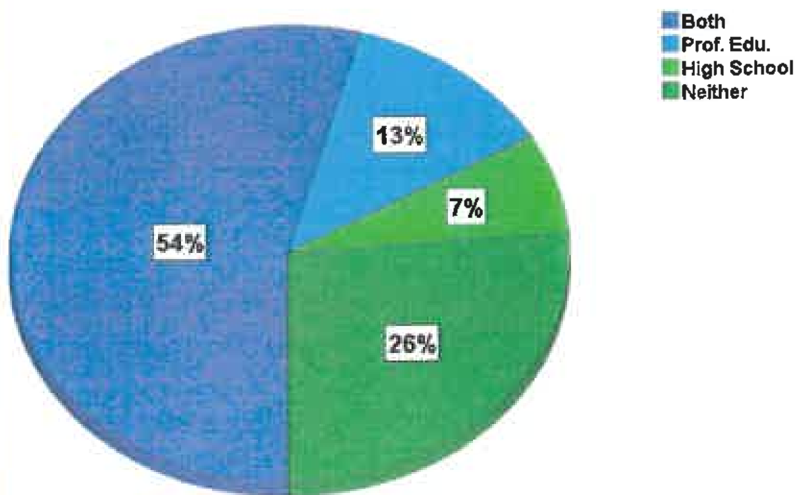
**Virginia Background**
HS in Virginia: 61%
Prof. Edu. in VA: 67%
HS or Prof. Edu. in VA: 74%

**Location Choice**
% Rural to Non-Metro: 22%
% Urban/Suburban to Non-Metro: 3%

## A Closer Look:

| Primary Location: USDA Rural Urban Continuum | | Rural Status of Childhood Location | | |
|---|---|---|---|---|
| **Code** | **Description** | **Rural** | **Suburban** | **Urban** |
| | **Metro Counties** | | | |
| 1 | Metro, 1 Million+ | 23% | 62% | 15% |
| 2 | Metro, 250,000 to 1 Million | 58% | 35% | 7% |
| 3 | Metro, 250,000 or Less | 62% | 33% | 5% |
| | **Non-Metro Counties** | | | |
| 4 | Urban, Pop. 20,000+, Metro Adjacent | 62% | 27% | 11% |
| 6 | Urban, Pop. 5,000-19,999, Metro Adjacent | 77% | 20% | 3% |
| 7 | Urban, Pop. 5,000-19,999, Non-Adjacent | 90% | 6% | 4% |
| 8 | Rural, Metro Adjacent | 76% | 20% | 5% |
| 9 | Rural, Non-Adjacent | 83% | 14% | 3% |
| | **Overall** | **36%** | **52%** | **12%** |

*Source: Va. Healthcare Workforce Data Center*




*Source: Va. Healthcare Workforce Data Center*

*More than one-third of all dental hygienists grew up in a rural area, and 22% of dental hygienists who grew up in a rural area currently work in a non-metro area of the state. In total, 10% of all dental hygienists currently work in a non-metro area of Virginia.*

## Top Ten States for Dental Hygienist Recruitment

| Rank | All Dental Hygienists | | | |
|---|---|---|---|---|
| | High School | # | Professional Degree | # |
| 1 | Virginia | 2,740 | Virginia | 2,960 |
| 2 | Outside U.S./Canada | 286 | North Carolina | 182 |
| 3 | Pennsylvania | 145 | Maryland | 170 |
| 4 | West Virginia | 134 | West Virginia | 122 |
| 5 | Maryland | 131 | Pennsylvania | 102 |
| 6 | North Carolina | 116 | Florida | 97 |
| 7 | New York | 112 | New York | 96 |
| 8 | Florida | 86 | Tennessee | 69 |
| 9 | Michigan | 71 | Washington, D.C. | 64 |
| 10 | New Jersey | 65 | Michigan | 54 |

*Source: Va. Healthcare Workforce Data Center*

*Among all dental hygienists, 61% received their high school degree in Virginia, and 67% received their initial professional degree in the state.*

| Rank | Licensed in the Past Five Years | | | |
|---|---|---|---|---|
| | High School | # | Professional Degree | # |
| 1 | Virginia | 500 | Virginia | 523 |
| 2 | Outside U.S./Canada | 69 | Maryland | 52 |
| 3 | West Virginia | 34 | North Carolina | 36 |
| 4 | Pennsylvania | 33 | West Virginia | 30 |
| 5 | Maryland | 32 | Florida | 27 |
| 6 | North Carolina | 28 | Pennsylvania | 26 |
| 7 | Florida | 24 | California | 20 |
| 8 | Ohio | 16 | Ohio | 17 |
| 9 | California | 15 | New York | 15 |
| 10 | New York | 15 | Washington, D.C. | 14 |

*Source: Va. Healthcare Workforce Data Center*

*Among dental hygienists who obtained their initial license in the past five years, 54% received their high school degree in Virginia, and 57% received their initial professional degree in the state.*

*In total, 17% of Virginia's licensees did not participate in the state's dental hygienist workforce. Four out of every five of these licensees worked at some point in the past year, including 69% who currently work as dental hygienists.*

### At a Glance:

**Not in VA Workforce**

| | |
|---|---|
| Total: | 1,057 |
| % of Licensees: | 17% |
| Federal/Military: | 6% |
| VA Border State/DC: | 18% |

## A Closer Look:

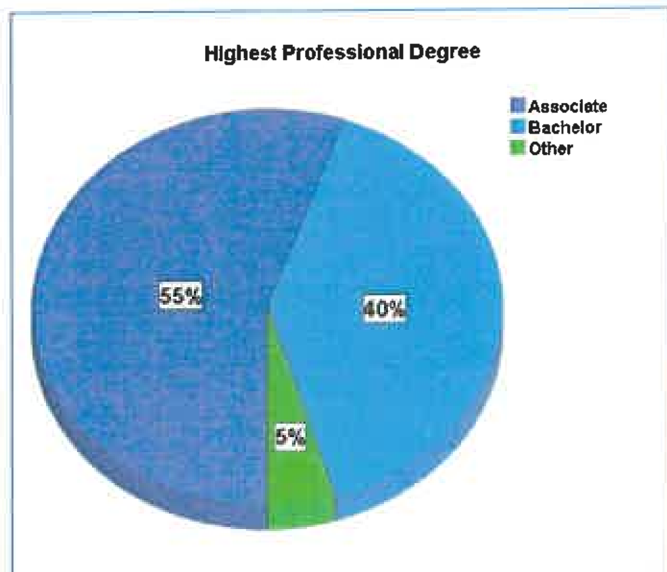
| Highest Professional Degree | | |
|---|---|---|
| **Degree** | **#** | **%** |
| Certificate | 66 | 2% |
| Associate Degree | 2,433 | 55% |
| Baccalaureate Degree | 1,754 | 40% |
| Post-Graduate Cert. | 14 | 0% |
| Master's Degree | 119 | 3% |
| Doctorate | 5 | 0% |
| **Total** | **4,392** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

### At a Glance:

**Education**
Associate: 55%
Baccalaureate: 40%

**Education Debt**
Carry Debt: 29%
Under Age 40 w/ Debt: 45%
Median Debt: $20k-$30k




*Source: Va. Healthcare Workforce Data Center*

*Among all dental hygienists, 55% hold an associate degree as their highest professional degree, while another 40% hold a baccalaureate degree.*

*Nearly three out of every ten dental hygienists carry education debt, including 45% of those dental hygienists who are under the age of 40. For those dental hygienists with education debt, the median outstanding balance is between $20,000 and $30,000.*

| Education Debt | | | | |
|---|---|---|---|---|
| **Amount Carried** | **All Dental Hygienists** | | **Hygienists Under 40** | |
| | **#** | **%** | **#** | **%** |
| None | 2,790 | 71% | 962 | 55% |
| Less than $10,000 | 300 | 8% | 194 | 11% |
| $10,000-$19,999 | 250 | 6% | 185 | 11% |
| $20,000-$29,999 | 175 | 4% | 119 | 7% |
| $30,000-$39,999 | 110 | 3% | 87 | 5% |
| $40,000-$49,999 | 75 | 2% | 44 | 3% |
| $50,000-$59,999 | 60 | 2% | 43 | 2% |
| $60,000-$69,999 | 44 | 1% | 32 | 2% |
| $70,000-$79,999 | 34 | 1% | 16 | 1% |
| $80,000-$89,999 | 37 | 1% | 31 | 2% |
| $90,000-$99,999 | 19 | 0% | 13 | 1% |
| $100,000 or More | 37 | 1% | 23 | 1% |
| **Total** | **3,931** | **100%** | **1,748** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

## At a Glance:

**Employment**
Employed in Profession: 91%
Involuntarily Unemployed: < 1%

**Positions Held**
1 Full-Time: 56%
2 or More Positions: 12%

**Weekly Hours:**
40 to 49: 12%
60 or More: 1%
Less than 30: 28%

Source: Va. Healthcare Workforce Data Center

## A Closer Look:

| Current Work Status | | |
|---|---|---|
| Status | # | % |
| Employed, Capacity Unknown | 2 | < 1% |
| Employed in a Capacity Related to Dental Hygiene | 4,079 | 91% |
| Employed, NOT in a Capacity Related to Dental Hygiene | 165 | 4% |
| Not Working, Reason Unknown | 0 | 0% |
| Involuntarily Unemployed | 5 | < 1% |
| Voluntarily Unemployed | 173 | 4% |
| Retired | 56 | 1% |
| Total | 4,480 | 100% |

*Source: Va. Healthcare Workforce Data Center*

*Among all dental hygienists, 91% are currently employed in the profession, 56% hold one full-time job, and 53% work between 30 and 39 hours per week.*

| Current Positions | | |
|---|---|---|
| Positions | # | % |
| No Positions | 234 | 5% |
| One Part-Time Position | 1,169 | 27% |
| Two Part-Time Positions | 193 | 4% |
| One Full-Time Position | 2,485 | 56% |
| One Full-Time Position & One Part-Time Position | 273 | 6% |
| Two Full-Time Positions | 3 | 0% |
| More than Two Positions | 44 | 1% |
| Total | 4,401 | 100% |

*Source: Va. Healthcare Workforce Data Center*

| Current Weekly Hours | | |
|---|---|---|
| Hours | # | % |
| 0 Hours | 234 | 5% |
| 1 to 9 Hours | 178 | 4% |
| 10 to 19 Hours | 341 | 8% |
| 20 to 29 Hours | 677 | 16% |
| 30 to 39 Hours | 2,310 | 53% |
| 40 to 49 Hours | 533 | 12% |
| 50 to 59 Hours | 34 | 1% |
| 60 to 69 Hours | 19 | 0% |
| 70 to 79 Hours | 9 | 0% |
| 80 or More Hours | 10 | 0% |
| Total | 4,345 | 100% |

*Source: Va. Healthcare Workforce Data Center*

## A Closer Look:

| Annual Income | | |
|---|---|---|
| **Income Level** | **#** | **%** |
| Volunteer Work Only | 20 | 1% |
| Less than $20,000 | 193 | 5% |
| $20,000-$29,999 | 131 | 4% |
| $30,000-$39,999 | 174 | 5% |
| $40,000-$49,999 | 267 | 7% |
| $50,000-$59,999 | 453 | 13% |
| $60,000-$69,999 | 543 | 15% |
| $70,000-$79,999 | 634 | 18% |
| $80,000-$89,999 | 497 | 14% |
| $90,000-$99,999 | 297 | 8% |
| $100,000 or More | 377 | 11% |
| **Total** | **3,586** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

### At a Glance:

**Earnings**
Median Income: $70k-$80k

**Benefits**
Paid Vacation: 69%
Retirement: 57%

**Satisfaction**
Satisfied: 95%
Very Satisfied: 62%

| Job Satisfaction | | |
|---|---|---|
| **Level** | **#** | **%** |
| Very Satisfied | 2,693 | 62% |
| Somewhat Satisfied | 1,444 | 33% |
| Somewhat Dissatisfied | 169 | 4% |
| Very Dissatisfied | 57 | 1% |
| **Total** | **4,363** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

*The typical dental hygienist makes between $70,000 and $80,000 per year. In addition, 77% of dental hygienists receive at least one employer-sponsored benefit, including 57% who have access to a retirement plan.*

| Employer-Sponsored Benefits | | | |
|---|---|---|---|
| **Benefit** | **#** | **%** | **% of Wage/Salary Employees** |
| Paid Vacation | 2,803 | 69% | 69% |
| Retirement | 2,322 | 57% | 58% |
| Paid Sick Leave | 1,385 | 34% | 34% |
| Dental Insurance | 857 | 21% | 21% |
| Group Life Insurance | 703 | 17% | 17% |
| Signing/Retention Bonus | 300 | 7% | 7% |
| **At Least One Benefit** | **3,135** | **77%** | **77%** |

*From any employer at time of survey.

*Source: Va. Healthcare Workforce Data Center*

## A Closer Look:

| Employment Instability in the Past Year | | |
|---|---|---|
| **In The Past Year, Did You . . .?** | **#** | **%** |
| Experience Involuntary Unemployment? | 44 | 1% |
| Experience Voluntary Unemployment? | 329 | 6% |
| Work Part-Time or Temporary Positions, but Would Have Preferred a Full-Time/Permanent Position? | 179 | 3% |
| Work Two or More Positions at the Same Time? | 622 | 12% |
| Switch Employers or Practices? | 381 | 7% |
| **Experience at Least One?** | **1,279** | **24%** |

*Source: Va. Healthcare Workforce Data Center*

*Over the past year, 1% of dental hygienists have experienced involuntary unemployment. By comparison, Virginia's average monthly unemployment rate was 2.9% during the same time period.[1]*

| Location Tenure | | | | |
|---|---|---|---|---|
| **Tenure** | **Primary** | | **Secondary** | |
| | **#** | **%** | **#** | **%** |
| Not Currently Working at This Location | 141 | 3% | 94 | 12% |
| Less than 6 Months | 290 | 7% | 147 | 18% |
| 6 Months to 1 Year | 426 | 10% | 96 | 12% |
| 1 to 2 Years | 938 | 22% | 163 | 20% |
| 3 to 5 Years | 894 | 21% | 130 | 16% |
| 6 to 10 Years | 542 | 13% | 80 | 10% |
| More than 10 Years | 972 | 23% | 99 | 12% |
| **Subtotal** | **4,204** | **100%** | **809** | **100%** |
| Did Not Have Location | 196 | | 4,449 | |
| Item Missing | 906 | | 48 | |
| Total | 5,306 | | 5,306 | |

*Source: Va. Healthcare Workforce Data Center*

*Among all dental hygienists, 83% receive an hourly wage at their primary work location.*

### At a Glance:

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

**Turnover & Tenure**
Switched Jobs: 7%
New Location: 23%
Over 2 Years: 57%
Over 2 Yrs., 2nd Location: 38%

**Employment Type**
Hourly Wage: 83%
Salary/Commission: 15%

*Source: Va. Healthcare Workforce Data Center*

*Nearly three out of every five dental hygienists have been employed at their primary work location for more than two years.*

| Employment Type | | |
|---|---|---|
| **Primary Work Site** | **#** | **%** |
| Salary/Commission | 477 | 15% |
| Hourly Wage | 2,654 | 83% |
| By Contract | 45 | 1% |
| Business/Practice Income | 5 | 0% |
| Unpaid | 11 | 0% |
| **Subtotal** | **3,192** | **100%** |
| Did Not Have Location | 196 | |
| Item Missing | 1,918 | |

*Source: Va. Healthcare Workforce Data Center*

[1] As reported by the U.S. Bureau of Labor Statistics. Over the past year, the non-seasonally adjusted monthly unemployment rate fluctuated between a low of 2.3% and a high of 3.5%. At the time of publication, the unemployment rate from November 2024 was still preliminary, and the unemployment rate from December 2024 had not yet been released.

## At a Glance:

**Concentration**
Top Region: 32%
Top 3 Regions: 74%
Lowest Region: 1%

**Locations**
2 or More (Past Year): 20%
2 or More (Now*): 17%

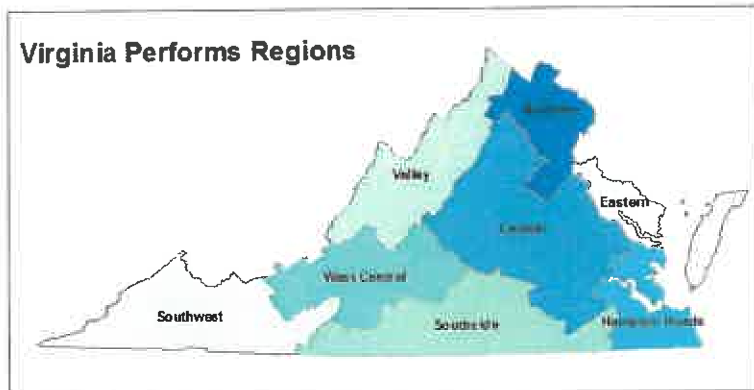
*Nearly three-quarters of all dental hygienists work in Northern Virginia, Hampton Roads, and Central Virginia.*

## A Closer Look:

**Regional Distribution of Work Locations**

| Virginia Performs Region | Primary Location | | Secondary Location | |
|---|---|---|---|---|
| | # | % | # | % |
| Central | 752 | 18% | 144 | 17% |
| Eastern | 54 | 1% | 11 | 1% |
| Hampton Roads | 984 | 24% | 165 | 19% |
| Northern | 1,332 | 32% | 329 | 38% |
| Southside | 133 | 3% | 16 | 2% |
| Southwest | 200 | 5% | 36 | 4% |
| Valley | 258 | 6% | 45 | 5% |
| West Central | 429 | 10% | 75 | 9% |
| Virginia Border State/D.C. | 15 | 0% | 10 | 1% |
| Other U.S. State | 16 | 0% | 24 | 3% |
| Outside of the U.S. | 0 | 0% | 1 | 0% |
| Total | 4,173 | 100% | 856 | 100% |
| Item Missing | 937 | | 3 | |

*Source: Va. Healthcare Workforce Data Center*




*Source: Va. Healthcare Workforce Data Center*

**Number of Work Locations**

| Locations | Work Locations in Past Year | | Work Locations Now* | |
|---|---|---|---|---|
| | # | % | # | % |
| 0 | 135 | 3% | 254 | 6% |
| 1 | 3,342 | 77% | 3,359 | 78% |
| 2 | 577 | 13% | 509 | 12% |
| 3 | 185 | 4% | 168 | 4% |
| 4 | 23 | 1% | 9 | 0% |
| 5 | 15 | 0% | 1 | 0% |
| 6 or More | 52 | 1% | 29 | 1% |
| Total | 4,328 | 100% | 4,328 | 100% |

*At the time of survey completion, Jan. 2024-Dec. 2024 (birth month of respondent).

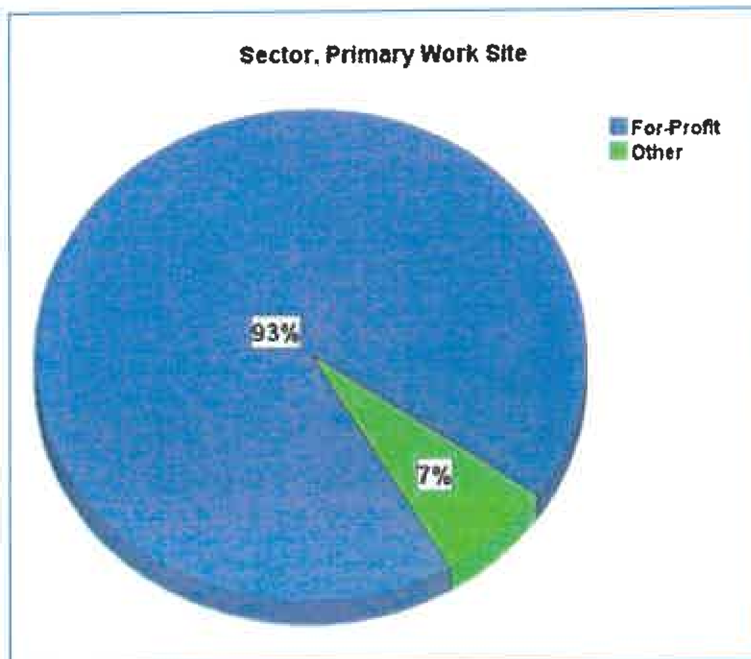
*Source: Va. Healthcare Workforce Data Center*

*Among all dental hygienists, 17% currently have multiple work locations, while 20% have had multiple work locations over the past year.*

## A Closer Look:

| Location Sector | | | | |
|---|---|---|---|---|
| Sector | Primary Location | | Secondary Location | |
| | # | % | # | % |
| For-Profit | 3,770 | 93% | 727 | 93% |
| Non-Profit | 105 | 3% | 22 | 3% |
| State/Local Government | 106 | 3% | 22 | 3% |
| Veterans Administration | 7 | 0% | 0 | 0% |
| U.S. Military | 46 | 1% | 7 | 1% |
| Other Federal Government | 14 | 0% | 5 | 1% |
| **Total** | **4,048** | **100%** | **783** | **100%** |
| Did Not Have Location | 196 | | 4,449 | |
| Item Missing | 1,062 | | 74 | |

*Source: Va. Healthcare Workforce Data Center*




*Source: Va. Healthcare Workforce Data Center*

*Among all dental hygienists, 6% work under the remote supervision of a public health dentist, and 4% work under the remote supervision of a dentist.*

## At a Glance:
### (Primary Locations)

**Sector**
For-Profit: 93%
Federal: 2%

**Top Establishments**
Solo Practice: 69%
Group Practice: 17%
Dental/Health Clinic: 9%

**Remote Supervision**
Public Health Dentistry: 6%
Dentistry: 4%

*Most dental hygienists work in the private sector, including 93% who work in the for-profit sector.*

| Remote Supervision | | | | |
|---|---|---|---|---|
| Response | Primary Location | | Secondary Location | |
| | # | % | # | % |
| **Public Health Dentistry** | | | | |
| Yes | 254 | 6% | 34 | 4% |
| No | 3,786 | 94% | 753 | 96% |
| **Total** | **4,040** | **100%** | **787** | **100%** |
| **Dentistry** | | | | |
| Yes | 154 | 4% | 54 | 7% |
| No | 3,882 | 96% | 736 | 93% |
| **Total** | **4,036** | **100%** | **790** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

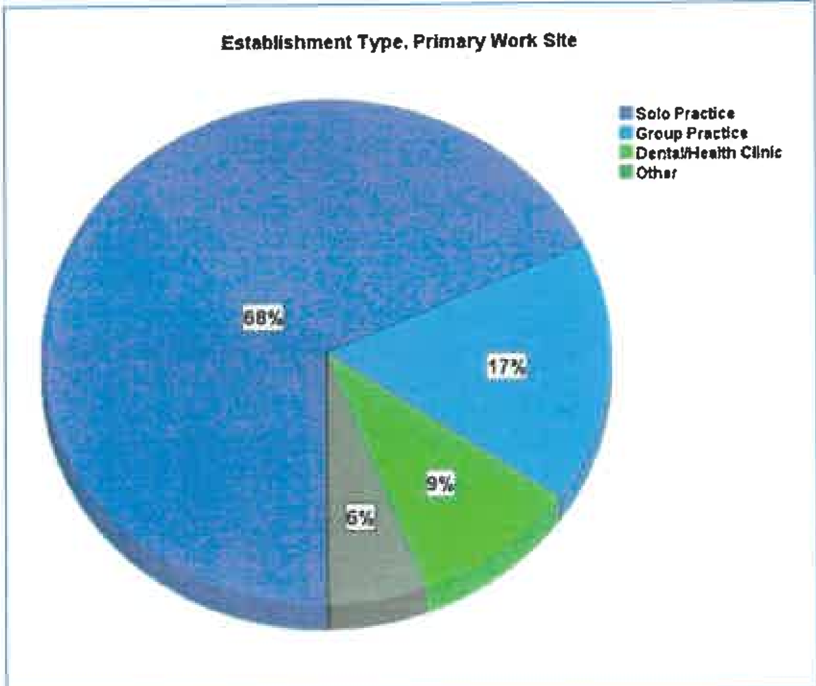
| Establishment Type | Primary Location | | Secondary Location | |
|---|---|---|---|---|
| | # | % | # | % |
| Solo Practice | 2,725 | 68% | 523 | 69% |
| Group Practice | 670 | 17% | 110 | 14% |
| Dental/Health Clinic | 379 | 9% | 66 | 9% |
| Dental School (Including Combined Dental/Dental Hygiene) | 65 | 2% | 29 | 4% |
| Public Health Program | 27 | 1% | 6 | 1% |
| Hospital/Health System | 21 | 1% | 2 | 0% |
| Insurance | 13 | 0% | 1 | 0% |
| Corrections | 11 | 0% | 2 | 0% |
| K-12 School or Non-Dental College | 10 | 0% | 3 | 0% |
| Supplier Organization | 4 | 0% | 2 | 0% |
| Nursing Home/Long-Term Care Facility | 2 | 0% | 1 | 0% |
| Other | 75 | 2% | 18 | 2% |
| **Total** | **4,002** | **100%** | **763** | **100%** |
| Did Not Have a Location | 196 | | 4,449 | |

*Location Type*

*Source: Va. Healthcare Workforce Data Center*

*More than two-thirds of all dental hygienists work at a solo dental practice as their primary work location, while another 17% work at a group dental practice.*

