# Virginia Department of Health
# Oral Health Plan

A Report to the General Assembly

October 2012

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## Executive Summary

At the direction of Item 296 (F) in Chapter 3 of the Acts of the Assembly 2012 Special Session I, the Virginia Department of Health (VDH), in collaboration with the Department of Medical Assistance Services, convened an advisory committee to assist in developing a comprehensive oral health plan focused on evaluating the "sustainability and efficiency of the current state-supported dental clinics operated by the department" as well as "the feasibility of transitioning the department's current dental prevention/treatment model to a prevention-only model."

The advisory committee met three times face-to-face, reviewing information on current VDH district and centrally-administered dental programs, including budgetary information, utilization of services at VDH dental clinics, and general demographics of patients seen within each service location. Available resources in each community, including the distribution of other safety net providers throughout the Commonwealth, were also considered.

Following a thorough review of this information, the advisory committee concluded that while the historical model of service delivery does not support the sustainability of VDH dental clinics without ongoing General Fund support, eliminating comprehensive dental services in all locations would pose a significant hardship to the health of patients in some communities. The advisory committee suggested that a *"targeted regional approach"* in which the individual needs and resources of each community were evaluated prior to making final program change decisions was necessary. Specifically, the committee made the following recommendations:

1. ***Adopt a targeted regional approach, individually evaluating the impact of closing dental clinics in each area, with consideration of the available resources to meet patient and community needs and the need to provide for transitional services in certain areas.***
2. ***Evaluate and identify whether there are some areas of the state that are unlikely to be able to develop and sustain safety net dental services without external support.***
3. ***Where appropriate and feasible, using a targeted regional approach, transition identified VDH public health dental clinics from a model of treatment and prevention to a prevention model.***
4. ***Identify and develop metrics for the ongoing surveillance of oral health to assess the impact of shifting to a preventive health model.***
5. ***Develop a communications plan.***
6. ***Maintain ongoing stakeholder input into the transition to a prevention model.***

## Purpose of Report

Item 296 (F) in Chapter 3 of the Acts of the Assembly 2012 Special Session I directed the State Health Commissioner, in consultation with the Department of Medical Assistance Services (DMAS), to appoint an advisory committee to develop a comprehensive oral health plan (Appendix A). This advisory committee was charged with evaluating the "sustainability and efficiency of the current state-supported dental clinics operated by the department." In addition, the advisory committee was tasked with evaluating "the feasibility of transitioning the department's current dental prevention/treatment model to a prevention-only model." Additionally, Item 295 (E) in Chapter 3 of the Acts of the Assembly 2012 Special Session I states that "It is the intent of the General Assembly that the State Health Commissioner continue providing services through the child development clinics and access to children's dental services."

Financing for the Virginia Department of Health (VDH) Local Dental Services (44002) was reduced as part of Governor McDonnell's proposed budget for the 2013-1014 biennium. This budget originally included closing state supported dental clinics and expanding a pilot project involving practice protocol changes for VDH dental hygienists. This would have cut a total of $1,664,306 (GF: $967,944/NGF: $696,362) out of a total budget of $7,036,703 and 20 FTEs effective July 1, 2012. The final budget restored funding for FY 13 and implemented the reduction for FY 14 in order to provide time to develop a transition plan.

Pursuant to legislation, VDH convened an advisory committee in the summer of 2012 to address this mandate. As required by the budget language, representatives from VDH, DMAS, Virginia Dental Association, Virginia Dental Hygienists Association, Virginia Oral Health Coalition, Virginia Health Care Foundation, Virginia Association of Free Clinics, and the Virginia Community Healthcare Association convened to discuss the items listed in Item 296(F). In addition to the groups mandated in the budget language, VDH also extended invitations to Virginia Commonwealth University School of Dentistry, Virginia Department for Aging and Rehabilitative Services, Virginia Sexual and Domestic Violence Action Alliance, Virginia Early Childhood Foundation and United Way of Greater Richmond and Petersburg (Appendix C) to assure representation of other stakeholders and broad population representation of those most likely to be impacted by the potential transition. The advisory committee met in July and twice in August of 2012. During those meetings, the group was presented with the charge, provided with information pertinent to dental services, and given opportunity to provide input and recommendations.

This group received information on the potential impact on dental services as a result of the Patient Protection and Affordable Care Act (PPACA), dental program models operated in other states, information on the current VDH local health district dental services model, and budgetary

information, in addition to the pilot project for remote supervision of dental hygienists, which included education and dental sealant preventive services in three local health districts. Following the first meeting, the advisory committee provided information to VDH regarding services and manpower available for dental services in other safety net systems including the free health clinics, federally qualified community health centers (FQHC), and special dental projects funded through the Virginia Health Care Foundation. In addition, the advisory committee requested additional data from VDH to better inform the discussion. Statewide and district level data were provided regarding locations of services; patient demographics; type of services provided; staffing models; payor source; and revenues and expenditures. In addition, other indicators related to the capacity of the dental health system were shared including free clinic service manpower, federally qualified health center manpower, Medicaid/FAMIS provider manpower, and various measures as proxy for poverty. The advisory committee discussed the implications of transitioning VDH dental services; the capacity of other safety net providers to absorb diagnostic and treatment services discontinued by VDH; the need to identify areas of the state posing the greatest challenges in terms of adequate access; budgetary constraints; and outlined next steps which would be recommended prior to transition of services to a prevention model. This report outlines these recommendations. It also provides an overview of the current VDH dental service program, as well as a vision for a prevention model and details the steps needed to make this type of transition with minimal negative impact to those who would no longer be served. The prevention model, as demonstrated through the remote supervision dental hygienist pilot in three health districts which is discussed in this report, has the potential to reach a large number of children at reduced costs with lasting impacts on prevention of dental caries and expensive treatments. However, it does not address the preventive needs of adults.

## Background

The clinical dental health program in the Commonwealth of Virginia originated in 1921. At that time, 76 counties participated in a survey by the Virginia Department of Health (VDH) that identified a significant need for a dental health safety net to provide services directly to the public. Historically, as many as 75 to 100 public health dentists have been employed at any one time in local Health Districts to meet the needs of the medically indigent. Over time, a more diverse safety net for dental care has evolved in Virginia and the number of VDH dental clinics has declined. Twenty-seven dentists, 41 assistants, and three hygienists are currently employed by the Health Districts under the management of the local Health Director and the Deputy Commissioner for Community Health Services (CHS). These are the local CHS dental clinics operated by VDH addressed specifically in the language of Item 296 of the 2012 Appropriation Act.

VDH dental clinics are operated as optional (“non-mandated”) programs in communities, with significant local autonomy regarding program structure, services provided and staffing. Local

Districts choose to provide dental services if the population needs require it for assurance of care in the community and they are financially able to support the program. These direct clinical services are not mandated or required by law. Consequently, as a result of many factors, including fiscal challenges to fund mandated services, improvements and expansion of the Medicaid/FAMIS program, and establishment of other safety net provider entities such as Free Clinics and FQHCs, localities have discontinued many local VDH dental programs over the years. As of July 1, 2012, there were 27 full and part time dentist positions in 17 of the 35 Health Districts. These are funded primarily through state General Fund dollars that are matched by local dollars according to an established sharing formula, earned revenue, and State and Federal grants. In some Districts, significant additional local funds are provided as a choice and provide most of the program support.

In aggregate, VDH clinics in FY 11 provided services to approximately 20,000 individuals during 35,000 visits (see Appendix D). Eighty percent of visits were for children ages 0-18. The average dentist provided 1,189 visits in FY 11. The typical "mix of services" over the years mirrors that of private practices focused on children: "diagnostic and preventive" services (75%), "treatment services" (16%), and "other" (9%). Clinics are usually staffed by a single dentist with 1.5 auxiliaries on average, primarily dental assistants, in support. Only three dental hygienist positions are supported by local Districts. However, over the past three years, VDH has supplemented the community dental efforts in select Districts, by deploying Health Resources and Services Administration Workforce Grant funded hygienists to provide community and school based prevention programs. These grant funded positions have been critical in developing alternative or supplemental models for delivering preventive dental services in communities and have established a precedent for alternative VDH dental health efforts.

Of roughly $5.4 million that is allocated for VDH dental services in the FY14 budget, approximately $1.7 million is money from the General Fund that VDH can use for dental services. The remainder includes 100% local funds targeted for specific dental programs ($1.6 million), local matching funds (~$805,000), revenues from dental services (~$970,000), and grant funds that are targeted for a specific purpose and location (~$240,000). Of the $5.4 million, approximately $970,000 is estimated for earned revenue and this amount would decrease to about $97,000 if the model shifted services from treatment to prevention. The specific fund detail is provided in Appendix E.

The location of the current remaining clinics is a result of many factors, including the financial resources of the community, and has not necessarily been based on a strategic plan for the state as a whole. As a result, some localities with VDH dental clinics have more community dental resources than others to support the indigent population. They are, as a result, less dependent on the presence of VDH clinics providing comprehensive services that require a licensed dentist. In developing proposals to modify the VDH program, many community factors were evaluated to

simultaneously assess the potential risk to the assurance of care for the indigent populations in specific Districts and to identify the preferred strategic location of new preventive programs. Factors impacting the local capacity for provision of dental care, in the absence of a VDH clinic, include the presence of adequately staffed safety net clinics, including Free Clinics, FQHCs, and sufficient private Medicaid/FAMIS providers accepting new patients. The most recent manpower report, using data from 2009, was also used to determine if a District had an acceptable private practice dentist to population ratio, or needed a bigger workforce for the community at large according to the applied metric. The absolute impact of VDH clinics in communities was also assessed by quantifying the VDH clinic output in terms of patient visits. In addition, the advisory group reviewed the volume of low income patients treated, the number who qualified for free or reduced fee services and are uninsured, as well as those covered by Medicaid/FAMIS insurance. The understanding was that approximately 40% of current VDH clinic patients (those who qualify for free care) are expected to have the greatest challenges in accessing future care in the absence of VDH facilities. In some geographic areas, Medicaid/FAMIS recipients are expected to have difficulty finding providers as well in such a scenario.

In addition to the services provided in public health dental clinics, many communities also have access to dental services through other safety net providers, which include FQHCs, Free Clinics, private Medicaid/FAMIS providers, and additional non-profit organizations that support dental services for low income persons. In 2011, 18 FQHC organizations offered dental services at 34 delivery sites to 43,096 patients for a total of 85,756 patient visits. Dental services consist of preventive and restorative procedures as well as extractions. Community health centers employ the FTE equivalent of 29 dentists, 12 dental hygienists and 51 dental assistants and aides as well as utilizing numerous volunteers. Similarly, there are 28 Free Clinics that offered dental services in 2011 primarily to adults. They were staffed by 968 volunteer dental providers who provided 39,710 visits to 16,959 uninsured patients. In addition, there are 1,693 Medicaid/FAMIS dental providers throughout the Commonwealth. The Medicaid/FAMIS dental program provides comprehensive dental care to children under 21, including preventive, restorative, and orthodontia care. Dental coverage is not provided for adults with Medicaid coverage, with the exception of emergency extractions. A delineation of these dentists working in health districts with dental programs is noted in Appendix D.

