VOLUME 98, NUMBER 3 | JULY, AUGUST & SEPTEMBER 2021

VA DENTAL JOURNAL

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OF DENTAL, NURSING AND PHARMACY STUDENTS

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The Silver Scroll is awarded to the editor whose publication demonstrated the most overall improvement over the prior year of publication.

VA VDA DENTAL JOURNAL

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SHOULD WE BE ASKING OUR PATIENTS IF THEY HAVE BEEN VACCINATED?

Dr. Frank Iuorno, Jr.

This is the question we ask ourselves as we work back to some semblance of normal. Do we need to ask our patients if they have been vaccinated before treatment? When was the last time you have asked a patient if (s)he had the Hepatitis B vaccine, or the Chickenpox vaccine or Measles vaccine? Does knowing that information change the way you treat a patient? The real question centers on whether the doctor and staff have been vaccinated! To use a sports analogy, we need to play defense not offense when treating patients.

In fact, we approach all patients as if they have COVID (or a host of other potentially airborne/bloodborne transmissible diseases) which is why we implement universal precautions (originated in the 1980s in the wake of HIV) during treatment. We of course enhanced these precautions for COVID because of the highly contagious nature of this airborne pathogen, but the data now supports the fact that vaccinated individuals are protected from acquiring COVID and cannot unknowingly carry enough of a viral load to transmit the virus. This is key data to begin a transition into a more normal working environment…until a variant that is not covered by the vaccine surfaces.

Allow me to preface the following comments by stating that as I write this (June 1st), the CDC has not changed recommendations for dental offices and the VDA's updated interim guidance reflects this fact. The major paradox is that medical and dental healthcare facilities still need to screen patients prior to treatment, yet no other venues require screening. We hope and assume that the CDC will be updating guidance for dental offices soon and will update the VDA guidance document accordingly.

So, when treating patients, really nothing has changed for dentistry in the face of COVID other than the use of N95 masks, face shields and more stringent contact precautions. With the supportive data for fully vaccinated dental healthcare personnel (DHP), we assume that the CDC will support a more normal armamentaria with the removal of N95's and face shields for vaccinated DHP. We already know that the contact transmission data shows fomite transmission proves unlikely which may also encourage the CDC to mitigate "deep cleaning" routines and those all-too-frequent gown changes.

"Asking patients their vaccination status is not necessary and, in the absence of a universally accepted method of vaccine verification, is not advised."

What do we do about the times when we are not in the treatment areas covered in PPE and what does our administrative staff do…the reception area, back-office employees, etc.? This is when our offices (doctors and staff) play offense via vaccinations. We can again rely on the data to prove that fully vaccinated individuals who interact with patients and/or those people accompanying patients (whether or not vaccinated) can do so without a mask. The rub will be nonvaccinated providers and staff that remain at risk without knowing the status of the patient/accompanying individual. These employees will need to maintain PPE throughout the day. This is consistent with CDC guidelines outside of medical/dental facilities and we hope will carry through in their new guidance moving forward.

The reality is, if DHP have been vaccinated, normalcy is attainable once the CDC updates guidelines (in the absence of variants not yet discovered that are not covered by our current vaccines). If not vaccinated, DHP remain at risk and need to follow current guidelines wearing full PPE when treating patients and continue social distancing. Most assuredly, there will be variants, and vaccine boosters are likely coming. As for requiring the vaccine for employees, this question will be answered once vaccines move from emergency use authorization to full authorization.

Asking patients their vaccination status is not necessary and, in the absence of a universally accepted method of vaccine verification, is not advised. We must continue a strong sound defense against disease transmission using universal precautions that are consistent with current data on transmission. Our only offense continues to be vaccinations and booster shots when and if available. This is the tack we need to take when considering revisions in the future and I am hoping that the CDC looks at this through the same lens and updates guidance soon.

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WHAT PRICE SCIENCE?

Dr. Richard F. Roadcap

When the US dental profession was founded in the first half of the nineteenth century, its three components were education, literature, and a professional association. Science, and its application to dentistry, has been intertwined with all three, since the first dental school in the US opened its doors in 1840.

You may have noticed in reading the *Journal* that there are four themes in each issue: advocacy, membership, outreach, and science. Not only do the themes give us a framework for assembling articles, they also act as a guideline for acceptance. If an article cannot possibly be assigned to one of the four, we may question its suitability for our readers.

Of the four themes, science is the cornerstone for many state and regional dental publications. But scientific content can be the most difficult to obtain, and once it is in hand, it must withstand scrutiny that far exceeds other forms of content. We're proud that science has been in the forefront of each *Journal* issue for many years, and hope to continue that tradition. I've heard some state journals have abandoned original scientific manuscripts altogether, opting for re-prints of previously published articles, a practice we have avoided with one exception.[1]

Our science is presented in one of three formats: peer-reviewed manuscripts, abstracts prepared by students in graduate programs at VCU School of Dentistry, and a test of your oral pathology skills, prepared each issue by Dr. Sarah Glass. Scientific manuscripts often require months of review, followed by one or more revisions, then followed by a consensus among the reviewers to accept or reject the article for publication. Our board of editorial reviewers is listed on the masthead of each issue, and for their service we are eternally grateful. At times we call upon reviewers not listed in the *Journal*, who may have expertise in a specific subject and are well-qualified to render an opinion.

Unfortunately, we cannot recognize publicly the reviewers assigned to each manuscript. We employ what is known as a "single blind" method wherein the reviewers know the identity of the authors, but the authors do not know the identity of the reviewers. Some publications employ a "double blind" method, where neither the reviewers nor the authors know the identity of each other. Some time ago, we polled our reviewers as to their preferred method, and they overwhelmingly chose the "single blind" method. The alternate method poses certain problems in the digital era: reviewers ascertain authors' identities from internet searches of similar articles, and some content in the articles would have to be redacted to avoid revealing the identity of authors. It's hard to believe authors could remain anonymous if a reviewer used today's sophisticated search engines.

You may ask, "Is it fair for the reviewer to pass judgment on an author if their identity is known?" Proponents of both single-blind and double-blind methods cite studies that support their beliefs.[2,3] Some contend they can be fair and impartial, while others say they cannot if they know who wrote the article. This debate will continue for the time being. One of our reviewers told me some years ago, that if the subject were, for example, oral pathology, he would want to know if the authors had any expertise in that area.

We also treasure the abstracts prepared by residents in graduate programs at VCU. Five programs now contribute: Pediatric Dentistry, Oral and Maxillofacial Surgery, Advanced Education in General Dentistry, Periodontics, and Endodontics. I encourage you to at least read the subject matter and conclusion of each, as our students have offered up some "gems" for our consideration. Not only do the abstracts give us insight into today's dental education, they answer some of our toughest clinical questions. Are CBCTs better than radiographs in making a diagnosis? Are digital impressions better than elastomeric impressions? Are there alternatives to opioid pain relievers? These are some of the topics reviewed in previous issues. I look forward to reviewing each abstract, as there is much practical information to be gleaned despite the lengthy titles.

"Science is the cornerstone for many state and regional dental publications. But scientific content can be the most difficult to obtain, and once it is in hand, it must withstand scrutiny that far exceeds other forms of content."

Finally, I believe our readers would rebel if our Oral Pathology feature, "Through the Looking Glass" took a breather. Both Dr. Glass and her predecessor, Dr. John Svirsky, have made the arcane

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and inscrutable transparent to practicing dentists, to the delight of our readers, and most important, for the benefit of our patients. I feel certain more than one early life-saving diagnosis has resulted from their efforts. That could be considered priceless.

Despite the processes for manuscript review that were outlined here, the days of the peer-reviewed manuscript, available only to paid subscribers, may be numbered. Dental science and publishing is fast upon an era of "Open Access" where anyone, anywhere, can access an article without a subscription, often before the manuscript has undergone peer review. This is intended to release important scientific information that is time critical and may be needed before the months and years of the review process have ended. JADA Foundational Science, the ADA's first open-access publication, was launched this year.[4] Editor-in-Chief Jack Ferracane, PhD, a faculty member at Oregon Health Sciences University, said he wants to make the new publication open to scientists and clinicians of all disciplines.

Science and the dental profession in the United States have enjoyed a 180-year marriage. Like any marriage, the relationship has been strained at times. Science and the profession had become estranged about 1920, and it took decisive action by the profession's leadership to resolve the differences. (Another story, another time.) I'd love to hear from readers if they think we place too much, too little, or just the right amount of emphasis on science. Let's hope the relationship remains strong.

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MY ADA

Gary D. Oyster, DDS; ADA Trustee, 16th District

Many grocery stores encourage customer loyalty and continued patronage by offering excellent service. The ADA, through the board, councils, committees, and taskforces, is working hard to keep and recruit members.