*Among those dental hygienists who also have a secondary work location, 69% work at a solo dental practice, and 14% work at a group dental practice.*




*Source: Va. Healthcare Workforce Data Center*

## At a Glance:
(Primary Locations)

**Languages Offered**

| | |
|---|---|
| Spanish: | 28% |
| Arabic: | 5% |
| Korean: | 5% |

**Means of Communication**

| | |
|---|---|
| Other Staff Member: | 73% |
| Respondent: | 28% |
| Virtual Translation: | 12% |

*More than one-quarter of all dental hygienists are employed at a primary work location that offers Spanish language services for patients.*

## A Closer Look:

| Languages Offered | | |
|---|---|---|
| **Language** | **#** | **% of Workforce** |
| **Spanish** | 1,484 | 28% |
| **Arabic** | 275 | 5% |
| **Korean** | 253 | 5% |
| **Vietnamese** | 209 | 4% |
| **Persian** | 182 | 3% |
| **Tagalog/Filipino** | 177 | 3% |
| **Hindi** | 173 | 3% |
| **Chinese** | 128 | 2% |
| **Urdu** | 111 | 2% |
| **French** | 103 | 2% |
| **Amharic, Somali, or Other Afro-Asiatic Languages** | 97 | 2% |
| **Pashto** | 68 | 1% |
| **Others** | 254 | 5% |
| **At Least One Language** | **1,830** | **34%** |

*Source: Va. Healthcare Workforce Data Center*

| Means of Language Communication | | |
|---|---|---|
| **Provision** | **#** | **% of Workforce with Language Services** |
| **Other Staff Member is Proficient** | 1,340 | 73% |
| **Respondent is Proficient** | 505 | 28% |
| **Virtual Translation Services** | 214 | 12% |
| **Onsite Translation Service** | 123 | 7% |
| **Other** | 64 | 3% |

*Source: Va. Healthcare Workforce Data Center*

*Nearly three out of every four dental hygienists who are employed at a primary work location that offers language services for patients provide it by means of a staff member who is proficient.*

## At a Glance:
### (Primary Locations)

**Typical Time Allocation**

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

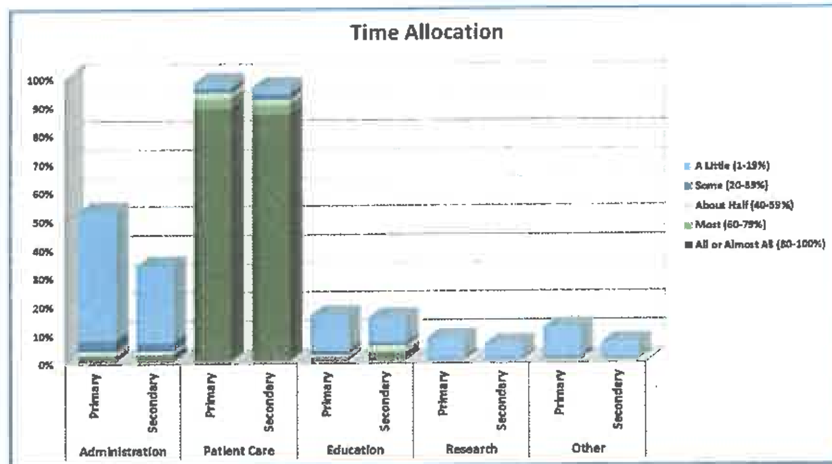
**Roles**

Patient Care: 92%
Administration: 2%
Education: 1%

**Patient Care Hygienists**

Median Admin. Time: 1%-9%
Avg. Admin. Time: 1%-9%

## A Closer Look:



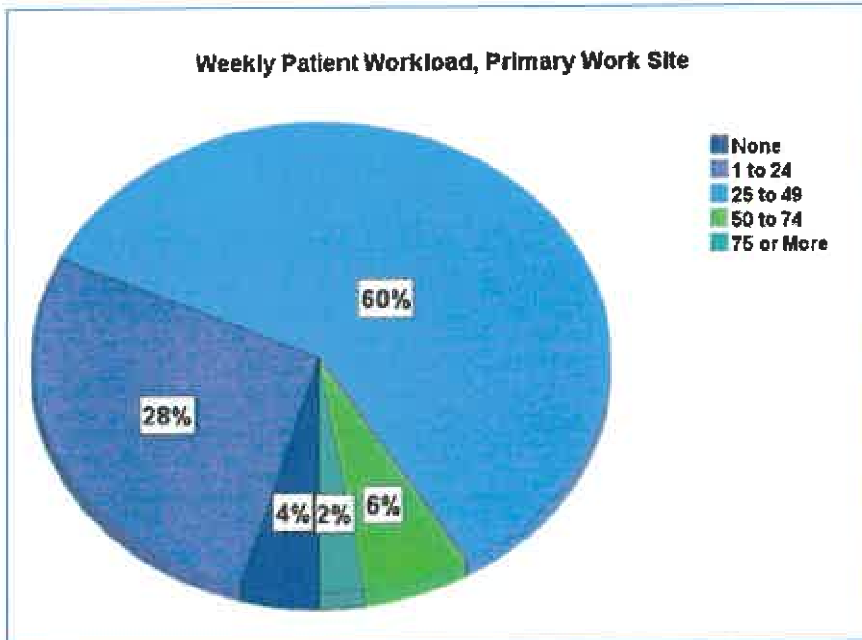

*Source: Va. Healthcare Workforce Data Center*

*Dental hygienists typically spend most of their time treating patients. In fact, 92% of dental hygienists fill a patient care role, defined as spending 60% or more of their time on patient care activities.*

| Time Allocation | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Time Spent | Admin. | | Patient Care | | Education | | Research | | Other | |
| | Pri. Site | Sec. Site | Pri. Site | Sec. Site | Pri. Site | Sec. Site | Pri. Site | Sec. Site | Pri. Site | Sec. Site |
| All or Almost All (80-100%) | 2% | 2% | 89% | 86% | 1% | 3% | 0% | 0% | 0% | 0% |
| Most (60-79%) | 0% | 0% | 4% | 3% | 0% | 0% | 0% | 0% | 0% | 0% |
| About Half (40-59%) | 1% | 1% | 2% | 2% | 1% | 2% | 0% | 0% | 0% | 0% |
| Some (20-39%) | 4% | 3% | 2% | 2% | 2% | 1% | 1% | 1% | 1% | 0% |
| A Little (1-19%) | 45% | 27% | 2% | 3% | 12% | 9% | 7% | 5% | 10% | 6% |
| None (0%) | 47% | 66% | 2% | 4% | 84% | 85% | 92% | 94% | 88% | 94% |

*Source: Va. Healthcare Workforce Data Center*

## A Closer Look:




Source: Va. Healthcare Workforce Data Center

## At a Glance:

**Patient Workload (Median)**
Primary Location: 25-49
Secondary Location: 1-24

*Dental hygienists typically treat between 25 and 49 patients per week at their primary work location. For those dental hygienists who also have a secondary work location, the median patient workload is between 1 and 24 patients per week.*

| Patient Care Visits | | | | |
|---|---|---|---|---|
| # of Patients Per Week | Primary | | Secondary | |
| | # | % | # | % |
| None | 183 | 4% | 78 | 10% |
| 1-24 | 1,122 | 28% | 518 | 66% |
| 25-49 | 2,424 | 60% | 158 | 20% |
| 50-74 | 242 | 6% | 20 | 3% |
| 75-99 | 44 | 1% | 3 | 0% |
| 100-124 | 27 | 1% | 5 | 1% |
| 125-149 | 7 | 0% | 0 | 0% |
| 150-174 | 8 | 0% | 2 | 0% |
| 175-199 | 2 | 0% | 1 | 0% |
| 200 or More | 13 | 0% | 0 | 0% |
| Total | 4,072 | 100% | 785 | 100% |

Source: Va. Healthcare Workforce Data Center

## A Closer Look:

| Retirement Expectations | | | | |
|---|---|---|---|---|
| Expected Retirement Age | All Dental Hygienists | | Hygienists 50 and Over | |
| | # | % | # | % |
| Under Age 50 | 480 | 13% | - | - |
| 50 to 54 | 399 | 10% | 20 | 2% |
| 55 to 59 | 684 | 18% | 124 | 10% |
| 60 to 64 | 990 | 26% | 359 | 29% |
| 65 to 69 | 898 | 23% | 496 | 40% |
| 70 to 74 | 199 | 5% | 139 | 11% |
| 75 to 79 | 42 | 1% | 32 | 3% |
| 80 or Over | 16 | 0% | 8 | 1% |
| I Do Not Intend to Retire | 116 | 3% | 58 | 5% |
| **Total** | **3,824** | **100%** | **1,236** | **100%** |

*Source: Va. Healthcare Workforce Data Center*

### At a Glance:

**Retirement Expectations**
All Dental Hygienists
Under 65: 67%
Under 60: 41%
Hygienists 50 and Over
Under 65: 41%
Under 60: 12%

**Time Until Retirement**
Within 2 Years: 7%
Within 10 Years: 26%
Half the Workforce: By 2044

*Two-thirds of all dental hygienists expect to retire by the age of 65. Among dental hygienists who are age 50 and over, 41% expect to retire by the age of 65.*

*Within the next two years, 8% of Virginia's dental hygienists expect to increase their patient care hours, and 6% expect to pursue additional educational opportunities.*

| Future Plans | | |
|---|---|---|
| Two-Year Plans: | # | % |
| **Decrease Participation** | | |
| Leave Profession | 181 | 3% |
| Leave Virginia | 131 | 2% |
| Decrease Patient Care Hours | 718 | 14% |
| Decrease Teaching Hours | 24 | 0% |
| **Increase Participation** | | |
| Increase Patient Care Hours | 414 | 8% |
| Increase Teaching Hours | 109 | 2% |
| Pursue Additional Education | 316 | 6% |
| Return to the Workforce | 40 | 1% |

*Source: Va. Healthcare Workforce Data Center*

| Time to Retirement | | | |
|---|---|---|---|
| Expect to Retire Within. . . | # | % | Cumulative % |
| 2 Years | 271 | 7% | 7% |
| 5 Years | 203 | 5% | 12% |
| 10 Years | 531 | 14% | 26% |
| 15 Years | 531 | 14% | 40% |
| 20 Years | 551 | 14% | 55% |
| 25 Years | 590 | 15% | 70% |
| 30 Years | 434 | 11% | 81% |
| 35 Years | 315 | 8% | 90% |
| 40 Years | 173 | 5% | 94% |
| 45 Years | 85 | 2% | 96% |
| 50 Years | 16 | 0% | 97% |
| 55 Years | 2 | 0% | 97% |
| In More than 55 Years | 3 | 0% | 97% |
| Do Not Intend to Retire | 116 | 3% | 100% |
| Total | 3,824 | 100% | |

Source: Va. Healthcare Workforce Data Center

*By comparing retirement expectations to age, we can estimate the maximum years to retirement for dental hygienists. While only 7% of dental hygienists expect to retire in the next two years, 26% expect to retire within the next decade. More than half of the current workforce expect to retire by 2044.*

Source: Va. Healthcare Workforce Data Center

*Using these estimates, retirement will begin to reach over 10% of the current workforce every five years by 2034. Retirement will peak at 15% of the current workforce around 2049 before declining to under 10% again around 2059.*

## At a Glance:

**FTEs**

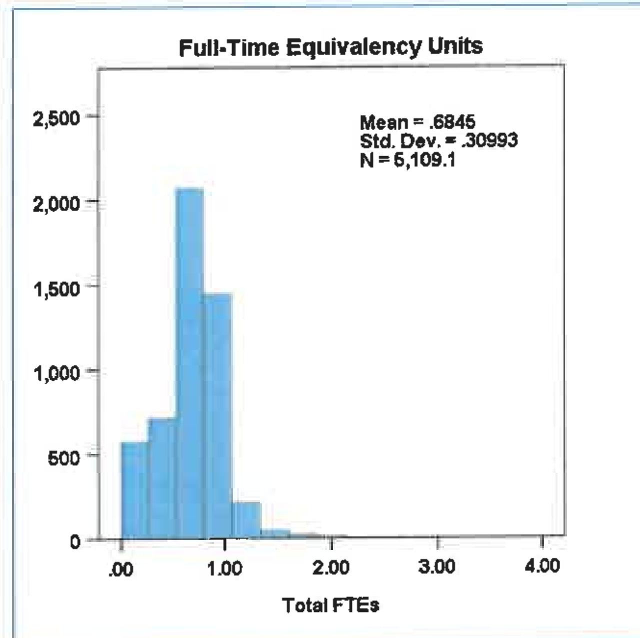
Total: 3,497
FTEs/1,000 Residents[2]: 0.401
Average: 0.68

**Age & Gender Effect**

Age, *Partial Eta²*: Negligible
Gender, *Partial Eta²*: Negligible

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

## A Closer Look:

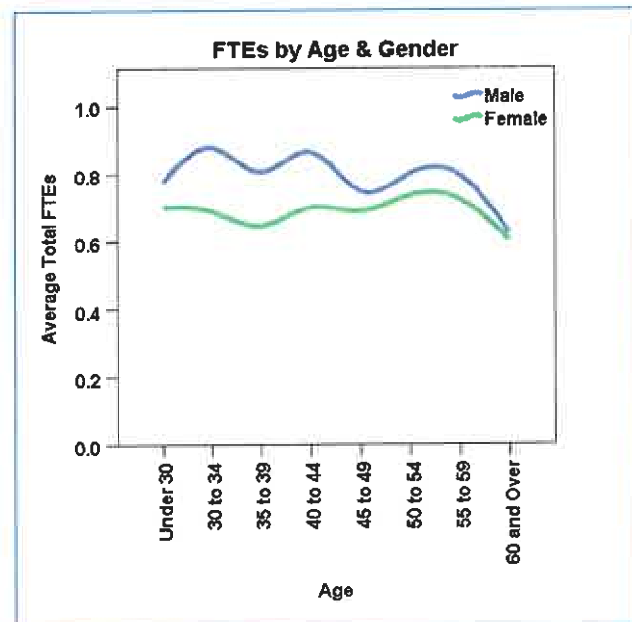



Source: Va. Healthcare Workforce Data Center

*The typical dental hygienist provided 0.70 FTEs in the past year, or approximately 28 hours per week for 50 weeks. Although FTEs appear to vary by gender, statistical tests did not verify that a difference exists.[3]*

| Full-Time Equivalency Units | | |
|---|---|---|
| Age | Average | Median |
| **Age** | | |
| Under 30 | 0.69 | 0.75 |
| 30 to 34 | 0.69 | 0.74 |
| 35 to 39 | 0.65 | 0.66 |
| 40 to 44 | 0.75 | 0.80 |
| 45 to 49 | 0.67 | 0.66 |
| 50 to 54 | 0.72 | 0.65 |
| 55 to 59 | 0.74 | 0.78 |
| 60 and Over | 0.60 | 0.58 |
| **Gender** | | |
| Male | 0.81 | 0.83 |
| Female | 0.68 | 0.75 |

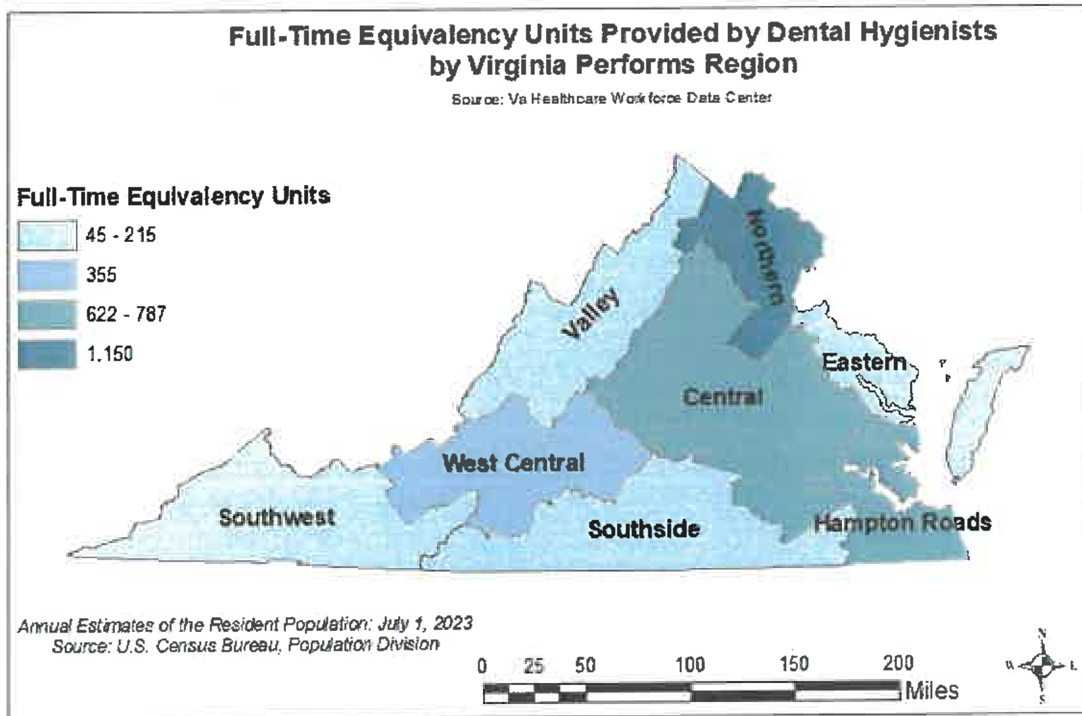
Source: Va. Healthcare Workforce Data Center

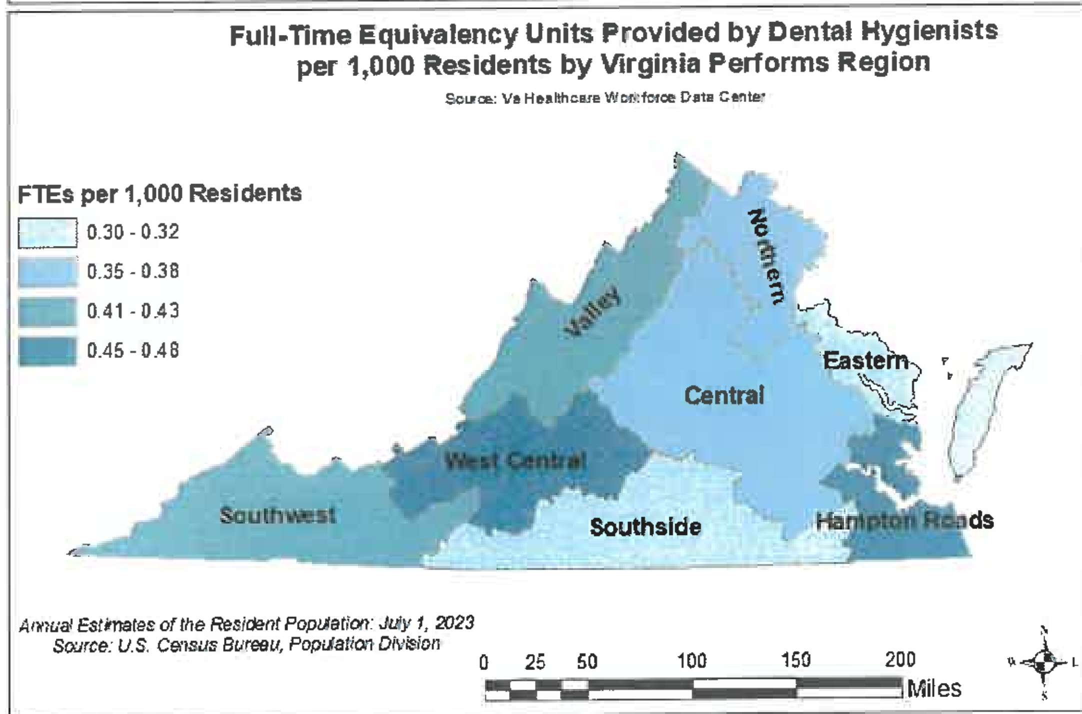


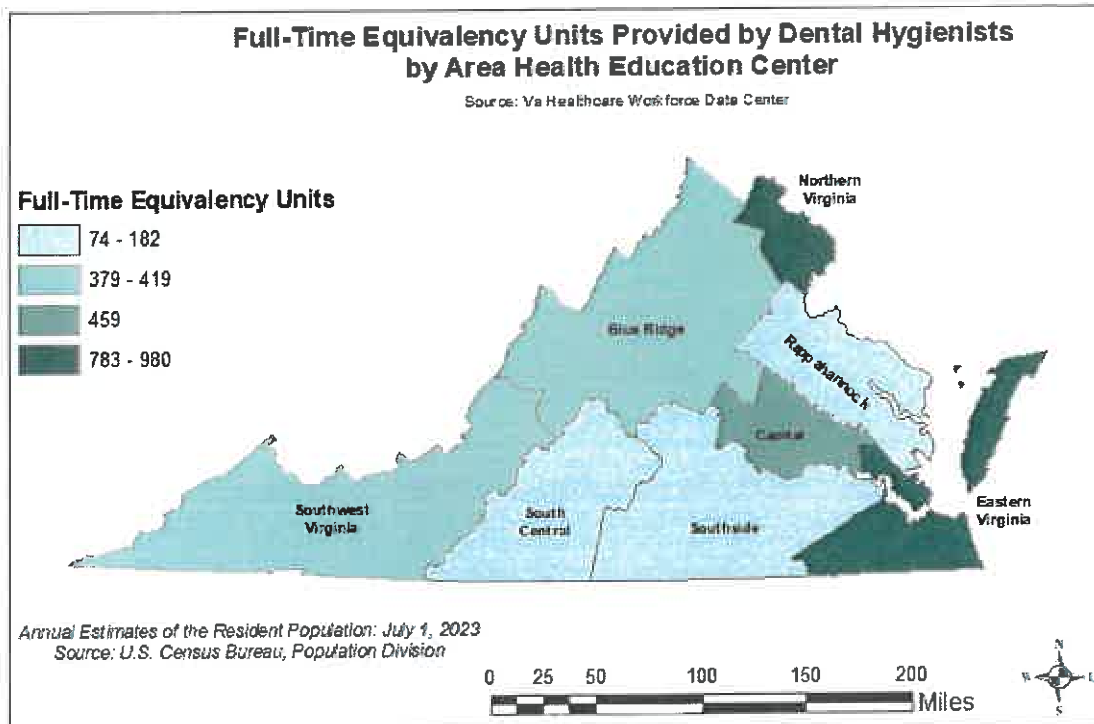

Source: Va. Healthcare Workforce Data Center

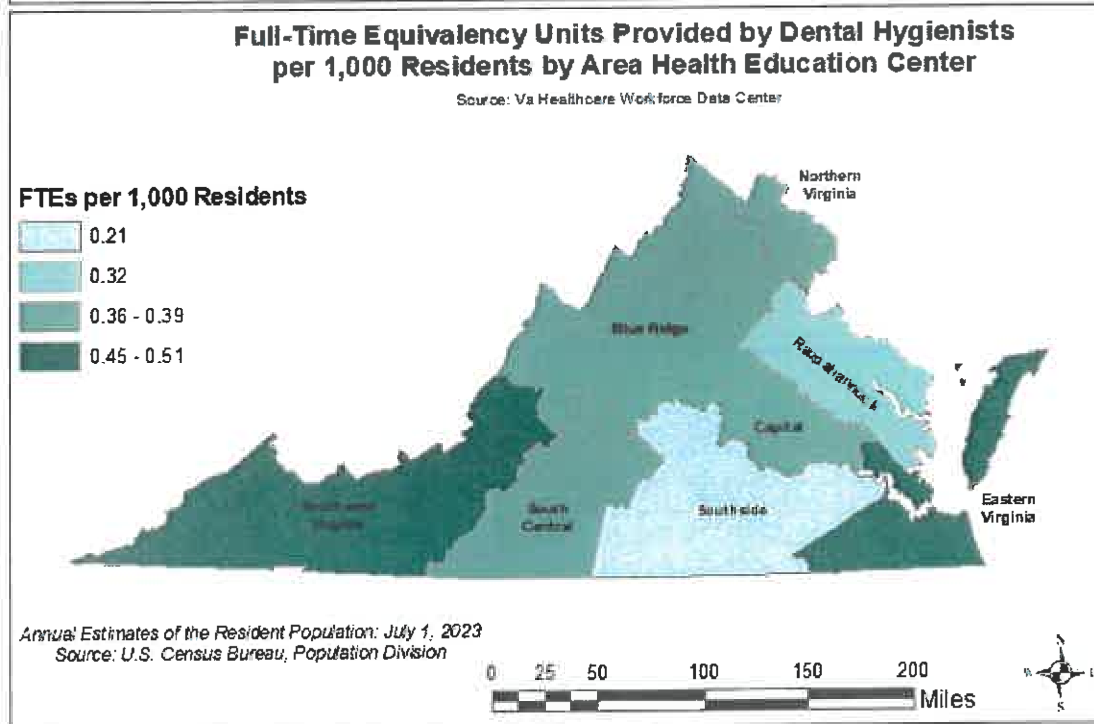
[2] Number of residents in 2023 was used as the denominator.
[3] Due to assumption violations in Mixed between-within ANOVA (Levene's Test was significant).