## Sustainability

The current challenge to VDH dental clinic programs is fiscal sustainability without continuing significant state or local resources. Funding for the District dental programs includes state General Fund allocations, required locality matching funds, 100% local funds, earned revenue (primarily Medicaid/FAMIS), limited federal funding (Maternal and Child Health Federal Block Grant) and local grants. In FY12, approximately $5.9 million dollars was expended by VDH for District dental services; local District dental programs collected revenues of $1.6 million. One

goal of the convened stakeholder meetings was to assist VDH in determining if there are program modifications that can be implemented to allow the programs to be sustainable in the absence of General Fund support. Best practices were identified and discussed but the unique constraints on public health clinical programs generally negated their value as potential remedies to the current model's weaknesses. The primary challenges to managing costs and revenues in VDH clinics are the inherent conflicts between best business practices and a state agency's service mission to the community. As a safety net provider of dental care, VDH is obligated to accept patients regardless of ability to pay or insurance status. This results in the average State clinic in FY12 providing 40% of care to patients that do not compensate VDH in any way, and 11% of care to patients that pay a sliding income scale discounted fee based on the existing Medicaid/FAMIS fee schedule. This fee schedule is very much below current market based fees and yields charges to patients that are almost inconsequential to reimbursing the cost of delivering the service. The remaining 49% of patients are children with Medicaid/FAMIS insurance that were, for some reason, not able to access care in the private sector. As it is not the intent or will of VDH to compete with other community providers, no effort is made to maximize the proportion of Medicaid/FAMIS insured children versus uncompensated care patients in District dental clinics.

Additionally, VDH infrastructure and manpower needs have not generally been able to keep up with evolving models of service care delivery. Many clinic facilities as equipped and configured are very challenged to optimize efficiency. The more contemporary model of professional health service delivery, that utilizes multiple auxiliaries in support of the dentist, is rarely available in VDH dental clinic settings. Also, public health dentists rarely function solely as direct service providers. As state employees, dentists and their staff are obligated to a significant amount of policy training, emergency preparedness involvement, and very often, management responsibilities in local Districts. Public health dentists are considered dental resources in the community for education, screenings and population based dental initiatives such as school fluoride mouth rinse programs. Some Districts with a single dentist provide services in multiple distant locations that require significant travel time each day. All of these factors impact dentists' clinical productivity and revenue generation potential.

Finally, the existing human resource management structure of state agencies creates challenges that impact the ability of VDH dental clinics to be operated in a manner that would improve the productivity component of a healthy fiscal bottom line. As with all public health employees, dental staff is generally motivated by the "mission" to serve. However, there are always practical considerations in any employment situation. State compensation policies limit the ability of VDH to attract and pay performance bonuses to individuals that would assist in achieving fiscal sustainability in an environment with facility and patient base constraints. Potential young new

hires are often burdened with extremely large education debt (on average $203,000[1]), and although they may be willing to practice in a community setting, the low salaries, absence of production incentives, and the need to pay personally for professional licensing and continuing education, render VDH positions uncompetitive with other employers. In some areas of the state the resulting recruitment and retention challenges are another impediment to sustainable dental operations and program continuity.

The conclusion, after much discussion, of the advisory committee, with the VDH Deputy Commissioner for Community Health Services informing the decision as well, is that VDH dental clinics providing comprehensive care are not designed to be financially self sustaining under the historical model of service delivery. The modifications necessary to address the challenges to sustainable operations would not be practical at this time and in this environment.

## Feasibility of Transitioning to a Prevention Model

In recent years, there has been a trend for public health oral health programs in other states to refocus efforts away from individual care that treats dental disease, to the more cost effective population based models with an emphasis on both oral disease prevention and oral health promotion. Effective preventive oral health models target high risk populations, provide evidence-based preventive clinical services, and encourage good oral health habits through oral health education. Additionally, these programs provide referrals for patients with treatment needs and encourage establishment of a dental home. School-based or school-linked programs have had great success in reaching children and help to make preventive services accessible to all. The Centers for Disease Control and Prevention Task Force on Community Preventive Services found strong evidence that school-based and school-linked sealant programs are effective in reducing tooth decay, with a median decrease in tooth decay of 60%.[2] Preventive services include the application of dental sealants and fluoride varnish; both are deemed effective in reducing the incidence of dental decay. This effective public health approach compliments comprehensive care programs by promoting the oral health of children. However, preventive health programs will not eliminate the need for comprehensive dental services.

The advisory committee acknowledged that, given the limited resources currently available, implementation of a prevention model is appropriate for certain areas. It was proposed that VDH adopt a "*targeted regional approach*" in which communities that currently require comprehensive VDH dental services be identified and distinguished from those communities that could be adequately served with prevention programs. The committee also recognized that some

[1] American Dental Education Association. Available at http://www.adea.org/publications/tde/Pages/Students.aspx
[2] Centers for Disease Control and Prevention. Promoting Oral Health: Interventions for Preventing Dental Caries, Oral and Pharyngeal Cancers, and Sports-Related Craniofacial Injuries—A Report on Recommendations of the Task Force on Community Preventive Services. MMWR Recomm Rep 2001; 50(RR-21):1-13.

communities may have adequate resources without VDH programs. They cautioned that elimination of comprehensive services should not occur in communities where there is significant need for restorative treatment and an absence of private practice and community safety net dental providers to meet these needs. In these cases, a comprehensive care model with a preventive component was advised. Where school based prevention programs are considered to be appropriate, discussion cited the need to determine program eligibility by use of National School Lunch Program (NSLP) participation rates. It was suggested that programs target primarily elementary schools with at least 50% NSLP participation, which is a commonly used indicator of low-income students. During the 2011-2012 school year, a total of 523 elementary schools met this criteria, which represents 45% of the public elementary schools in Virginia.

The stakeholder group described the key elements of a preventive health program to include the following 1) dental health education (for children and parents); 2) community awareness and education (about good oral hygiene and dental care); 3) education for health care providers including referral information; 4) comprehensive dental assessments; 5) sealants; 6) fluoride; 7) referrals; and 8) community-wide assessment of resources available within each community to meet the dental/oral health needs of the population, as well as support for providers.

Critical elements of a prevention model also include the provision of a comprehensive assessment and the existence of an active referral network (meaning providers who are taking new patients, specialists if necessary, and dental practices available to become dental homes for patients referred to them).

As with all public health initiatives, education was identified as an integral component of a preventive oral health program. Oral health education for children, as well as parents, was seen as a priority. Education for the community as a whole, including partners such as parent teacher associations, local head start programs, daycare programs, and community services boards, was also encouraged as was education for primary care providers to ensure education and care coordination between disciplines. Educational topics included the importance of good oral health as it relates to overall wellness, the importance and proper use of fluoride, diet and proper nutrition, benefits of preventive services including sealants and fluoride varnish, oral hygiene practices and habits that will lead to oral health throughout the lifespan, and the importance of the establishment of a dental home for routine care.

The advisory committee expressed the need for appropriate facilities and equipment for provision of services and proper risk assessment, clinical patient assessment, and triage of care to providers accepting new referrals. In-depth training on patient assessment, proper application of preventive products, and community engagement for providers was also cited as essential for success of a preventive model. Quality assurance measures including routine review of clinical procedures and adherence to program guidelines, and retention checks to determine the success rate of dental sealants, as well as frequent needs assessment of the communities to gauge the

reach of preventive programs were advised. Establishment of referral procedures and coordination of care with community providers was also a priority.

Public health programs that support the placement of dental sealants are quite successful and, in many states, dental hygienists are the primary providers in school-based sealant programs. A dental hygienist is widely accepted as equally skilled in applying dental sealants as a dentist. A 10-year retrospective study comparing the longevity of sealants placed by dentists, dental hygienists, and dental assistants found that all classifications of dental operators are effective in applying sealants.[3]

## VDH Hygienist Pilot Program

Since 2008, VDH has operated preventive programs utilizing dental hygienists to conduct school-based dental sealant programs and provide fluoride varnish for children. In an effort to achieve a Healthy People 2010 oral health objective to increase the proportion of children aged 6 to 9 years with dental sealants, Virginia began exploring alternative practice protocols to increase access to dental preventive services. In 2009, legislation enacted by the General Assembly established a pilot program in three targeted dental Health Professional Shortage Area (dHPSA) districts allowing an alternate model of service delivery. The protocol, deemed "*remote supervision,"* was designed as a less restrictive oversight requirement for VDH dental hygienists in three health districts. Based on the legislation, in July of 2009, VDH established and convened a committee with representation from the VDH Dental Health Program, the VDH district health directors and Community Health Services, the Virginia Dental Hygienists Association, the Virginia Dental Association, and the Virginia Board of Dentistry to develop the operational practice protocol for the hygienists. The protocol allowed the dental hygienists to perform an assessment and to develop a treatment plan for preventive services without an exam by a dentist and to provide preventive dental services within their scope of practice without the dentist's general or direct supervision. The protocol dictated supervision by a public health dentist through regular and periodic communications with the dental hygienist, as well as quality assurance measures to ensure quality care.

During the 2010-2011 school year, 64 of the 75 (85%) targeted public elementary and middle schools in the Cumberland Plateau, Lenowisco, and Southside Health Districts participated in the school-based sealant program. The program specifically targeted children enrolled in the National School Lunch Program. Remote supervision dental hygienists used either portable dental equipment inside the school for sealant placement and varnish application, or a mobile dental van that was set up on-site. Of the children screened, 59% received dental sealants on their permanent molar teeth; 3,186 molars were sealed for an average of 3.6 sealants per child. With a general supervision model of the sealant program operating at the same time as the "remote

[3] Folke BD, Walton JL, Feigal RJ. Occlusal Sealants Success Over Ten Years in a Private Practice: Comparing longevity of sealants placed by dentists, hygienists and assistants. Pediatr Dent. 2004: 26: 426-432.

supervision" model, cost comparisons could be done. The cost calculated per child to apply 3.6 sealants was 25% more under the general supervision model than under remote supervision ($86.76 vs. $69.35). On average, the cost per sealant was $24.10 under general supervision and $19.26 under remote supervision. According to the American Dental Association Fee Schedule for the South Atlantic Region, the average charge in private dental offices is $46.00 for a dental sealant.

Program protocol requires that all VDH dental sealant programs monitor sealant quality and effectiveness through retention checks of sealants. During the pilot project, sealants on third and seventh grade students previously placed in second and sixth grades were evaluated. The retention rate per provider was very high, ranging from 92.5% to 100% for the children who received sealants in 2009-2011.These rates are well within acceptable averages nationally. Any teeth not retaining sealants were re-sealed and new sealants were placed on teeth previously unable to be sealed because they were unerupted or only partially erupted.