The challenges in this endeavor are complex because of the differences between pre-baby boomers, baby boomers, Gen X, Millennials, and Gen Z (students), and also because of their values. Many of the Gen X and Millennials are employed dentists who may not directly value the benefits of advocacy and legislation to promote the practice of dentistry.

"By keeping a strong membership, we will be able to achieve positive legislation for patients and dentists..."

In addition to these membership issues, the public image of dentistry as the preeminent driver of trusted oral health information must be maintained. Dental benefit programs need to be sufficiently funded and third-party payer issue must be addressed.

By keeping a strong membership, we will be able to achieve positive legislation for patients and dentists like the Competitive Health Insurance Reform act, which was passed last year. We will promote health equity with webinars.

The budget committee and ADA Treasurer, Dr. Ted Sherwin, have come up with a 3-year plan and successfully reduced a $12.7 million deficit to a manageable $1.6 million. Reserves are up by 11% and net worth increased by $19.5 million. This work has been essential to maintaining ADA services while hopefully not raising your dues. The ADA is working hard to come up ways to have more young minority members be positioned in leadership roles.

Think of the ADA as a home. Its rooms feature a diverse collection of people, across a spectrum of both race and gender. All of them must work together to fulfill the duties and obligations of the home.

Two emerging issues are interstate compacts and the Half Dues Recruitment Campaign (Science Forward). Interstate compacts are a statutory agreement between states. Each party is a signatory to the same contract. It can be a means of addressing common problems. It is authorized under Article 1 Section 10 CL3 of the US Constitution. This may be an answer to the threat of a federally mandated solution. There are many interstate compacts in existence now covering a wide range of subjects. State licensure processes will remain in place and state practice acts are not impacted. State boards will function as they do now. This should result in the reduction of barriers to license portability plus allow state boards to accurately track practitioners subject to disciplinary action. The ADA has applied on behalf of dentistry and dental hygiene.

As we are recovering from the pandemic and patients are returning to our practices, a new problem is emerging: a shortage of hygienists and assistants not returning (for various reasons). This has left many practices scrambling to cover patients. Taskforces at the ADA and states are trying to come up with solutions. Possible scope of practice changes may be needed.

A new committee, Give Veterans a Smile, is in the planning stages. The goal of this committee is to help veterans that cannot receive care through the VA. The planning committee is chaired by Dr. Carol Summerhays and is planning a summit meeting next year.

As you can see, the ADA is working very hard to meet a variety of member needs. But only through member participation and action can the ADA be Your ADA.

MOVING HEALTH FORWARD

2021 CATALYST ANNUAL SUMMIT

Sarah Bedard Holland; CEO, Virginia Health Catalyst

Throughout the COVID-19 pandemic, Virginia's dental community has moved mountains to ensure patients and staff remain safe and healthy. VDA members have created new protocols, retooled visit structures, and implemented new technologies to continue to meet the needs of patients, even during a global health crisis. This year's 2021 Catalyst Annual Summit on October 7 in Richmond will celebrate this spirit of innovation.

As we move into a post-pandemic world Virginia's health care community is at a crossroads. We have a chance to improve our health care system so it works for all Virginians, removes silos to care, and addresses systemic racism. While these are lofty goals, through collaboration and shared learning we can reach them.

The 2021 summit has an agenda full of nationally recognized speakers including Dr. Bob Russell, a leader in value-based care, and the Public Health Dental Director for Iowa. Dr. Russell will share his passion and expertise as a public health dentist and a change agent who is transforming the dental care system. Along with Dr. Russell, our agenda features experts from across Virginia, who will share tangible and innovative ways to create tomorrow's health care system together. For VDA members, several sessions will leave you with tangible takeaways for your work. These include breakout sessions featuring clinical technical education topics like integrating HPV vaccine education into patient care.

The summit's full agenda will be available when registration opens in August. Be sure to visit our website **vahealthcatalyst.org** to register and receive the early bird pricing later this summer. I can't wait to see each of you in person in October!

"FROM SMALL SEEDS"

Marvin E. Pizer, DDS, MS, MA, FICD*

In 1973 I published an article in the *Virginia Medical Monthly* proposing the injection of oxygen directly into the middle of known malignancy followed by Cobalt-60 radiation. This applied to malignancy not metastasized. In Dr. Archer's textbook "Oral and Maxillofacial Surgery", (Fifth Edition, 1975), Charlotte D. Donlan, MD, FACR, a distinguished radiation therapist, mentioned my name and techniques for testing malignancies. (Chapter 2.9, page 1815, volume ii).

I recently remembered these thoughts I had, and research conducted on dogs with breast cancers, relating to injecting oxygen directly into cancerous cells. It seems that we have always had a dog in and around our house. Our veterinarian was Dr. Bud Fenton, who not only had an animal hospital but also made house calls. He knew how much I loved animals and asked me to visit his hospital and the different diseases and treatments for his "patients." I enjoyed and learned some ways to treat my dogs more like family. The one sentence that Dr. Fenton said on occasions that really upset me was, "We will put your dog to sleep." Once a female dog with breast cancer and obvious metastases was to be euthanized and I asked Dr. Fenton if I could perform some research on this dog.

I called my favorite radiation therapist, and she began to willingly work with me in Dr. Fenton's hospital. Over a period of a year we worked together. I injected oxygen into female dogs' malignancies in their breasts and Dr. Donlan proceeded with Cobalt-60 radiation afterwards. In probably 18 months we did 12 dogs of all sizes and species that were scheduled to be "put to sleep." Following Drs. Donlan and Pizer's treatment, the dogs were euthanized, their breasts removed, and carefully studied by a veterinary

pathologist. The findings were the same for all of the treated dogs. There was no evidence of any premalignant or malignant cells in any of the treated breasts. Dr. Donlan and I could not have been more content. Unfortunately, Dr. Fenton, our vet, passed away and the hospital was closed.

About this time I recognized from a journal that the same idea was being researched at the Medical College of Virginia, Radiation Department. I sent the head professor a summary of what we had accomplished and he responded with a letter about his similar research and success with white mice. Their work had been so successful that they tried it clinically with patients. Unfortunately, to my knowledge, this failed and we were so sad to hear about their patients. I still believe there is a seed for a potentially useful clinical application of our oxygen injection and radiation treatment – that our "seedling" still holds a curative possibility through additional research.

** with gratitude for the assistance of Kenneth E. Danty in writing this letter*

SMOKING HABITS AND ATTITUDES

OF DENTAL, NURSING AND PHARMACY STUDENTS

Daniel M. Laskin DDS, MS, Caroline K. Carrico, PhD and Spiro C. Stilianoudakis, MA

Although smoking has decreased from 43% in adults 18 years of age or older in 1965 to 24% in 1997 and 14% in 2020, tobacco use is still one of the major preventable causes of disease and death in the United States.[1] Healthcare professionals, as highly respected individuals, are in an ideal situation to educate patients about the dangers of smoking by anti-tobacco use counseling as well as by serving as role models.[2] However, their ability to do this effectively will depend upon their own smoking habits and attitudes toward smoking.[3] These generally become well established or modified during their professional education when they are exposed to smoking policies, general information about the dangers of smoking, and instruction on how to initiate smoking cessation programs.

Most prior studies on the delivery of smoking cessation programs and professionals as role models have focused on the medical profession. However, there is evidence that smoking cessation programs are also effective when delivered by non-physician health professionals.[4] Therefore, the aim of this study was to determine the smoking prevalence and attitudes toward smoking among a group of future dentists, nurses, and pharmacists.

Materials and Methods

This cross-sectional study was reviewed and approved by the Institutional Review Board at Virginia Commonwealth University. An original 7-question survey was constructed by the study team (Figure 1). The survey included questions regarding demographics (program, age, gender) along with past and current smoking status. Those who indicated that they had smoked were asked when they started and if they currently smoke. Those who reported currently smoking were asked how often they smoke, their primary reason for smoking, and whether they wish to quit in the future. All respondents were also asked if they believe smoking is a danger to their health.