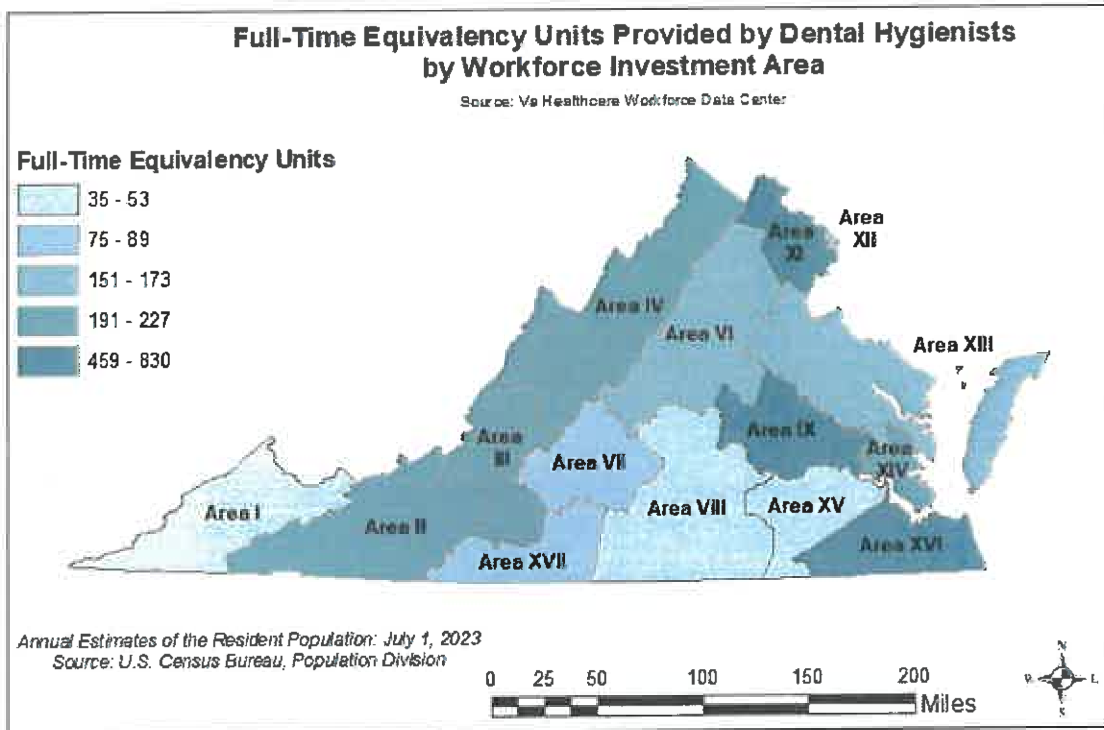
## Virginia Performs Regions



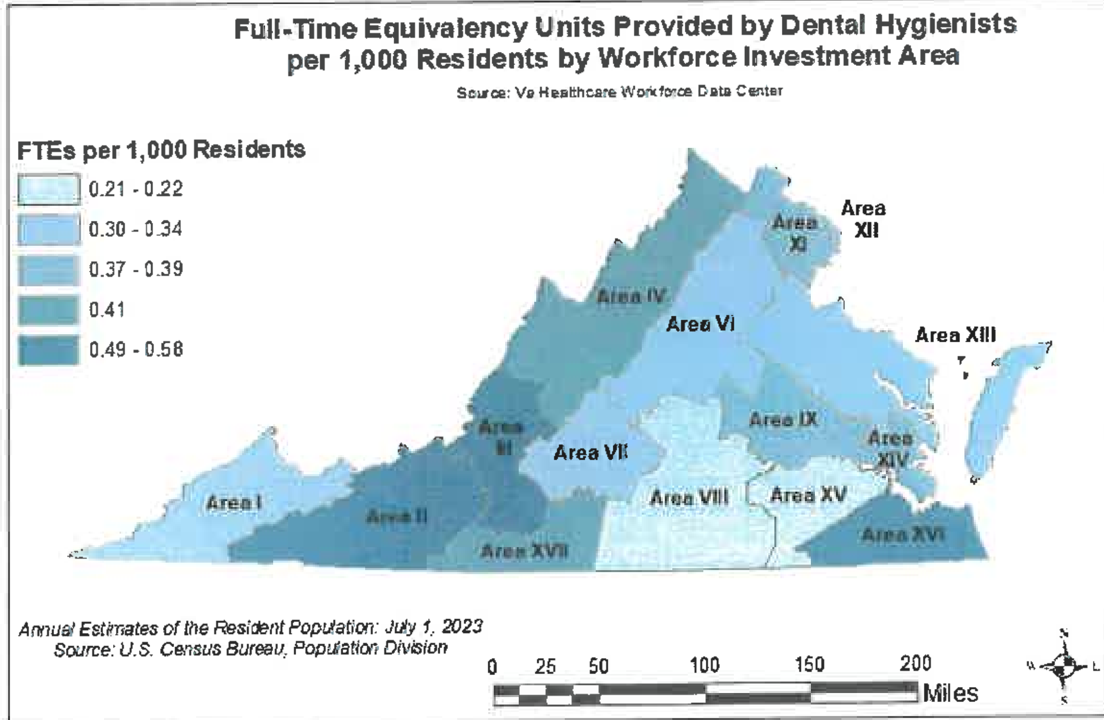




Full-Time Equivalency Units Provided by Dental Hygienists
by Area Health Education Center
Source: Va Healthcare Workforce Data Center
Full-Time Equivalency Units
74 - 182
379 - 419
459
783 - 980
Northern Virginia
Blue Ridge
Rappahannock
Capital
Southwest Virginia
South Central
Southside
Eastern Virginia
Annual Estimates of the Resident Population: July 1, 2023
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles

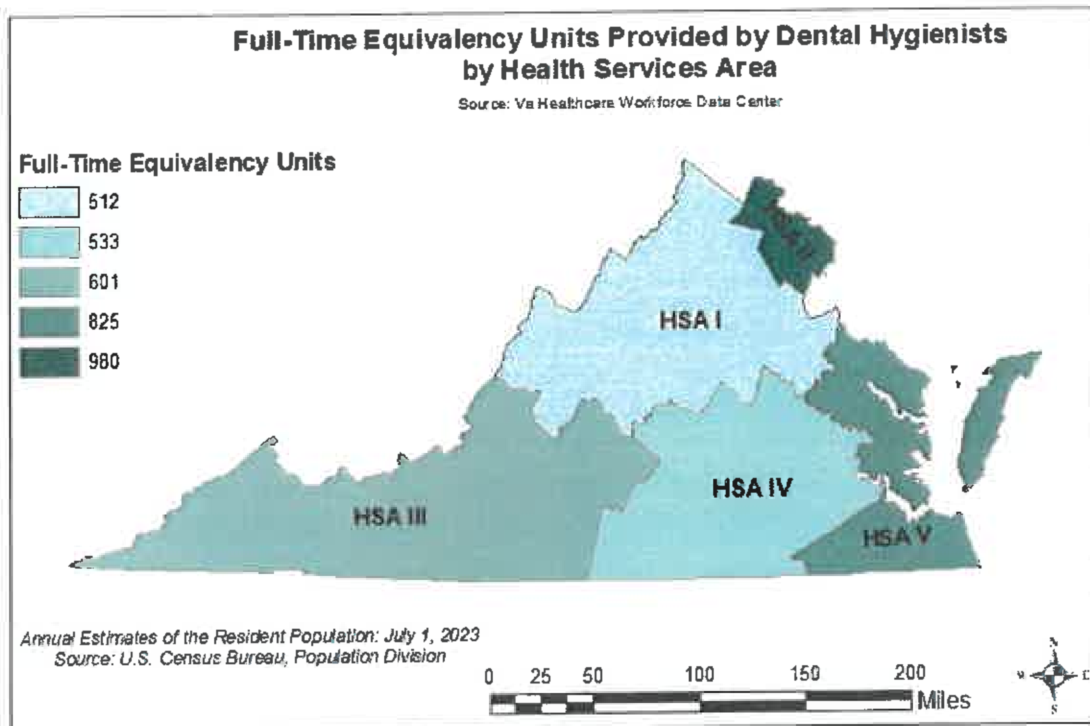

Full-Time Equivalency Units Provided by Dental Hygienists
per 1,000 Residents by Area Health Education Center
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.21
0.32
0.36 - 0.39
0.45 - 0.51
Northern Virginia
Blue Ridge
Rappahannock
Capital
South Central
Southside
Eastern Virginia
Annual Estimates of the Resident Population: July 1, 2023
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles

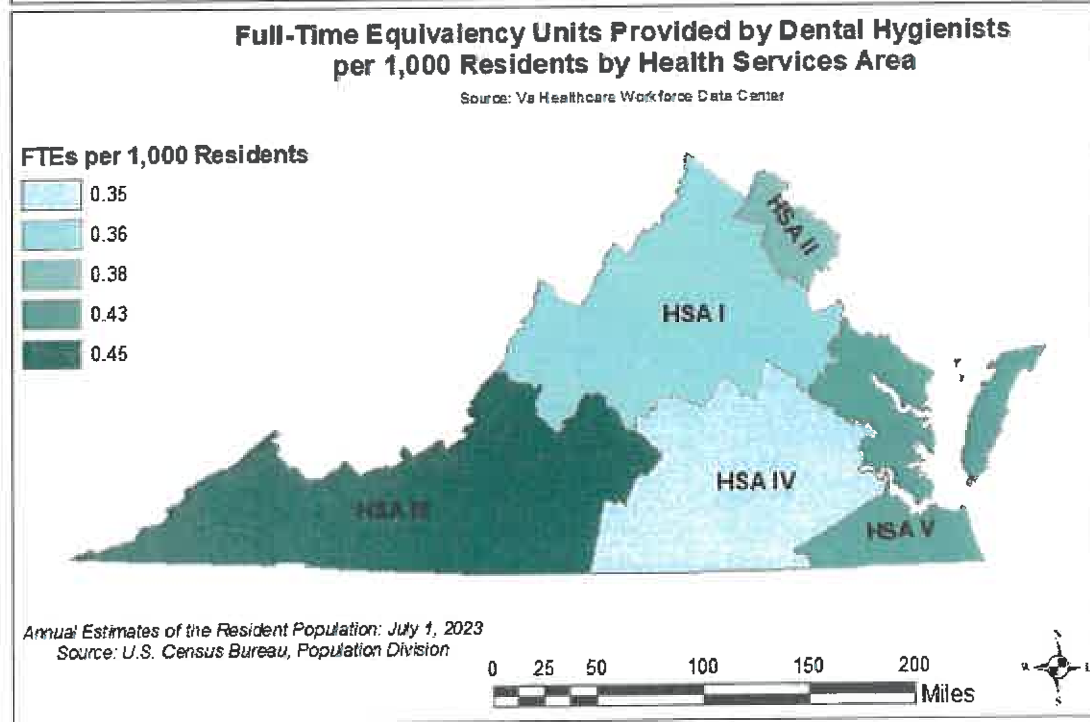


Full-Time Equivalency Units Provided by Dental Hygienists
by Workforce Investment Area
Source: Va Healthcare Workforce Data Center
Full-Time Equivalency Units
35 - 53
75 - 89
151 - 173
191 - 227
459 - 830
Area I
Area II
Area III
Area IV
Area VI
Area VII
Area VIII
Area IX
Area XI
Area XII
Area XIII
Area XIV
Area XV
Area XVI
Area XVII
Annual Estimates of the Resident Population: July 1, 2023
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles

Full-Time Equivalency Units Provided by Dental Hygienists
per 1,000 Residents by Workforce Investment Area
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.21 - 0.22
0.30 - 0.34
0.37 - 0.39
0.41
0.49 - 0.58
Area I
Area II
Area III
Area IV
Area VI
Area VII
Area VIII
Area IX
Area XI
Area XII
Area XIII
Area XIV
Area XV
Area XVI
Area XVII
Annual Estimates of the Resident Population: July 1, 2023
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles


Full-Time Equivalency Units Provided by Dental Hygienists
by Health Services Area
Source: Va Healthcare Workforce Data Center
Full-Time Equivalency Units
512
533
601
825
980
HSA I
HSA II
HSA III
HSA IV
HSA V
Annual Estimates of the Resident Population: July 1, 2023
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles


Full-Time Equivalency Units Provided by Dental Hygienists
per 1,000 Residents by Health Services Area
Source: Va Healthcare Workforce Data Center
FTEs per 1,000 Residents
0.35
0.36
0.38
0.43
0.45
HSA I
HSA II
HSA III
HSA IV
HSA V
Annual Estimates of the Resident Population: July 1, 2023
Source: U.S. Census Bureau, Population Division
0 25 50 100 150 200
Miles

**Full-Time Equivalency Units Provided by Dental Hygienists by Planning District**

Source: Va Healthcare Workforce Data Center

**Full-Time Equivalency Units**

- 9 - 28
- 50 - 93
- 103 - 175
- 445
- 774 - 980

*Annual Estimates of the Resident Population: July 1, 2023*
*Source: U.S. Census Bureau, Population Division*

0 25 50 100 150 200 Miles

**Full-Time Equivalency Units Provided by Dental Hygienists per 1,000 Residents by Planning District**

Source: Va Healthcare Workforce Data Center

**FTEs per 1,000 Residents**

- 0.16 - 0.20
- 0.27 - 0.29
- 0.31 - 0.34
- 0.38 - 0.45
- 0.59 - 0.63

*Annual Estimates of the Resident Population: July 1, 2023*
*Source: U.S. Census Bureau, Population Division*

0 25 50 100 150 200 Miles

## Appendix A: Weights

| Rural Status | Location Weight | | | Total Weight | |
|---|---|---|---|---|---|
| | # | Rate | Weight | Min. | Max. |
| Metro, 1 Million+ | 3,686 | 89.37% | 1.119 | 1.060 | 1.371 |
| Metro, 250,000 to 1 Million | 454 | 92.73% | 1.078 | 1.021 | 1.321 |
| Metro, 250,000 or Less | 456 | 90.35% | 1.107 | 1.048 | 1.356 |
| Urban, Pop. 20,000+, Metro Adj. | 94 | 92.55% | 1.080 | 1.023 | 1.323 |
| Urban, Pop. 20,000+, Non-Adj. | 0 | NA | NA | NA | NA |
| Urban, Pop. 2,500-19,999, Metro Adj. | 237 | 88.19% | 1.134 | 1.074 | 1.389 |
| Urban, Pop. 2,500-19,999, Non-Adj. | 156 | 89.10% | 1.122 | 1.063 | 1.375 |
| Rural, Metro Adj. | 95 | 86.32% | 1.159 | 1.097 | 1.419 |
| Rural, Non-Adj. | 47 | 89.36% | 1.119 | 1.060 | 1.371 |
| Virginia Border State/D.C. | 560 | 79.11% | 1.264 | 1.197 | 1.548 |
| Other U.S. State | 578 | 80.45% | 1.243 | 1.177 | 1.522 |

*Source: Va. Healthcare Workforce Data Center*

| Age | Age Weight | | | Total Weight | |
|---|---|---|---|---|---|
| | # | Rate | Weight | Min. | Max. |
| Under 30 | 815 | 71.78% | 1.393 | 1.321 | 1.548 |
| 30 to 34 | 835 | 88.14% | 1.135 | 1.076 | 1.261 |
| 35 to 39 | 845 | 90.89% | 1.100 | 1.043 | 1.223 |
| 40 to 44 | 851 | 92.83% | 1.077 | 1.021 | 1.197 |
| 45 to 49 | 719 | 91.24% | 1.096 | 1.039 | 1.218 |
| 50 to 54 | 663 | 92.61% | 1.080 | 1.024 | 1.200 |
| 55 to 59 | 607 | 91.93% | 1.088 | 1.031 | 1.209 |
| 60 and Over | 1,028 | 86.28% | 1.159 | 1.099 | 1.288 |

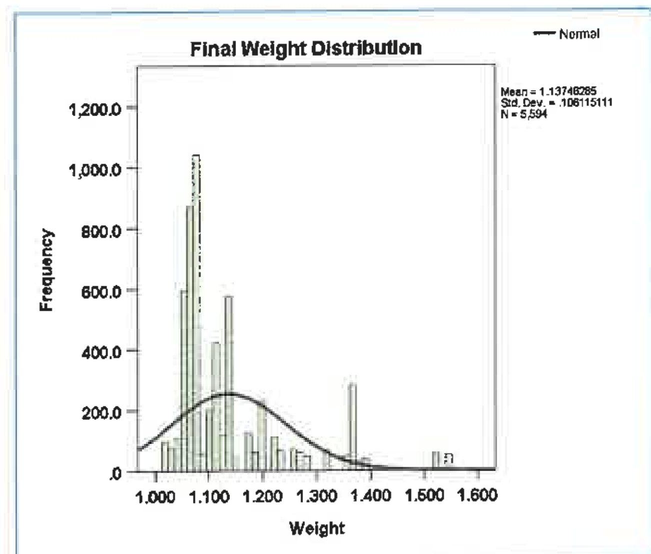
*Source: Va. Healthcare Workforce Data Center*

See the Methods section on the HWDC website for details on HWDC methods:
https://www.dhp.virginia.gov/PublicResources/HealthcareWorkforceDataCenter/

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

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

**Overall Response Rate: 0.879145**




*Source: Va. Healthcare Workforce Data Center*

## Regulatory Committee Report

The Regulatory Committee met on May 16, 2025, and made the following recommendations:

- Regulatory Changes: Creating a Pathway for Dental Hygienists to do Restorative Procedures. Creating this pathway would not require a dental hygienist to become a DA II. Stakeholders have asked the Board to correct this issue to be less burdensome to dental hygienists and to create better access to care. The committee reviewed the ADHA's Dental Hygienists Restorative Duties by state. Several states allow for dental hygienists to perform restorative procedures with appropriate training.
    - Recommendation: to adopt fast-track regulatory amendments to create a pathway for dental hygienists to perform restorative procedures without registering as a DA II. This will be discussed further in the agenda by Ms. Barrett under "Regulation and Legislation".
- 2022 Petition for Rulemaking: The committee considered the petition for rulemaking to consider other avenues of refresher courses. The committee reviewed criteria for CODA Accredited programs vs. ADA/ADHA/AADH courses. CODA's accreditation process includes peer reviews to evaluate the quality of dental education programs vs. ADA/ADHA/AADH courses does not endorse individual courses or instructors. The committee considered the public comment. The board staff reported that they have received no complaints on someone having difficulty finding a CODA Accredited refresher course.
    - Recommendation: to maintain the Board's current position in regulation to only accept CODA accredited refresher courses and to withdraw the NOIRA. This will be discussed further in the agenda by Ms. Barrett under "Regulation and Legislation".
- The need for radiological providers: At the December 2024 board meeting, the board referred this topic be discussed at the regulatory committee meeting. The board staff reported that they haven't received any complaints regarding the lack of radiological providers and training. The committee agreed.
    - Recommendation: Board maintain current status and regulations of providers listed within the regulations.

**Board of Dentistry**
**Current Regulatory Actions**
**As of May 20, 2025**

## In the Governor's Office

None.

## In the Secretary's Office

| VAC | Stage | Subject Matter | Submitted from agency | Time in current location | Notes |
|---|---|---|---|---|---|
| 18VAC60-21<br>18VAC60-30 | Final | Training in infection control | 7/5/2022 | 1050 days (2.9 years) | Amendments require specific training in infection control for dental assistants. Promulgated in response to a petition for rulemaking. |
| 18VAC60-21<br>18VAC60-25 | NOIRA | Continuing education requirements for jurisprudence | 7/12/2022 | 1043 days (2.8 years) | Board is considering amendments to Chapters 21 and 25 to require jurisprudence continuing education for dentists and dental hygienists. |
| 18VAC60-30 | Proposed | Elimination of direct pulp-capping as a delegable task | 7/22/2022 | 999 days (2.7 years) | Eliminates direct pulp-capping as a delegable task for a DAII. |

## At DPB

None.

## At OAG

| VAC | Stage | Subject Matter | Submitted from agency | Time in current location | Notes |
|---|---|---|---|---|---|
| 18VAC60-15 | Fast-Track | Amendment to allow agency subordinates to | 9/16/2024 | 246 days | Conforms agency subordinate regulation to statutory changes |

| | | hear credentials cases | | | from 2023 General Assembly session. |
|---|---|---|---|---|---|
| 18VAC60-21 | Proposed | Training requirements for botulinum toxin injections for cosmetic purposes | 9/16/2024 | 246 days | Pursuant to legislative directive. This action will replace emergency regulations that will be in effect until 11/05/2025. |

**Recently effective, published, or awaiting publication**

| VAC | Stage | Subject Matter | Publication date | Effective date/ next steps |
|---|---|---|---|---|
| 18VAC60-21<br>18VAC60-25 | NOIRA | Expansion and clarification of refresher courses required for reinstatement | 8/12/2024 | Comment period 8/12/2024 – 9/11/2024. Board will consider Regulatory Committee recommendation on next steps. |
| 18VAC60-21 | Revised Proposed | Digital scan technicians | 5/19/2025 | Regulations for the training of digital scan technicians to practice under a licensed dentist |

**Board of Dentistry**
**Legislative Report**
**2025 General Assembly**

HB 1899 - License to teach dentistry; foreign dental program graduates; repeal sunset.
Chief Patron: Willett

**License to teach dentistry; foreign dental program graduates; repeal sunset.** Repeals the July 1, 2025, sunset on the current provision of law allowing the Board of Dentistry to grant, without examination, a faculty license to teach dentistry in an accredited dental program to a graduate of a dental school or college or the dental department of an institution of higher education in a foreign country who has been granted a certification letter from the dean or program director of an accredited dental program confirming that the applicant has clinical competency and clinical experience that meet the credentialing standards of the dental school with which the applicant is to be affiliated. This bill is identical to SB 1360.

Passed House: Y Passed Senate: Y
03/18/2025 Approved by Governor-Chapter 47 (Effective 07/01/25)
Acts of Assembly Chapter text (CHAP0047)

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SB 1475 - Dentists & dental hygienists; work group to assess expedited pathways for licensure, report.
Chief Patron: Pillion
**(Bill attached to end of report)**

**Board of Dentistry; expedited licensure.** Directs the Board of Dentistry to convene a work group including the Virginia Dental Association and the Virginia Dental Hygienists' Association to assess expedited pathways for licensure for dentists and dental hygienists. The bill specifies that the work group shall (i) review the licensure by credentialing statutes governing dentists and the licensure statutes governing dental hygienists and make recommendations on how such statutes can be updated to reflect an expedited pathway for licensure and (ii) study options for and make recommendations on a pathway for qualified internationally trained dentists to practice dental hygiene under the supervision of a licensed dentist.

Passed House: Y Passed Senate: Y
03/21/2025 Approved by Governor-Chapter 363 (Effective 07/01/25)
Acts of Assembly Chapter text (CHAP0363)

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SB 1478 - School of Dentistry of Virginia Commonwealth University; efficacy of expanding facilities, report.
Chief Patron: Stanley

**DEAD BILL**

**State Council of Higher Education for Virginia; School of Dentistry of Virginia Commonwealth University; efficacy of expanding facilities; study; report.** Directs the State Council of Higher Education for Virginia to, in consultation with the entities set forth in the bill, study and submit to the Governor, the Senate Committees on Education and Health and Finance and Appropriations, and the House Committees on Education and Appropriations by November 1, 2025, a report on the efficacy of expanding the School of Dentistry of Virginia Commonwealth University's facilities into a building owned by the Commonwealth located in Southern Virginia.

Passed House: N Passed Senate: N
01/17/2025 Senate: Referred to Committee on Rules
01/24/2025 Reported from Rules and rereferred to Finance and Appropriations (12-Y 0-N)
01/29/2025 Passed by indefinitely in Finance and Appropriations (14-Y 0-N)

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HB 1861 - Department of Health Professions; health regulatory boards; regulations; licensure by endorsement.
Chief Patron: Price
**AGENCY BILL**

**Department of Health Professions; health regulatory boards; regulations; licensure by endorsement.** Directs each health regulatory board regulated by the Department of Health Professions to enact regulations to provide a licensure by endorsement pathway for professions which do not currently have licensure by endorsement. **This bill is identical to SB 1438.**

Passed House: Y Passed Senate: Y
Enrolled Bill communicated to Governor on March 11, 2025
03/24/2025 Approved by Governor-Chapter 553 (Effective 07/01/25)

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SB 826 - Predetermination for licensing eligibility; prior convictions.
Chief Patron: Locke

**Department of Professional and Occupational Regulation; Department of Health Professions; predetermination for licensing eligibility; prior convictions.** Prohibits the use of "good moral character" or crimes of "moral turpitude," despite existing statutory language which was not changed by this legislation allowing such use, by a regulatory board within DPOR or DHP when refusing a person a license, certificate, or registration to practice, pursue, or engage in any regulated occupation or profession. The bill requires such regulatory board denying a registration, license, or certificate based on information in the applicant's criminal history record to notify the applicant in writing of (i) the specific offense or offenses that contributed to such denial; (ii) how the criminal history directly relates to the occupation for which the registration,

license, or certificate applies; and (iii) how the regulatory board weighed rehabilitation factors when making its decision.

The bill further allows an applicant to request a written predetermination from a regulatory board within DPOR or DHP concerning whether his criminal record would disqualify him from obtaining a license, certificate, registration, or other authority to engage in a particular occupation, trade, or profession in the Commonwealth. It appears no fee can be charged for this determination, which will create a bifurcated licensure process and has significant legal and financial ramifications for DHP and its regulatory boards.