In addition to the sealant programs provided under the pilot remote supervision protocol, preventive services were provided under existing practice protocols in the target health districts. These include the fluoride varnish program in Special Supplemental Nutrition Program for Women, Infants and Children (WIC) clinics; dental education programs; and a referral program. Between 2009 and 2011, screenings and fluoride varnish application were provided for over 1,700 infants and young children. The dental hygienists also provided dental health education to 13,105 individuals in settings such as public schools and Head Start centers, as well as professional trainings for health providers.

Referrals and coordination of care are important components of prevention programs. The hygienist model depends on the availability of community dentists to accept referrals from the program and to provide needed routine and restorative care, ultimately establishing a dental home for program participants. Establishing a good working relationship with community dentists is essential for program success. Each year, local dentists are contacted and informed of the sealant program and invited to be included in a referral list that is provided to all parents encouraging follow-up care in community dental practices. Referrals to private and safety-net practices are made and care coordination and follow-up through home visiting programs or program dental staff for families that includes assistance with obtaining a dental home, making and keeping dental appointments, and oral health education, is provided. During the 2009-2010 and 2010-2011 school years, dental hygienists referred 48% of sealant program children to a dentist for evaluation or treatment for fillings, root canals, and/or extractions. An additional 1,263 WIC participant children were referred to a dentist to establish a dental home.

Annual progress reports regarding this alternative practice protocol were submitted to the Governor and the General Assembly. The positive outcomes of this pilot workforce model combined with the support of the Virginia Oral Health Coalition, the Virginia Dental

Association, and the Virginia Dental Hygiene Association, resulted in a statutory change for the supervision of dental hygienists. Senate Bill 146 became law effective July 1, 2012 permitting "remote supervision" for all dental hygienists employed by VDH.

### Community Engagement

Public Health Hygienists are uniquely qualified to engage the community in dental initiatives. With the support of local health districts, school boards, school staff and local parent teacher associations, hygienists are able to promote programs through participation in school board meetings, health fairs, back-to-school nights, and other community events. Hygienists frequently provide fun and interactive education for children and easy to understand oral health messages for adults, as well as low cost oral hygiene aides such as brushes and floss which helps to create community awareness. Continual communication and interaction with community partners is instrumental in program promotion.

### Advantages of a Preventive Services Model

A recent North Carolina study examined school attendance of over 2,000 school children, and the results indicated children with poor oral health status were nearly three times more likely than were their counterparts to miss school as a result of dental pain.[4] The Association of State and Territorial Dental Directors lists dental hygienist practice laws that expand role and function in the public health setting, and the provision of preventive oral health services including school dental sealant programs, among the top strengths of a state oral health program for children and adolescents.[5]

Expanded access to services in non- traditional settings such as schools reduces the barriers to care often experienced by low income households, such as transportation challenges, time off from work and child care issues with siblings. The assessment component of a preventive program may identify a child's significant need a parent is not aware of and may help in accessing care before a small problem escalates to a serious or even life threatening condition. The combined benefit of children receiving preventive services, with initiation of families pursuing dental homes for children for follow up care, can potentially improve oral health in the community in a cost effective manner. Effective community dental hygienists will also have an expanded skill set that could benefit the community beyond the provision of clinical services. However, VDH may be challenged to satisfy these unique personnel requirements in all regions of the Commonwealth.

[4] Jackson SL, et al., "Impact of Poor Oral Health on Children's School Attendance". American J of Public Health, 2011.

[5] Association of State and Territorial Dental Directors School and Adolescent Oral Health Committee. Strengths and Successes of State School and Adolescent Oral Health Programs. 2012. Retrieved from http://www.astdd.org/strengths-and-successes-of-state-school-and-adolescent-oral-health-%28saoh%29-programs/

Preventive dental interventions are cost-effective in reducing disease burden and associated expenditures. Providing preventive services in community settings greatly reduces the cost of delivering this care. Prevention of dental decay through preventive services reduces associated dental treatment costs, especially among high-risk children, where sealants applied to permanent molars have been shown to avert tooth decay over an average of 5-7 years.[6] [7] When access to regular preventive dental services is not available, dental care for many children is postponed until symptoms, such as toothache and facial abscess, become so acute that care is sought in hospital emergency departments. Care in emergency departments is more costly and often provides only a temporary fix with more permanent care required in the near future.[8]

If VDH adopts a prevention model for dental services, organizations that may be better equipped to provide comprehensive treatment and have greater flexibility to organize practices in a way that can be sustainable could benefit from initial assessment and prompt referral of program participants. It is a reasonable expectation that these referrals from a school-based program will increase overall dental treatment utilization in the community. Establishing a synergy in the community between Health Department-delivered population-based preventive services and education, and local direct service providers, may be the ideal model for minimizing the oral disease burden in a community while most efficiently utilizing community dental resources. Free Clinics, FQHCs, non-profit dental safety net organizations and private Medicaid/FAMIS providers are generally more flexible in adapting business and clinical best practices as they evolve and can potentially be more productive in the direct delivery of care.

## Challenges

The impact of eliminating VDH dental treatment services will be varied across the Commonwealth. Low income patients faced with the loss of treatment services from their local health department may be able to access services from other safety net providers; however, patients residing is some areas of the Commonwealth could experience a significant hardship if the health department were to close its dental clinics.

As noted previously, a number of factors were evaluated to determine the potential impact on existing patients and the local community should public health dental clinics be eliminated. Some of these factors included the number of patients seen at a dental clinic, the availability of FQHC and/or free dental clinics in the area, the number of patients covered by Medicaid/FAMIS, and the number of significant Medicaid/FAMIS dental providers (those billing $10,000 or more

[6] Quinonez, Downs, Shugars, et al. "*Assessing Cost-Effectiveness of Sealant Placement in Children*". Accepted for publication: Journal of Public Health Dentistry.
[7] Werner C, Pereira A, Eklund S. "*Cost-effectiveness study of a school-based sealant program. Journal of Dentistry for Children"*. March- April 2000.
[8] Childrens Dental Health Project. Cost effectiveness of preventive dental services. 2005. Retrieved from http://www.cdc.gov/oralhealth/publications/library/burdenbook/pdfs/CDHP_policy_brief.pdf

during the previous year) in the area. Based on this high level assessment, it seems clear that even though some areas have other resources that could substitute for the loss of services from a public health dental clinic, there are several areas that currently lack these resources.

For example, in the Lenowisco Health District, a total of 915 patients were seen for a total of 1698 visits in fiscal year 2011. These services were spread across the Lee, Scott, and Wise/Norton health department sites. A majority of these patients (530) were children, many of whom are covered by Medicaid/FAMIS. There are no dental services within either FQHCs or free clinics in this area. There were eight Medicaid/FAMIS providers that billed more than $10,000 over the year; however, this represents less than one provider for each 1,500 Medicaid/FAMIS enrollees in the area. Thus, it is unlikely they would have much additional capacity to take on new patients. Children and adults without Medicaid/FAMIS, or other sources of insurance coverage would have few, if any, alternatives in the region. Indeed, even those with dental insurance coverage would likely experience difficulty accessing services, as manpower studies estimate that the region needs an additional 20.9 dental providers to have sufficient access.

In addition, even areas that have coverage from other safety net providers (FQHCs, Free Clinics, Medicaid/FAMIS providers) may still lack sufficient resources to meet the needs of patients that are not eligible for Medicaid/FAMIS (adults) and who would find paying even sliding scale rates to be a significant financial hardship. Thus, any plan to close public health dental clinics should include provisions for a longer transition period in certain regions of the state where the loss of dental clinics would result in a significant hardship to the community.

Non-profit and charitable organizations may work to fill gaps created by the closing of dental clinics. In Orange County, the Piedmont Regional Dental Clinic was established in 2011 through fundraising efforts and assistance from the Virginia Health Care Foundation. The clinic was established, in part, to close the gap in the number of patients that qualify for Medicaid/FAMIS and the number of dentists that are available to take Medicaid/FAMIS patients[9]. However, sustainability of a safety net dental clinic requires a mix of patients that brings in sufficient revenue to support annual operating costs.

In its guide to developing sustainable dental safety net clinics, the Virginia Health Care Foundation recommends a 70/30 model, in which 70% of patient visits are reimbursed by Medicaid or FAMIS and the remaining 30% of visits are self-pay on a sliding scale for

[9] Simmons, R. Nonprofit Orange dental clinic looks to hire. The Charlottesville Daily Progress. February 27, 2011. Accessed on August 12, 2012 at http://www2.dailyprogress.com/news/2011/feb/27/nonprofit-orange-dental-clinic-looks-hire-ar-871737/

individuals (typically adults) without coverage.[10] This model for sustainability requires sliding scale payments to average about $30 per visit in today's health economics setting.

Virginia public health dental clinics currently have approximately 49% of visits reimbursed by Medicaid, 40% are for indigent patients that do not pay any fees, and 11% are for patients that pay a sliding scale. Thus, for a non-profit organization to operate a safety net clinic, the mix of patients would have to differ from that currently seen by public health clinics in order to remain sustainable without the provision of general state funds or some other source of ongoing support. Some localities may not have a sufficient number of Medicaid eligible children to support the ongoing operation of a clinic and thus could be left without a reliable source of dental care.

It should be noted that the preventive interventions outlined in this report primarily address children, who are currently also the primary recipients of comprehensive care through VDH dental clinics.

## Recommendations

1. ***Adopt a targeted regional approach, individually evaluating the impact of closing dental clinics in each area, with consideration of the available resources to meet patient and community needs and the need to provide for transitional services in certain areas.***

   The advisory committee agreed that while some areas could potentially absorb the loss of health department dental services, there are other areas that will experience a great challenge accessing care if the health department ceased to provide comprehensive dental services. Adults are the primary client base in areas such as Newport News, and transitioning this population will be especially difficult given the lack of Medicaid/FAMIS coverage and dental benefits for this population. While safety net services offered by the FQHCs, private providers, Virginia Health Care Foundation supported non profits, and the Free Clinics have continued to grow over the past decade, the demand for these services has increased due to unemployment, the faltering economy, and a growing cohort of uninsured people. Further study will be needed to assess the areas where termination of health department services will lead to persons not being able to get care through other safety net providers. The implementation of the PPACA could have a positive impact on increasing children's access to care through expansion of Medicaid eligibility; however, details of the implementation of the PPACA are yet undetermined.