Age _____ Gender _____ Year in School _____

Have you ever smoked?
Yes No

If yes, when did you start?
High School College Professional School

Do you smoke now?
Yes No

If yes, how often do you smoke?
Less than once a week Every week, but not every day Every day

Which of the following is your main reason for smoking?
Habit Relieve stress Boredom Reward for hard work Pleasure Depression Other

Do you believe smoking is a danger to your health?
Yes No

Do you wish to quit smoking in the future?
Yes No

Figure 1: Smoking Survey

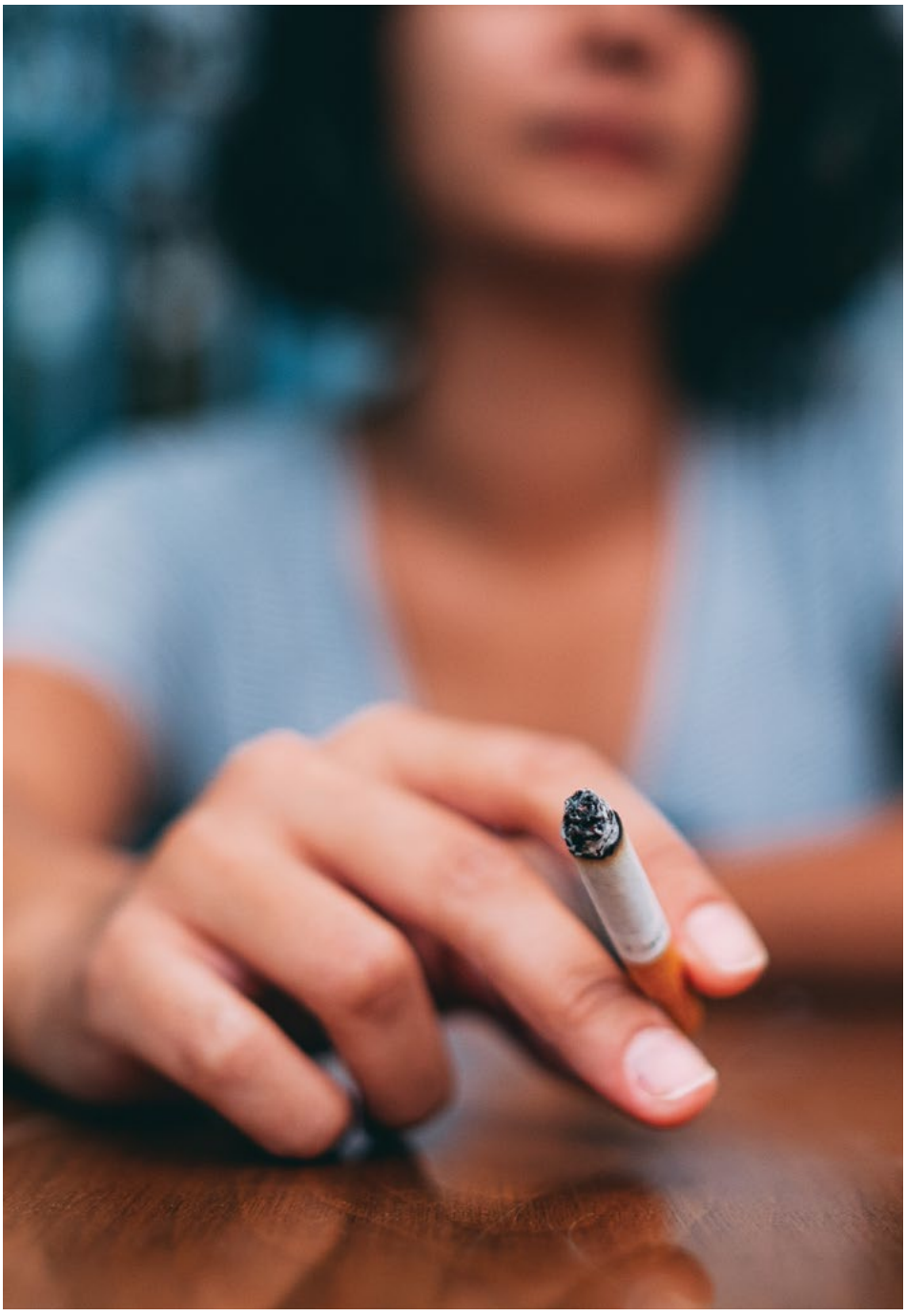
Study data were collected and managed using REDCap electronic data capture tools hosted at Virginia Commonwealth University.[5] REDCap (Research Electronic Data Capture) is a secure, web-based software platform designed to support data capture for research studies. Professional students in Pharmacy, Nursing, and Dentistry were eligible to participate in the study. School of Pharmacy students received an email with a public link from the Associate Dean of Admissions with an invite to participate. Similarly, undergraduate nursing students were sent an email to participate with a public link by the Assistant Dean in the Office of Student Success at the School of Nursing. Within the School of Dentistry, a public link was emailed via Listserv to all students by the study PL(DL). Participation was voluntary and all responses were anonymous.

Results

A total of 256 students responded to the survey (Table 1). The response rate of the respondents was 24% for dentistry (n=94),13% for pharmacy (n=72), and 32% for nursing (n=90). The average age was 26.9 (SD=4.5), 25.5 (SD=4.2), and 27.9 (SD=9.5) for dentistry, pharmacy, and nursing, respectively. A majority of the nursing students had completed one year of schooling (51.1%), while most dental and pharmacy students were in their second year (33.3% and 38.3%, respectively).

Eighty-one of the 256 respondents (31.7%) indicated that they had smoked in the past (dentistry – 23/94, 24%; pharmacy – 28/72, 39%; nursing – 30/90, 33%). There was no significant difference in age among the three groups of smokers, but there was a significantly greater proportion of females in the nursing group than in the other

"A relatively large number of respondents indicated that they were previously smokers (31.7%). Based on the fact that most started smoking in high school or college (age 16 or older), this was a considerably greater percentage than the 19.3% reported in the general population."



two groups (Table 1). Most had started smoking in high school or college (Table 2). Only one started while in professional school.

Only 19 of the 81 past smokers were now still smoking (dentistry – 4/23 (18%); pharmacy – 5/28 (18%); nursing – 10/30 (33%)). Nursing students who smoked were on average younger than non-smokers (24.0 (3.6) vs 27.9 (9.5), but pharmacy and dental students who still smoked were older (28.4 (3.8) vs 25.5 (4.2) and 32.5 (7.7) vs 26.9 (4.5), respectively. No student in dentistry and only four in pharmacy and five in nursing smoked every day. The reasons stated for smoking are shown in Table 3. Except for stress noted by the nursing students, there was no generally focused reason given by the other groups. All the smokers believed that smoking was a danger to their health. However, whereas all 10

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Variable	Dentistry (n=94)	Nursing (n=90)	Pharmacy (n=72)	P-value
Age (mean (SD))	26.9 (4.5)	27.9 (9.5)	25.5 (4.2)	0.097
Unknown age (%)	6 (6.4)	7 (7.8)	7 (9.7)	
Gender (%)				<0.001
Male	39 (41.5)	5 (5.6)	22 (30.6)	
Female	55 (58.5)	84 (93.3)	50 (69.4)	
Other	0 (0.0)	1 (1.1)	0 (0.0)	
Year in program (%)				<0.001
0	0 (0.0)	23 (25.6)	12 (16.7)	
1	22 (23.4)	46 (51.1)	21 (29.2)	
2	36 (38.3)	11 (12.2)	24 (33.3)	
3	22 (23.4)	7 (7.8)	14 (19.4)	
4+	14 (14.9)	3 (3.3)	1 (1.4)	
Have you ever smoked (%)				0.128
No	71 (75.5)	60 (66.7)	44 (61.1)	
Yes	23 (24.5)	30 (33.3)	28 (39.9)	

Table 1: Socio-demographic variables stratified by program. P-values are obtained from Analysis of Variance tests for continuous variables and Chi-Square tests for categorical variables.

Variable	Dentistry (n=4)	Nursing (n=10)	Pharmacy (n=5)	P-value
When did you start smoking (%)				0.247
High School	0 (0.0)	3 (30.0)	3 (60.0)	
College	2 (50.0)	6 (60.0)	2 (40.0)	
Professional School	1 (25.0)	0 (0.0)	0 (0.0)	
Other	1 (25.0)	1 (10.0)	0 (0.0)	
Age (SD)	24.0 (3.6)	28.4 (3.9)	32.50 (7.8)	0.032
How often do you smoke (%)				0.111
Less than once a week	3 (75.0)	2 (20.0)	1 (20.0)	
Every week, but not every day	1 (25.0)	3 (30.0)	0 (0.0)	
Every day	0 (0.0)	5 (50.0)	4 (80.0)	
Do you want to quit (%)				0.065
No	2 (50.0)	0 (0.0)	1 (20.0)	
Yes	2 (50.0)	10 (100.0)	4 (80.0)	
Do you feel that smoking is a danger to your health (%)				--
No	0 (0.0)	0 (0.0)	0 (0.0)	
Yes	4 (100.0)	10 (100.0)	5 (100.0)	

Table 2: Smoking related variables for students that were classified as current smokers (n=19). P-values are obtained from Analysis of Variance tests for continuous variables and Chi-Square tests for categorical variables.

nursing students wished to quit, only 4/5 pharmacy students and 2/4 dental students wanted to stop smoking.