Legal advice has been requested regarding implementation and the requirements of this legislation.

Passed House: Y Passed Senate: Y
Enrolled Bill Communicated to Governor on March 5, 2025
03/24/2025 Approved by Governor-Chapter 505 (Effective 07/01/25)

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SB 1293 - Autism spectrum disorder; school board employees, professional development and continuing education.
Chief Patron: Stanley

**School board employees; professional development and continuing education; optional programs; children with autism spectrum disorder.** This legislation is directed toward the Department of Education and available training for educators regarding communicating with children diagnosed with autism spectrum disorder.

An enactment clause requires boards of DHP to communicate a recommendation to licensees to complete continuing education on communicating with children diagnosed with autism spectrum disorder. **This is not a requirement, simply a communication with a recommendation.**

Passed House: Y Passed Senate: Y
Enrolled Bill Communicated to Governor on March 11, 2025
03/24/2025 Approved by Governor-Chapter 516 (Effective 07/01/25)

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SB 1363 - Health Professions, Board of; transfer of powers and duties.
Chief Patron: Pillion
Status: Acts of Assembly Chapter
**AGENCY BILL**

**Elimination of Board of Health Professions; transfer of powers and duties.** Eliminates the Board of Health Professions and transfers certain powers and duties from the Board to the Department of Health Professions.

Passed House: Y Passed Senate: Y
Enrolled Bill Communicated to Governor on March 5, 2025
03/21/2025: Approved by Governor-Chapter 341 (Effective 07/01/25)

# VIRGINIA ACTS OF ASSEMBLY - 2025 SESSION

## CHAPTER 363

*An Act to direct the Board of Dentistry to convene a work group to assess expedited pathways for licensure for dentists and dental hygienists.*

[S 1475]

Approved March 21, 2025

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

**1.** *§ 1. That the Board of Dentistry shall convene a work group of stakeholders including the Virginia Dental Association and the Virginia Dental Hygienists' Association to assess expedited pathways for licensure for dentists and dental hygienists and make recommendations on modernizing licensure for the provision of essential preventative and restorative dental care. In conducting its work, the work group shall (i) review the licensure by credentialing statutes governing dentists and the licensure statutes governing dental hygienists and make recommendations on how such statutes can be updated to reflect an expedited pathway for licensure, giving consideration to recent regulatory changes with the licensure by endorsement pathway at the Board of Medicine, and (ii) study options for and make recommendations on a pathway for qualified internationally trained dentists to practice dental hygiene under the supervision of a licensed dentist. The work group shall report its recommendations to the Chairs of the Senate Committee on Education and Health and House Committee on Health and Human Services on or before November 30, 2025.*

**Agenda Item: Consideration of fast-track regulatory action to create a pathway for dental hygienists to perform restorative procedures without registering as a DAII**

**Included in your agenda package:**

- Draft amendments to Chapters 21, 25, and 30.

**Staff note:** The Regulatory Committee reviewed the current regulations, which require a dental hygienist to obtain and maintain a separate registration as a DAII to perform restorative procedures, and recommended the included changes to remove the requirement to hold a second credential. The Regulatory Committee recommended that the Board adopt these changes as a fast-track regulatory action.

**Action needed:**

- Motion to accept the recommendation of the Regulatory Committee to initiate a fast-track action.

**Project 8213 - Fast-Track**

**Board of Dentistry**

**Revision of dental hygienist training and duties to eliminate need for dual licensure as a dental hygienist and registration as a DAII**

**18VAC60-21-10. Definitions.**

A. The following words and terms when used in this chapter shall have the meanings ascribed to them in § 54.1-2700 of the Code of Virginia:

"Board"

"Dental hygiene"

"Dental hygienist"

"Dentist"

"Dentistry"

"License"

"Maxillofacial"

"Oral and maxillofacial surgeon"

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

"AAOMS" means the American Association of Oral and Maxillofacial Surgeons.

"ADA" means the American Dental Association.

"Advertising" means a representation or other notice given to the public or members thereof, directly or indirectly, by a dentist on behalf of himself, the dentist's facility, the dentist's partner or associate, or any dentist affiliated with the dentist or the dentist's facility

by any means or method for the purpose of inducing purchase, sale, or use of dental methods, services, treatments, operations, procedures, or products, or to promote continued or increased use of such dental methods, treatments, operations, procedures, or products.

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

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

"Dental assistant II" means a person under the direction and direct supervision of a dentist who is registered by the board to perform reversible, intraoral procedures as specified in 18VAC60-21-150 and 18VAC60-21-160.

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

"Nonsurgical laser" means a laser that is not capable of cutting or removing hard tissue, soft tissue, or tooth structure.

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

"Radiographs" means intraoral and extraoral radiographic images of hard and soft tissues used for purposes of diagnosis.

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

"Direct supervision" means that the dentist examines the patient and records diagnostic findings prior to delegating restorative or prosthetic treatment and related services to a dental hygienist or dental assistant II for completion the same day or at a later date. The dentist prepares the tooth to be restored and remains immediately available in the office to provide the dental hygienist or dental assistant II ~~for~~ guidance or assistance during the delivery of treatment and related services. The dentist examines the patient to evaluate the treatment and services before the patient is dismissed.

"Direction" means the level of supervision (i.e., immediate, direct, indirect, or general) that a dentist is required to exercise with a dental hygienist, a dental assistant I, a dental assistant II, or a certified registered nurse anesthetist or the level of supervision that a dental hygienist is required to exercise with a dental assistant to direct and oversee the delivery of treatment and related services.

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

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

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

(iii) preparing the patient for dismissal following treatment, or (iv) administering topical local anesthetic, sedation, or anesthesia as authorized by law or regulation.

"Remote supervision" means that a supervising dentist is accessible and available for communication and consultation with a dental hygienist during the delivery of dental hygiene services but such dentist may not have conducted an initial examination of the patients who are to be seen and treated by the dental hygienist and may not be present with the dental hygienist when dental hygiene services are being provided. For the purpose of practice by a public health dental hygienist, "remote supervision" means that a public health dentist has regular, periodic communications with a public health dental hygienist regarding patient treatment, but such dentist may not have conducted an initial examination of the patients who are to be seen and treated by the dental hygienist and may not be present with the dental hygienist when dental hygiene services are being provided.

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

"Analgesia" means the diminution or elimination of pain.

"Continual" or "continually" means repeated regularly and frequently in a steady succession.

"Continuous" or "continuously" means prolonged without any interruption at any time.

"Deep sedation" means a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. Reflex withdrawal from a painful stimulus is not considered a purposeful response. The ability to independently maintain ventilatory function may be impaired.

Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

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

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

"Inhalation analgesia" means the inhalation of nitrous oxide and oxygen to produce a state of reduced sensation of pain with minimal alteration of consciousness.

"Local anesthesia" means the elimination of sensation, especially pain, in one part of the body by the topical application or regional injection of a drug.

"Minimal sedation" means a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and physical coordination may be impaired, airway reflexes and ventilator and cardiovascular functions are unaffected. Minimal sedation includes the diminution or elimination of anxiety through the use of pharmacological agents in a dosage that does not cause depression of consciousness and includes "inhalation analgesia" when used in combination with any such sedating agent administered prior to or during a procedure.

"Moderate sedation" means a drug-induced depression of consciousness, during which patients respond purposefully to verbal commands, either alone or accompanied by light

tactile stimulation. Reflex withdrawal from a painful stimulus is not considered a purposeful response. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

"Monitoring" means to observe, interpret, assess, and record appropriate physiologic functions of the body during sedative procedures and general anesthesia appropriate to the level of sedation as provided in Part VII (18VAC60-21-260 et seq.) of this chapter.

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

"Provide" means, in the context of regulations for moderate sedation or deep sedation or general anesthesia, to supply, give, or issue sedating medications. A dentist who does not hold the applicable permit cannot be the provider of moderate sedation or deep sedation or general anesthesia.

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

"Topical oral anesthetic" means any drug, available in creams, ointments, aerosols, sprays, lotions, or jellies, that can be used orally for the purpose of rendering the oral cavity insensitive to pain without affecting consciousness.

"Vital signs" means clinical measurements, specifically pulse rate, respiration rate, and blood pressure, that indicate the state of a patient's essential body functions.

**18VAC60-21-130. Nondelegable duties; dentists.**

Only licensed dentists shall perform the following duties:

1. Final diagnosis and treatment planning;

2. Performing surgical or cutting procedures on hard or soft tissue except a dental hygienist performing gingival curettage as provided in 18VAC60-21-140;

3. Prescribing or parenterally administering drugs or medicaments, except a dental hygienist, who meets the requirements of 18VAC60-25-100, may parenterally administer Schedule VI local anesthesia to patients 18 years of age or older;

4. Authorization of work orders for any appliance or prosthetic device or restoration that is to be inserted into a patient's mouth;

5. Operation of high speed rotary instruments in the mouth;

6. Administering and monitoring moderate sedation, deep sedation, or general anesthetics except as provided for in § 54.1-2701 of the Code and Part VII (18VAC60-21-260 et seq.) of this chapter;

7. Condensing, contouring, or adjusting any final, fixed, or removable prosthodontic appliance or restoration in the mouth with the exception of packing and carving amalgam and placing and shaping composite resins by dental hygienists or dental assistants II with advanced training as specified in 18VAC60-25-100 E or 18VAC60-30-120;

8. Final positioning and attachment of orthodontic bonds and bands; and

9. Final adjustment and fitting of crowns and bridges in preparation for final cementation.

**18VAC60-25-100. ~~Administration of controlled substances~~ Requirements for delegation to a dental hygienist.**

A. A licensed dental hygienist may:

1. Administer topical oral fluoride varnish under an oral or written order or a standing protocol issued by a dentist or a doctor of medicine or osteopathic medicine pursuant to subsection V of § 54.1-3408 of the Code of Virginia;

2. Administer topical Schedule VI drugs, including topical oral fluorides, topical oral anesthetics, and topical and directly applied antimicrobial agents for treatment of periodontal pocket lesions pursuant to subsection J of § 54.1-3408 of the Code of Virginia; ~~and~~

3. If qualified in accordance with subsection B or C of this section, administer Schedule VI nitrous oxide/inhalation analgesia and, to persons 18 years of age or older, Schedule VI local anesthesia parenterally under the indirect supervision of a dentist~~.~~; and

4. If qualified in accordance with subsection F of this section, perform restorative procedures under the direct supervision of a dentist.

B. To administer only nitrous oxide/inhalation analgesia, a dental hygienist shall:

1. Successfully complete a didactic and clinical course leading to certification in administration of nitrous oxide offered by a CODA accredited dental or dental hygiene program, which includes didactic and clinical instruction in the following topics:

a. Patient physical and psychological assessment;

b. Medical history evaluation;

c. Equipment and techniques used for administration of nitrous oxide;

d. Neurophysiology of nitrous oxide administration;

e. Pharmacology of nitrous oxide;

f. Recordkeeping, medical, and legal aspects of nitrous oxide;

g. Adjunctive uses of nitrous oxide for dental patients; and

h. Clinical experiences in administering nitrous oxide, including training with live patients.

2. Successfully complete an examination with a minimum score of 75% in the administration of nitrous oxide/inhalation analgesia given by the accredited program.

C. To administer local anesthesia parenterally to patients 18 years of age or older, a dental hygienist shall:

1. Successfully complete a didactic and clinical course leading to certification in administration of local anesthesia that is offered by a CODA accredited dental or dental hygiene program, which includes didactic and clinical instruction in the following topics:

a. Patient physical and psychological assessment;

b. Medical history evaluation and recordkeeping;

c. Neurophysiology of local anesthesia;

d. Pharmacology of local anesthetics and vasoconstrictors;

e. Anatomical considerations for local anesthesia;

f. Techniques for maxillary infiltration and block anesthesia;

g. Techniques for mandibular infiltration and block anesthesia;

h. Local and systemic anesthetic complications;

i. Management of medical emergencies; and

j. Clinical experiences in administering local anesthesia injections on patients.

2. Successfully complete an examination with a minimum score of 75% in the parenteral administration of local anesthesia given by the accredited program.

D. A dental hygienist who holds a certificate or credential issued by the licensing board of another jurisdiction of the United States that authorizes the administration of nitrous

oxide/inhalation analgesia or local anesthesia may be authorized for such administration in Virginia if:

1. The qualifications on which the credential or certificate was issued were substantially equivalent in hours of instruction and course content to those set forth in subsections B and C of this section; or

2. If the certificate or credential issued by another jurisdiction was not substantially equivalent, the hygienist can document experience in such administration for at least 24 of the past 48 months preceding application for licensure in Virginia.

E. A dentist who provides direction for the administration of nitrous oxide/inhalation analgesia or local anesthesia shall ensure that the dental hygienist has met the qualifications for such administration as set forth in this section.

F. To perform restorative procedures, a dental hygienist shall:

1. Successfully complete a course in restoration procedures that is offered by a CODA accredited dental, dental hygiene, or dental assistant program which includes didactic and clinical instruction in the following topics:

a. No less than 15 hours of placing, packing, carving, and polishing of amalgam restorations, placement of a non-epinephrine retraction cord, and pulp capping procedures and no less than six class I and six class II restorations completed on a manikin simulator to competency;

b. No less than 40 hours of placing and shaping composite resin restorations, placement of a non-epinephrine retraction cord, and pulp capping procedures, and no less than 12 class I, 12 class II, five class III, five class IV, and five class V restorations completed on a manikin simulator to competency; and

c. At least 10 hours of making final impressions, placement of a non-epinephrine retraction cord, final cementation of crowns and bridges after preparation, and adjustment and fitting by the dentist, and no less than four crown impressions, two placements of retraction cord, five crown cementations, and two bridge cementations on a manikin simulator to competency.

2. Successfully complete clinical experience applying the techniques leared in the preclinical coursework and laboratory training in the following modules:

a. At least 30 hours of placing, packing, carving, and polishing of amalgam restorations, placement of a non-epinephrine retraction cord, and no less than six class I and six class II restorations completed on a live patient to competency;

b. At least 60 hours of placing and shaping composite resin restorations, placement of a non-epinephrine retraction cord, and no less than six class I, six class II, five class III, three class IV, and five class V restorations completed on a live patient to competency; and

c. At least 30 hours of making final impressions; placement of non-epinephrine retraction cord; final cementation of crowns and bridges after preparation, adjustment, and fitting by the dentist; and no less than four crown impressions, two placements of retraction cord, five crown cementations, and two bridge cementations on a live patient to competency.

3. Successful completion of the following competency examinations given by the accredited educational program:

a. A written examination at the conclusion of didactic coursework; and

b. A clinical competency exam.

G. A dental hygienist who holds a certificate or credential issued by the licensing board of another jurisdiction of the United States that authorizes performance of restoration procedures may be authorized for such practice in Virginia if:

1. The qualifications on which the credential or certificate was issued were substantially equivalent in hours of instruction and course content to those set forth in subsections F 2 and F 3 of this section; or

2. If the certificate or credential issued by another jurisdiction was not substantially equivalent, the hygienist can document experience in such restoration procedures for at least 24 of the past 48 months preceding application for licensure in Virginia.

H. A dentist who provides direction for restoration procedures shall ensure that the dental hygienist has met the qualifications for such restoration procedures as set forth in this section.

**18VAC60-30-116. ~~Requirements for educational programs.~~ (Repealed.)**

~~In order to train persons for registration as a dental assistant II, an educational program shall meet the following requirements:~~

~~1. The program shall be provided by an educational institution that maintains a program accredited by the Commission on Dental Accreditation of the American Dental Association.~~

~~2. The program shall have a program coordinator who is registered in Virginia as a dental assistant II or is licensed in Virginia as a dental hygienist or dentist. The program coordinator shall have administrative responsibility and accountability for operation of the program.~~

~~3. The program shall have a clinical practice advisor who is a licensed dentist in Virginia and who may also serve as the program coordinator. The clinical practice advisor shall~~

~~assist in the laboratory training component of the program and conduct the program's calibration exercise for dentists who supervise the student's clinical experience.~~

~~4. A dental assistant II, registered in Virginia, who assists in teaching the laboratory training component of the program shall have a minimum of two years of clinical experience in performing duties delegable to a dental assistant II.~~

~~5. The program shall enter into a participation agreement with any dentist who agrees to supervise clinical experience. The dentist shall successfully complete the program's calibration exercise on evaluating the clinical skills of a student. The dentist supervisor may be the employer of the student.~~

~~6. Each program shall enroll practice sites for clinical experience, which may be a dental office, a nonprofit dental clinic, or an educational institution clinic.~~

~~7. All treatment of patients shall be under the immediate supervision of a licensed dentist who is responsible for the performance of duties by the student. The dentist shall attest to the successful completion of the clinical competencies and restorative experiences.~~

**18VAC60-30-120. Educational requirements for dental assistants II.**

~~A. A prerequisite for entry into an educational program preparing a person for registration as a dental assistant II shall be current certification as a Certified Dental Assistant (CDA) conferred by the Dental Assisting National Board or active licensure as a dental hygienist.~~

~~B.~~ To be registered as a dental assistant II, a person shall complete a competency-based program from an educational institution that ~~meets the requirements of 18VAC60-30-116~~ is accredited by CODA. An applicant may be registered as a dental assistant II with specified competencies completed in education as described in this subsection:

1. Didactic coursework in dental anatomy that includes basic histology, understanding of the periodontium and temporal mandibular joint, pulp tissue and nerve innervation,

occlusion and function, muscles of mastication, and any other item related to the restorative dental process.

2. Didactic coursework in operative dentistry, to include materials used in direct and indirect restorative techniques, economy of motion, fulcrum techniques, tooth preparations, etch and bonding techniques and systems, and luting agents.

3. Laboratory training to be completed in the following modules:

a. No less than 15 hours of placing, packing, carving, and polishing of amalgam restorations, placement of a non-epinephrine retraction cord, and pulp capping procedures and no less than six class I and six class II restorations completed on a manikin simulator to competency;

b. No less than 40 hours of placing and shaping composite resin restorations, placement of a non-epinephrine retraction cord, and pulp capping procedures, and no less than 12 class I, 12 class II, five class III, five class IV, and five class V restorations completed on a manikin simulator to competency; and

c. At least 10 hours of making final impressions, placement of a non-epinephrine retraction cord, final cementation of crowns and bridges after preparation, and adjustment and fitting by the dentist, and no less than four crown impressions, two placements of retraction cord, five crown cementations, and two bridge cementations on a manikin simulator to competency.

4. Clinical experience applying the techniques learned in the preclinical coursework and laboratory training in the following modules:

a. At least 30 hours of placing, packing, carving, and polishing of amalgam restorations, placement of a non-epinephrine retraction cord, and no less than six class I and six class II restorations completed on a live patient to competency;

b. At least 60 hours of placing and shaping composite resin restorations, placement of a non-epinephrine retraction cord, and no less than six class I, six class II, five class III, three class IV, and five class V restorations completed on a live patient to competency; and

c. At least 30 hours of making final impressions; placement of non-epinephrine retraction cord; final cementation of crowns and bridges after preparation, adjustment, and fitting by the dentist; and no less than four crown impressions, two placements of retraction cord, five crown cementations, and two bridge cementations on a live patient to competency.

5. Successful completion of the following competency examinations given by the accredited educational programs:

a. A written examination at the conclusion of didactic coursework; and

b. A clinical competency exam.

**Agenda Item: Notice of intended regulatory action regarding Dentist and Dental Hygienist Compact**

**Included in your agenda package:**

- Chapter 31 of the 2024 Acts of Assembly, which entered Virginia into the Dentist and Dental Hygienist Compact.

**Action needed:**

- Motion to adopt a notice of intended regulatory action to implement the Dentist and Dental Hygienist Compact in Virginia, which will include:
    - Changes necessary to conform to rules established by the Compact;
    - Setting a fee to practice on a compact privilege in Virginia;
    - Specify renewal requirements for compact privilege holders; and
    - Incorporate individuals practicing under a compact privilege into disciplinary provisions of the Board.

# VIRGINIA ACTS OF ASSEMBLY -- 2024 SESSION

## CHAPTER 31

*An Act to amend the Code of Virginia by adding in Chapter 27 of Title 54.1 an article numbered 5, consisting of a section numbered 54.1-2729.02, relating to the Dentist and Dental Hygienist Compact.*

[S 22]

Approved March 8, 2024

**Be it enacted by the General Assembly of Virginia:**
**1. That the Code of Virginia is amended by adding in Chapter 27 of Title 54.1 an article numbered 5, consisting of a section numbered 54.1-2729.02, as follows:**

*Article 5.*

*Dentist and Dental Hygienist Compact.*

***§ 54.1-2729.02. Dentist and Dental Hygienist Compact.***

*The General Assembly hereby enacts, and the Commonwealth of Virginia hereby enters into, the Dentist and Dental Hygienist Compact with any and all states legally joining therein according to its terms, in the form substantially as follows:*

*DENTIST AND DENTAL HYGIENIST COMPACT.*

*Article 1.*

*Title; Purpose.*

*This article shall be known and cited as the Dentist and Dental Hygienist Compact. The purposes of this Compact are to facilitate the interstate practice of dentistry and dental hygiene and improve public access to dentistry and dental hygiene services by providing dentists and dental hygienists licensed in a participating state the ability to practice in participating states in which they are not licensed. The Compact does this by establishing a pathway for dentists and dental hygienists licensed in a participating state to obtain a compact privilege that authorizes them to practice in another participating state in which they are not licensed. The Compact enables participating states to protect the public health and safety with respect to the practice of such dentists and dental hygienists, through the state's authority to regulate the practice of dentistry and dental hygiene in the state. The Compact:*

*1. Enables dentists and dental hygienists who qualify for a compact privilege to practice in other participating states without satisfying burdensome and duplicative requirements associated with securing a license to practice in those states;*

*2. Promotes mobility and addresses workforce shortages through each participating state's acceptance of a compact privilege to practice in that state;*

*3. Increases public access to qualified licensed dentists and dental hygienists by creating a responsible, streamlined pathway for licensees to practice in participating states;*

*4. Enhances the ability of participating states to protect the public's health and safety;*

*5. Does not interfere with licensure requirements established by a participating state;*

*6. Facilitates the sharing of licensure and disciplinary information among participating states;*

*7. Requires dentists and dental hygienists who practice in a participating state pursuant to a compact privilege to practice within the scope of practice authorized in that state;*

*8. Extends the authority of a participating state to regulate the practice of dentistry and dental hygiene within its borders to dentists and dental hygienists who practice in the state through a compact privilege;*

*9. Promotes the cooperation of participating states in regulating the practice of dentistry and dental hygiene within those states; and*

*10. Facilitates the relocation of military members and their spouses who are licensed to practice dentistry or dental hygiene.*

*Article 2.*

*Definitions.*

*As used in this Compact, unless the context requires otherwise, the following definitions shall apply:*

*"Active military member" means any person with full-time duty status in the Armed Forces of the United States, including members of the National Guard and Reserve.*

*"Adverse action" means disciplinary action or encumbrance imposed on a license or compact privilege by a state licensing authority.*

*"Alternative program" means a nondisciplinary monitoring or practice remediation process applicable to a dentist or dental hygienist approved by a state licensing authority of a participating state in which the dentist or dental hygienist is licensed. This includes, but is not limited to, programs to which licensees with substance abuse or addiction issues are referred in lieu of adverse action.*

*"Clinical assessment" means an examination or process required for licensure as a dentist or dental*

*hygienist, as applicable, that provides evidence of clinical competence in dentistry or dental hygiene.*

*"Commissioner" means the individual appointed by a participating state to serve as the member of the Commission for that participating state.*

*"Compact" means this Dentist and Dental Hygienist Compact.*

*"Compact privilege" means the authorization granted by a remote state to allow a licensee from a participating state to practice as a dentist or dental hygienist in a remote state.*

*"Continuing professional development" means a requirement, as a condition of license renewal to provide evidence of successful participation in educational or professional activities relevant to practice or area of work.*

*"Criminal background check" means the submission of fingerprints or other biometric-based information for a license applicant for the purpose of obtaining that applicant's criminal history record information as defined in 28 C.F.R. § 20.3(d) from the Federal Bureau of Investigation and the state's criminal history record repository as defined in 28 C.F.R. § 20.3(f).*

*"Data system" means the Commission's repository of information about licensees, including but not limited to examination, licensure, investigative, compact privilege, adverse action, and alternative program information.*

*"Dental hygienist" means an individual who is licensed by a state licensing authority to practice dental hygiene.*

*"Dentist" means an individual who is licensed by a state licensing authority to practice dentistry.*

*"Dentist and Dental Hygienist Compact Commission" or "Commission" means a joint government agency established by this Compact comprised of each state that has enacted the Compact and a national administrative body comprised of a commissioner from each state that has enacted this Compact.*

*"Encumbered license" means a license that a state licensing authority has limited in any way other than through an alternative program.*

*"Executive board" means the chair, vice chair, secretary, and treasurer and any other commissioners as may be determined by commission rule or bylaw.*

*"Jurisprudence requirement" means the assessment of an individual's knowledge of the laws and rules governing the practice of dentistry or dental hygiene, as applicable, in a state.*

*"License" means current authorization by a state, other than authorization pursuant to a compact privilege, or other privilege, for an individual to practice as a dentist or dental hygienist in that state.*