[10] The "70/30" Model: A Sustainable Approach to Community-based Dental Care. The Virginia Health Care Foundation. Accessed August 12, 2012 at http://www.vhcf.org/wp-content/uploads/2010/09/73_30_MTMI.pdf

VDH proposes to work with the dental advisory committee to evaluate the dental needs and resources in each geographic area to determine whether the closing of a local health department dental clinic will result in significant hardship. In areas where significant hardship is likely, a transition plan will be developed, in consultation with the advisory committee over the next 12 months. The need for an extended assessment period is based on the advisory committee's understanding and appreciation of the complexity associated with how local health department dental clinics are operated and funded, and the need to directly involve local governments in the assessment. Local government involvement is essential given the fact that the dental clinics are supported with a combination of state and local funds through the VDH cooperative budget, and that the amount of the local contribution is determined using a formula based on ability to pay. There are 73 different local governments included within the 17 local health districts that provide dental services. An extended assessment period will assure that the transition is as seamless as possible. Depending on the findings and recommendations developed during the extended assessment period, transitioning may include identifying other safety net provider entities that could assume the role of providing direct services, working with the Virginia Dental Association to identify capacity in the private sectors, exploring sources of local funding and support that may increase the capacity of new or existing safety net partners, and implementing appropriate VDH strategies for prevention services and referral. Operational plans for new initiatives will be transmitted through the Office of Family Health Services to VDH leadership in the Commissioner's office.

2. ***Evaluate and identify whether there are some areas of the state that are unlikely to be able to develop and sustain safety net dental services.***

   In the absence of VDH comprehensive dental programs, individual communities will need to encourage the development of local safety net services. In some communities this may be challenging due to a lack of dental providers, or a lack of a sufficient patient base that has some type of funding (e.g., Medicaid/FAMIS). It will be important to identify where these communities are, what resources and organizations can address this issue, and the role VDH can play.

3. ***Where appropriate and feasible, using a targeted regional approach, transition identified VDH public health dental clinics from a model of treatment and prevention to a prevention model.***

   Public health's mission is to promote prevention. Other roles which public health is tasked with include assurance, surveillance, and policy development. No other health system is tasked with these leadership roles. In this era of declining resources, the health department,

as well as other health organizations, must choose where to direct its efforts that will yield the best return on investment while fulfilling its basic mandates. While many may perceive the health department as a safety net provider, its role is much broader and prevention is the primary goal of services delivered. Major federal funding streams such as the Maternal and Child Health Block Grant have elevated the most important service provided to that of infrastructure-building. The health department is asked to assure that services are available and not be the direct service provider except in limited cases.

Direct health services once delivered at the health department have been transitioning to other public and private sector partners in a number of areas over the last 10-15 years. Following the expansion of managed care Medicaid and implementation of the federal S-CHIP program (FAMIS), child health services have dramatically declined at most health departments. In many instances, these services have been transitioned to private providers or the health department serves as the stopgap provider until Medicaid/FAMIS enrollment is complete and the client transitions to a private sector provider. The 2012 Appropriation Act also called for transitioning the last three general medical clinics in the state to other safety net providers outside of the health department.

As DMAS has increased dental providers accepting Medicaid/FAMIS over the past several years, the availability of dental providers for children has increased. The percentage of low-income children receiving dental services in Virginia has more than doubled from 21.8% in 2000 to 45.7% in 2009. While 80% of health department dental patients are children and approximately half of these are no-charge patients, it is not clear how many of these children would qualify for Medicaid/FAMIS. The health department cannot under law require Medicaid/FAMIS application nor can the agency collect citizenship status. It is plausible however in areas such as Southwest Virginia that there may be a cohort of potentially eligible children who could qualify for Medicaid/FAMIS and could be transitioned to alternative providers. Other safety net advocates, such as the Virginia Health Care Foundation, have had great success in helping enroll children in Medicaid and FAMIS. It may be able to play a role particularly in helping to identify and assist families whose children may qualify for Medicaid or FAMIS.

Shifting VDH's focus to one of prevention has the advantages of reducing costs, increasing the number of children that receive oral assessments and preventive care, and, with a sufficient referral base, improving overall oral health.

***4. Identify and develop metrics for the ongoing surveillance of oral health to assess the impact of shifting to a preventive health model.***

The elimination of VDH dental clinics and the shift to a preventive health model is not without risk. While this model offers the possibility of screening a greater number of

children than under the current model, the advisory committee raised concerns that closing clinics could lead to an increase in the number of people with untreated oral health problems, resulting in an increase in emergency room visits and more importantly, a deterioration in our population's health status.

VDH will work with the advisory committee to identify any additional metrics that should be implemented to monitor the oral health of Virginians.

***5. Develop a communications plan.***

As VDH's role in the assurance of oral health in the community evolves, communication with partners, the community, and individuals directly impacted is critical. Communication strategies must be developed to facilitate a successful transition.

6. ***Maintain ongoing stakeholder input into the transition to a prevention model.***

A successful transition to a targeted regional approach toward the delivery of dental services will require ongoing coordination with other stakeholders within the dental and health community. As such, it will be essential that VDH continue ongoing collaboration with the advisory committee over the course of this transition and continue to identify, reach out to and incorporate other stakeholders. Specifically, the advisory committee will assist VDH in addressing recommendations 1-5 above.

## Conclusion

VDH convened a dental advisory committee comprised of diverse and engaged stakeholders to assist in developing a comprehensive plan to address reductions in the General Fund appropriation for VDH local dental services. The advisory committee, while recognizing the important role that the current system has played in promoting optimal oral health, concluded that, operating under the historical model of service delivery, comprehensive dental services are no longer sustainable in the absence of ongoing General Fund support. The committee identified challenges in moving to a preventive services model uniformly, across the Commonwealth, noting the lack of existing dental services in many regions. The committee recommended adopting a targeted, regional approach, in which replacing VDH comprehensive care programs with preventive services would be implemented in areas with other adequate community dental treatment resources. Ideally, the most challenged communities lacking adequate dental resources would continue to receive comprehensive dental services through VDH public health clinics, at least until the community and its partners in the private and non-profit sectors can address the need. While it was recognized that fiscal constraints may impose a reduction of VDH dental services in communities, the impact should be mitigated to the extent possible by considering the uniqueness of communities and distributing available funding accordingly to support the most

appropriate and affordable program option. The advisory committee focused specifically on services that are currently delivered by VDH, which are predominantly focused on children. Thus, the oral health needs of adults should be evaluated more closely in the future.

**Appendix A:**
**Chapter 3 Acts of Assembly Virginia General Assembly Special Session 1 (Budget Bill)**

| Department of Health (601) | | FY 2013 | FY 2014 |
|---|---|---|---|
| 296. | Community Health Services (44000) | 231,852,833 | 229,955,064 |
| | Local Dental Services (44002) | 7,036,703 | 5,372,397 |
| | Restaurant and Food Safety, Well and Septic Permitting and other Environmental Health Services (44004) | 34,502,864 | 34,502,864 |
| | Local Family Planning Services (44005) | 23,756,626 | 23,756,626 |
| | Support for Local Management, Business, and Facilities (44009) | 57,328,917 | 57,328,917 |
| | Local Maternal and Child Health Services (44010) | 42,299,966 | 42,299,966 |
| | Local Immunization Services (44013) | 10,986,239 | 10,986,239 |
| | Local Communicable Disease Investigation, Treatment, and Control (44014) | 17,644,195 | 17,644,195 |
| | Local Personal Care Services (44015) | 4,139,638 | 4,139,638 |
| | Local Chronic Disease and Prevention Control (44016) | 10,540,345 | 10,306,882 |
| | Local Nutrition Services (44018) | 23,617,340 | 23,617,340 |
| Fund Sources: | General | 94,327,893 | 93,126,486 |
| | Special | 98,514,894 | 97,818,532 |
| | Dedicated Special Revenue | 2,472,715 | 2,472,715 |
| | Federal Trust | 36,537,331 | 36,537,331 |

Authority: §§ 32.1-11 through 32.1-12, 32.1-31, 32.1-163 through 32.1-176, 32.1-198 through 32.1-211, 32.1-246, and 35.1-1 through 35.1-26, Code of Virginia; Title V of the U.S. Social Security Act; and Title X of the U.S. Public Health Service Act.

A. 1. Notwithstanding § 32.1-163 through § 32.1-176, Code of Virginia, the State Health Commissioner shall charge a fee of no more than $425.00, for a construction permit for on-site sewage systems designed for less than 1,000 gallons per day, and alternative discharging systems not supported with certified work from an authorized onsite soil evaluator or a professional engineer working in consultation with an authorized onsite soil evaluator.

2. Notwithstanding § 32.1-163 through § 32.1-176, Code of Virginia, the State Health Commissioner shall charge a fee of no more than $350.00, for the certification letter for less than 1,000 gallons per day not supported with certified work from an authorized onsite soil evaluator or a professional engineer working in consultation with an authorized onsite soil evaluator.

3. Notwithstanding § 32.1-163 through § 32.1-176, Code of Virginia, the State Health Commissioner shall charge a fee of no more than $225.00, for a construction permit for an onsite

sewage system designed for less than 1,000 gallons per day when the application is supported with certified work from a licensed onsite soil evaluator.

4. Notwithstanding § 32.1-163 through § 32.1-176, Code of Virginia, the State Health Commissioner shall charge a fee of no more than $320.00, for the certification letter for less than 1,000 gallons per day supported with certified work from an authorized onsite soil evaluator or a professional engineer working in consultation with an authorized onsite soil evaluator.

5. Notwithstanding § 32.1-163 through § 32.1-176, Code of Virginia, the State Health Commissioner shall charge a fee of no more than $300.00, for a construction permit for a private well.

6. Notwithstanding § 32.1-163 through § 32.1-176, Code of Virginia, the State Health Commissioner shall charge a fee of no more than $1,400.00, for a construction permit or certification letter designed for more than 1,000 gallons per day.

7. The State Health Commissioner shall appoint two manufacturers to the Advisory Committee on Sewage Handling and Disposal, representing one system installer and the Association of Onsite Soil Engineers.

B. The State Health Commissioner is authorized to develop, in consultation with the regulated entities, a hotel, campground, and summer camp plan and specification review fee, not to exceed $40.00, a restaurant plan and specification review fee, not to exceed $40.00, an annual hotel, campground, and summer camp permit renewal fee, not to exceed $40.00, and an annual restaurant permit renewal fee, not to exceed $40.00 to be collected from all establishments, except K-12 public schools, that are subject to inspection by the Department of Health pursuant to §§ 35.1-13, 35.1-14, 35.1-16, and 35.1-17, Code of Virginia. However, any such establishment that is subject to any health permit fee, application fee, inspection fee, risk assessment fee or similar fee imposed by any locality as of January 1, 2002, shall be subject to this annual permit renewal fee only to the extent that the Department of Health fee and the locally imposed fee, when combined, do not exceed the fee amount listed in this paragraph. This fee structure shall be subject to the approval of the Secretary of Health and Human Resources.

C. Pursuant to the Department of Health's Policy Implementation Manual (#07-01), individuals who participate in a local festival, fair, or other community event where food is sold, shall be exempt from the annual temporary food establishment permit fee of $40.00 provided the event is held only one time each calendar year and the event takes place within the locality where the individual resides.