Discussion

A relatively large number of respondents indicated that they were previously smokers (31.7%). Based on the fact that most started smoking in high school or college (age 16 or older), this was a considerably greater percentage than the 19.3% reported in the general population by the Centers for Disease Control for their approximate school year (2010), especially since smoking is generally reported to be less in persons with higher education level.[6]

The number of initial smokers who continued to smoke in 2020 was greatly reduced in the dental and pharmacy groups, but not the nursing students, although the percentage of smokers in all groups was still more than the national average for that year (14%). A review of the smoking-based information in the curriculum in the three schools provides a possible explanation for this difference. Whereas, both dentistry and pharmacy provide lectures on the adverse effects of smoking and the need for smoking cessation programs, this is not included in the nursing curriculum. Since all health professional education programs are accredited and therefore have relatively the same basic curriculum, one would expect a similar situation in other universities.

The trend seen in these health professional students is also mimicked in the populations of practicing health professionals, with nurses demonstrating higher rates of smoking than other health professionals, and even higher rates than the general population.[7] This further stresses the importance of increased curriculum regarding smoking in nursing school.

Based on the relationship between stress and smoking among professional students previously reported in the

literature[8-10] one would expect that this is the reason for the overall greater percentage of smokers in the respondents compared to the general population. However, although the relief of stress was reported as the reason by 60% of the nursing students who currently smoke, this was not true for those in dentistry or pharmacy.

Because this study was based in one university, the relative numbers of respondents was small, and this could have led to the difference in percentages found in comparison to those in national surveys. However, the significance of these data lies in the trends that they display. In this regard, two factors stand out. The first is that, although there is always room for improvement, the number of professional students who smoke is relatively small. Thus, they are in a good position to serve as future role models and educators. The second is the relationship between the anti-smoking curricular content and the smoking habits of the students. There is a need for all professional schools to evaluate their curriculum in this area to be sure that the students receive adequate information. This will not only help assure that these students are less likely to smoke, but also upon graduation it will allow them to play an important part in helping to further reduce the smoking habits of others.

"Although there is always room for improvement, the number of professional students who smoke is relatively small. Thus, they are in a good position to serve as future role models and educators."

Reason for smoking (%)	Dentistry (n=4)	Nursing (n=10)	Pharmacy (n=5)	P-value
				0.114
Habit	0 (0.0)	1 (10.0)	2 (40.0)	
Relieve stress	0 (0.0)	6 (60.0)	1 (20.0)	
Boredom	2 (50.0)	0 (0.0)	0 (0.0)	
Reward for hard work	1 (25.0)	0 (0.0)	1 (20.0)	
Pleasure	1 (25.0)	1 (10.0)	1 (20.0)	
Depression	0 (0.0)	1 (10.0)	0 (0.0)	
Other	0 (0.0)	1 (10.0)	0 (0.0)	

Table 3: Evaluating the reason for smoking among students that were still considered smokers. The p-value is obtained from a Chi-Square test.

Conclusion

Relatively few dental, nursing and pharmacy students in this survey are smokers and they serve as good future anti-smoking role models and public educators. This should encourage those who are still smokers to quit thus adding to this pool. Non-physician healthcare professional schools need to assure that their curricula provide the proper background education and training for this to occur.

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Authors:
Daniel M. Laskin DDS, MS, Professor and Chairman Emeritus, Department of Oral and Maxillofacial Surgery, Virginia Commonwealth University School of Dentistry

Caroline K. Carrico PhD, Associate Professor, VCU School of Dentistry, Department of Dental Public Health and Policy Oral Health Services Research Core, VCU Philips Institute for Oral Health Research. Affiliate Associate Professor, Department of Biostatistics, VCU School of Medicine

Spiro C. Stilianoudakis, MA, Graduate student, Department of Biostatistics, Virginia Commonwealth University School of Medicine

Address Correspondence to:
Dr. Daniel M. Laskin
Department of Oral and Maxillofacial Surgery
VCU School of Dentistry
521 N. 11th St.
Richmond, VA, 23298-0566
804-828-3547 (Phone)
804-828-1753 (Fax)
dmlaskin@vcu.edu

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V S P E N I N S U L A J N Z D N R H C I C S E C U R I T Y J
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PRIDE

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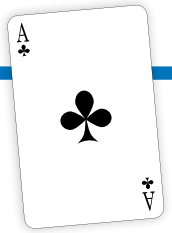
THROUGH THE LOOKING GLASS

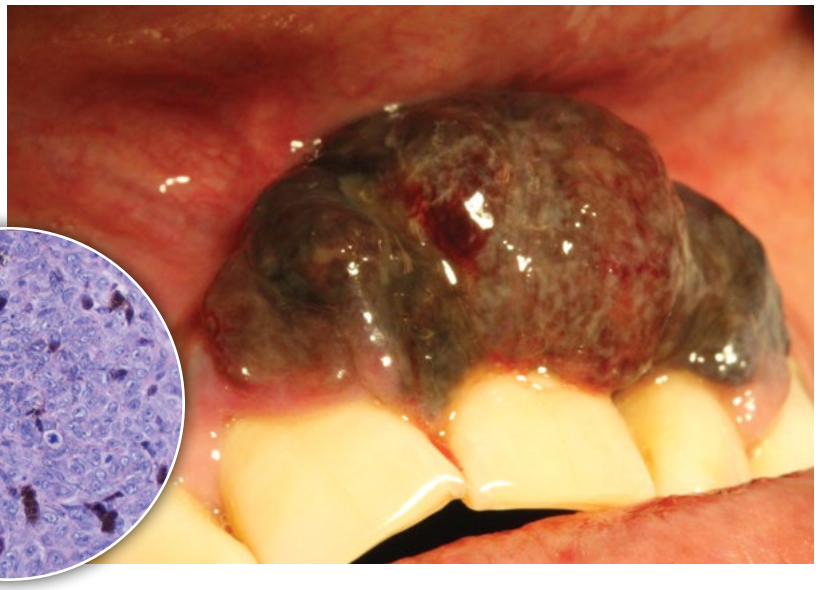
WITH DR. SARAH GLASS

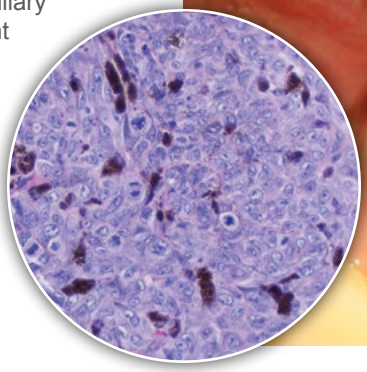
EXPLORE THE FANTASTICAL WORLD OF ORAL PATHOLOGY

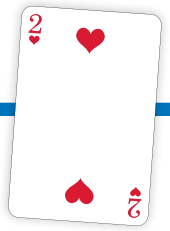
Editor's Note: Dr. Sarah Glass is a board certified Oral and Maxillofacial Pathologist. She works as an assistant professor at VCU School of Dentistry, and her job responsibilities include teaching, working in the biopsy service, and seeing oral medicine patients.



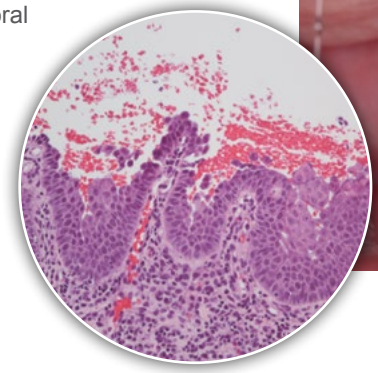
A 58-year-old male patient presents for an urgent appointment with a fast-growing mass on the maxillary buccal gingival tissue. Adjacent teeth are mobile on exam. What is the diagnosis?

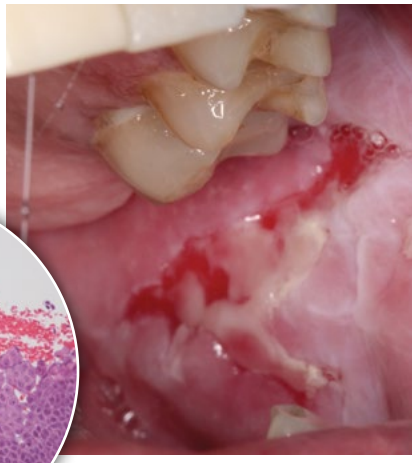




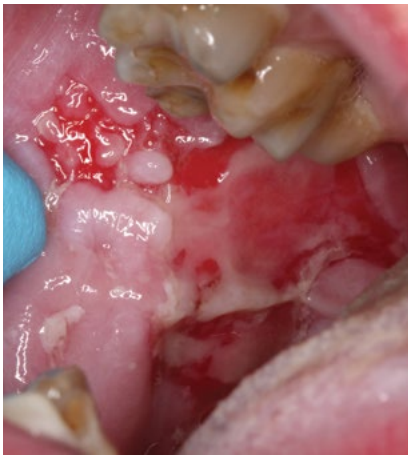


A 57-year-old male patient presents for an urgent appointment with oral pain. He is unable to eat without his oral mucosa sloughing. The tissue demonstrates a positive Nikolsky sign on exam. What is the diagnosis?