*"Licensee" means an individual who holds an unrestricted license from a participating state to practice as a dentist or dental hygienist in that state.*

*"Model compact" means the model for the Dentist and Dental Hygienist Compact on file with the Council of State Governments or other entity as designated by the Commission.*

*"Participating state" means a state that has enacted this Compact and been admitted to the Commission in accordance with the provisions herein and commission rules.*

*"Qualifying license" means a license that is not an encumbered license issued by a participating state to practice dentistry or dental hygiene.*

*"Remote state" means a participating state where a licensee who is not licensed as a dentist or dental hygienist is exercising or seeking to exercise the compact privilege.*

*"Rule" means a regulation promulgated by an entity that has the force of law.*

*"Scope of practice" means the procedures, actions, and processes a dentist or dental hygienist licensed in a state is permitted to undertake in that state and the circumstances under which the licensee is permitted to undertake those procedures, actions, and processes. Such procedures, actions, and processes and the circumstances under which they may be undertaken may be established through means, including, but not limited to, statute, regulations, case law, and other processes, available to the state licensing authority or other government agency.*

*"Significant investigative information" means information, records, and documents received or generated by a state licensing authority pursuant to an investigation for which a determination has been made that there is probable cause to believe that the licensee has violated a statute or regulation that is considered more than a minor infraction for which the state licensing authority could pursue adverse action against the licensee.*

*"State" means any state, commonwealth, district, or territory of the United States that regulates the practices of dentistry and dental hygiene.*

*"State licensing authority" means an agency or other entity of a state that is responsible for the licensing and regulation of dentists or dental hygienists.*

*Article 3.*

*State Participation in the Compact.*

*A. In order to join this Compact and thereafter continue as a participating state, a state must:*

*1. Enact a compact that is not materially different from the model compact as determined in accordance with Commission rules;*

*2. Participate fully in the Commission's data system;*

*3. Have a mechanism in place for receiving and investigating complaints about its licensees and*

*license applicants;*

*4. Notify the Commission, in compliance with the terms of this Compact and Commission rules, of any adverse action or the availability of significant investigative information regarding a licensee and license applicant;*

*5. Fully implement a criminal background check requirement, within a time frame established by Commission rule, by receiving the results of a qualifying criminal background check;*

*6. Comply with the Commission rules applicable to a participating state;*

*7. Accept the National Board Examinations of the Joint Commission on National Dental Examinations or another examination accepted by Commission rule as a licensure examination;*

*8. Accept for licensure such applicants for a dentist license who graduate from a predoctoral dental education program accredited by the Commission on Dental Accreditation, or another accrediting agency recognized by the U.S. Department of Education for the accreditation of dentistry and dental hygiene education programs, resulting in the Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.M.D.) degree;*

*9. Accept for licensure such applicants for a dental hygienist license who graduate from a dental hygiene education program accredited by the Commission on Dental Accreditation or another accrediting agency recognized by the U.S. Department of Education for the accreditation of dentistry and dental hygiene education programs;*

*10. Require for licensure that applicants successfully complete a clinical assessment;*

*11. Have continuing professional development requirements as a condition for license renewal; and*

*12. Pay a participation fee to the Commission as established by Commission rule.*

*B. Providing alternative pathways for an individual to obtain an unrestricted license does not disqualify a state from participating in this Compact.*

*C. When conducting a criminal background check, the state licensing authority shall:*

*1. Consider such information in making a licensure decision;*

*2. Maintain documentation of completion of the criminal background check and background check information to the extent allowed by state and federal law; and*

*3. Report to the Commission whether it has completed the criminal background check and whether the individual was granted or denied a license.*

*D. A licensee of a participating state who has a qualifying license in that state and does not hold an encumbered license in any other participating state shall be issued a compact privilege in a remote state in accordance with the terms of this Compact and Commission rules. If a remote state has a jurisprudence requirement, a compact privilege will not be issued to the licensee unless the licensee has satisfied the jurisprudence requirement.*

*Article 4.*

*Compact Privilege.*

*A. To obtain and exercise the compact privilege under the terms and provisions of this Compact, the licensee shall:*

*1. Have a qualifying license as a dentist or dental hygienist in a participating state;*

*2. Be eligible for a compact privilege in any remote state in accordance with subsections D, G, and H of this section;*

*3. Submit to an application process whenever the licensee is seeking a compact privilege;*

*4. Pay any applicable Commission and remote state fees for a compact privilege in the remote state;*

*5. Meet any jurisprudence requirement established by a remote state in which the licensee is seeking a compact privilege;*

*6. Have passed a National Board Examination of the Joint Commission on National Dental Examinations or another examination accepted by Commission rule;*

*7. For a dentist, have graduated from a predoctoral dental education program accredited by the Commission on Dental Accreditation, or another accrediting agency recognized by the U.S. Department of Education for the accreditation of dentistry and dental hygiene education programs, resulting in the Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.M.D.) degree;*

*8. For a dental hygienist, have graduated from a dental hygiene education program accredited by the Commission on Dental Accreditation or another accrediting agency recognized by the U.S. Department of Education for the accreditation of dentistry and dental hygiene education programs;*

*9. Have successfully completed a clinical assessment for licensure;*

*10. Report to the Commission adverse action taken by any nonparticipating state when applying for a compact privilege and, otherwise, within 30 days from the date the adverse action is taken;*

*11. Report to the Commission when applying for a compact privilege the address of the licensee's primary residence and thereafter immediately report to the Commission any change in the address of the licensee's primary residence; and*

*12. Consent to accept service of process by mail at the licensee's primary residence on record with the Commission with respect to any action brought against the licensee by the Commission or a participating state, and consent to accept service of a subpoena by mail at the licensee's primary residence on record with the Commission with respect to any action brought or investigation conducted*

*by the Commission or a participating state.*

*B. The licensee must comply with the requirements of subsection A of this section to maintain the compact privilege in the remote state. If those requirements are met, the compact privilege will continue as long as the licensee maintains a qualifying license in the state through which the licensee applied for the compact privilege and pays any applicable compact privilege renewal fees.*

*C. A licensee providing dentistry or dental hygiene in a remote state under the compact privilege shall function within the scope of practice authorized by the remote state for a dentist or dental hygienist licensed in that state.*

*D. A licensee providing dentistry or dental hygiene pursuant to a compact privilege in a remote state is subject to that state's regulatory authority. A remote state may, in accordance with due process and that state's laws, by adverse action revoke or remove a licensee's compact privilege in the remote state for a specific period of time and impose fines or take any other necessary actions to protect the health and safety of its citizens. If a remote state imposes an adverse action against a compact privilege that limits the compact privilege, that adverse action applies to all compact privileges in all remote states. A licensee whose compact privilege in a remote state is removed for a specified period of time is not eligible for a compact privilege in any other remote state until the specific time for removal of the compact privilege has passed and all encumbrance requirements are satisfied.*

*E. If a license in a participating state is an encumbered license, the licensee shall lose the compact privilege in a remote state and shall not be eligible for a compact privilege in any remote state until the license is no longer encumbered.*

*F. Once an encumbered license in a participating state is restored to good standing, the licensee must meet the requirements of subsection A of this section to obtain a compact privilege in a remote state.*

*G. If a licensee's compact privilege in a remote state is removed by the remote state, the individual shall lose or be ineligible for the compact privilege in any remote state until the following occur:*

*1. The specific period of time for which the compact privilege was removed has ended; and*

*2. All conditions for removal of the compact privilege have been satisfied.*

*H. Once the requirements of subsection G of this section have been met, the licensee must meet the requirements in subsection A of this section to obtain a compact privilege in a remote state.*

*Article 5.*

*Active Military Members or Their Spouses.*

*Active military members and their spouses shall not be required to pay to the Commission the fee otherwise charged by the Commission for a compact privilege. If a remote state chooses to charge a fee for a compact privilege, it may choose to charge a reduced fee or no fee to active military members and their spouses for a compact privilege.*

*Article 6.*

*Adverse Actions.*

*A. A participating state in which a licensee is licensed shall have exclusive authority to impose adverse action against the qualifying license issued by that participating state.*

*B. A participating state may take adverse action based on the significant investigative information of a remote state, so long as the participating state follows its own procedures for imposing adverse action.*

*C. Nothing in this Compact shall override a participating state's decision that participation in an alternative program may be used in lieu of adverse action and that such participation shall remain nonpublic if required by the participating state's laws. Participating states must require licensees who enter any alternative program in lieu of discipline to agree not to practice pursuant to a compact privilege in any other participating state during the term of the alternative program without prior authorization from such other participating state.*

*D. Any participating state in which a licensee is applying to practice or is practicing pursuant to a compact privilege may investigate actual or alleged violations of the statutes and regulations authorizing the practice of dentistry or dental hygiene in any other participating state in which the dentist or dental hygienist holds a license or compact privilege.*

*E. A remote state shall have the authority to:*

*1. Take adverse actions as set forth in subsection D of Article 4 against a licensee's compact privilege in the state;*

*2. In furtherance of its rights and responsibilities under this Compact and the Commission's rules issue subpoenas for both hearings and investigations that require the attendance and testimony of witnesses and the production of evidence. Subpoenas issued by a state licensing authority in a participating state for the attendance and testimony of witnesses, or the production of evidence from another participating state, shall be enforced in the latter state by any court of competent jurisdiction, according to the practice and procedure of that court applicable to subpoenas issued in proceedings pending before it. The issuing authority shall pay any witness fees, travel expenses, mileage, and other fees required by the service statutes of the state where the witnesses or evidence are located; and*

*3. If otherwise permitted by state law, recover from the licensee the costs of investigations and*

*disposition of cases resulting from any adverse action taken against that licensee.*

*F. Joint investigations.*

*1. In addition to the authority granted to a participating state by its dentist or dental hygienist licensure act or other applicable state law, a participating state may jointly investigate licensees with other participating states.*

*2. Participating states shall share any significant investigative information, litigation, or compliance materials in furtherance of any joint or individual investigation initiated under this Compact.*

*G. Authority to continue investigation.*

*1. After a licensee's compact privilege in a remote state is terminated, the remote state may continue an investigation of the licensee that began when the licensee had a compact privilege in that remote state.*

*2. If the investigation yields what would be significant investigative information had the licensee continued to have a compact privilege in that remote state, the remote state shall report the presence of such information to the data system as required by subdivision B 6 of Article 8 as if it was significant investigative information.*

*Article 7.*

*Establishment and Operation of the Dentist and Dental Hygienist Compact Commission.*

*A. The Compact participating states hereby create and establish a joint government agency whose membership consists of all participating states that have enacted the Compact. The Dentist and Dental Hygienist Compact Commission is an instrumentality of the participating states acting jointly and not an instrumentality of any one state. The Commission shall come into existence on or after the effective date of the Compact as set forth in subsection A of Article 11.*

*B. Participation, voting, and meetings.*

*1. Each participating state shall have and be limited to one commissioner selected by that participating state's state licensing authority or, if the state has more than one state licensing authority, selected collectively by the state licensing authorities.*

*2. The commissioner shall be a member or designee of such authority or authorities.*

*3. The Commission may by rule or bylaw establish a term of office for commissioners and may by rule or bylaw establish term limits.*

*4. The Commission may recommend to a state licensing authority or authorities, as applicable, removal or suspension of an individual as the state's commissioner.*

*5. A participating state's state licensing authority, or authorities, as applicable, shall fill any vacancy of its commissioner on the Commission within 60 days of the vacancy.*

*6. Each commissioner shall be entitled to one vote on all matters that are voted upon by the Commission.*

*7. The Commission shall meet at least once during each calendar year. Additional meetings may be held as set forth in the bylaws. The Commission may meet by telecommunication, video conference, or other similar electronic means.*

*C. The Commission shall have the following powers:*

*1. Establish the fiscal year of the Commission;*

*2. Establish a code of conduct and conflict of interest policies;*

*3. Adopt rules and bylaws;*

*4. Maintain its financial records in accordance with the bylaws;*

*5. Meet and take such actions as are consistent with the provisions of this Compact, the Commission's rules, and the bylaws;*

*6. Initiate and conclude legal proceedings or actions in the name of the Commission, provided that the standing of any state licensing authority to sue or be sued under applicable law shall not be affected;*

*7. Maintain and certify records and information provided to a participating state as the authenticated business records of the Commission and designate a person to do so on the Commission's behalf;*

*8. Purchase and maintain insurance and bonds;*

*9. Borrow, accept, or contract for services of personnel, including, but not limited to, employees of a participating state;*

*10. Conduct an annual financial review;*

*11. Hire employees, elect or appoint officers, fix compensation, define duties, grant such individuals appropriate authority to carry out the purposes of this Compact, and establish the Commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel, and other related personnel matters;*

*12. As set forth in the Commission rules, charge a fee to a licensee for the grant of a compact privilege in a remote state and thereafter, as may be established by Commission rule, charge the licensee a compact privilege renewal fee for each renewal period in which that licensee exercises or intends to exercise the compact privilege in that remote state. Nothing herein shall be construed to prevent a remote state from charging a licensee a fee for a compact privilege or renewals of a compact*

*privilege, or a fee for the jurisprudence requirement if the remote state imposes such a requirement for the grant of a compact privilege;*

*13. Accept any and all appropriate gifts, donations, grants of money, other sources of revenue, equipment, supplies, materials, and services, and receive, utilize, and dispose of the same, provided that at all times the Commission shall avoid any appearance of impropriety and/or conflict of interest;*

*14. Lease, purchase, retain, own, hold, improve, or use any property, real, personal, or mixed, or any undivided interest therein;*

*15. Sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property, real, personal, or mixed;*

*16. Establish a budget and make expenditures;*

*17. Borrow money;*

*18. Appoint committees, including standing committees, which may be composed of members, state regulators, state legislators or their representatives, and consumer representatives, and such other interested persons as may be designated in this Compact and the bylaws;*

*19. Provide and receive information from, and cooperate with, law-enforcement agencies;*

*20. Elect a chair, vice chair, secretary, and treasurer and such other officers of the Commission as provided in the Commission's bylaws;*

*21. Establish and elect an executive board;*

*22. Adopt and provide to the participating states an annual report;*

*23. Determine whether a state's enacted compact is materially different from the model compact language such that the state would not qualify for participation in this Compact; and*

*24. Perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact.*

*D. Meetings of the Commission.*

*1. All meetings of the Commission that are not closed pursuant to this subsection shall be open to the public. Notice of public meetings shall be posted on the Commission's website at least 30 days prior to the public meeting.*

*2. Notwithstanding subdivision 1 of this subsection, the Commission may convene an emergency public meeting by providing at least 24 hours prior notice on the Commission's website, and any other means as provided in the Commission's rules, for any of the reasons it may dispense with notice of proposed rulemaking under subsection L of Article 9. The Commission's legal counsel shall certify that one of the reasons justifying an emergency public meeting has been met.*

*3. Notice of all Commission meetings shall provide the time, date, and location of the meeting, and if the meeting is to be held or accessible via telecommunication, video conference, or other electronic means, the notice shall include the mechanism for access to the meeting through such means.*

*4. The Commission may convene in a closed, nonpublic meeting for the Commission to receive legal advice or to discuss:*

*a. Noncompliance of a participating state with its obligations under this Compact;*

*b. The employment, compensation, discipline, or other matters, practices, or procedures related to specific employees or other matters related to the Commission's internal personnel practices and procedures;*

*c. Current or threatened discipline of a licensee or compact privilege holder by the Commission or by a participating state's licensing authority;*

*d. Current, threatened, or reasonably anticipated litigation;*

*e. Negotiation of contracts for the purchase, lease, or sale of goods, services, or real estate;*

*f. Accusing any person of a crime or formally censuring any person;*

*g. Trade secrets or commercial or financial information that is privileged or confidential;*

*h. Information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;*

*i. Investigative records compiled for law-enforcement purposes;*

*j. Information related to any investigative reports prepared by or on behalf of or for use of the Commission or other committee charged with responsibility of investigation or determination of compliance issues pursuant to this Compact;*

*k. Legal advice;*

*l. Matters specifically exempted from disclosure to the public by federal or participating state law; and*

*m. Other matters as promulgated by the Commission by rule.*

*5. If a meeting, or portion of a meeting, is closed, the presiding officer shall state that the meeting will be closed and reference each relevant exempting provision, and such reference shall be recorded in the minutes.*

*6. The Commission shall keep minutes that fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, and the reasons therefor, including a description of the views expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under*

*seal, subject to release only by a majority vote of the Commission or order of a court of competent jurisdiction.*

*E. Financing of the Commission.*

*1. The Commission shall pay, or provide for the payment of, the reasonable expenses of its establishment, organization, and ongoing activities.*

*2. The Commission may accept any and all appropriate sources of revenue, donations, and grants of money, equipment, supplies, materials, and services.*

*3. The Commission may levy on and collect an annual assessment from each participating state and impose fees on licensees of participating states when a compact privilege is granted, to cover the cost of the operations and activities of the Commission and its staff, which must be in a total amount sufficient to cover its annual budget as approved each fiscal year for which sufficient revenue is not provided by other sources. The aggregate annual assessment amount for participating states shall be allocated based upon a formula that the Commission shall promulgate by rule.*

*4. The Commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same, nor shall the Commission pledge the credit of any participating state, except by and with the authority of the participating state.*

*5. The Commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the Commission shall be subject to the financial review and accounting procedures established under its bylaws. All receipts and disbursements of funds handled by the Commission shall be subject to an annual financial review by a certified or licensed public accountant, and the report of the financial review shall be included in and become part of the annual report of the Commission.*

*F. The executive board.*

*1. The executive board shall have the power to act on behalf of the Commission according to the terms of this Compact. The powers, duties, and responsibilities of the executive board shall include:*

*a. Overseeing the day-to-day activities of the administration of this Compact, including compliance with the provisions of the Compact and the Commission's rules and bylaws;*

*b. Recommending to the Commission changes to the rules or bylaws, changes to this Compact legislation, fees charged to Compact participating states, fees charged to licensees, and other fees;*

*c. Ensuring compact administration services are appropriately provided, including by contract;*

*d. Preparing and recommending the budget;*

*e. Maintaining financial records on behalf of the Commission;*

*f. Monitoring Compact compliance of participating states and providing compliance reports to the Commission;*

*g. Establishing additional committees as necessary;*

*h. Exercising the powers and duties of the Commission during the interim between Commission meetings, except for adopting or amending rules, adopting or amending bylaws, and exercising any other powers and duties expressly reserved to the Commission by rule or bylaw; and*

*i. Other duties as provided in the rules or bylaws of the Commission.*

*2. The executive board shall be composed of up to seven members:*

*a. The chair, vice chair, secretary, and treasurer of the Commission and any other members of the Commission who serve on the executive board shall be voting members of the executive board; and*

*b. Other than the chair, vice chair, secretary, and treasurer, the Commission may elect up to three voting members from the current membership of the Commission.*

*3. The Commission may remove any member of the executive board as provided in the Commission's bylaws.*

*4. The executive board shall meet at least annually.*

*a. An executive board meeting at which it takes or intends to take formal action on a matter shall be open to the public, except that the executive board may meet in a closed, nonpublic session of a public meeting when dealing with any of the matters covered under subdivision D 4 of this section.*

*b. The executive board shall give five business days' notice of its public meetings, posted on its website and as it may otherwise determine to provide notice to persons with an interest in the public matters the executive board intends to address at those meetings.*

*5. The executive board may hold an emergency meeting when acting for the Commission to:*

*a. Meet an imminent threat to public health, safety, or welfare;*

*b. Prevent a loss of Commission or participating state funds; or*

*c. Protect public health and safety.*

*G. Qualified immunity, defense, and indemnification.*

*1. The members, officers, executive director, employees, and representatives of the Commission shall be immune from suit and liability, both personally and in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error, or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that nothing in this subdivision shall be construed to protect any such person from suit or liability for any damage, loss, injury, or liability caused by the intentional or willful*

*or wanton misconduct of that person. The procurement of insurance of any type by the Commission shall not in any way compromise or limit the immunity granted hereunder.*

*2. The Commission shall defend any member, officer, executive director, employee, and representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or as determined by the Commission that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that nothing herein shall be construed to prohibit that person from retaining his own counsel at his own expense, and provided further, that the actual or alleged act, error, or omission did not result from that person's intentional or willful or wanton misconduct.*

*3. Notwithstanding subdivision 1 of this subsection, should any member, officer, executive director, employee, or representative of the Commission be held liable for the amount of any settlement or judgment arising out of any actual or alleged act, error, or omission that occurred within the scope of that individual's employment, duties, or responsibilities for the Commission, or that the person to whom that individual is liable had a reasonable basis for believing occurred within the scope of the individual's employment, duties, or responsibilities for the Commission, the Commission shall indemnify and hold harmless such individual, provided that the actual or alleged act, error, or omission did not result from the intentional or willful or wanton misconduct of the individual.*

*4. Nothing herein shall be construed as a limitation on the liability of any licensee for professional malpractice or misconduct, which shall be governed solely by any other applicable state laws.*

*5. Nothing in this Compact shall be interpreted to waive or otherwise abrogate a participating state's state action immunity or state action affirmative defense with respect to antitrust claims under the Sherman Act, Clayton Act, or any other state or federal antitrust or anticompetitive law or regulation.*

*6. Nothing in this Compact shall be construed to be a waiver of sovereign immunity by the participating states or by the Commission.*

*Article 8.*

*Data System.*

*A. The Commission shall provide for the development, maintenance, operation, and utilization of a coordinated database and reporting system containing licensure, adverse action, and the presence of significant investigative information on all licensees and applicants for a license in participating states.*

*B. Notwithstanding any other provision of state law to the contrary, a participating state shall submit a uniform data set to the data system on all individuals to whom this Compact is applicable as required by the rules of the Commission, including:*

*1. Identifying information;*

*2. Licensure data;*

*3. Adverse actions against a licensee, license applicant, or compact privilege and information related thereto;*

*4. Nonconfidential information related to alternative program participation, the beginning and ending dates of such participation, and other information related to such participation;*

*5. Any denial of an application for licensure, and the reason(s) for such denial, (excluding the reporting of any criminal history record information where prohibited by law);*

*6. The presence of significant investigative information; and*

*7. Other information that may facilitate the administration of this Compact or the protection of the public, as determined by the rules of the Commission.*

*C. The records and information provided to a participating state pursuant to this Compact or through the data system, when certified by the Commission or an agent thereof, shall constitute the authenticated business records of the Commission and shall be entitled to any associated hearsay exception in any relevant judicial, quasi-judicial or administrative proceedings in a participating state.*

*D. Significant investigative information pertaining to a licensee in any participating state will only be available to other participating states.*

*E. It is the responsibility of the participating states to monitor the database to determine whether adverse action has been taken against a licensee or license applicant. Adverse action information pertaining to a licensee or license applicant in any participating state will be available to any other participating state.*

*F. Participating states contributing information to the data system may designate information that may not be shared with the public without the express permission of the contributing state.*

*G. Any information submitted to the data system that is subsequently expunged pursuant to federal law or the laws of the participating state contributing the information shall be removed from the data system.*

*Article 9.*

*Rulemaking.*

*A. The Commission shall promulgate reasonable rules in order to effectively and efficiently implement and administer the purposes and provisions of this Compact. A Commission rule shall be invalid and have no force or effect only if a court of competent jurisdiction holds that the rule is invalid*

*because the Commission exercised its rulemaking authority in a manner that is beyond the scope and purposes of this Compact, or the powers granted hereunder, or based upon another applicable standard of review.*

*B. The rules of the Commission shall have the force of law in each participating state, provided, however, that where the rules of the Commission conflict with the laws of the participating state that establish the participating state's scope of practice as held by a court of competent jurisdiction, the rules of the Commission shall be ineffective in that state to the extent of the conflict.*

*C. The Commission shall exercise its rulemaking powers pursuant to the criteria set forth in this section and the rules adopted thereunder. Rules shall become binding as of the date specified by the Commission for each rule.*

*D. If a majority of the legislatures of the participating states rejects a Commission rule or portion of a Commission rule, by enactment of a statute or resolution in the same manner used to adopt this Compact within four years of the date of adoption of the rule, then such rule shall have no further force and effect in any participating state or to any state applying to participate in this Compact.*

*E. Rules shall be adopted at a regular or special meeting of the Commission.*

*F. Prior to adoption of a proposed rule, the Commission shall hold a public hearing and allow persons to provide oral and written comments, data, facts, opinions, and arguments.*

*G. Prior to adoption of a proposed rule by the Commission, and at least 30 days in advance of the meeting at which the Commission will hold a public hearing on the proposed rule, the Commission shall provide a notice of proposed rulemaking:*

*1. On the website of the Commission or other publicly accessible platform;*

*2. To persons who have requested notice of the Commission's notices of proposed rulemaking; and*

*3. In such other way(s) as the Commission may by rule specify.*

*H. The notice of proposed rulemaking shall include:*

*1. The time, date, and location of the public hearing at which the Commission will hear public comments on the proposed rule and, if different, the time, date, and location of the meeting where the Commission will consider and vote on the proposed rule;*

*2. If the hearing is held via telecommunication, video conference, or other electronic means, the Commission shall include the mechanism for access to the hearing in the notice of proposed rulemaking;*