D. Out of this appropriation, $504,205 the first year and $504,205 the second year from the general fund and $362,947 the first year and $362,947 the second year from nongeneral funds is provided to address the cost of leasing new or expanding existing local health department facilities. First priority shall be given to Prince William, Isle of Wight, Suffolk, and Roanoke City.

**Appendix A:**
**Chapter 3 Acts of Assembly Virginia General Assembly Special Session 1 (Budget Bill)**

E. The State Health Commissioner shall work with public and private dental providers to develop options for delivering dental services in underserved areas, including the use of public-private partnerships in the development and staffing of facilities, the use of dental hygiene and dental students to expand services and enhance learning experiences, and the availability of reimbursement mechanisms and other public and private resources to expand services.

F. The State Health Commissioner, in consultation with the Department of Medical Assistance Services, shall appoint an advisory committee comprised of relevant stakeholders including representatives from the Virginia Dental Association, the Virginia Dental Hygienists Association, the Virginia Oral Health Coalition, the Virginia Health Care Foundation, the Virginia Association of Free Clinics, and the Virginia Community Healthcare Association to develop a comprehensive oral health plan. The plan shall evaluate the sustainability and efficiency of the current state-supported dental clinics operated by the department. The plan shall also include the feasibility of transitioning the department's current dental prevention/treatment model to a prevention-only model. The commissioner shall issue a final report from the advisory committee to the Chairmen of the Senate Finance and House Appropriations Committees no later than October 1, 2012.

## Appendix B: SB146

## CHAPTER 102

*An Act to amend and reenact § 54.1-2722 of the Code of Virginia and to repeal the third enactments of Chapters 99 and 561 of the Acts of Assembly of 2009, as amended by Chapter 289 of the Acts of Assembly of 2011, relating to dental hygienists' scope of practice.*

[S 146]

Approved March 6, 2012

Be it enacted by the General Assembly of Virginia:

1. That § 54.1-2722 of the Code of Virginia is amended and reenacted as follows:

§ 54.1-2722. License; application; qualifications; practice of dental hygiene.

A. No person shall practice dental hygiene unless he possesses a current, active, and valid license from the Board of Dentistry. The licensee shall have the right to practice dental hygiene in the Commonwealth for the period of his license as set by the Board, under the direction of any licensed dentist.

B. An application for such license shall be made to the Board in writing, and shall be accompanied by satisfactory proof that the applicant (i) is of good moral character, (ii) is a graduate of an accredited dental hygiene program offered by an accredited institution of higher education, (iii) has passed the dental hygiene examination given by the Joint Commission on Dental Examinations, and (iv) has successfully completed a clinical examination acceptable to the Board.

C. The Board may grant a license to practice dental hygiene to an applicant licensed to practice in another jurisdiction if he (i) meets the requirements of subsection B ~~of this section~~; (ii) holds a current, unrestricted license to practice dental hygiene in another jurisdiction in the United States; (iii) has not committed any act that would constitute grounds for denial as set forth in § 54.1-2706; and (iv) meets other qualifications as determined in regulations promulgated by the Board.

D. A licensed dental hygienist may, under the direction or general supervision of a licensed dentist and subject to the regulations of the Board, perform services that are educational, diagnostic, therapeutic, or preventive. These services shall not include the establishment of a final diagnosis or treatment plan for a dental patient. Pursuant to subsection V of § 54.1-3408, a licensed dental hygienist may administer topical oral fluorides under an oral or written order or a standing protocol issued by a dentist or a doctor of medicine or osteopathic medicine.

A dentist may also authorize a dental hygienist under his direction to administer Schedule VI nitrous oxide and oxygen inhalation analgesia and, to persons 18 years of age or older, Schedule VI local anesthesia. In its regulations, the Board of Dentistry shall establish the education and

training requirements for dental hygienists to administer such controlled substances under a dentist's direction.

For the purposes of this section, "general supervision" means that a dentist has evaluated the patient and prescribed authorized services to be provided by a dental hygienist; however, the dentist need not be present in the facility while the authorized services are being provided.

*For the purposes of this section, "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 done 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.*

The Board shall provide for an inactive license for those dental hygienists who hold a current, unrestricted license to practice in the Commonwealth at the time of application for an inactive license and who do not wish to practice in Virginia. The Board shall promulgate such regulations as may be necessary to carry out the provisions of this section, including requirements for remedial education to activate a license.

E. (Expires July 1, 2012) Notwithstanding any provision of law ~~or regulation to the contrary~~, a dental hygienist employed by the Virginia Department of Health who holds a license issued by the Board of Dentistry may provide educational and preventative dental care in the ~~Cumberland Plateau, Southside, and Lenowisco Health Districts, which are designated as Virginia Dental Health Professional Shortage Areas by the Virginia Department of Health~~ *Commonwealth under the remote supervision of a dentist employed by the Department of Health.* A dental hygienist providing such services shall practice pursuant to a protocol *adopted by the Commissioner of Health on September 23, 2010, having been* developed jointly by *(i)* the medical directors of ~~each of the districts,~~ *the Cumberland Plateau, Southside, and Lenowisco Health Districts; (ii)* dental hygienists employed by the Department of Health~~,~~*; (iii)* the Director of the Dental Health Division of the Department of Health~~,~~*; (iv)* one representative of the Virginia Dental Association~~,~~*;* and *(v)* one representative of the Virginia Dental Hygienists' Association. *Such protocol shall be adopted by the Board as regulations.*

*F.* A report of services provided by dental hygienists pursuant to such protocol, including their impact upon the oral health of the citizens of ~~these districts~~ *the Commonwealth*, shall be prepared and submitted by ~~the medical directors of the three health districts~~ *the Department of Health* to the Virginia Secretary of Health and Human Resources ~~by January 1, 2012~~ *annually*. Nothing in this section shall be construed to authorize or establish the independent practice of dental hygiene.

2. That the third enactments of Chapters 99 and 561 of the Acts of Assembly of 2009, as amended by Chapter 289 of the Acts of Assembly of 2011, are repealed.

**Appendix C**
**Advisory Committee Members**

| Organization | Representative |
|---|---|
| Department of Medical Assistance Services | Daniel Plain, Dental Program Manager |
| Department of Medical Assistance Services | Marjorie Chema, DDS, Dental Consultant |
| Chesterfield Health District, Virginia Department of Health | Parham Jaberi, MD, Health District Director, District Health Representative |
| Virginia Community Healthcare Association | Neal Graham, Chief Executive Officer |
| Virginia Community Healthcare Association | Rick Shinn, Director, Government Affairs |
| Virginia Association of Free Clinics | Linda Wilkinson, Executive Director |
| Virginia Association of Free Clinics | Darryl Pirok, DDS |
| Virginia Chapter American Academy of Pediatrics | Lauren Bull, Consultant |
| Virginia Chapter American Academy of Pediatrics | John Unkel, MD, DDS |
| Virginia Commonwealth University School of Dentistry | David Sarrett, DMD, Dean |
| Virginia Commonwealth University School of Dentistry | Kim Isringhausen, Department Head |
| Virginia Dental Association | Terry Dickinson, DDS, Executive Director |
| Virginia Dental Association | Tripp Perrin, Lobbyist |
| Virginia Dental Association | Chuck Duvall, Lobbyist |
| Virginia Dental Hygienists Association | Kelly Williams, BOD Liaison |
| Virginia Department for Aging and Rehabilitative Services | Elaine Smith, Program Coordinator |
| Virginia Early Childhood Foundation | Karin Bowles, Government Affairs |
| Virginia Health Care Foundation | Deborah Oswalt, Executive Director |
| Virginia Health Care Foundation | Doug Davis, Deputy Director |
| Virginia Health Care Foundation | Julie Ericksen, Dental Opportunities Coordinator |
| Virginia Oral Health Coalition | Sarah Bedard Holland, Executive Director |
| Virginia Oral Health Coalition | Anna Healy James, Consultant |
| Virginia Sexual and Domestic Violence Action Alliance | Kristi VanAudenhove, Co-Director |
| Virginia Society of Pediatric Dentistry | Patrice Wunsch |
| Virginia Society of Pediatric Dentistry | Frank Farrington, DDS |
| United Way Greater Richmond and Petersburg | Jacque Hale, Director Community Mobilization |
| Virginia Department of Health | Tonya McRae Adiches, RDH, Acting Dental Programs Manager |
| Virginia Department of Health | Lynn Browder, DDS, MBA, Dental Clinical Programs Manager |
| Virginia Department of Health | Jeff Lake, Deputy Commissioner for Community Health Services, Senior Management Representative |

## Appendix C
## Advisory Committee Members

| Organization | Representative |
|---|---|
| Virginia Department of Health | Dev Nair, PhD, MPH, Director, Division of Policy and Evaluation |
| Virginia Department of Health | Cornelia Ramsey, PhD, MSPH, Director, Division of Child and Family Health |
| Virginia Department of Health | Susan Tlusty, Manager, Surveys and Analyses |