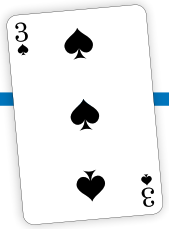




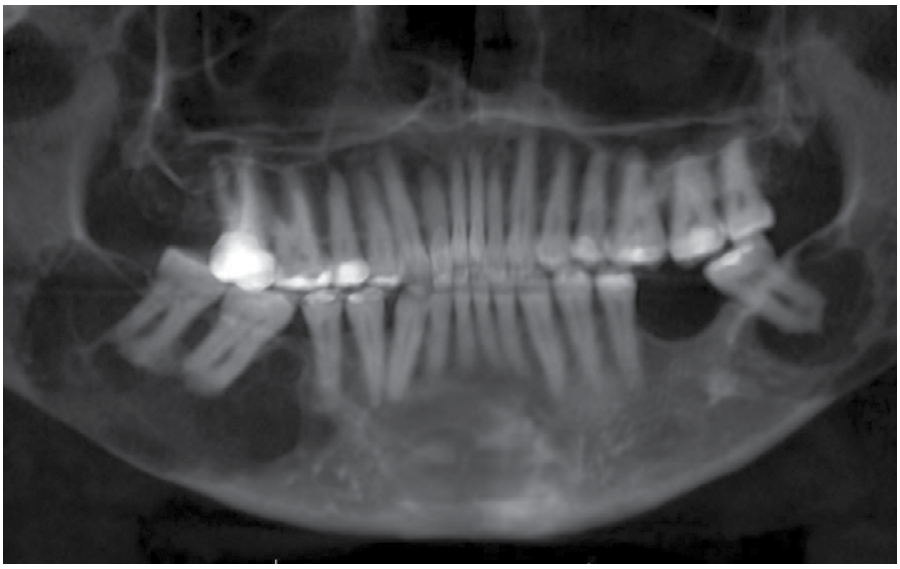
Left cheek



Right cheek



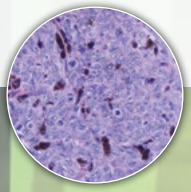
Bilateral mandibular lesions are seen on a panoramic image of a 45-year-old female. On surgical exploration, the lesions are empty. What is the diagnosis?



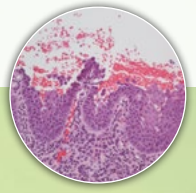
>> ANSWERS ON NEXT PAGE

>> THROUGH THE LOOKING GLASS ANSWERS CONTINUED FROM PAGE 17

1. Although rare, the hard palate and maxillary gingiva are high risk sites for **oral malignant melanoma**. The biopsy confirms the diagnosis. Most cases contain melanin, which corresponds to brown pigmentation clinically, however, some cases may be amelanotic.



2. The histopathology shows an intraepithelial split due to desmoglein 3 autoantibodies. This patient has **pemphigus vulgaris**.



3. The panoramic image shows two large radiolucencies. Also noted are scattered radiopacities around the apices of several teeth. This patient has florid cemento-osseous dysplasia with associated **simple bone cysts/traumatic bone cysts**. Simple bones cysts can arise in association with other fibro-osseous proliferations.

RANDOMIZED AND CONTROLLED CLINICAL TRIAL OF BONE HEALING AFTER ALVEOLAR RIDGE PRESERVATION USING XENOGRAFTS AND ALLOGRAFTS VERSUS PLASMA RICH IN GROWTH FACTORS

Stumbhras A, et al. | J Oral Implantol. 2020; 46(5):515-25

BACKGROUND: Implant therapy requires maintaining a sufficient amount of alveolar bone volume. Recently, dental implant therapy has shifted from implant placement in a fully healed bone to treatment protocols that reduce overall treatment time, such as immediate implant placement. Bone resorption is greatest the first 3 months with two-thirds of volume loss on the buccal bone plate, resulting in the palatal/lingual shift of the alveolar crest, especially in the thin periodontal biotype. Although the dimensions of alveolar bone are important for a proper dimensional position of the implant, the quantity of newly regenerated bone is related to successful integration and long-term stability of dental implants.

PURPOSE: The purpose of this randomized controlled trial was to compare bone regeneration in the anterior maxilla between bone substitutes and autologous platelet concentrate in alveolar ridge preservation.

METHOD: Forty patients requiring tooth extraction in the anterior maxilla were randomly allocated to the following 4 treatment modalities: spontaneous healing (control), natural bovine bone mineral covered with resorbable native collagen membrane(BBM), freeze-dried bone allograft covered with resorbable native collagen membrane (FDBA), and plasma rich in growth factors (PRGF) alone. Patients were randomly allocated into groups and the one surgeon was unblinded after extraction. Core-biopsies were taken for histological analysis after 12 weeks.

RESULTS: Histomorphometrically analysis revealed that the newly formed tissue was highest in the PRGF group 75.5% ± 16.3%,the control group 46.5% ± 15.2%, BBM group 20.3% ± 21.9% and FDBA group 7.2% ± 8.6%. Residual bone graft material occupied 45.0% ± 19% of the sample volume in the BBM/Collagen Membrane group as compared with the 38.5% ± 26.4% in the FDBA group. This difference was not statistically significant. The new mineralized tissue formation was in the following order in the studied sample: PRGF > control > BBM > FDBA.

CONCLUSION: Authors concluded that the use of PRGF for extraction socket preservation in the esthetic area increased bone regeneration and the amount of newly formed bone. Histologically, sites treated with FDBA have a smaller percentage of residual bone graft substitute. The present study demonstrated significantly greater new bone formation in ridge preservation with PRGF as compared with spontaneous healing and sites grafted with BBM whether FDBA covered with collagen membrane. However, the author did not compare the dimensional change of each group in their study. Although there is more mineralized tissue based on the findings of this randomized controlled trial, future clinical trials are needed to determine the clinical benefits of PRGF histologically and dimensionally.

Dr. Michael Ha; Resident in Periodontics, Virginia Commonwealth University

THE IMPACT OF 3D IMPLANT POSITION ON EMERGENCE PROFILE DESIGN

Esquivel J, et al. | Int J Periodont Restor Dent. 2021;41(1):79-86.

BACKGROUND: Both implant position and the thickness of soft tissue have an influence on the abutment design. Ideally, the implant should be placed in the optimal spatial position to maintain the adjacent hard and soft tissues. However, when the implant is not placed in the ideal position, then prosthetic variations to the implant prosthetic abutment and restoration are required.

PURPOSE: The purpose of this study was to illustrate and explain the effect of different implant positions on the emergence profile design. This is essential for prosthetic and surgical treatment planning as well as for long-term esthetic and functional success.

METHOD: This article reviewed literature associated with this topic and addressed various subtopics relating to 3D implant position and emergence profile design, such as implant depth, interproximal position, and bodily position.

RESULTS: Optimal 3D implant position is the first and fundamental factor for esthetic treatment outcomes. The stability of bone and soft tissue is compromised when an implant is not placed in the optimal spatial position, and additional surgical procedures may be required to correct this. Implant depth—ideally, the implant should be placed 3-4mm apical to the ideal prospective gingival zenith on the restoration. Placing any deeper will increase the risk of biologic complications and placing too shallow will create an aggressive flare on the emergence design. Interproximal position— biologic principles, such as necessary space between adjacent implants and/or teeth must be considered. Ideally, the implant should be positioned in the center of the mesiodistal width of the proposed restoration. This allows a bi-concave/convex emergence design on both sides of the implant mesiodistally. If the implant is offset from the center, then this will cause one side of the emergence profile to be flat/straight with the other side being excessively contoured. Bodily position—this depends on the anatomy and morphology of the existing hard tissue. There should be at least 2mm between the implant body and buccal plate. Ideally, the implant position should be slightly lingual in the bony housing/post extraction socket. The further facial the implant is placed, the flatter the facial emergence profile and the greater the risk of buccal bone loss and compromised esthetic results.