*3. The text of the proposed rule and the reason therefor;*

*4. A request for comments on the proposed rule from any interested person; and*

*5. The manner in which interested persons may submit written comments.*

*I. All hearings will be recorded. A copy of the recording and all written comments and documents received by the Commission in response to the proposed rule shall be available to the public.*

*J. Nothing in this section shall be construed as requiring a separate hearing on each Commission rule. Rules may be grouped for the convenience of the Commission at hearings required by this section.*

*K. The Commission shall, by majority vote of all commissioners, take final action on the proposed rule based on the rulemaking record.*

*1. The Commission may adopt changes to the proposed rule provided the changes do not enlarge the original purpose of the proposed rule.*

*2. The Commission shall provide an explanation of the reasons for substantive changes made to the proposed rule as well as reasons for substantive changes not made that were recommended by commenters.*

*3. The Commission shall determine a reasonable effective date for the rule. Except for an emergency as provided in subsection L of this section, the effective date of the rule shall be no sooner than 30 days after the Commission issuing the notice that it adopted or amended the rule.*

*L. Upon determination that an emergency exists, the Commission may consider and adopt an emergency rule with 24 hours' notice, with opportunity to comment, provided that the usual rulemaking procedures provided in this Compact and in this section shall be retroactively applied to the rule as soon as reasonably possible, in no event later than 90 days after the effective date of the rule. For the purposes of this provision, an emergency rule is one that must be adopted immediately in order to:*

*1. Meet an imminent threat to public health, safety, or welfare;*

*2. Prevent a loss of Commission or participating state funds;*

*3. Meet a deadline for the promulgation of a rule that is established by federal law or rule; or*

*4. Protect public health and safety.*

*M. The Commission or an authorized committee of the Commission may direct revisions to a previously adopted rule for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions shall be posted on the website of the Commission. The revision shall be subject to challenge by any person for a period of 30 days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge shall be made in writing and delivered to the Commission prior to the end of the notice period. If no challenge is made, the revision will take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the Commission.*

*N. No participating state's rulemaking requirements shall apply under this Compact.*

*Article 10.*
*Oversight, Dispute Resolution, and Enforcement.*

*A. Oversight.*

*1. The executive and judicial branches of state government in each participating state shall enforce this Compact and take all actions necessary and appropriate to implement the Compact.*

*2. Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the Commission is located. The Commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings. Nothing herein shall affect or limit the selection or propriety of venue in any action against a licensee for professional malpractice, misconduct, or any such similar matter.*

*3. The Commission shall be entitled to receive service of process in any proceeding regarding the enforcement or interpretation of this Compact or a Commission rule and shall have standing to intervene in such a proceeding for all purposes. Failure to provide the Commission service of process shall render a judgment or order void as to the Commission, this Compact, or promulgated rules.*

*B. Default, technical assistance, and termination.*

*1. If the Commission determines that a participating state has defaulted in the performance of its obligations or responsibilities under this Compact or the promulgated rules, the Commission shall provide written notice to the defaulting state. The notice of default shall describe the default, the proposed means of curing the default, and any other action that the Commission may take and shall offer training and specific technical assistance regarding the default.*

*2. The Commission shall provide a copy of the notice of default to the other participating states.*

*C. If a state in default fails to cure the default, the defaulting state may be terminated from this Compact upon an affirmative vote of a majority of the commissioners, and all rights, privileges, and benefits conferred on that state by this Compact may be terminated on the effective date of termination. A cure of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.*

*D. Termination of participation in this Compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be given by the Commission to the governor, the majority and minority leaders of the defaulting state's legislature, the defaulting state's state licensing authority or authorities, as applicable, and each of the participating states' state licensing authority or authorities, as applicable.*

*E. A state that has been terminated is responsible for all assessments, obligations, and liabilities incurred through the effective date of termination, including obligations that extend beyond the effective date of termination.*

*F. Upon the termination of a state's participation in this Compact, that state shall immediately provide notice to all licensees of the state, including licensees of other participating states issued a compact privilege to practice within that state, of such termination. The terminated state shall continue to recognize all compact privileges then in effect in that state for a minimum of 180 days after the date of said notice of termination.*

*G. The Commission shall not bear any costs related to a state that is found to be in default or that has been terminated from this Compact, unless agreed upon in writing between the Commission and the defaulting state.*

*H. The defaulting state may appeal the action of the Commission by petitioning the U.S. District Court for the District of Columbia or the federal district where the Commission has its principal offices. The prevailing party shall be awarded all costs of such litigation, including reasonable attorney fees.*

*I. Dispute resolution.*

*1. Upon request by a participating state, the Commission shall attempt to resolve disputes related to this Compact that arise among participating states and between participating states and nonparticipating states.*

*2. The Commission shall promulgate a rule providing for both mediation and binding dispute resolution for disputes as appropriate.*

*J. Enforcement.*

*1. The Commission, in the reasonable exercise of its discretion, shall enforce the provisions of this Compact and the Commission's rules.*

*2. By majority vote, the Commission may initiate legal action against a participating state in default in the United States District Court for the District of Columbia or the federal district where the Commission has its principal offices to enforce compliance with the provisions of this Compact and its promulgated rules. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing party shall be awarded all costs of such litigation, including reasonable attorney fees. The remedies herein shall not be the exclusive remedies of the Commission. The Commission may pursue any other remedies available under federal or the defaulting participating state's law.*

*3. A participating state may initiate legal action against the Commission in the U.S. District Court*

*for the District of Columbia or the federal district where the Commission has its principal offices to enforce compliance with the provisions of this Compact and its promulgated rules. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing party shall be awarded all costs of such litigation, including reasonable attorney fees.*

*4. No individual or entity other than a participating state may enforce this Compact against the Commission.*

*Article 11.*

*Effective Date, Withdrawal, and Amendment.*

*A. This Compact shall come into effect on the date on which the compact statute is enacted into law in the seventh participating state.*

*1. On or after the effective date of this Compact, the Commission shall convene and review the enactment of each of the states that enacted the Compact prior to the Commission convening (charter participating states) to determine if the statute enacted by each such charter participating state is materially different than the model compact.*

*a. A charter participating state whose enactment is found to be materially different from the model compact shall be entitled to the default process set forth in Article 10.*

*b. If any participating state is later found to be in default, or is terminated or withdraws from the Compact, the Commission shall remain in existence and the Compact shall remain in effect even if the number of participating states should be less than seven.*

*2. Participating states enacting the Compact subsequent to the charter participating states shall be subject to the process set forth in subdivision C 23 of Article 7 to determine if their enactments are materially different from the model compact and whether they qualify for participation in the Compact.*

*3. All actions taken for the benefit of the Commission or in furtherance of the purposes of the administration of the Compact prior to the effective date of the Compact or the Commission coming into existence shall be considered to be actions of the Commission unless specifically repudiated by the Commission.*

*4. Any state that joins the Compact subsequent to the Commission's initial adoption of the rules and bylaws shall be subject to the Commission's rules and bylaws as they exist on the date on which the Compact becomes law in that state. Any rule that has been previously adopted by the Commission shall have the full force and effect of law on the day the Compact becomes law in that state.*

*B. Any participating state may withdraw from this Compact by enacting a statute repealing that state's enactment of the Compact.*

*1. A participating state's withdrawal shall not take effect until 180 days after enactment of the repealing statute.*

*2. Withdrawal shall not affect the continuing requirement of the withdrawing state's licensing authority or authorities to comply with the investigative and adverse action reporting requirements of this Compact prior to the effective date of withdrawal.*

*3. Upon the enactment of a statute withdrawing from this Compact, the state shall immediately provide notice of such withdrawal to all licensees within that state. Notwithstanding any subsequent statutory enactment to the contrary, such withdrawing state shall continue to recognize all compact privileges to practice within that state granted pursuant to this Compact for a minimum of 180 days after the date of such notice of withdrawal.*

*C. Nothing contained in this Compact shall be construed to invalidate or prevent any licensure agreement or other cooperative arrangement between a participating state and a nonparticipating state that does not conflict with the provisions of this Compact.*

*D. This Compact may be amended by the participating states. No amendment to this Compact shall become effective and binding upon any participating state until it is enacted into the laws of all participating states.*

*Article 12.*

*Construction and Severability.*

*A. This Compact and the Commission's rulemaking authority shall be liberally construed so as to effectuate the purposes and the implementation and administration of the Compact. Provisions of the Compact expressly authorizing or requiring the promulgation of rules shall not be construed to limit the Commission's rulemaking authority solely for those purposes.*

*B. The provisions of this Compact shall be severable and if any phrase, clause, sentence, or provision of this Compact is held by a court of competent jurisdiction to be contrary to the constitution of any participating state, a state seeking participation in the Compact, or of the United States, or the applicability thereof to any government, agency, person, or circumstance is held to be unconstitutional by a court of competent jurisdiction, the validity of the remainder of this Compact and the applicability thereof to any other government, agency, person, or circumstance shall not be affected thereby.*

*C. Notwithstanding subsection B of this section, the Commission may deny a state's participation in this Compact or, in accordance with the requirements of subsection B of Article 10, terminate a participating state's participation in the Compact, if it determines that a constitutional requirement of a participating state is a material departure from the Compact. Otherwise, if this Compact shall be held*

*to be contrary to the constitution of any participating state, the Compact shall remain in full force and effect as to the remaining participating states and in full force and effect as to the participating state affected as to all severable matters.*

*Article 13.*

*Consistent Effect and Conflict with Other State Laws.*

*A. Nothing herein shall prevent or inhibit the enforcement of any other law of a participating state that is not inconsistent with this Compact.*

*B. Any laws, statutes, regulations, or other legal requirements in a participating state in conflict with this Compact are superseded to the extent of the conflict.*

*C. All permissible agreements between the Commission and the participating states are binding in accordance with their terms.*

**2. Pursuant to Article 11 of § 54.1-2729.02 of the Code of Virginia, as created by this act, the Dentist and Dental Hygienist Compact (the Compact) will become effective on the date the Compact is enacted by a seventh participating state or upon the effective date of this act, whichever is later.**

**Agenda Item: Consideration of next steps following publication of NOIRA related to 2022 petition for rulemaking**

**Included in your agenda package:**

- Petition for rulemaking received in January 2022;
- NOIRA related to acceptance of petition for rulemaking, which completed Executive Branch review and was published on August 21, 2024;
- Public comments received during the public comment period following publication of the NOIRA; and
- Refresher course program information.

**Staff note:** The Regulatory Committee reviewed the criteria for evaluation of refresher courses used by CODA and ADA/AADH/ADHA, as well as heard reports from staff regarding availability of CODA-accredited programs and issues concerning ADA/AADH/ADHA responses to programs which fail to meet requirements. The Regulatory Committee recommended that the full Board not continue with the existing regulatory action and, instead, withdraw the action. The existing regulatory requirements to complete a refresher course offered by a CODA-accredited program will remain in effect.

**Action needed:**

- Motion to accept the recommendation of the Regulatory Committee and withdraw the regulatory action related to the 2022 petition for rulemaking.

# COMMONWEALTH OF VIRGINIA
# Board of Dentistry

9960 Mayland Drive, Suite 300
Richmond, Virginia 23233-1463

(804) 367-4538 (Tel)
(804) 527-4428 (Fax)

## Petition for Rule-making

*The Code of Virginia (§ 2.2-4007) and the Public Participation Guidelines of this board require a person who wishes to petition the board to develop a new regulation or amend an existing regulation to provide certain information. Within 14 days of receiving a valid petition, the board will notify the petitioner and send a notice to the Register of Regulations identifying the petitioner, the nature of the request and the plan for responding to the petition. Following publication of the petition in the Register, a 21-day comment period will begin to allow written comment on the petition. Within 90 days after the comment period, the board will issue a written decision on the petition. If the board has not met within that 90-day period, the decision will be issued no later than 14 days after it next meets.*

| Please provide the information requested below. (Print or Type) | | |
|---|---|---|
| Petitioner's full name (Last, First, Middle initial, Suffix,)<br>Joyce Ann Turcotte | | |
| Street Address<br>2010 Sharon St. | Area Code and Telephone Number<br>203-261-2857 | |
| City<br>Boca Raton | State<br>FL | Zip Code<br>33486 |
| Email Address (optional)<br>jturcotte@pls.org | Fax (optional)<br>203-459-2911 | |

**Respond to the following questions:**

1. What regulation are you petitioning the board to amend? Please state the title of the regulation and the section/sections you want the board to consider amending.

Section 18VAC60-25-210A3(iii) Reinstatement or reactivation of a license
Acceptable Clinical Examinations Effective March 19, 2021
Definitions to Applied Terms
"Clinical Competency Exam" means a formal test of knowledge and competence in the evaluation, diagnosis, and treatment of dental conditions and the prevention of dental diseases which includes live patient and/or manikin based testing methods to demonstrate the skills needed to safely provide care and treatment of patients".

2. Please summarize the substance of the change you are requesting and state the rationale or purpose for the new or amended rule.

Summary of Substance: Dental Hygiene Refresher Programs accepted by the American Dental Association and the American Academy of Dental Hygiene are evaluated according to their established standards and guidelines for didactic and clinical competency.

Rationale: The current regulation Section 18VAC60-25-210A3(iii) does not include Dental Hygiene Programs recognized by the ADA and AADH for license reinstatement for experienced dental hygienists.

3. State the legal authority of the board to take the action requested. In general, the legal authority for the adoption of regulations by the board is found in § 54.1-2400 of the Code of Virginia. If there is other legal authority for promulgation of a regulation, please provide that Code reference.

§ 54.1-2400
12. To issue inactive licenses or certificates and promulgate regulations to carry out such purpose. Such regulations shall include, but not be limited to, the qualifications, renewal fees, and conditions for reactivation of licenses or certificates

Signature: Joyce Ann Turcotte    Date: 1/26/2022

March 2019

**Form: TH-01**
**April 2020**

**townhall.virginia.gov**

# Notice of Intended Regulatory Action (NOIRA) Agency Background Document

| | |
|---|---|
| **Agency name** | Board of Dentistry, Department of Health Professions |
| **Virginia Administrative Code (VAC) Chapter citation(s)** | 18VAC60-21<br>18VAC60-25 |
| **VAC Chapter title(s)** | Regulations Governing the Practice of Dentistry<br>Regulations Governing the Practice of Dental Hygiene |
| **Action title** | Refresher courses required for reinstatement |
| **Date this document prepared** | June 10, 2022 |

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Order 14 (as amended, July 16, 2018), the Regulations for Filing and Publishing Agency Regulations (1VAC7-10), and the *Form and Style Requirements for the Virginia Register of Regulations and Virginia Administrative Code.*

## Brief Summary

*Provide a brief summary (preferably no more than 2 or 3 paragraphs) of the subject matter, intent, and goals of this this regulatory change (i.e., new regulation, amendments to an existing regulation, or repeal of an existing regulation.*

In response to a petition for rulemaking, the Board is proposing to amend 18VAC60-21-240 and 18VAC60-25-210 to expand the type of refresher courses reinstatement applicants may take. The Board is also proposing to amend these regulations to clarify that the number of course hours required, and the amount of didactic training and clinical training required, will depend on the number of years a dentist or dental hygienist has been out of practice.

## Acronyms and Definitions

*Define all acronyms or technical definitions used in this form.*

N/A

## Mandate and Impetus

*Identify the mandate for this regulatory change and any other impetus that specifically prompted its initiation (e.g., new or modified mandate, petition for rulemaking, periodic review, or board decision). For purposes of executive branch review, "mandate" has the same meaning as defined in Executive Order 14 (as amended, July 16, 2018), "a directive from the General Assembly, the federal government, or a court that requires that a regulation be promulgated, amended, or repealed in whole or part."*

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There is no mandate for this action. The impetus for expansion of types of refresher courses accepted is a petition for rulemaking filed by a petitioner requesting that the Board amend 18VAC60-25-240 to accept refresher courses accepted by the American Dental Association or the American Academy of Dental Hygiene. Because the same limitations apply to regulations regarding dentists applying for reinstatement or reactivation of a license, the Board intends to amend 18VAC60-21-240 as well.

In addition, the Board has received numerous applications for reinstatement or reactivation with insufficient completion of refresher courses. For example, the Board feels that a dentist who has not practiced in Virginia or any other jurisdiction for ten years should complete more than a refresher course that totaled three hours of didactic training. The Board intends to clarify that didactic and clinical training may be required due to time out of practice and that course hours will be dependent on time out of practice.

## Legal Basis

*Identify (1) the promulgating agency, and (2) the state and/or federal legal authority for the regulatory change, including the most relevant citations to the Code of Virginia and Acts of Assembly chapter number(s), if applicable. Your citation must include a specific provision, if any, authorizing the promulgating agency to regulate this specific subject or program, as well as a reference to the agency's overall regulatory authority.*

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Regulations of the Board of Dentistry are promulgated under the general authority of Chapter 24 of Title 54.1 of the Code of Virginia. Virginia Code § 54.1-2400(6) specifically states that the general powers and duties of health regulatory boards shall be "[t]o promulgate regulations in accordance with the Administrative Process Act (§ 2.2-4000 et seq.) that are reasonable and necessary to administer effectively the regulatory system."

## Purpose

*Describe the specific reasons why the agency has determined that this regulation is essential to protect the health, safety, or welfare of citizens. In addition, explain any potential issues that may need to be addressed as the regulation is developed.*

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The Board is initiating this rulemaking following receipt and consideration of a petition for rulemaking to expand the available refresher courses for dental hygienists applying for reinstatement or reactivation. The Board, in its review of the petition, recognized that the same limitation applied to dentists applying for reinstatement or reactivation. In order to ensure application for reinstatement or reactivation is less burdensome on both categories of licensure, the Board determined to initiate rulemaking.

Additionally, the Board has received numerous applications for reinstatement or reactivation with insufficient completion of refresher courses. For example, the Board feels that a dentist who has not practiced in Virginia or any other jurisdiction for ten years should complete more than a refresher course that totaled three hours of didactic training. The Board intends to clarify that didactic and clinical training may be required due to time out of practice and that course hours will be dependent on time out of practice. This change will protect the public because the Board and the public can be confident that licensees who have been inactive for significant periods of time are able to safely practice on citizens of the Commonwealth.

## Substance

*Briefly identify and explain the new substantive provisions that are being considered, the substantive changes to existing sections that are being considered, or both.*

The Board will consider amending 18VAC60-21-240 and 18VAC60-25-210 to (1) expand the types of refresher programs accepted for reinstatement or reactivation of a license, and (2) clarify that the number of hours and type of training, including amount of didactic training and amount of clinical training, will vary depending on the amount of time an applicant has been out of practice.

## Alternatives to Regulation

*Describe any viable alternatives to the regulatory change that were considered, and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the regulatory change. Also, include discussion of less intrusive or less costly alternatives for small businesses, as defined in § 2.2-4007.1 of the Code of Virginia, of achieving the purpose of the regulatory change.*

Licensure of dentists and dental hygienists, including requirements for reinstatement and reactivation, are dictated by regulation. There is no alternative to amending regulations to lessen the burden on applicants searching for acceptable refresher courses.

## Periodic Review and Small Business Impact Review Announcement

This NOIRA is not being used to announce a periodic review or a small business impact review.

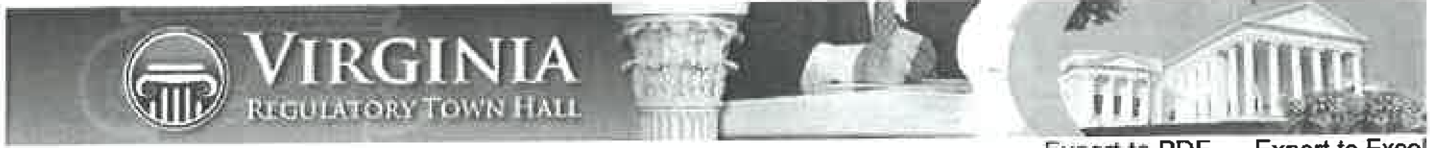
## Public Participation

*Indicate how the public should contact the agency to submit comments on this regulation, and whether a public hearing will be held, by completing the text below. In addition, as required by § 2.2-4007.02 of the Code of Virginia describe any other means that will be used to identify and notify interested parties and seek their input, such as regulatory advisory panels or general notices.*

The Board of Dentistry is providing an opportunity for comments on this regulatory proposal, including but not limited to (i) the costs and benefits of the regulatory proposal, (ii) any alternative approaches, and (iii) the potential impacts of the regulation.

Anyone wishing to submit written comments for the public comment file may do so through the Public Comment Forums feature of the Virginia Regulatory Town Hall web site at: https://townhall.virginia.gov. Comments may also be submitted by mail, email or fax to Erin Barrett, Agency Regulatory Coordinator, 9960 Mayland Drive, Henrico, VA 23233 or erin.barrett@dhp.virginia.gov or by fax to (804) 915-0382. In order to be considered, comments must be received by 11:59 pm on the last day of the public comment period.

A public hearing will be held following the publication of the proposed stage, and notice of the hearing will be posted on the Virginia Regulatory Town Hall website (https://townhall.virginia.gov) and on the Commonwealth Calendar website (https://commonwealthcalendar.virginia.gov/). Both oral and written comments may be submitted at that time.






Agency **Department of Health Professions**

Board **Board of Dentistry**

Chapter Regulations Governing the Practice of Dentistry [18 VAC 60 - 21]

| | |
|---|---|
| **Action** | Expansion and clarification of refresher courses required for reinstatement of a license |
| **Stage** | NOIRA |
| **Comment Period** | Ended on 9/11/2024 |

3 comments

**All good comments for this forum** Show Only Flagged

Back to List of Comments

**Commenter:** Frank Iuorno 8/28/24 9:18 am

**Refresher Course Requirements**

I applaud the BOD for clarifying the requirements for refresher courses, however, see no significant detail in the NOIRA documentation upon which to comment. These courses are few and far between and difficult to find. I would suggest that a complete listing of possible courses that meet requirements be developed to be sure that potential licensees have access to an appropriate courses.

CommentID: **227465**

**Commenter:** Virginia Dental Association 9/10/24 4:17 pm

**Proposal to Amend Regulations on Refresher Courses for Reinstatement Applicants**

I am writing on behalf of the Virginia Dental Association in response to the Virginia Board of Dentistry's proposal to amend 18VAC60-21-240 and 18VAC60-25-210 to expand the types of refresher courses reinstatement applicants may take.

The NOIRA states the Board is also proposing to amend these regulations to clarify that the number of course hours required, and the amount of didactic training and clinical training required, will depend on the number of years a dentist or dental hygienist has been out of practice. Without spelling out the specifics of that proposal, it is difficult to comment on their appropriateness.

As many licensed dentists, dental hygienists and expanded functions dental assistants had careers put on hold in the past five years, we believe that it is particularly important at this time to have a clearly defined path to reinstating a lapsed license that is not unnecessarily burdensome in demonstrating continued competence.

As of this writing, the VDA is aware of only one refresher course for dentists and dental hygienists offered in Virginia that meets the criteria adopted in December 2, 2022 in Guidance Document 60-

12 and is aware of no currently offered refresher courses that meet the criteria for a dental assistant II whose license has lapsed.

A nurse in Virginia, by comparison, whose license has lapsed for more than a year, has nine different options to demonstrate continued competency, certified by upwards of 13 providers.

The current guidance document for reinstatement of a license for a dentist, dental hygienist or dental assistant II requires that the refresher course be offered by a CODA-accredited program. However, CODA does not accredit refresher courses themselves and, in the case of dental assistant II's, CODA also does not accredit that educational program.

The physical space in which a refresher course is offered is not indicative of its quality, and the board accepts more than fifteen sponsors of continuing education for purposes of annual licensure renewal for oral healthcare professionals.

The VDA supports the Board of Dentistry's stated proposal to expand the type of refresher courses reinstatement applicants may take and asks the Board to limit its requirements to what is necessary to demonstrate continued competency.

Dustin Reynolds, DDS

President, Virginia Dental Association
CommentID: **227759**

**Commenter:** Catherine Berard 9/11/24 4:51 pm

**Proposal to Amend Regulations on Refresher Courses for Reinstatement of a License**

Thank you for the opportunity to respond to the Notice of Intended Regulatory Action (NOIRA) regarding proposed amendments to 18VAC60-21-240 and 18VAC60-25-210 to expand the type of refresher courses reinstatement applicants may take and to amend these regulations to clarify that the number of course hours required, and the amount of didactic training and clinical training required, will depend on the number of years a dentist or dental hygienist has been out of practice.

We applaud the Board for recognizing the limited menu of refresher course options available to dentists and dental hygienists applying for reinstatement or reactivation and initiating action to address that situation.

The Virginia Dental Hygienists' Association (VDHA) advocates for continued competence, lifelong learning and ongoing professional development for dental hygienists, and we recognize that the important component of that is continuing education for license reinstatement.

We support efforts to expand the type and options of license reinstatement refresher courses. In developing standards for those courses, we encourage the Board to focus on didactic and clinical requirements necessary in demonstrating continued competency. Individual applicant assessment should establish the number of course hours needed rather than numbers stipulated by regulation.