# Appendix D
# VDH Dental Population Served

| District/Localities | Individuals (Local HD Patients) FY 2011 | Visits (Local HD Patients) FY 2011 | Revenue FY12 | Expenditures FY12 | Balance FY12 | FY11 Individuals VDH | FY11 Visits VDH | FY11 Individual Children | FY11 Visits VDH Children (0-18 years old) | FY11 Visits VDH Adults (> 18 years old) | FY11 VDH Rest/Surg Services Provided | VDH Medicaid/ FAMIS served | VDH Sliding Scale Served | Free Clinic with Dental Component | FHQC DDS FTE Updated 8/14/2012 | # Significant Medicaid Providers FY11 (>$10,000) | # Significant Medicaid Providers per 1500 Enrollees (ages 0-20) | Manpower Needed for DDS/Pop. = 1/2311 (state avg.) | Medicaid/FAMIS Enrollees (0-20) | Total F/Red Lunch Eligibles 2011 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Alexandria** | 295 | 913 | $ 4,273 | $ (178,705) | $ (174,432) | 295 | 913 | 271 | 836 | 77 | 215/23 | 71 | 224 | NO | Yes | 16 | 2.41 | -12.5 | 9,969 | 6,506 |
| Alexandria | 295 | 913 | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| **Arlington** | 665 | 1507 | | | | 665 | 1507 | 379 | 862 | 645 | 652/227 | 0 | 665 | No | Yes | 15 | 2.33 | -11.1 | 9,642 | 16,520 |
| Arlington | 665 | 1507 | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| **Central Shenandoah** | 2379 | 4074 | $ 327,482 | $ (562,446) | $ (234,964) | 2379 | 4074 | 2355 | 4013 | 61 | 1208/171 | 1998 | 381 | YES | Yes | 35 | 1.93 | 24 | 27,149 | 16,867 |
| Augusta | | | | | | | | | | | | | | | | | | | | |
| Buena Vista | | | | | | | | | | | | | | | | | | | | |
| Bath | | | | | | | | | | | | | | | | | | | | |
| Staunton | | | | | | | | | | | | | | | | | | | | |
| Waynesboro | 600 | 1077 | | | | 600 | 1077 | | 1042 | 35 | | | | | | | | | | |
| Harrisonburg/Rockingham | 1413 | 2377 | | | | 1413 | 2377 | | 2377 | 0 | | | | | | | | | | |
| Lexington/Rockbridge | 366 | 620 | | | | 366 | 620 | | 594 | 26 | | | | 441 pts | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| **Alleghany/Roanoke** | | | | | | 0 | 0 | | 0 | 0 | | | | YES | Yes | | | 10.8 | 24,686 | 15,286 |
| Roanoke County | | | | | | | | | | | | | | | | | | | | |
| Clifton Forge | | | | | | | | | | | | | | | | | | | | |
| Botetourt | | | | | | | | | | | | | | | | | | | | |
| Craig | | | | | | | | | | | | | | | Yes | | | | | |
| Covington | | | | | | | | | | | | | | | | | | | | |
| Salem City | | | | | | | | | | | | | | | | | | | | |
| Roanoke City | | | | | | | | | | | | | | 795/299 pts | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| **Central Virginia** | 1111 | 1930 | $ 132,136 | $ (221,104) | $ (88,968) | 1111 | 1930 | 1089 | 1892 | 38 | 506/72 | 1055 | 56 | YES | Yes | 28 | 1.52 | 30 | 27,648 | 15,688 |
| Amherst | | | | | | | | | | | | | | | | | | | | |
| Appomattox | | | | | | | | | | | | | | | | | | | | |
| Bedford | 1111 | 1930 | | | | 1111 | 1930 | | 1892 | 38 | | | | | | | | | | |
| Bedford City | | | | | | | | | | | | | | | | | | | | |
| Campbell | | | | | | | | | | | | | | | | | | | | |
| Lynchburg | | | | | | | | | | | | | | 2587 pts | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| **Chesterfield** | 452 | 720 | $ 47,240 | $ (205,888) | $ (158,648) | 452 | 720 | 303 | 489 | 231 | 395/52 | 280 | 172 | NO | 0 | 69 | 2.63 | -34.5 | 39,307 | 13,817 |
| Chesterfield | 452 | 720 | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| **Crater** | 0 | 0 | | | | 0 | 0 | | 0 | 0 | | | | | | | | 32.2 | NA | 14,598 |
| Dinwiddie | | | | | | | | | | | | | | | | | | | | |
| Prince George | | | | | | | | | | | | | | | | | | | | |
| Surry | | | | | | | | | | | | | | 18 pts | | | | | | |
| Sussex | | | | | | | | | | | | | | | | | | | | |
| Emporia-Greensville | | | | | | | | | | | | | | | | | | | | |
| Hopewell City | | | | | | | | | | | | | | | | | | | | |
| Petersburg City | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| **Chickahominy** | 0 | 0 | | | | 0 | 0 | | 0 | 0 | | | | | | | | 9.1 | 10,279 | 3,912 |
| Hanover | | | | | | | | | | | | | | 692 pts | | | | | | |
| Goochland | | | | | | | | | | | | | | 570 pts | | | | | | |
| New Kent | | | | | | | | | | | | | | | | | | | | |
| Charles City | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| **Cumberland Plateau** | 182 | 574 | $ 2,401 | $ (62,378) | $ (59,977) | 182 | 574 | 35 | 40 | 534 | 5/342 | 147 | 35 | NO | Yes | 20 | 1.99 | 28.1 | 15,058 | 8,996 |
| Dickinson | | | | | | | | | | | | | | | Yes | | | | | |
| Buchanan | | | | | | | | | | | | | | | | | | | | |
| Tazewell | | | | | | | | | | | | | | | | | | | | |
| Russell | 182 | 574 | | | | 182 | 574 | | 40 | 534 | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| **Fairfax** | 758 | 2704 | | | | 758 | 2704 | 705 | 2508 | 196 | | 227 | 531 | No | 0 | | 0 | -342.6 | 73,094 | 44,179 |
| Fairfax | 758 | 2704 | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |



Note : Green Shading indicates 100% Local funding;
Blue Shading indicates programs with more than 50% Local funding
Grey shading indicates programs that have been discontinued
Peach shading indicates vacant position

# Appendix D
# VDH Dental Population Served

| District/Localities | Individuals (Local HD Patients) FY 2011 | Visits (Local HD Patients) FY 2011 | Revenue FY12 | Expenditures FY12 | Balance FY12 | FY11 Individuals VDH | FY11 Visits VDH | FY11 Individual Children | FY11 Visits VDH (0-18 years old) | FY11 Visits VDH Adults (> 18 years old) | FY11 VDH Rest/Surg Services Provided | VDH Medicaid/ FAMIS served | VDH Sliding Scale Served | Free Clinic with Dental Component | FHQC DDS FTE Updated 8/14/2012 | # Significant Medicaid Providers FY11 (>$10,000) | # Significant Medicaid Providers per 1500 Enrollees (ages 0-20) | Manpower Needed for DDS/Pop. = 1/2311 (state avg.) | Medicaid/FAMIS Enrollees (0-20) | Total F/Red Lunch Eligibles 2011 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Hampton City | | | | | | 0 | 0 | | | 0 | | | | Yes | Yes | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| Henrico | 1025 | 1850 | $ 115,356 | $ (242,298) | $ (126,942) | 1025 | 1850 | 984 | 1781 | 69 | 757/83 | 584 | 441 | NO | 0 | 41 | 1.6 | -40.2 | 38,439 | 18,174 |
| Henrico | 1025 | 1850 | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| Lenowisco | 915 | 1698 | $ 79,165 | $ (231,370) | $ (152,205) | 915 | 1698 | 530 | 1512 | 186 | 432/313 | 668 | 247 | No | 0 | 8 | 0.88 | 20.9 | 13,623 | 8,212 |
| Lee | 140 | 155 | | | | 140 | 155 | | 155 | 0 | | | | | | | | | | |
| Scott | 62 | 100 | | | | 62 | 100 | | 100 | 0 | | | | | | | | | | |
| Wise/Norton | 713 | 1443 | | | | 713 | 1443 | | 1257 | 186 | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| Lord Fairfax | | | | | | 0 | 0 | | 0 | 0 | | | | | | | | 52.5 | 15,281 | 12,752 |
| Frederick | | | | | | | | | | | | | | | | | | | | |
| Clarke | | | | | | | | | | | | | | | | | | | | |
| Page | | | | | | | | | | | | | | | | | | | | |
| Shenandoah | | | | | | | | | | | | | | | | | | | | |
| Warren | | | | | | | | | | | | | | | | | | | | |
| Winchester City | | | | | | | | | | | | | | 146 pts | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| Loudoun | 578 | 1206 | $ 44,012 | $ (156,440) | $ (112,428) | 578 | 1206 | 543 | 1134 | 72 | 557/60 | 231 | 347 | No | Yes | 29 | 3.13 | -39.7 | 13,877 | 10,296 |
| Loudoun | 578 | 1206 | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| Mount Rogers | 1499 | 2073 | $ 93,455 | $ (576,259) | $ (482,804) | 1499 | 2073 | 1334 | 1832 | 241 | 824/130 | 929 | 570 | YES | Yes | 30 | 1.87 | 23.3 | 24,062 | 13,992 |
| Carroll | 201 | 296 | | | | 201 | 296 | | 286 | 10 | | | | | | | | | | |
| Smyth | 709 | 831 | | | | 709 | 831 | | 784 | 47 | | | | | | | | | | |
| Washington/ Bristol | 589 | 946 | | | | 589 | 946 | | 762 | 184 | | | | 260 pts | | | | | | |
| Wythe | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| Norfolk | 767 | 1171 | $ 64,400 | $ (200,494) | $ (136,094) | 767 | 1171 | 683 | 1039 | 132 | 614/120 | 430 | 337 | No | 0 | 51 | 2.4 | 32.5 | 31,881 | 22,471 |
| Norfolk | 767 | 1171 | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| Peninsula | 1672 | 1830 | $ 30,497 | $ (449,278) | $ (418,781) | 1672 | 1830 | 0 | 16 | 1814 | 2/1423 | 0 | 1672 | YES | Yes | 33 | 1.46 | 13.6 | 33,831 | 21,742 |
| Newport News | 1672 | 1830 | | | | | | | | | | | | | Yes | | | | | |
| York | | | | | | | | | | | | | | 410 pts | | | | | | |
| James City | | | | | | | | | | | | | | | | | | | | |
| Poquoson City | | | | | | | | | | | | | | | | | | | | |
| Williamsburg | | | | | | | | | | | | | | | Yes | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| Piedmont | 0 | 0 | | | | 0 | 0 | | 0 | 0 | | | | | | | | 14.2 | 13,664 | 8,280 |
| Amelia | | | | | | | | | | | | | | | | | | | | |
| Buckingham | | | | | | | | | | | | | | | | | | | | |
| Charlotte | | | | | | | | | | | | | | | | | | | | |
| Cumberland | | | | | | | | | | | | | | | | | | | | |
| Lunenburg | | | | | | | | | | | | | | | | | | | | |
| Nottoway | | | | | | | | | | | | | | | | | | | | |
| Prince Edward | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| Pittsylvania Danville | 978 | 1392 | $ 73,824 | $ (225,093) | $ (151,269) | 978 | 1392 | 753 | 1088 | 304 | 262/73 | 636 | 342 | YES | Yes | 11 | 1.11 | 18.3 | 14,864 | 9,619 |
| Danville | 501 | 742 | | | | 501 | 742 | | 581 | 161 | | | | 447 pts | | | | | | |
| Pittsylvania | 477 | 650 | | | | 477 | 650 | | 507 | 143 | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| Prince William | 744 | 2040 | $ 94,079 | $ (366,690) | $ (272,611) | 744 | 2040 | 558 | 1533 | 507 | 925/248 | 320 | 424 | YES | Yes | 65 | 2.02 | 16.1 | 48,172 | 33,537 |
| Prince William | 744 | 2040 | | | | | | | 0 | | | | | 545 pts | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| Rappahannock | 1229 | 2085 | $ 211,599 | $ (283,160) | $ (71,561) | 1229 | 2085 | 1229 | 2085 | 0 | 737/156 | 1192 | 37 | YES | Yes | 37 | 1.93 | 24.8 | 28,766 | 18,008 |
| Caroline | 490 | 932 | | | | 490 | 932 | | 932 | 0 | | | | | | | | | | |
| King George | | | | | | | | | | 0 | | | | | | | | | | |
| Spotsylvania | 238 | 355 | | | | 238 | 355 | | 355 | 0 | | | | | | | | | | |
| Fredericksburg | | | | | | | | | 0 | 0 | | | | 411 pts | | | | | | |
| Stafford | 501 | 798 | | | | 501 | 798 | | 798 | 0 | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |



Note : Green Shading indicates 100% Local funding;
Blue Shading indicates programs with more than 50% Local funding
Grey shading indicates programs that have been discontinued
Peach shading indicates vacant position

# Appendix D
# VDH Dental Population Served

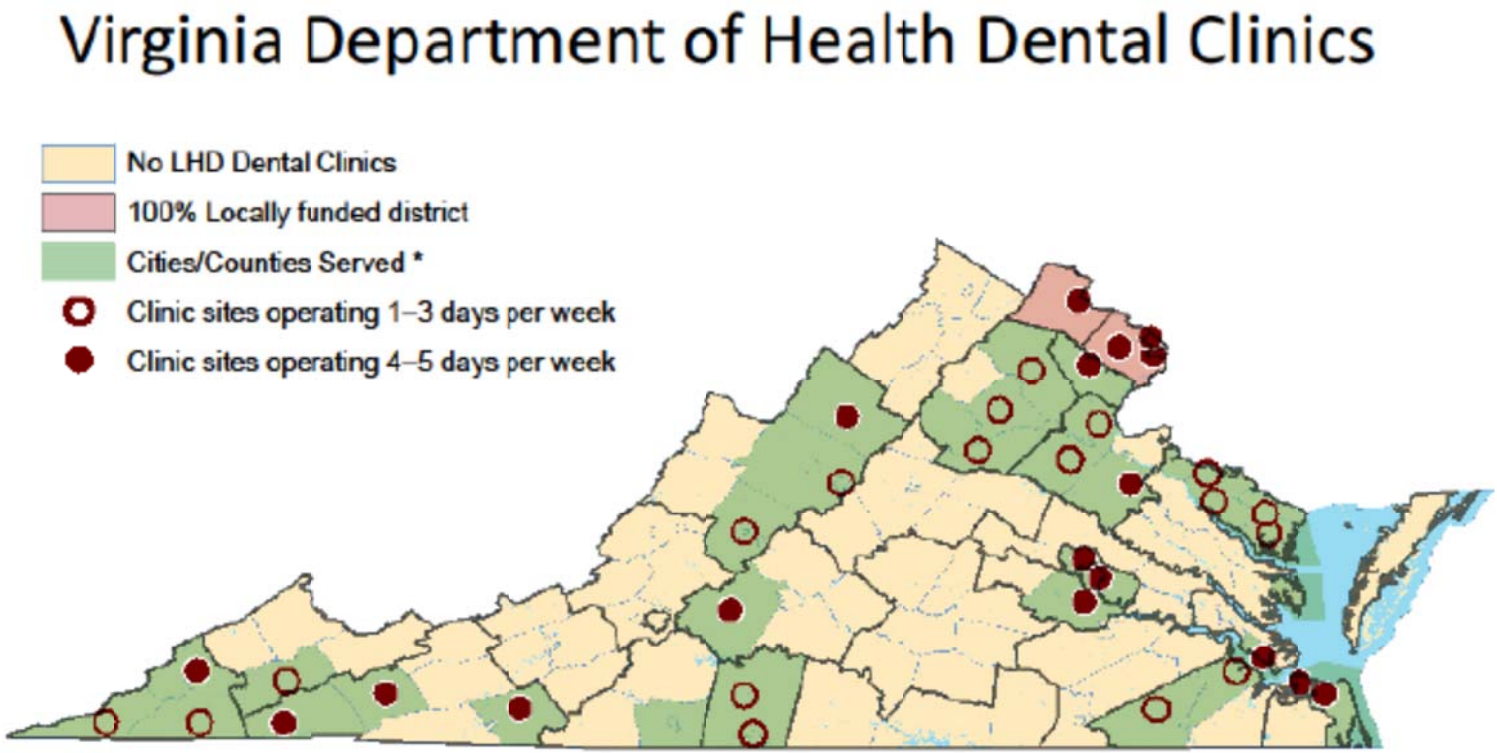
| District/Localities | Individuals (Local HD Patients) FY 2011 | Visits (Local HD Patients) FY 2011 | Revenue FY12 | Expenditures FY12 | Balance FY12 | FY11 Individuals VDH | FY11 Visits VDH | FY11 Individual Children | FY11 Visits VDH (0-18 years old) | FY11 Visits VDH Adults (> 18 years old) | FY11 VDH Rest/Surg Services Provided | VDH Medicaid/ FAMIS served | VDH Sliding Scale Served | Free Clinic with Dental Component | FHQC DDS FTE Updated 8/14/2012 | # Significant Medicaid Providers FY11 (>$10,000) | # Significant Medicaid Providers per 1500 Enrollees (ages 0-20) | Manpower Needed for DDS/Pop. = 1/2311 (state avg.) | Medicaid/FAMIS Enrollees (0-20) | Total F/Red Lunch Eligibles 2011 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Rappahannock Rapidan** | **1061** | **1528** | **$ 109,957** | **$ (283,160)** | **$ (173,203)** | **1061** | **1528** | **944** | **1357** | **171** | **516/338** | **679** | **382** | **YES** | **PRDC** | **12** | **1.27** | **27.2** | **14,128** | **8,587** |
| Culpepper | 263 | 407 | | | | 263 | 407 | | 363 | 44 | | | | | | | | | | |
| Fauquier | 385 | 552 | | | | 385 | 552 | | 488 | 64 | | | | 348 pts | | | | | | |
| Madison | 51 | 76 | | | | 51 | 76 | | 65 | 11 | | | | 30 pts | | | | | | |
| Orange | 362 | 493 | | | | 362 | 493 | | 441 | 52 | | | | | | | | | | |
| Rappahannock | 0 | | | | | 0 | 0 | | 0 | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| **Richmond City** | **954** | **1515** | **$ -** | **$ (214,137)** | **$ (214,137)** | **954** | **1515** | **429** | **676** | **839** | **434/738** | **0** | **954** | **Yes** | **Yes** | **55** | **4.34** | **-25.4** | **19,023** | **16,681** |
| Richmond City | 954 | 1515 | | | | | | | 0 | | | | | 1058 pts | | | | | | |
| | | | | | | | | | 0 | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| **Southside** | **0** | **0** | | | | **0** | **0** | | **0** | **0** | | | | | | | | **20.1** | **11,835** | **8,050** |
| Brunswick | | | | | | | | | 0 | | | | | | | | | | | |
| Halifax & South Boston | | | | | | | | | 0 | | | | | | | | | | | |
| Mecklenburg | | | | | | | | | 0 | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| **Thomas Jefferson** | **0** | **0** | | | | **0** | **0** | | **0** | **0** | | | | | **Yes** | | | **4.1** | **19,150** | **10,512** |
| Albemarle | | | | | | | | | 0 | | | | | | | | | | | |
| Nelson | | | | | | | | | 0 | | | | | | Yes | | | | | |
| Fluvanna | | | | | | | | | 0 | | | | | | | | | | | |
| Louisa | | | | | | | | | 0 | | | | | | | | | | | |
| Greene | | | | | | | | | 0 | | | | | | | | | | | |
| Charlottesville City | | | | | | | | | 0 | | | | | 1807 pts | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| **Three Rivers** | **2036** | **2408** | **$ 23,815** | **$ (132,910)** | **$ (109,095)** | **2036** | **2408** | **750** | **1169** | **1239** | **841/840** | | | **YES** | **0** | **12** | | **19.7** | **NA** | **8,840** |
| King & Queen | | | | | | 0 | 0 | | 0 | 0 | | | | 89 pts | | | | | | |
| Lancaster | 63 | 115 | | | | 63 | 115 | | 115 | 0 | | | | 930 pts | | | | | | |
| Northumberland | 73 | 106 | | | | 73 | 106 | | 106 | 0 | | | | | | | | | | |
| Richmond | 265 | 343 | | | | 265 | 343 | | 343 | 0 | | | | | | | | | | |
| Westmoreland | 54 | 92 | | | | 54 | 92 | | 92 | 0 | | | | | | | | | | |
| Mathews | 1581 | 1752 | | | | 1581 | 1752 | | 513 | 1239 | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| **West Piedmont** | **247** | **278** | **$ 15,395** | **$ (73,031)** | **$ (57,636)** | **247** | **278** | **247** | **278** | **0** | **0/0** | | | **No** | **0** | **18** | | **28** | **19,341** | **11,196** |
| Franklin | 0 | 0 | | | | 0 | 0 | | 0 | | | | | | | | | | | |
| Henry/Martinsville | 247 | 278 | | | | 247 | 278 | | 278 | | | | | | | | | | | |
| Patrick | 0 | 0 | | | | 0 | 0 | | 0 | | | | | | | | | | | |
| | | | | | | | | | 0 | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| **Western Tidewater** | **758** | **1039** | **$ 39,981** | **$ (184,283)** | **$ (144,302)** | **758** | **1039** | **341** | **468** | **571** | **433/301** | **402** | **356** | **YES** | **Yes** | **17** | **1.68** | **34.2** | **15,142** | **10,193** |
| Isle of Wight | 292 | 380 | | | | 292 | 380 | | 140 | 240 | | | | | | | | | | |
| Franklin City | | | | | | | | | 0 | | | | | | | | | | | |
| Suffolk | | | | | | | | | 0 | | | | | 396 pts | | | | | | |
| Southampton | 466 | 659 | | | | 466 | 659 | | 328 | 331 | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| **Virginia Beach** | **292** | **1318** | **$ 67,254** | **$ (308,753)** | **$ (241,499)** | **292** | **1318** | **251** | **1124** | **194** | **513/139** | **50** | **242** | **NO** | **0** | **53** | **2.46** | **-39.1** | **32,357** | **21,636** |
| Virginia Beach | 292 | 1318 | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| **Total** | **20350** | **35575** | **$1,576,321** | **$ (5,157,877)** | **$ (3,581,556)** | **20597** | **35853** | **14713** | **27732** | **8121** | | **9899** | **8415** | | **0** | **655** | **39** | **138** | **644,268** | **429,147** |

Note : Green Shading indicates 100% Local funding;
Blue Shading indicates programs with more than 50% Local funding
Grey shading indicates programs that have been discontinued
Peach shading indicates vacant position

## Appendix E
## Breakout of FY 2013 – 2014 Appropriation

| Virginia Department of Health | | | | |
|---|---|---|---|---|
| Local Dental Resources (Appropriation) | | | | |
| FY 2013 - FY 2014 | | | | |
| **SUBPROG** | **Fund Details** | | **FY 2013** | **FY 2014** |
| Local Dental Services | 0100 | General Fund | 2,677,977 | 1,710,033 |
| | 0202 | 100% Local Funds | 1,642,542 | 1,642,542 |
| | 0204 | Local Match for GF | 1,501,668 | 805,306 |
| | 0205 | Fee Revenues | 972,225 | 972,225 |
| | 0211/0901 | Private Grants& Contracts | 242,291 | 242,291 |
| | | | | |
| **Total** | | | **7,036,703** | **5,372,397** |

**Appendix F**
**Map of VDH Dental Clinic Locations**




Source: Virginia Department of Health, Dental Health Program, Report of Dental Services: July 1, 2010 to June 30, 2011

* Residents of other jurisdictions may receive dental services at these locations.
* Programs in Henry/Martinsville and Three Rivers (Mathews) were discontinued.