CONCLUSION: The importance of emergence profile design of the implant abutment comes from its potential to modify the root-like eminence of the soft tissues, its contour, the papilla shape, and the soft tissue zenith position in the final restoration. Developing naturally emerging dental implant restorations is a challenging and multifactorial task. The design of the emergence profile in implant restorations must be done with great precision and knowledge of both esthetic and biologic principles. The implant abutment emergence profile design is influenced not only by the implant position but by the hard and soft tissue conditions as well. In order to increase esthetic success in dental implant therapy, one must understand this and have adequate implant position and tissue thickness.

Dr. Erin E. Block; Resident in Periodontics, Virginia Commonwealth University

PERI-IMPLANT SOFT TISSUE PHENOTYPE MODIFICATION AND ITS IMPACT ON PERI-IMPLANT HEALTH: A SYSTEMATIC REVIEW AND NETWORK META-ANALYSIS

Tavelli L, et al. | J Periodontol. 2021; 92(1):21-44.

BACKGROUND: The peri-implant soft tissue phenotype (PSP) includes keratinized mucosa width (KMW), mucosal thickness (MT) and supracrestal tissue height (STH). It is considered a critical factor on the esthetic outcomes, the stability of mucosal margin and marginal bone loss. Several techniques that augment the PSP to improve peri-implant health have been investigated but their efficacy and whether they are beneficial for peri-implant health is still debatable.

PURPOSE: The purpose of this systematic review was to investigate the efficacy of different PSP modification techniques in augmenting PSP and in promoting implant health.

METHOD: A detailed systematic literature search was conducted by two calibrated examiners to identify clinical studies that attempted PSP modification and reported findings on KMW, MT and STH. Selected articles were classified based on the surgical approach to increase PSP, either bilaminar or an apically positioned flap (APF) technique. To assess and compare different techniques a network meta-analysis including only randomized-controlled trials (RCTs) reporting on PSP outcomes was conducted.

RESULTS: The qualitative analysis included 52 articles, and 23 RCTs were included in the network meta-analysis. Sixteen RCTs reported the outcomes of PSP modification therapy with bilaminar techniques, whereas 7 involved the use of APF. The analysis showed that bilaminar techniques in combination with soft tissue grafts (connective tissue graft [CTG], collagen matrix [CM], and acellular dermal matrix [ADM]) resulted in a significant increase in MT compared to non-augmented sites but no significant differences in KMW. CTG and ADM provided higher MT gain as compared to CM and non-augmented sites. CTG or CM approaches showed beneficial effects on marginal bone level stability whereas APF- based approaches were inconclusive. APF-based approaches in combination with free gingival graft (FGG), CTG, CM, or ADM showed a significant KMW gain compared to non-augmented sites with FGG exhibiting a significantly higher KMW gain than APF alone. APF with any soft tissue graft was associated with reduction of probing depth, soft tissue dehiscence and plaque index compared to non-augmented sites.

CONCLUSION: The highest amount of MT gain was obtained with CTG or ADM, whereas the most effective technique for increasing KMW was APF in combination with FGG. APF-based approaches were associated with a significant reduction in probing depth, soft tissue dehiscence and plaque index, whereas bilaminar techniques with CTG or CM showed beneficial effects on marginal bone level stability.

Dr. Lina Elnakka; Resident in Periodontics, Virginia Commonwealth University

IMPLANT SURVIVAL AFTER SURGICAL TREATMENT OF EARLY APICAL PERI-IMPLANTITIS: AN AMBISPECTIVE COHORT STUDY COVERING A 20-YEAR PERIOD

Penarrocha-Diago, et al. Int J Implantol. 2020;13(1):1-10

BACKGROUND: Early apical peri-implantitis (EAP) or implant periapical disease is a phenomenon that occurs when a host inflammatory response occurs following implant placement in the apical region which can compromise osseointegration and lead to implant failure. The literature available on this topic suggests a prevalence of 0.26-7.8% of all implants. This disease process can present with clinical signs such as the presence of a fistula, intraoral swelling, and drainage in acute situations. Radiographically, apical radiolucency may or may not be present and diagnosis can be supported by symptoms such as pain and a sensation of tightness. Surgical treatment of this condition involves the reflection of a full-thickness flap, ostectomy at the area of interest with degranulation and may include apical resection of the implant body. Treatment goals include the resolution of symptoms, eradication of infection, and successful osseointegration. This publication explores the efficacy of this treatment in terms of implant retention and survival.

PURPOSE: The purpose of this ambispective cohort study was to describe implant survival at least 1 year after the surgical treatment of early apical peri-implantitis (EAP) and explore potential risk factors of such treatment.

METHOD: An ambispective cohort study was conducted, involving all patients in whom EAP was detected and surgically treated between 1996 and 2016. Reporting followed the STROBE guidelines. The time from implant placement (IP) to EAP surgery (EAPS), the diagnostic stage and intraoperative variables (location, apical lesion in the tooth being replaced, mesial and distal tooth-implant distance measured at the apex, periapical surgery of the adjacent tooth, guided bone regeneration, implant resection, explantation) were recorded to determine their impact upon treatment outcome.

RESULTS: The initial sample consisted of 58 implants in 46 patients. The mean time from IP to EAPS was 21.7 ± 10.1 days. At the time of surgery, 8 implants presented mobility and were explanted. The final sample consisted of 50 implants in 39 patients evaluated for implant survival after surgical treatment. A cumulative survival rate of 78.3% was recorded. The mean survival time of the EAP treated implants was 85.4 months (standard deviation [SD] 5.94). The diagnostic stage ($P < 0.001$) and the existence of a previous periapical lesion in the tooth being replaced ($P = 0.022$) had a significant influence upon implant survival.

CONCLUSION: Authors concluded that the cumulative survival rate was 78.3%, with a mean survival time of 85.4 months. The diagnostic stage of EAP and the presence of a lesion in the tooth being replaced significantly influenced the survival of implants with EAP subjected to surgical treatment.

Dr. William W. Porzio; Resident in Periodontics, Virginia Commonwealth University

SOFT TISSUE HEALING AROUND PLATFORM-SWITCHING AND PLATFORM MATCHING SINGLE IMPLANTS: A RANDOMIZED CLINICAL TRIAL

Cheng, et al. | J Periodontol. 2020;91(12):1609-1620.

BACKGROUND: Platform-switching (PS) design in implants has been shown to reduce marginal bone loss. The influence of platform-switching on peri-implant soft tissue healing has yet to be elucidated.

PURPOSE: The purpose of this study was to compare the healing of peri-implant soft tissue around PS and Platform-matching (PM) abutments after implant uncovery using clinical parameters, biomarker profiles in peri-implant crevicular fluid (PICF), and gene expressions in peri-implant mucosa.

METHOD: Patients recruited for this study were: non-smokers requiring two implants in separate quadrants. For each patient, one PS implant and one PM implant were placed using a two-stage protocol. Following two to eight months of post-operative healing, all implants were uncovered and connected to the PS or PM healing abutments. Clinical measurements and PICF were taken at 1, 2, 4, and 6 weeks following the 2nd stage procedure. >

TREATMENT OF PERIODONTAL INTRABONY DEFECTS USING BOVINE POROUS BONE MINERAL AND GUIDED TISSUE REGENERATION: A RANDOMIZED CONTROL CLINICAL TRIAL

Liu K, et al. | J Periodontol. 10 February 2021; https://doi.org/10.1002/JPER.20-0860

BACKGROUND: Guided tissue regeneration (GTR) is an important part of periodontal therapy to help restore lost periodontium. While space maintenance and cell occlusion are the guiding principles of GTR, the addition of bone grafts, such as bovine porous bone mineral (BPBM) and biologics are frequently used in together. Platelet-rich fibrin (PRF) contains autologous biologic agents that can promote the proliferation, differentiation and migration of fibroblasts, periodontal ligament cells and osteoblasts and theoretically improve GTR outcomes.

PURPOSE: The purpose of this randomized split mouth clinical control trial is to compare treatment effects of GTR + BPBM and GTR+BPBM/PRF.

METHOD: There were a total of 15 patients with Stage IV Grade C Periodontitis with bilateral intrabony defects with a depth of > 3mm. Smokers, uncontrolled systemic disease, poor oral hygiene and pregnant women were excluded. Presurgical treatment included initial therapy with scaling and root planing and oral hygiene instructions. Surgical therapy consisted of sulcular incisions, full thickness mucoperiosteal flap, scaling and root debridement. 10mL whole blood was obtained from each patient in sterile tubes without any anticoagulation and centrifuged for 3 mins at 700 RPM. Then the plasma layer and buffy coat layer was harvested, known has liquid PRF, and mixed with BPBM for test sites. BPBM/PRF sticky bone block was placed in the defect with a collagen membrane on top in test sites. In the control sites, BPBM without PRF was placed with a collagen membrane. Sites were sutured closed with 5-0 nylon. Post surgical treatment consisted of 500mg amoxicillin TID for 7 days, chlorhexidine rinse BID, suture removal at 2 weeks and postoperative exams at 5, 12, 24 months.