Thank you

Catherine Berard, BSDH, RDH

VDHA Public Health and Professional Affairs Council Chair

CommentID: **227779**

| CODA -Accredited Refresher Course | ADA/ADHA/AADH Refresher Courses |
|---|---|
| CODA-accredited programs<br>• CODA is a semi-autonomous agency of the ADA that accredits dental and dental-related education programs.<br>• CODA's accreditation process includes **peer reviews to evaluate the quality of dental education programs.**<br>• CODA accredits programs such as predoctoral (DDS/DMD) dental education programs, advanced dental education programs, dental hygiene and allied dental education programs.<br>• **CODA provides programs and the public with advance notice when revising policies or standards.** | ADA/ADHA/AADH continuing education courses<br>• The ADA offers continuing education courses to help dental professionals find quality providers.<br>• The ADA CERP/ADHA/AADH service helps dental professionals identify quality continuing dental education providers.<br>• The ADA CERP/ADHA/AADH services **does not** endorse or approve individual courses or instructors. |

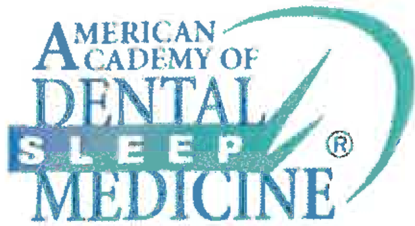
CODA provides a quality review for a refresher course to ensure that an applicant is able to demonstrate clinical competency vs. ADA/ADHA/AADH that does not endorse or approve individual courses. Therefore, the Board cannot ensure quality instruction of a refresher course. A refresher course is meant to prove clinical competency and that would be difficult without approval of course content, which the board will not do for ADA (ex.CERP), ADHA, or AADH courses.

No one has complained to the BOD of the ability of finding a CODA-Accredited course for refresher courses. The courses reviewed by the board that have been CODA-Accredited refresher courses have been clinical sound content. The board receives a few a week from all over the country, not just locally.

Received responses from 12 states Alaska, California, North Carolina, Indiana, Florida, Iowa, Arizona, Montana, Minnesota, North Dakota, West Virginia, and Nebraska either will not pre-approve a provider or only accepts CODA Accredited programs for refresher courses.

Received 2 responses from Kentucky and Massachusetts that they accept other refresher course programs besides CODA Accredited.

The Board will not pre-approve individual CE courses

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April 30, 2025

Sultan Chaudhry, DDS
President, Virginia Board of Dentistry
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463

SENT VIA EMAIL: denbd@dhp.virginia.gov

Dear Dr. Chaudhry,

The American Academy of Dental Sleep Medicine (AADSM) recently published an update to its *Dental Sleep Medicine Standards for Screening, Treatment, and Management of Sleep-Related Breathing Disorders in Adults Using Oral Appliance Therapy*.

In this update, the AADSM identified three critical components of oral appliance therapy (OAT) for obstructive sleep apnea to be completed in person, rather than by teledentistry, specifically noting they are essential for ensuring treatment accuracy, patient safety, proper fit, and long-term success:

- The comprehensive dental sleep medicine examination where the dentist assesses the patient's existing restorations (like fillings, crowns and dentures), their teeth and bite, the temporomandibular joint, and craniofacial structures to ensure that the patient is a suitable candidate for oral appliance therapy.

- Taking dental impressions, which are imprints of your teeth, gums and surrounding oral structures taken by digital scans or dental putty and must be precise to create a custom-fit appliance that fits correctly, is comfortable and effectively treats obstructive sleep apnea.

- Taking a bite registration, which is a personalized measurement that helps the dentist find the best starting position for a patient's oral appliance.

The standards continue to outline that qualified dentists are the appropriate clinicians to provide OAT. Dentists are trained to evaluate the patient's dentition as well as intraoral hard and soft tissues; consider craniofacial structures and oral, dental, and periodontal tissues to select the appropriate appliance for a patient; and manage treatment effects from OAT on the temporomandibular joint (TMJ), dental occlusion, and related structures - all which impact adherence and treatment success.

Thank you in advance for considering these papers as you continue to ensure public safety. A repository of AADSM standards is available at aadsm.org/standards_for_practice.php, and the AADSM is available as a resource should you want any additional clinical expertise on the topic of OAT for obstructive sleep apnea. Please reach out to kpostol@aadsm.org.

Sincerely,
Kevin Postol, DDS
President, AADSM

# Board of Dentistry 2026 Calendar

Virginia Department of
Health Professions

**January**

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**November**

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**December**

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Formal Hearing: March 5, June 11, Sept. 3, Dec. 3
Board Meeting: March 6, June 12, Sept 4, Dec 4

Tentative Dates: Feb 27, May 15, Oct 23

SCC-A: Jan 9, Feb 6, Apr 3, May 1, July 10, Aug 7, Sept 11, Oct 2, Nov 6, Dec 11
SCC-B: Jan 16, Feb 13, Mar 13, Apr 10, May 8, July 17, Aug 14, Sept 18, Oct 9, Nov 13
SCC-C: Jan 23, Feb 20, Mar 20, Apr 17, June 26, July 24, Aug 21, Sept 25, Oct 16, Nov 20

Virginia Department of
# Health Professions
Board of Dentistry

Disciplinary Board Report

## November 21, 2024 – May 21, 2025

The table below includes all cases that have received Board action since November 21, 2024 through May 21, 2025.

| Year 2024 | Cases Received | Cases Closed No Violation | Cases Closed W/Violation | Total Cases Closed |
|---|---|---|---|---|
| November | 11 | 10 | 1 | 11 |
| December | 55 | 20 | 7 | 27 |
| January | 71 | 54 | 3 | 57 |
| February | 36 | 47 | 1 | 34 |
| March | 80 | 38 | 10 | 48 |
| April | 52 | 21 | 1 | 22 |
| May | 16 | 22 | 1 | 23 |
| TOTALS | 321 | 212 | 24 | 222 |

## Closed Case with Violations consisted of the following:

### Patient Care Related:

- **13 Standard of Care: Diagnosis/Treatment:** Instances in which the diagnosis/treatment was improper, delayed, or unsatisfactory. Also, include failure to diagnose/treat & other diagnosis/treatment issues.
- **4 Standard of Care: Exceeding the Scope:** practicing outside the permitted functions of license
- **3 Standard of Care: Malpractice Reports:** Malpractice settlement payment for standard of care violations
- **1 Drug Related, Patient Care:** Dispensing in violation of the Drug Control Act, prescription forgery, stealing drugs from patients, or personal use.
- **1 Fraud, Patient Care:** Performing unwarranted/unjust services or the falsification/alteration of patient records

### Non-Patient Care Related:

- **2 Business Practice Issues:** Recordkeeping or continuing education.

Virginia Department of
Health Professions
Board of Dentistry

Disciplinary Board Report

## CCA's

There were **7** CCAs issued from November 21, 2024 through May 21, 2025.

## Suspensions/Revocations

There have been **2** Summary Suspensions issued from November 21, 2024 through May 21, 2025. There has been **1** Voluntary Permanent Surrender and **0** Revocations from November 21, 2024 through May 21, 2025.

# DRAFT
# Recommendations for a Dental Assisting Professional Model

1/10/2025


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## A Path Forward for the Dental Assisting Profession

Dentistry is experiencing significant challenges related to the workforce, including an insufficient number of qualified dental assistants. The workforce shortage impacts practice capacity, efficiency, productivity, patient access, and quality of care.

The dental assisting workforce shortage was already a problem before the start of the COVID-19 pandemic, but the pandemic both exacerbated the shortage and delayed progress on solutions. In a 2022 stakeholder forum that included executives and strategists from more than 20 organizations, participants consistently returned to the observation that the lack of uniformity in the dental assisting profession across states was an important factor impeding meaningful progress in alleviating the shortage. Increasing uniformity and establishing standards was a key theme underlying the most important initiatives identified by forum participants.

A shared understanding of what dental assistants do and how they can advance will greatly improve dentistry's ability to recruit and retain qualified personnel, and to develop pipelines for the future workforce. Without a shared understanding, dentistry will continue to see

- Challenges in attracting and educating dental assisting candidates
- Loss of qualified dental assisting personnel from the field
- Reduced capacity of the oral healthcare infrastructure and diminished access to care
- Unclear understanding of minimum requirements for patient safety
- Duplication of effort in developing mid- and long-term solutions to address the workforce shortage
- Inefficiency, frustration and confusion

State legislation and regulation of the dental assisting profession shapes the career of a dental assistant. Bringing uniformity to dental assistants' scope of practice and exam, education, and credential requirements can help lay out a consistent path for the profession that offers a long-term career journey. Providing a clear roadmap for that journey will assist with both recruitment and retention of assistants. And those moving between states or working in multiple states over the course of their career will be able to continue to work without significant pause.

There is overwhelming support in dentistry for uniform national standards. A 2023 survey of dental assistants, dentists and employers, and educators showed 83% supported this idea.

The Dental Assisting Professional Model Workgroup was established to address the wide variation in how states regulate dental assisting with a focus on recommending a model that could be used as the basis for state-to-state uniformity. The Workgroup drafted a model that offers multiple pathways into the profession and a framework for professional advancement, supporting the recruitment and retention of dental assistants.

## About the Dental Assisting Professional Model Workgroup

The Dental Assisting Professional Model Workgroup consists of 20 members, including dental assistants, dentists, educators, dental hygienists, and regulators. The Workgroup, formed in early 2024, sought to help address the shortage by creating a national model that:

- Elevates the dental assisting profession and attracts more candidates to the field
- Provides a road map for career growth that can support recruitment and retention of dental assistants over the long term
- Improves professional mobility of dental assistants from state to state
- Increases practice efficiency and enhances access to care
- Provides states with a straightforward framework for regulation that reflects the needs of dentistry

Nominating organizations included:

- American Association of Dental Administrators
- American Association of Dental Boards
- American Dental Assistants Association
- American Dental Association
- American Dental Education Association
- American Dental Hygienists' Association
- Association of Dental Support Organizations
- Dental Assisting National Board
- Hispanic Dental Association
- National Network for Oral Health Access

Six additional members were invited to participate to bring the expertise and perspective gained in specific roles and to broaden geographic diversity.

Two co-chairs provided leadership to the Workgroup:

- Dolores Cottrell, DDS, Executive Secretary, New York State Board for Dentistry (New York)
- Helen Sublette, BS, CDA, COA, CDIPC, FADAA, Owner, Coastal Dental Professionals Consulting (North Carolina)

Workgroup meetings were led by third-party facilitators, with the Dental Assisting National Board (DANB) staff leading workgroup coordination and contributing subject matter expertise. A full list of Workgroup members, including credentials, affiliation, and nominating organization, can be found in Appendix A.

The framework outlined in this document is the product of 12 months' work by the Dental Assisting Professional Model Workgroup and reflects the Workgroup's consensus.

## Guiding Principles & Approach

The Workgroup prioritized a national model that supports:

- **Public protection**, including patient safety and occupational safety
- **Uniformity**, with an effort to build upon existing commonalities among state's scopes of practice and requirements
- **Roadmap for advancement**, that sets a clear path for dental assistants to grow
- **Implementation feasibility**, for a model embraced nationwide

To support these priorities, the Workgroup's deliberations were informed by the following sources of data:

- Survey research revealing broad stakeholder perspectives

- Clinical data, derived from a job task analysis survey, about frequency of tasks performed by dental assistants
- Data about commonalities among states related to dental assisting regulation
- Subject matter expertise provided by Workgroup members themselves

In the spirit of the guiding principles, recommendations that follow are for national minimum standards. Each dental assistant level offers multiple pathways that are as equivalent as possible, ensuring they do not create further barriers for states, employers, or dental assistants. The levels consist of both on-the-job and formal education options that offer third-party validation.

The Workgroup's approach has been informed by the following factors:

- Dental assisting education that is accredited by the Commission on Dental Accreditation (CODA) provides excellent preparation for dental assistants, but programs collectively do not have the capacity to supply all the dental assistants that are needed, and their capacity is declining; the collective annual enrollment of CODA-accredited dental assistant programs has decreased by almost half in the last decade
- There are other sources of high-quality education for dental assistants, including some community college programs and public career and technical education (CTE) programs, and some for-profit education sources might also provide quality instruction; uniform objective criteria are needed for states to evaluate offerings from all of these sources
- In many states, hiring individuals with no dental assisting experience and training them on the job is the predominant mode of entry into the dental assisting profession; however, this trend is associated with poor retention, inconsistencies in training, high turnover, and frequent vacancies that diminish the capacity of dental offices to see patients

The Workgroup's recommendations seek to balance the necessity to be able to train some dental assistants on the job with the need to protect the public. The recommendations also seek to provide adequate training and education at each level so as to provide a foundation for advancement to the next level and enhance the ability of employers to recruit and retain dental assistants; elevating dental assisting as a rewarding career will also help dental assisting education programs recruit students.

## The Recommended Model

### Model Snapshot

The Workgroup's recommendations for a professional model for dental assisting is summarized in brief in the following graphic. Additional details for each element of the model are contained in the sections that follow.

| Dental Assisting Professional Model Snapshot | | |
|---|---|---|
| Entry Level Dental Assistant | **Level 1 Functions**<br>Essential chairside and basic intraoral functions | Complete infection control and safety orientation prior to or on first day of work as a DA<br>Earn CPR/BLS within 3 months<br>Within 12 months:<br>Complete on-the-job training + pass a standardized national exam **or**<br>Complete a board-approved course or program that includes a final exam |
| | **Infection control** | Complete on-the-job training + pass a standardized national exam **or**<br>Complete a board-approved course or program that includes a final exam |
| | **Radiography** | Complete on-the-job training + pass a standardized national exam **or**<br>Complete a board-approved course + pass a standardized national exam **or**<br>Pass a course through or graduate from a CODA-accredited program |
| Intermediate Level Dental Assistant | **Level 2 Functions**<br>Intermediate intraoral and preventive functions | Meet Level 1 requirements, complete a board-approved course, and pass a national standardized exam **or**<br>Graduate from a CODA-accredited program* |
| | **Nitrous Oxide Monitoring** | Complete Level 1<br>Hold BLS certification<br>Complete a board-approved course that includes a final exam **or**<br>Graduate from a CODA-accredited program* |
| Restorative Expanded Functions Dental Assistant | **Level 3 Functions**<br>Advanced intraoral, expanded and restorative functions | Meet Level 2 requirements, hold national dental assistant certification, complete a board-approved program, and pass a national standardized exam **or**<br>Graduate from a CODA-accredited program* that included instruction in the functions |

\A.note.about.completion.of.CODA_accredited.dental.assisting.programs¿ A dental assistant who has completed a dental assisting program accredited by CODA will have met educational requirements for both Level 1 and Level 2.
If a CODA-accredited dental assisting program included the required instruction in restorative functions, a dental assistant completing such a program will also have met educational requirements for Level 3.

## Level 1: Entry level

**Overview**
Level 1 dental assistants have foundational dental knowledge and perform essential chairside and basic intraoral functions.

**Supervision**
Tasks are performed under the dentist's personal and direct supervision, until the dental assistant has met established requirements. Then, the dental assistant may work under indirect supervision.

*Personal Supervision: The dentist is personally operating on a patient and authorizes the dental assistant to aid in treatment by concurrently performing supportive procedures.*

*Direct Supervision: The dentist is on the premises while work is performed by dental assistants; the dentist directs dental assistants' activities and verifies that functions have been performed correctly.*

*Indirect Supervision: The dentist is in the office, authorizes the procedures, and remains in the office while the procedures are being performed.*

**Description**

Level 1 dental assistants support the dentist, the dental team, and the dental office's clinical operations. Their primary role is to assist dentists as they perform dental procedures on patients, under the dentist's personal supervision, and to execute supportive tasks before, during and after such procedures. Level 1 dental assistants also perform duties under the direct supervision of dentists.

**Delegable Tasks**

- Administrative, non-clinical tasks
- Clinical extraoral tasks
- Fundamental patient appointment support tasks
- Tasks that support diagnosis of the patient's condition
- Tasks that are reversible and pose a minimal risk of patient pain, injury or long-term ill effects
- Tasks that address or assist in addressing dental and medical emergencies

Examples of Level 1 tasks are:

- Maintain field of operation during dental procedures by retraction, suction, irrigation, drying, placing and removing cotton rolls, etc.
- Provide patient preventive education and oral hygiene instruction
- Take and record vital signs
- Apply topical anesthetic
- Apply topical fluoride
- Take impressions for study models and fabrication of appliances, including digital impressions
- Place and remove dental dam
- Remove temporary crowns and cements

Other tasks appropriate for Level 1 are listed in Appendix B.

Note on radiography and infection control: Radiography and infection control tasks, such as sterilizing instruments, are fundamental to the job of dental assistants and are performed by dental assistants at all levels. However, incorrect performance of these tasks carries the risk of irreversible harm to patients and personnel; therefore, special consideration has been given to addressing patient and occupational safety concerns related to these functions. Accordingly, apart from a first-day orientation required to begin working as a Level 1 dental assistant, these functions will be addressed separately.

**Entry-Level Orientation**

Prior to beginning work in a dental setting, a dental assistant should be provided with an infection control and safety orientation that covers essential topics, including the following:

- Fundamentals of Infection Prevention and Control: Personnel role in preventing infections; standard and transmission-based precautions; CDC resources

- Patient Protection and Occupational Safety: Hand hygiene; PPE; respiratory illness precautions; sharps safety and percutaneous injury response; work practice and engineering controls; safe injection practices; hepatitis B immunization
- Sterilization and Disinfection: Sterilization of a variety of patient care items; instrument sterilization process; sterilizer monitoring; disinfecting environmental surfaces; waste disposal; dental unit water quality monitoring/management
- Basic Radiation Safety: Occupational safety for those working in a setting where x-rays are used

**Training Period**
A dental assistant may work in a dental office while receiving training in Level 1 functions for up to 12 months prior to meeting the pathway requirements.

**CPR/BLS**
A dental assistant must hold current CPR/BLS certification within three months of beginning work in a dental office and keep CPR/BLS certification current during employment. CPR/BLS certification must meet either American Heart Association or American Red Cross guidelines.

**Pathways**

| | Training/Education | Assessment |
|---|---|---|
| Pathway 1 | **On-the-job training**<br>Receive in-office training that follows a standardized content outline or training manual *(See required training/course content outline below.)* | Standardized nationally recognized exam approved by the dental board |
| Pathway 2 | **Course or program**<br>Complete a course or dental assisting program that is either approved by the state dental board or CODA accredited | End-of-course exam |

**Required training or course content**
The training or course should cover:

Foundational Knowledge
- Principles of four-handed dentistry
- Treatment documentation and charting
- Universal tooth numbering system
- Tooth names, anatomy and morphology
- Oral anatomical landmarks
- Dental terminology
- Management of hazardous waste (transport, disposal, documentation)
- Patient privacy laws (HIPAA)

Essential Chairside Functions
- Review and update patient medical history, including identifying contraindications for treatment

- Perform preliminary patient examination
- Prepare patients and operatory for treatment
- Explain and obtain patient consent for procedure
- Discuss risks, benefits and alternative treatments with patient
- Set up instrument trays
- Set up anesthetic syringe
- Prepare and deliver dental materials for procedure
- Maintain field of operation during dental procedures by retraction, suction, irrigation, drying, placing and removing cotton rolls, etc.
- Observe patient during procedure
- Provide patient preventive education and oral hygiene instruction
- Take and record vital signs

Basic Intraoral Functions

- Apply topical anesthetic
- Apply topical fluoride
- Remove temporary crowns and cements
- Take impressions for study models and fabrication of appliances, including digital impressions
- Place and remove dental dam

**Board approval criteria**

For board-approval, the course must address the required content shown above and meet one of these criteria:

- Offered by a provider that is either PACE- or ADA CERP-approved
- Offered by a provider accredited by an agency recognized by the U.S. Department of Education
- A public high school or adult CTE program approved by the state department of education

(PACE or Program Approval for Continuing Education is a continuing education provider approval program operated by the Academy for General Dentistry. ADA CERP or Continuing Education Recognition Program is a continuing education provider recognition program operated by the American Dental Association.)

## Infection Control

**Description**

The dental assistant performs infection prevention and control tasks, including processing instruments and devices, preventing cross-contamination, and following OSHA protocols.

**Training Period**

After orientation, a dental assistant may work in a dental office for a training period of up to 90 days before completing infection control requirements. During the training period, the dental assistant should receive instruction and training in infection control and should be monitored by a team member who has demonstrated knowledge of infection control through licensure, registration, or assessment and who maintains infection control knowledge through continuing education.

**Pathways**

| | Training/Education | Assessment |
|---|---|---|
| Pathway 1 | **On-the-job training**<br>Receive in-office training that follows a standardized content outline or training manual *(See required training/course content outline below.)* | Standardized nationally recognized exam approved by the dental board |
| Pathway 2 | **Course or program**<br>Complete an infection control course or dental assisting program that is either approved by the state dental board or CODA accredited | End-of-course exam |

**Required training or course content**

The training or course should cover:

- CDC's Guidelines for Infection Control in Dental Health-Care Settings
- CDC's Summary of Infection Prevention Practices in Dental Settings: Basic Expectations for Safe Care
    - Transmission and prevention of infectious diseases
    - Overview of laws and guidelines applicable to oral healthcare settings
    - Personnel health elements of an infection control program
    - Preventing transmission of bloodborne pathogens
    - Hand hygiene
    - Personal protective equipment (PPE)
    - Respiratory hygiene/cough etiquette
    - Contact dermatitis and latex hypersensitivity
    - Sharps Safety and the Needlestick Prevention Act
    - Safe injection practices
    - Sterilization and disinfection of patient-care items and devices
    - Environmental infection control
    - Dental unit waterlines, biofilm and water quality
- OSHA Bloodborne Pathogens Standards
    - Exposure control
    - Methods of compliance
    - Special practices
    - Hepatitis B vaccination and post-exposure evaluation and follow-up
    - Communication of hazards to employees
    - Recordkeeping

**Board approval criteria**

For board-approval, the course must address the required content shown above and meet one of these criteria:

- Offered by a provider that is either PACE- or CERP-approved
- Offered by a provider accredited by an agency recognized by the U.S. Department of Education
- A public high school or adult CTE program approved by the state department of education

## Radiography

**Description**
The dental assistant performs dental radiography tasks, including seating and positioning the patient, positioning the x-ray equipment, and taking images.

**Pathways**
A dental assistant must meet radiography training and assessment requirements before exposing radiographs.

| | Training/Education | Assessment |
|---|---|---|
| Pathway 1 | **On-the-job training**<br>Receive in-office training from a dentist, registered dental hygienist, dental therapist, or a dental assistant who has completed the state's radiography requirements<br>*(See required training/course content outline below.)* | Standardized nationally recognized exam approved by the dental board |
| Pathway 2 | **Board-approved course**<br>Complete a course or CTE program approved by the state dental board or other state agency regulating use of x-rays | Standardized nationally recognized exam approved by the dental board |
| Pathway 3 | **CODA-accredited course or program**<br>Complete a dental radiography course or graduate from a CODA-accredited program | End-of-course exam |

**Training and course content criteria**
The training or course should cover:

Radiography Technique

- Review health and dental history for indications/contraindications for exposure to radiation
- How to seat patient based on technique
- Purpose of dental images
- Techniques to acquire dental images
- Identify anatomical variations that require a technique modification to acquire images
- Identify and correct technique errors to obtain a diagnostic image
- Identify what should appear in a diagnostic dental image
- Identify orientation landmarks in a dental image
- Identify dental materials in dental images
- Identify, understand purpose of and how to handle radiographic equipment
- Legal requirements

Radiation Protection

- Factors affecting x-ray production
- Protocols to ensure minimum radiation dose
- Monitor for x-ray unit malfunctions
- Potential negative health effects of radiation

- Operator safety
- Patient safety
- Addressing patient concerns regarding risks associated with exposure to radiation
- State regulatory requirements for radiation exposure

**Board approval criteria**
For board-approval, the course must address the required content shown above and meet one of these criteria:

- Offered by a provider that is either PACE- or CERP-approved
- Offered by a provider accredited by an agency recognized by the U.S. Department of Education
- A public high school or adult CTE program approved by the state department of education

## Level 2: Intermediate intraoral functions

**Overview**
Level 2 dental assistants perform intermediate intraoral and preventive functions.

**Supervision**
Tasks are performed under the dentist's direct and indirect supervision.

**Description**
Level 2 dental assistants perform intraoral functions of intermediate complexity that carry a higher level of risk for injury or pain for the patient than those included in Level 1. These functions are reversible intraoral functions delegated by the dentist under direct or indirect supervision. Safe and effective performance of these functions requires knowledge of oral anatomy, hand skills and mastery of specific operational techniques beyond those required for Level 1.

The purpose of delegating Level 2 functions to dental assistants is to improve efficiency of the dental office and allow dental hygienists and dentists to spend more time on procedures requiring the professional skill and judgment commensurate with their education and training.

**Delegable Tasks**

- Intermediate tasks that are reversible
- May carry an increased risk of pain or injury for the patient
- Can be delegated to a dental assistant while a dentist is on the premises but may be working in another operatory

Examples of Level 2 tasks are:

- Coronal polishing
- Place sealants
- Place and remove retraction materials
- Fabricate and place temporary crowns
- Cement temporary crowns
- Place and remove matrix band and wedge
- Remove periodontal dressings

- Place post-extraction dressings
- Remove sutures

Other tasks appropriate for Level 2 are listed in Appendix B.