**Appendix G**
**Map of FQHC Dental Clinic Locations**

## Community Health Centers in Virginia Providing Dental Services

**I. Alexandria Neighborhood Health Services**
1. Arlandria Health Department- Alexandria
2. Arlington Health Department- Arlington

**II. Blue Ridge Medical Center**
1. Mobile Unit- Arrington

**III. Capital Area Health Network**
1. Vernon J. Harris Medical Center- Richmond
2. Glenwood Medical Center- Richmond

**IV. The Daily Planet**
1.The Daily Planet Health Clinic- Richmond

**V. Central Virgina Health Services**
1. Central Virginia Health Center- New Canton
2. Charlotte Primary Care- Charlotte Courthouse
3. Southside Community Health Center- Alberta
4. Hopewell-Prince George Community Health Center- Prince George
5. Westmoreland Medical Center- Montross
6. Charles City Regional Health Services- Charles City
7. Appomattox Area Health & Wellness Center- Petersburg
8. Community Health Center of the Rappahannock- Fredericksburg
9. Health & Wellness Center of Louisa- Louisa
10. Caroline Family Practice- Bowling Green

**VI. Eastern Shore Rural Health Systems**
1. Franktown Community Health Center- Franktown
2. Atlantic Community Health Center- Oak Hall
3. Metompkin School Based Clinic- Parksley
4. Pungoteague School Based Clinic- Melfa

**VII. Greater Prince William Community Health Center**
1. Mobile Unit- Mannassas

**VIII. Hampton Roads Community Health Center**
1. Portsmouth Community Health Center- Portsmouth

**IX. Harrisonburg Community Health Center**
1. Harrisonburg Community Health Center- Harrisonburg

**X. Highland Community Health Center**
1. Highland Community Health Center-Monterey

**XI. Horizon Health Services**
1. Ivor Dental Center- Ivor

**XII. Johnson Health Center**
1. James River Dental Center- Madison Heights

**XIII. Monroe Health Center**
1. Craig County Dental Center- New Castle

**XIV. Olde Town Medical Center**
1. Olde Town Dental Center- Williamsburg

**XV. Piedmont Access to Health Services (PATHS)**
1. PATHS Community Health Center- Danville

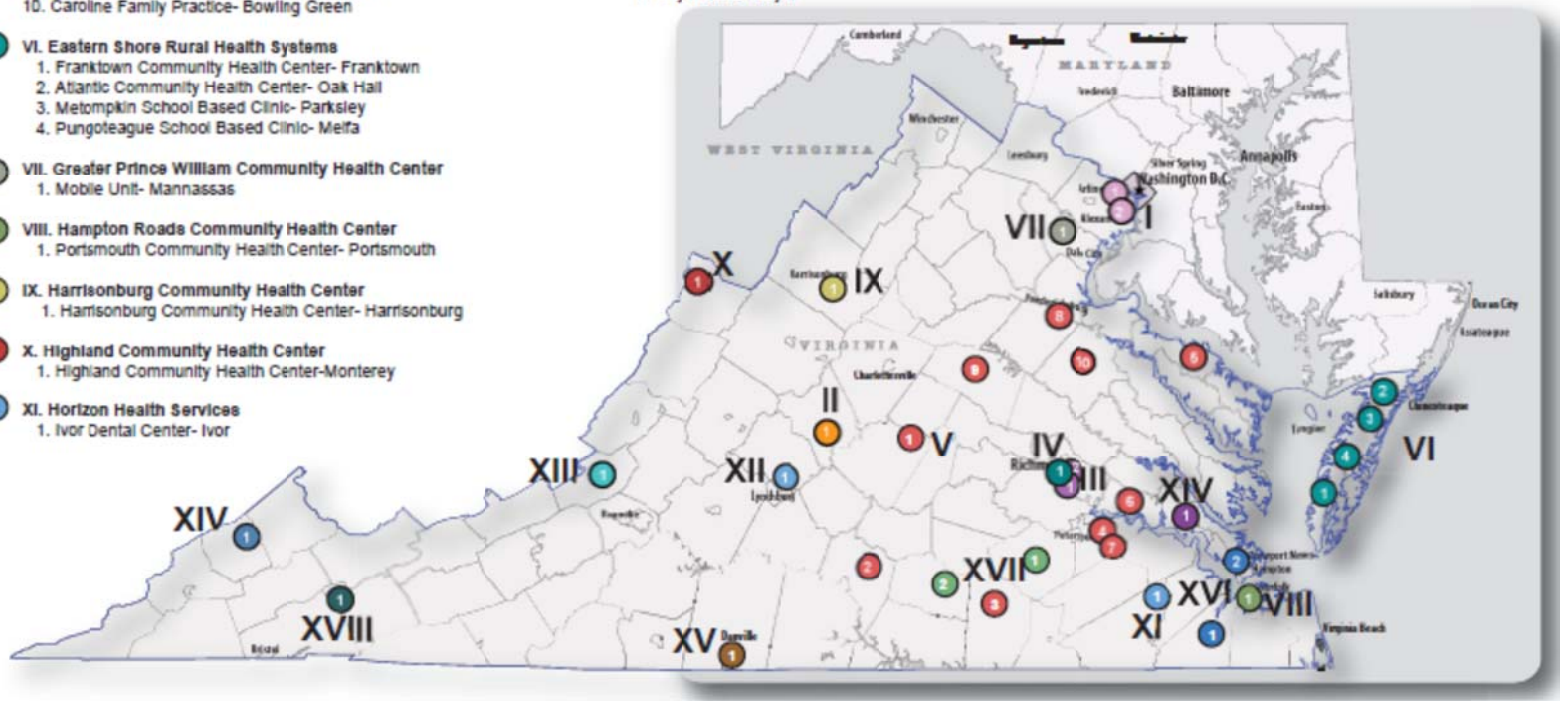
**XVI. Peninsula Institute for Community Health (PICH)**
1. Main Street Physicians- Suffolk
2. Community Dental Services- Newport News

**XVII. Southern Dominion Health Services**
1. Dinwiddie Family Dentistry- Dinwiddie
2. Southern Dominion Family Dentistry- Victoria

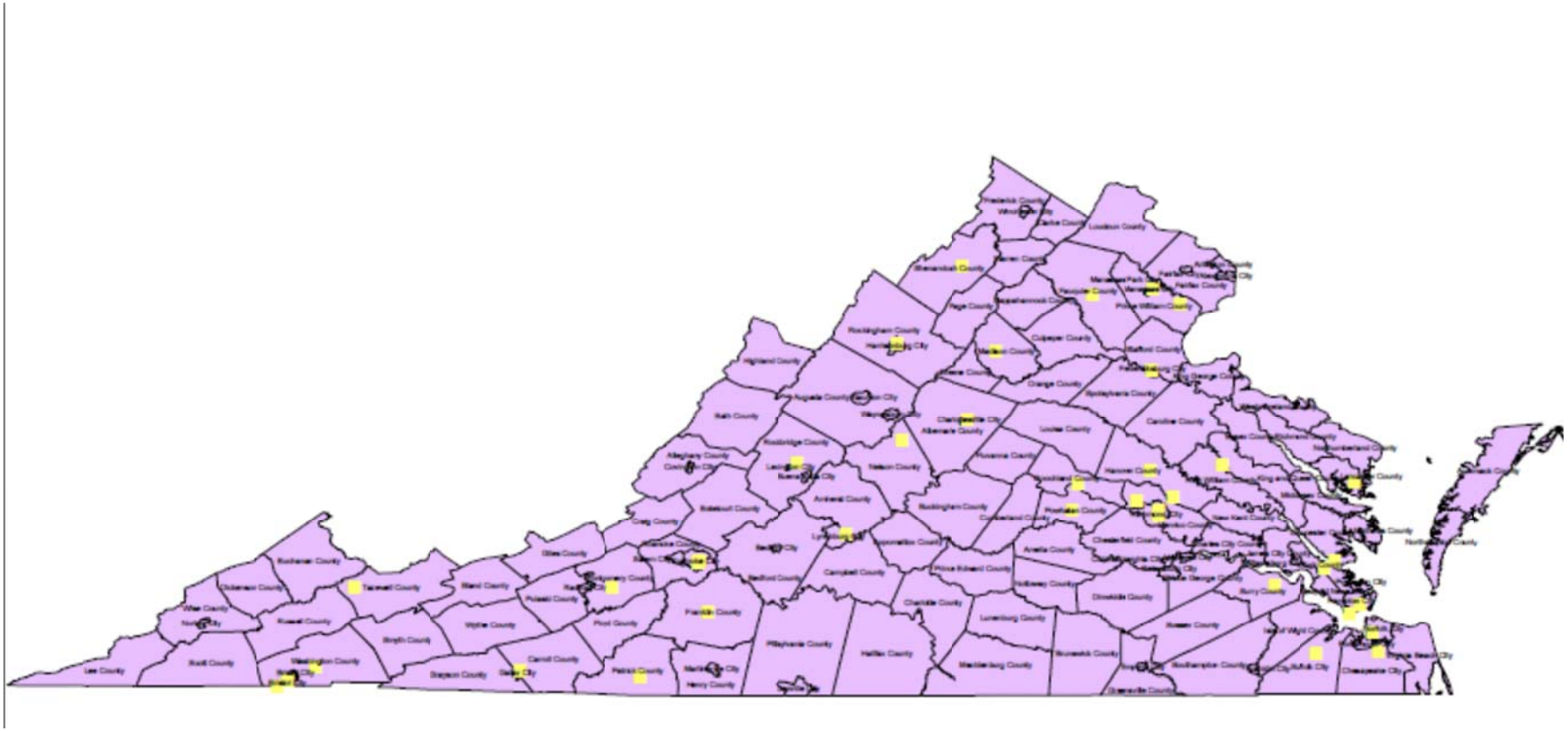
**XVIII. Southwest Virginia Community Health Systems**
1. Southwest Regional Dental Center- Saltville

**XIV. Stone Mountain Health Services**
1. Hayst Clinic- Hayst

VIRGINIA COMMUNITY HEALTHCARE ASSOCIATION



**Appendix H**
**Map of Free Clinic Dental Clinic Locations**



**Appendix I**
**Map of VDH, FQHC, and Free Clinic Dental Clinic Locations**