RESULTS: Probing depth (PD) in the test group was significantly less than the control group at 12 and 24 months with a mean difference 0.5-0.7mm. Clinical attachment level (CAL) gain in the test group was 1mm at 12 and 24 months postoperative. There were no differences in radiographic depth between the two groups.

CONCLUSION: The authors concluded that the addition of PRF was beneficial in improving clinical parameters, particularly with an increase of 1mm CAL compared to the control sites, which remained stable at 2 years. In addition, PRF combined with BPBM creates a sticky bone block which improved handling and significantly reduced surgery time. This may help prevent saliva contamination of the graft material. Saliva contamination can produce less successful outcomes in regeneration. The authors in this study have demonstrated the benefits of PRF, which include improved handling, shorter surgery time, and the addition of growth factors found in PRF can augment regeneration. Further clinical studies with a larger sample size and histologic data would be beneficial.

Dr. Nitya Reddy; Resident in Periodontics, Virginia Commonwealth University

Concentrations of cytokines in PICF were analyzed. Peri-implant mucosa (1 x 2 x 2 mm) was harvested around the healing abutments for analysis of gene expression at uncovering and 6 weeks following uncovering.

RESULTS: Eighteen patients participated in this study. Compared to PM, PS showed significantly decreased probing depth at 1 and 2 weeks as well as modified sulcus bleeding index at 1, 4, and 6 weeks ($P<0.05$). Over the course of the observation, a decrease in osteoprotegerin and interleukin-1β concentrations in PICF along with an increase in receptor activator of nuclear factor kappa-B ligand, periostin, and peroxidasin gene expressions in peri-implant mucosa were noted within both groups ($P < 0.05$) without significant intergroup differences.

CONCLUSION: Authors concluded, within the limitations of this study, implants with PS design demonstrated significant benefits over PM design in probing depth and modified sulcus bleeding index reduction during the 6-week healing period. However, molecular changes within PICF and peri-implant mucosa as a response to PM and PS appear to be negligible in this study.

Dr. Sara E. Holden; Resident in Periodontics, Virginia Commonwealth University

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THE ASSOCIATION OF MANDIBULAR THIRD MOLAR IMPACTION WITH THE DENTAL AND PERIODONTAL LESIONS IN THE ADJACENT SECOND MOLARS

Tai S, et al. | J Periodontol. 05 February 2021. https://doi.org/10.1002/JPER.20-0424

BACKGROUND: There is a consensus that symptomatic impacted mandibular third molars (MTMs) need to be removed, although the prophylactic extraction of asymptomatic impacted MTMs remains controversial. The impactions of MTMs causes a variety of diseases, such as pericoronitis, facial infections, caries of adjacent teeth, periodontitis, external root resorption, cyst/neoplastic changes, orthodontic/prosthetic difficulties, and temporomandibular joint symptoms.

PURPOSE: The purpose of this study was to provide clues and guidelines for oral surgeons to estimate the need for prophylactic removal of asymptomatic impacted MTMs in clinical practice.

METHOD: Using a database of 1,800 panoramic radiographs, 2,650 impacted MTMs were evaluated for the type of impaction. Additionally, MTMs and adjacent mandibular second molars (MSMs) were evaluated for periodontal lesions and the presence and type of dental lesions, such as caries.

RESULTS: Mesioangular MTM impaction was the most common finding, with 68% of teeth evaluated, followed by horizontal(23%), inverted(8%), and disto-angular(1%) impactions. Dental lesions were found in 7% of MTMs, and were most common with mesio-angular(9%) and disto-angular impactions(13%). Periodontal lesions were present on 37% MTMs evaluated. These lesions were most commonly seen mesioangular and horizontal impactions. Adjacent MSMs were found to have dental lesions in 25% of teeth, with lesions most commonly on the distal surfaces adjacent to mesioangular and disto-angular MTMs. Similar incidence of periodontal lesions were seen on adjacent MTMs (35%), again most commonly on with mesioangular and disto-angular MTM impactions. A significant association was seen between increasing age and the prevalence and severity of mesioangular impactions.

CONCLUSION: Based on these findings, the authors recommended early prophylactic extraction of mesioangular MTMs as soon as possible to preserve adjacent MSMs. Extraction of horizontally impacted MTMs is recommended if either the MTMs or MSMs have lesions or if there is a gap between the teeth communicating with the oral cavity. Inverted impactions have a low probability of causing lesions and the procedure for their removal is complicated, so prophylactic extraction is not encouraged.

Dr. Daniel J. Hall; Resident in Periodontics, Virginia Commonwealth University

OMEGA-3 PUFA AND ASPIRIN AS ADJUNCTS TO PERIODONTAL DEBRIDEMENT IN PATIENTS WITH PERIODONTITIS AND TYPE 2 DIABETES MELLITUS: RANDOMIZED CLINICAL TRIAL

Castro Dos Santos NC, et al. | J Periodontol. 2020;91(10):1318–1327.

BACKGROUND: Periodontitis is an inflammatory condition associated with bacterial infection that is modified by multiple host response genes in combination with lifestyle and environmental factors. Diabetes is one of the major risk factors for periodontitis. Considering the inflammatory profile of patients with diabetes, it has been hypothesized that adjunctive treatments that modulate the host-response could represent a good and effective treatment approach for these patients. Omega-3 polyunsaturated fatty acids (ω-3 PUFA) have been investigated for their therapeutic actions in periodontitis. Studies also showed that aspirin (ASA) triggers the resolution of inflammation.

PURPOSE: The purpose of this study was to investigate periodontal and immunological effects of daily supplementation with 3 g fish oil with ω-3 and 100 mg ASA for 2 months as an adjunctive therapy to periodontal debridement for the treatment of periodontitis in patients with type 2 diabetes.

METHOD: This was a placebo-controlled, double-blind, randomized clinical study. A total of seventy-five patients received periodontal treatment and were randomly assigned to receive placebo and periodontal debridement (control group, CG), ω-3 PUFA + ASA after periodontal debridement (test group 1, TG1), or ω-3 PUFA + ASA before periodontal debridement (test group 2, TG2). Periodontal parameters and gingival crevicular fluid (GCF) were collected at baseline, 3 months after periodontal debridement and ω-3 PUFA + ASA or placebo for TG1 and CG, after ω-3 PUFA + ASA (before periodontal debridement) for TG2, and 6 months after periodontal debridement (all groups). GCF was analyzed for cytokine levels by multiplex ELISA.

RESULTS: None of the patients reported adverse events or presented complications because of long-term use of low-dose ASA. Ten patients in TG1 and nine patients in TG2 achieved the clinical endpoint for treatment (less than or equal to four sites with probing depth ≥ 5 mm), as opposed to four (16%) in CG. There was clinical attachment gain in moderate and deep pockets for TG1. IFN-γ and interleukin (IL)-8 levels decreased over time for both test groups. IL-6 levels were lower for TG1. Hemoglobin A1c (HbA1c) levels reduced for TG1.

CONCLUSION: The results of this randomized clinical study suggest that daily supplementation with ω-3 PUFA and low-dose aspirin for 2 months as an adjunct to periodontal debridement promotes clinical and immunological benefits for patients with type 2 diabetes, especially when the supplementation/protocol starts after periodontal debridement. Comparing three different groups demonstrated the importance of periodontal debridement in reducing mean probing depth over time, and its limitation in providing significant changes in mean clinical attachment loss when used alone.

Dr. Sarang Saadat; Resident in Periodontics, Virginia Commonwealth University

A RANDOMIZED CONTROLLED STUDY COMPARING GUIDED BONE REGENERATION WITH CONNECTIVE TISSUE GRAFT TO REESTABLISH BUCCAL CONVEXITY AT IMPLANT SITES: A 1-YEAR VOLUMETRIC ANALYSIS

Bruyckere TD, et al. | J Clin Periodontol. 2018; 45(11):1375-1378.

BACKGROUND: Recently, a randomized clinical trial (RCT) has been published comparing Guided Bone Regeneration (GBR) with Connective Tissue Graft (CTG) to treat minor horizontal defects at the buccal aspect of single implants. Both increased the buccal soft tissue profile (BSP) between 0.7 and 1.5 mm depending on the vertical distance from the implant shoulder, without a significant difference between the groups. However, these results are based on superimposed CBCT slides, which may lack accuracy, since soft tissue outlines may be difficult to assess even when lip retractors are used. Superimposed digital surface models overcome this shortcoming and allow for a volumetric analysis.

PURPOSE: The primary objective of this study was to volumetrically compare GBR with CTG when applied at single implant sites demonstrating a minor horizontal alveolar defect.