**Pathways**

| | Education | Assessment |
|---|---|---|
| Pathway 1 | **Board-approved course**<br>Meet Level 1 requirements. Then, complete a course approved by the state dental board that addresses Level 2 functions | Standardized nationally recognized exam approved by the dental board |
| Pathway 2 | **CODA-accredited program**<br>Graduate from a CODA-accredited program that covers Level 2 functions | End-of-course exam |

**Required course content**
The course should cover Level 2 functions:
- Coronal polishing
- Place sealants
- Place and remove retraction materials
- Fabricate and place temporary crowns
- Cement temporary crowns
- Place and remove matrix band and wedge
- Remove periodontal dressings
- Place post-extraction dressings

**Board approval criteria**
For board-approval, the course must address the required content shown above and meet one of these criteria:
- Offered by a provider that is either PACE- or CERP-approved
- Offered by a provider accredited by an agency recognized by the U.S. Department of Education
- A public high school or adult CTE program approved by the state department of education

## Level 3: Expanded restorative functions

**Overview**
Level 3 dental assistants perform advanced intraoral restorative functions.

**Supervision**
Tasks are performed under the dentist's direct and indirect supervision.

**Description**

Level 3 dental assistants perform intraoral restorative functions of advanced complexity that carry a higher level of risk for injury or pain for the patient than those included in Level 2. These functions are reversible intraoral restorative functions delegated by the dentist under direct or indirect supervision. Safe and effective performance of these functions requires more advanced knowledge of oral anatomy, hand skills and mastery of specific operational techniques beyond those required for Level 2.

The purpose of delegating Level 3 functions to dental assistants is to improve efficiency of the dental office and allow dental hygienists and dentists to spend more time on procedures requiring the professional skill and judgment commensurate with their education and training, which helps increase the capacity of dental offices to see patients and improves access to dental care.

**Delegable Tasks**

- Expanded restorative functions that are reversible, not including cavity or crown preparation or the cutting or removal of hard or soft tissue
- May carry an increased risk of pain or injury for the patient
- Can be delegated to a dental assistant while a dentist is on the premises but may be working in another operatory

Examples of Level 3 tasks are:

- Place liners and bases
- Place, contour, finish and adjust direct restorations in a cavity prepared by the dentist or dental therapist
- Final impressions
- Place and cement prefabricated crowns (such as stainless steel crowns) on a tooth prepared by the dentist or dental therapist
- Interim therapeutic restorations
- Cementation of a permanent indirect restoration (crown) on a tooth prepared by the dentist or dental therapist

Other tasks appropriate for Level 1 are listed in Appendix B.

**Pathways**

| | Education | Assessment |
|---|---|---|
| Pathway 1 | **Board-approved Restorative EFDA program**<br>Meet Level 2 requirements and earn national accredited dental assistant certification recognized by the state board.<br><br>Then, complete a restorative EFDA program approved by the state dental board that addresses Level 3 functions | Standardized nationally recognized written and/or hands-on exam approved by the dental board |

| | Education | Assessment |
|---|---|---|
| Pathway 2 | **CODA-accredited program**<br>Graduate from a CODA-accredited program that covers Level 3 functions | Standardized nationally recognized written and/or hands-on exam approved by the dental board |

**Program criteria**
The program should cover:

- Dental anatomy and physiology
- Place, contour, finish and adjust direct restoration
- Final impressions
- Place and cement fabricated crowns
- Interim therapeutic restorations
- Cementation of permanent indirect restorations

For board-approval, the course must be offered by a provider that is accredited by an agency recognized by the U.S. Department of Education, including CODA.

## Nitrous Oxide Monitoring

**Pathway**

| Prerequisite | Education | Assessment |
|---|---|---|
| Meet Level 1 requirements<br><br>Hold BLS certification | **Course or program**<br>Complete a board-approved course or graduate from a CODA-accredited program that covers nitrous oxide monitoring | End-of-course exam |

**Required course content**
The course should cover:

- Advantages and contraindications of nitrous oxide
    - Advantages: Discuss the safety, rapid recovery, minimal side effects, and suitability for various patients.
    - Contraindications: Cover conditions such as COPD, pregnancy, psychiatric conditions, and immune disorders. Focus on pre-sedation patient screening and ensuring proper patient selection.
- Inhalation sedation equipment
    - Overview of equipment: Review nitrous oxide delivery systems, how to adjust concentrations, and ensure proper equipment function.
    - Hands-on training: Practice setting up and operating the equipment, including how to monitor oxygen levels.
- Sedation procedure and patient monitoring
    - Chemical makeup of nitrous oxide: Overview of nitrous oxide pharmacology and how it works in the body.

- Patient education: Train dental assistants on how to explain the procedure, effects, and what patients should expect before and after sedation.
- Steps of sedation:
  - Patient positioning
  - Administration of nitrous oxide/oxygen
  - Monitoring patient response and adjusting gas flow
  - Pediatric sedation considerations
  - Patient Monitoring: Focus on continuous monitoring of respiration, responsiveness, and any signs of oversedation.

- Emergencies and complications
  - Common complications:
    - Oversedation
    - Nausea and vomiting
    - Airway obstruction
    - Vertigo or disorientation
  - Emergency management: Apply BLS skills in case of respiratory depression or unconsciousness. Briefly review the recognition of these emergencies, but rely on participants' existing knowledge of CPR, airway management, and AED use.
- Post-sedation care and documentation
  - Post-sedation recovery: Emphasize how to monitor patients during recovery from nitrous oxide sedation, focusing on re-establishing full awareness and checking for any delayed reactions.
  - Patient communication: Train on discussing post-sedation instructions with patients or caregivers, including any risks of driving or returning to regular activities.
  - Documentation: Review the legal and procedural documentation for sedation events, focusing on how to record sedation dosages, patient reactions, and any interventions performed.

**Board approval criteria**
For board-approval, the course must address the required content shown above and meet one of these criteria:

- Offered by a provider that is either PACE- or CERP-approved
- Offered by a provider accredited by an agency recognized by the U.S. Department of Education
- A public high school or adult CTE program approved by the state department of education

Note: There are 13 states that allow dental assistants who have met specified requirements to administer nitrous oxide in addition to monitoring. The Workgroup's recommendations do not address administration of nitrous oxide by dental assistants and also do not recommend against allowing dental assistants who have met appropriate requirements conforming to sound public protection principles from performing this function.

## Designations for Each Dental Assisting Level

One of the factors contributing to the lack of uniformity across states affecting the dental assisting profession is the inconsistent use of designations and titles in different states. The meaning of the term "registered dental assistant" varies greatly in the states that use it; it may mean:

- An entry-level dental assistant
- An assistant who has met radiography requirements or requirements to perform other individual functions (like coronal polishing)
- An intermediate level between the entry level and the restorative expanded functions level
- The highest level of dental assistant in the state, but not authorized to perform restorative functions
- A restorative expanded functions assistant

Similarly, in some states, the term "EFDA" or "EDDA" is roughly equivalent to the intermediate level in other states, and a different designation is used for the restorative expanded functions level.

The most uniformity of titles is seen at the entry level, where 30 states simply call this level "dental assistant." However, there are still 20 states and DC that use a different term to refer to these assistants.

While it is not essential for states to use the same terms to achieve greater uniformity of scope of practice and requirements for dental assistants, the Workgroup believes that adopting more uniform designations for dental assistants at each tier will reduce confusion and support the objective of achieving an understandable roadmap for dental assistants to navigate their careers.

The Workgroup recommends these designations for dental assistants at each level described in the model:

| Level as Outlined Above | Recommended Designation |
|---|---|
| Level 1 | Dental Assistant 1 |
| Level 2 | Dental Assistant 2 |
| Level 3: Restorative EFDA | Dental Assistant 3 – Restorative EFDA |

***Rationale***

These designations

- Help demonstrate a clear progression from the first tier to the highest tier
- Are easy to understand and do not use terms that are new or unfamiliar in the dental field
- Provide flexibility for states to credential or not credential each of the levels

We recognize that in states that are already using these designations, the adoption of different meanings for these terms could cause temporary confusion during a transition period or states could continue to use these terms in a way that is out of alignment with the model. To completely avoid creating conflict with any existing state designations, it would be necessary to recommend terms that are not currently in use in any state, and doing so would introduce a different set of drawbacks, in that the terms would likely be unfamiliar, unintuitive, and not aligned with general naming conventions for allied health personnel.

While there is no perfect solution, the Workgroup has determined that recommending terms that are clear, easy to understand, and familiar will support the goal of uniformity more than inventing new, unfamiliar terms.

## Emerging Functions

How states choose to address new dental assisting functions that emerge over time, because of new technology or efforts to expand dental assisting scope of practice, is an area where the best efforts to move towards a more uniform model for the dental assisting profession may encounter challenges.

Our intention has been to describe each level using objective criteria, including the underlying principles that govern decision-making for each level, to create a framework that will allow states and employers to determine whether a function may be delegated to dental assistants meeting the requirements of one of the defined levels or whether additional new knowledge and skills are required.

New or "emerging" functions may come under discussion when new technology creates new functions or alters the skill level needed to perform existing functions – for example, digital imaging technology has changed the skill level needed for making impressions. In addition, stakeholders may propose expanding the scope of practice for dental assistants to include functions not previously performed by assistants, such as administration of local anesthetic, blood draws (phlebotomy), application of silver diamine fluoride, scaling/prophylaxis or periodontal probing.

Because one of our guiding principles has been to build on commonalities that already exist among states, we have not included in the model functions that have only recently come under discussion but have not been authorized or addressed in more than a few states. However, we believe that the model provides a framework for consideration of how to treat these functions and encourages states, as they engage in these discussions, to ask the following questions:

- What is the rationale for considering adding a new function to dental assistants' scope or recategorizing an existing function?
- Is adoption of new technology is occurring rapidly, and are employers seeking guidance around delegation?
- Will the public benefit from authorization of new functions for dental assistants, such as through increases in access to care?
- Will dental offices benefit through increasing their capacity to see patients?
- Will the addition of new functions support retention and recruitment of dental assistants?

If the function is worth additional consideration, the following questions can provide a framework for categorizing the function into an existing level or developing pathways for a separate new level or category:

- Is the function intraoral?
- Is the function reversible?
- Is the function invasive? Does it penetrate hard or soft tissue?
- Will the function result in the placement of a permanent restoration or appliance?
- What is the risk of pain or injury to the patient?

- Does the function require advanced hand skills or mastery of advanced operational techniques?
- Does any existing level have the knowledge needed, or is new knowledge required?

It may also be important to consider whether the function overlaps with any other healthcare professions' scope of practice and whether laws and regulations governing those professions address the performance of that function by those outside the profession. For example, is starting IV lines or doing blood draws prohibited for those not licensed as a nurse or phlebotomist?

If new knowledge is required, developing a set of requirements that includes education from an accredited source and/or assessment from a national organization offering accredited exams/certifications would support future uniformity as the function is adopted in additional states.

**Maintaining the Model**

The recommendations described in this document were developed in collaboration and with representation and input from key dental and dental assisting organizations. The Workgroup believes there is value in forming a more permanent coalition to continue considering questions that affect the uniformity of the dental assisting profession, including providing guidance on incorporating emerging functions into practice and regulations. When discussions of a new function reach critical mass across states, the coalition, preliminarily named the National Dental Assisting Professional Model Coalition, will develop recommendations for uniform treatment of that function by states.

**Registration**

An important question that states must consider when determining how best to regulate dental assistants is whether to require registration for some or all levels of assistant.

"Registration" is a broad term signifying varying levels of rigor and continued oversight over a profession, depending on the state. For our purposes, "registration" encompasses any issuance of a state credential to a dental assistant who has met competence requirements set forth by the state.

The Workgroup notes that there are many practical benefits to requiring registration for dental assistants at all levels, including these:

- Accurate and up-to-date rosters of employed dental assistants in every state will greatly assist the dental community in monitoring trends in dental assisting employment and measuring the success of steps taken to mitigate the shortage.
- Information collected through registration will allow for additional research into factors influencing successful recruitment and retention that could provide valuable insights to those seeking solutions to the workforce shortage.

For these reasons alone, we encourage policymakers in state to require registration for all dental assistants.

Registering dental assistants will also bring these public protection benefits:

- Regulators report that in states where dental assistants are not registered, a dental hygienist whose license is revoked for disciplinary reasons may legally work in a dental setting as a dental assistant, which may pose a risk to patient health and safety; giving the state board of dentistry regulatory authority over dental assistants will eliminate this problem.

- Registration allows the state to revoke an authorization to work in cases where dental assistants have demonstrated that they are a danger to patients.

- Registration removes the burden from employers to verify that dental assistants have met requirements.

- Registration enables the state to require and verify that dental assistants complete continuing education requirements, which fosters a more competent workforce and supports delivery of high-quality patient care.

- Registered or licensed dental assistants may be required to complete education required of other health professionals, such as child abuse recognition and reporting, identifying victims of human trafficking, cultural competency, and similar topics that benefit the public; these requirements support public safety and the provision of a higher level of care to patients.

- Registration facilitates the process of verifying credentials when a dental assistant moves to a new state.

Despite these considerable benefits, the Workgroup recognizes that it may be unfeasible in some states, for administrative or political reasons, to adopt a model calling for registration of all dental assistants. With this in mind, we have sought to propose a model founded on objective criteria that are straightforward for an employer to verify, so that, if registration cannot be implemented in a state, the state can nonetheless participate in the benefits brought about by adopting uniform descriptions, scopes of practice, and requirements for each level of dental assistant.

We also make note of the strong trend among states to require registration for the restorative EFDA level (Level 3 in the model). Of the 25 states that expressly allow some level of dental assistant to perform expanded restorative functions, 21 require registration or licensure for that level. Functions performed at this level hold the highest risk of injury or harm to the patient, and registration of this level aligns with each state's public protection interests. We therefore recommend registration for the restorative EFDA level.

**Continuing Education**

We encourage states to require continuing education (CE) for dental assistants. For Level 1, at a minimum, CE in infection prevention and control should be required. For Level 2 and Level 3, we

encourage states to adopt similar CE requirements to include, at a minimum, infection control and patient safety CE.

While CE requirements in the 24 states that require CE for dental assistants vary from one hour/unit per year to 15 hours/units per year, we encourage states to adopt requirements for Level 2 and Level 3 that are no less than the average number of units across all the states that have a CE requirement for dental assistants – approximately 8 hours/units per year. We also note that 12 hours/units per year is the most common quantity of CE units required, and this higher number may be a more appropriate requirement for Level 3.

As long as CE requirements are within reasonable ranges, we don't believe a state that has adopted the model should view moderate differences in approaches to CE as a reason for not recognizing the status of a dental assistant from another state that has also adopted the model.

**Jurisprudence Education or Exam**
The Workgroup supports verification of dental assistants' knowledge of state laws, rules, and regulation through a required course or examination. However, for the foreseeable future, we expect the content of such courses or exams to continue to be state-specific, and for any jurisprudence requirements to be determined and administered at the state level.

## Guidance for Implementation

**Approaches to transition**
As states consider adopting the recommended model, we expect stakeholders to express concerns about how the new framework will affect dental assistants who have already been employed and working before the introduction of the new model.

To facilitate the transition to a new model, we recommend establishing an alternative pathway for dental assistants who are already working to qualify for the appropriate equivalent level in the new model.

Each state may handle the transition differently, because the current variations in state regulation of dental assistant do not allow for a uniform solution to transition these dental assistants.

Broadly speaking, a state's options for transitioning existing participants in the workforce to equivalent levels in the new model consist of:

- Allow dental assistants who were working prior to adoption of the model to continue performing those duties they have already been performing; provide a grace period for them to meet requirements outlined in the model for qualifying to perform new functions.

- Require dental assistants who were working prior to adoption of the model to meet all requirements under the new model within a reasonably generous timeframe.

- Require dental assistants who were working prior to adoption of the model to meet modified requirements that take into account their existing level of knowledge gained through prior training, education and experience; an example of a modified requirement is

allowing work experience and a dentist's attestation of competence to substitute for all or part of an education or exam requirement.

In some states, it might be appropriate to deploy some combination of the above approaches, if prior requirements create different considerations for different levels.

**Resources and Support**

Certain aspects of the Workgroup's recommendations will require resources and support materials that may not be currently available. In some cases, existing materials, such as training manuals, course curricula, and exams, may need to be adapted to bring them into alignment with the recommended model. In other cases, new materials may need to be developed to support successful implementation. Identifying and evaluating existing resources and developing plans for the creation of new resources has been outside the scope of the Workgroup's current 12-month endeavor. It has been the Workgroup's intention to provide enough detail to allow relevant organizations and providers of services to begin to identify what work will be needed to help advance and support the model.

We call upon all stakeholders in dentistry to support and participate in the development of the tools that states, employers, and dental assistants will need to ensure that adoption of the model by a state will bring about real changes that support a high quality of care and provide the foundation for attractive career prospects for potential dental assistants, enhanced recruitment and retention, and improvements in dental offices' capacity to serve patients.

## Model Statutory and Regulatory Language

A future version of this document will include model legal language for statutes (laws) and rules/regulations for state policymakers and regulators who wish to implement the model in their states to use as a template.

## Phase 2: Orthodontic and Anesthesia Functions

The foregoing model is the product of 12 months' intensive analysis and deliberation by the Workgroup. Most of our discussion centered around tasks that dental assistants perform in a general dentistry setting. As we deliberated, we understood that there are several subsets of dental assisting tasks that require deeper analysis and engagement with the dentist specialists in whose practices those dental assisting functions are performed, and that the close consideration required would be outside the scope of what the Workgroup would be able to address in its proposed 12-month timeframe. Specifically, orthodontic functions and anesthesia functions are two critical areas that warrant detailed attention.

*Orthodontic Functions*

In some states, orthodontic duties are included in a dental assistant's scope of practice along with general dental assisting functions and specialty functions. In four states, the state has carved out a separate specialty designation for orthodontic assistants, with accompanying specialized scope and requirements. While there is much overlap among the orthodontic functions addressed across states, as with general duties, no two states have the same scope of practice with respect to

orthodontic dental assisting and no two states have the same requirements for assistants who perform orthodontic expanded functions. However, identifying a common orthodontic assisting scope of practice and set of requirements will bring these benefits:

- Protect the public in orthodontic settings, where there is a significant trend toward delegating intraoral functions to dental assistants
- Establish a clear way for dental assistants to train and qualify to perform orthodontic expanded functions
- Identify and define an attractive option for dental assistants to pursue career advancement

*Anesthesia Functions*

Administration of anesthesia is the dental office procedure that carries the greatest risk for immediate adverse outcomes. Many states have adopted or amended rules addressing requirements for dentists to administer anesthesia in their offices to conform with the 2016 *ADA Guidelines for the Use of Sedation and General Anesthesia by Dentists* in the last eight years, and these requirements frequently also address the role of auxiliaries in assisting in anesthesia procedures. There are currently seven states that have defined requirements for a "dental anesthesia assistant," an "oral maxillofacial surgery assistant" or similarly titled role. Unsurprisingly, there are variations in the scope of practice and requirements for these anesthesia assistants across states.

Establishing recommendations for a uniform scope of practice and requirements for anesthesia assistants will help states regulate this critical area with more certainty that they are following best practices and providing the safest patient care.

In a second phase to this project, DANB intends to convene two smaller sets of stakeholders and subject matter experts to collaborate on developing recommendations for uniform regulation of orthodontic assistants and anesthesia assistants, following the same guiding principles centered on protecting the public, building on existing commonalities among states, providing and clearly defining a career roadmap for dental assistants, and supporting feasible implementation.

## Appendix A: Dental Assisting Professional Model Workgroup Members

| Workgroup Member (State) | Affiliation | Nominating Organization |
|---|---|---|
| Dolores A. Cottrell, DDS, MSHA (NY) – Workgroup Co-Chair | Executive Secretary, New York State Board for Dentistry | Invited participant |
| Helen Sublette, BS, CDA, COA, CDIPC, FADAA (NC) – Workgroup Co-Chair | Owner, Coastal Dental Professionals Consulting | American Dental Assistants Association |
| Bridgett Anderson, LDA, MBA (MN) | Executive Director, Minnesota Board of Dentistry | American Association of Dental Administrators |
| Christian Avelar, CDA, RDA (NJ) | Dental Assistant, Mountain Lakes Premier Dental | Hispanic Dental Association |
| Bobby Carmen, DDS, MAGD (OK) | Owner, Bobby J Carmen DDS; President, Oklahoma Board of Dentistry | American Association of Dental Boards |
| Tracy Cramer (OR) | State Representative (District-22), Oregon House of Representatives | Invited participant |
| Megen Elliott, MS, CDA, RDH (WI) | Dental Assistant Program Director, Northwood Technical College | American Dental Hygienists' Association |
| Rebecca Erwin, CDA, RDH (WV) | Dental Assisting Instructor, Putnam Career & Technical Center | Invited participant |
| Nabil Fehmi, DDS (AZ) | Founder and Chief Clinical Officer, Westwind Integrated Health | Association of Dental Support Organizations |
| David Fried, DMD (CT) | Co-Chair, Council on Government Affairs and Past President, Connecticut State Dental Association; Faculty, General Dentistry, University of Connecticut | ADA Council on Dental Practice |
| Sandra Garcia-Young, CDA, CDIPC, RDA, FADAA, FAADOM (TX) | Practice Administrator, CentroMed; Trustee, The DALE Foundation | DALE Foundation |
| Margaret Gingrich, DDS (MI) | Owner and General Dentist, Gingrich Dental PC | ADA Council on Dental Practice |
| Sarah Holland, MS (VA) – Public Representative | Founding CEO, Virginia Health Catalyst; Co-Founder, American Network of Oral Health Coalitions | Invited participant |
| Kay Jukes, BS, CDA, RDA (TX) | Dental Assisting Program Director, Houston Community College | American Dental Education Association |
| Lenny Mayorga, DDS (CA) | Pediatric Dentist, AltaMed Health Services | Hispanic Dental Association |

| Workgroup Member (State) | Affiliation | Nominating Organization |
|---|---|---|
| Julie Muhle, M.Ed., BOE, CDA, CRFDA (NV) | Academic Program Director for Dental Assisting, Truckee Meadows Community College | Invited participant |
| Jamie Sacksteder, (VA) | Executive Director, Virginia Board of Dentistry | American Association of Dental Administrators |
| Enrique Sanchez-Castillo, CDA, EFDA (IN) | Expanded Function Dental Assistant, Meridian Health Services | Invited participant |
| Leah Schulz, DDS (CO) | Director of Dental Projects, Salud Family Health; President, Colorado Dental Association | National Network for Oral Health Access |
| Janée Tamayo, CDA, CPFDA (NC) | Dental Flight Chief, U.S. Air Force; Chair, Dental Assisting National Board | Dental Assisting National Board |

Kerri Friel, CDA, COA, RDH, MA (RI), a professor in the Dental Health Department at the Community College of Rhode Island, participated in select Workgroup meetings as part of her role on a dental assistant workforce coalition.

## Appendix B: Supplemental List of Functions

Dental assistants perform an extraordinary number of functions and tasks, and it would not be possible to consider and address all of them in these recommendations. The functions presented above in each level are representative of that level and are also the most commonly addressed in state dental practice acts and regulations. To supplement these selected functions and provide additional guidance, the Workgroup makes the following recommendations for levels of delegation of functions that are not addressed above:

**Level 1:**

1. Transfer dental instruments
2. Record dental screenings
3. Record charting of the oral cavity and surrounding structures
4. Chart existing restorations or conditions
5. Recognize basic dental emergencies
6. Instructing in the use and care of dental appliances
7. Remove debris created in the course of treatment
8. Application of disclosing solutions
9. Recording patient treatment
10. Perform mouth mirror inspection of the oral cavity
11. Assist with basic restorative procedures, including prosthodontics and restorative dentistry
12. Recognize basic medical emergencies
13. Providing nutritional counseling for oral health and maintenance
14. Perform intra/extraoral photography
15. Apply hot/cold packs
16. Provide pre- and post-operative instructions
17. Monitor vital signs
18. Clean and polish removable appliances and prostheses
19. Assist with basic intraoral surgical procedures, including extractions, periodontics, endodontics, and implants
20. Respond to basic medical emergencies
21. Instruct patients on bleaching procedures
22. Review medical/dental history
23. Complete laboratory authorization forms for provider review/approval
24. Respond to basic dental emergencies
25. Prepare a patient for nitrous oxide analgesia administration
26. Use light curing device
27. Pour and trim diagnostic casts for evaluation by the provider

**Level 2:**

1. Monitor and respond to post-surgical bleeding
2. Polish assigned teeth with a slow-speed rotary handpiece immediately before an acid etch procedure
3. Remove excess temporary cement from supragingival surfaces of a tooth with hand instruments only
4. Cleanse/polish teeth in preparation for a procedure
5. Place periodontal dressings

**Level 3:**

1. Place temporary fillings
2. Remove temporary fillings
3. Before cementation by the dentist, adjusting and polishing contacts and occlusion of indirect restorations
4. Etch, wash and dry dentin
5. Extraorally adjust dentures

Virginia Department of
# Health Professions
## Board of Dentistry

**FY 2025 Budget- Cash Balance February 28,2025**

| | |
|---|---|
| **Cash Balance as of June 30, 2024** | 3,487,273 |
| **YTD FY 2025 Revenue** | 1,983,477 |
| **Less: YTD FY 2025 Direct & Allocated Expenditures** | 2,339,349 |
| **Cash Balance as of February 28, 2025** | **$3,131,401** |