METHOD: In brief, a mucoperiosteal flap was raised in the control group by means of a midcrestal incision, sulcular incisions at both neighboring teeth, and a vertical parapapillary releasing incision at the distal neighboring tooth. Following implant installation, the buccal concavity was augmented with deproteinized bovine bone mineral (DBBM) and a collagen membrane. Following apical release of the tissues, a cover screw was placed and primary wound closure was achieved for submerged healing. After 3 months, the implant was uncovered by means of a pouch procedure. A screw-retained provisional crown was placed which was replaced by a screw-retained permanent restoration 3 months later. The flap design in the test group was identical to the one in the control group, yet without a vertical parapapillary releasing incision. Instead of augmenting with DBBM, an appropriately sized CTG harvested from the palatal flap or palatal mucosa in the premolar area, was pulled into the envelope and immobilized. Transmucosal healing with a healing abutment was allowed. Aftercare and prosthetic procedures were identical in both groups.

RESULTS: Twenty-one patients were included per group. After 1 year, GBR resulted in a significant volumetric increase of 20.74 mm3 ($P < .001$) corresponding to linear increase BSP of 1.30 mm ($P < .001$). For CTG, this was 15.86 ($P < .001$) and 1.19 mm ($P < .001$), respectively. The changes over time in volume ($P = .173$) and BSP ($P = .241$) were not significantly different between the groups. Of the final volumetric increases, 29% and 26% were the results of installing and altering prosthetic components in the control and test groups, respectively. Alveolar process deficiency significantly reduced from pre-op to 1 year following GBR ($P < .001$) and CTG ($P < .001$). The difference between the groups was not significant ($P = .342$). However, 58% of patients treated with GBR and 38% treated with CTG failed to show perfect soft tissue convexity at the buccal aspect.

CONCLUSION: GBR as well as CTG are effective in reducing horizontal alveolar defects for aesthetic purposes.

Dr. Nicholas G. Yesbeck; Resident in Periodontics, Virginia Commonwealth University

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DR. AMY DAVID

VENUS AND MARS

VDA ETHICS SERIES

Dana H. Chamberlain, DDS

The Oxford English Dictionary gives us the following two definitions:

Ethics: Moral principles that govern a person's behavior or the conducting of an activity.

Morals: A person's standards of behavior or beliefs concerning what is and is not acceptable.

It seems that these two terms, while perhaps not precisely interchangeable, are intricately intertwined. It would be nice if ethical (or moral) decision making was easy and that all the choices were either, yes or no, black or white, and so forth. I have found, however, that the world is not made that way, at least mine isn't. There can be infinite shades of grey between those two extremes and often, making an ethical decision is very complicated. Sometimes the appropriate answer is "It depends." Some of the factors that the answer may depend on are our age, our culture, our religion, the context in which the situation exists, or even our gender.

"There can be infinite shades of grey between those two extremes and often, making an ethical decision is very complicated."

In the middle of the past century, Lawrence Kohlberg, at Harvard University, expanding on work done by France's Jean Piaget in the 1930s, sought to determine how Moral Reasoning develops. In 1969, he published a 20-year longitudinal study on the question using subjects of various ages from children to young adults. In it, he argued that Moral Development occurs through a series of six invariant stages with progressively higher levels. These stages were described as:

- Obedience & Punishment, where behavior is driven by Avoiding Punishments.
- Individual Interest, where behavior is driven by Self-interest and Reward.
- Interpersonal, where behavior is driven by Social Approval.
- Authority, where behavior is driven by Authority and Conforming to Norms.
- Social Contract, where behavior is driven by a balance of Social Order and Individual Rights.
- Universal Ethics, where behavior is driven by Internal Moral Principles.

His model of Moral Reasoning was centered on the ability to make decisions based on "Universal" abstract principles of justice, duty and use of impartial reasoning and logic and has been termed "Justice Reasoning". By his parameters, he determined that females tended to only reach Stage 3 while males would reach stages 4 or 5. Very few individuals reached stage 6.

Carol Gilligan joined Kohlberg as a research assistant in 1970. She questioned the implication that women were morally inferior, as the results suggested, and objected that his findings had a cultural and gender bias toward white, upper class men and boys since all his subjects came from those demographics. From her own studies, using girls and women as subjects, she argued that women's moral considerations had to include feelings of compassion and empathy for others as well as commitments that arise out of relationships and social context. She referred to this as "Care Reasoning" rather than "Justice Reasoning".

Now, before we settle comfortably into our Gender Camps, I should point out that subsequent research and assessments of the data over intervening decades have found that purely gender differences were much less significant, especially when taking into consideration other factors like educational levels, occupational status, and cultures. Even Kohlberg argues against two different Moralities but for a continuum with Justice on one end and Caring on the other. As with most continuums, I suppose that there is a Bell Curve putting most of us toward the middle.

Men may be from Mars and women from Venus, but it seems we tend to spend, at least, some of our vacation time in each other's worlds. This is yet another indication that Ethical Decision Making is rarely cut and dried, hot and cold, yes and no, or black and white, but can certainly be challenging.

Editor's Note: Dr. Chamberlain, a VDA member, practices in Marion.

UNDERSTANDING AND MITIGATING THE THREAT OF CYBER-CRIME

RISK MANAGEMENT IN THE DIGITAL AGE

E. Andrew Gerner, CFP®

Introduction

If you purchased gasoline in the month of May 2021, you are likely aware of The Colonial Pipeline hacking event. Most Americans felt the impact of the supply chain disruption caused by this event. Unfortunately, Colonial Pipeline is only the most recent company name on a large list of cyber-crime victims, a list that includes names like Microsoft, Target, Sony, and LinkedIn. While it may be tempting to dismiss costly data breaches and hacking attacks as endemic to large national and international commercial enterprises, the reality is that 62% of ransomware attacks are perpetrated against small and medium-sized businesses and 29% of the victims are in the healthcare industry.[1] As evidence supporting those statistics, take for example the March 2020 ransomware attack of a Maryland-based dental IT company that formerly supported hundreds of dental practices in Maryland, DC and Virginia. As a result of that breach, most of the IT company's dental practice clients were affected. Prudent dentists, particularly practice owners, can no longer afford to passively manage data security and cyber-crime risk mitigation.

Background

While theft of data like credit card information and social security numbers was once the primary target of cyber criminals, ransomware attacks are now the most prevalent and fastest growing form of cyber-crime. The shift is not coincidental: while patient records are not of great value to a hacker, cyber criminals know that such records are extremely valuable to the healthcare providers that maintain the records. Additionally, perpetrators of cyber-crime calculate that the likelihood of obtaining a sizable ransom increases when they target industries subject to heightened data security standards and greater regulatory penalties. Subsequently, phishing attacks and brute force remote desktop protocol breaches are the two most common forms of attack, and they often target smaller healthcare organizations that they view as vulnerable.

"While patient records are not of great value to a hacker, cyber criminals know that such records are extremely valuable to the healthcare providers that maintain the records."

The Anatomy of a Cyber Attack

To understand and hopefully prevent a successful cyber-attack, it is first necessary to understand what the attack is.

Phishing: Direct email of malware or links to credential-stealing sites. In a phishing attack, a cyber-criminal exploits human error by impersonating a legitimate requestor of data. Often the attacker poses as a business associate and emails a seemingly valid request for information or emails a link to a site that appears legitimate but exists only to collect login and password information.

Remote desktop protocol (RDP) attack: exploitation of a convenient and commonly used tool that enables remote access to a workstation or server. RDP runs on a standard port (tcp/3389) and is easily identified while scanning.[2] Once an RDP target is identified, hackers may deploy "brute force" password-guessing software or exploit one of the many vulnerabilities that allow unauthenticated access to a computer.

In either case, once a cyber-criminal accesses a victim's network, he installs malware that encrypts all data and contacts the victim to demand payment, usually in Bitcoin or other cryptocurrency, in exchange for the encryption key required to unlock the data.

Risk Mitigation

Businesses and practices that store sensitive data can implement several strategies to reduce cyber-crime victimization risk and impact. These strategies include:

1. Contracting with a highly competent IT Managed Services Provider (MSP)
2. Implementing multi-factor authentication on network devices
3. Forcing regularly scheduled password resets
4. Training employees to recognize and report suspicious email activity
5. Limiting and/or requiring unique credentials for remote access, especially for vendors
6. Ensuring timely patches to network infrastructure

7. Purchasing robust data breach / cyber liability insurance – consider limits of not less than $1,000,000 per claim. Cyber liability insurance that is made available as an add-on to conventional business-owner insurance, while better than nothing, may only partially address the logistical and financial needs of a practice owner who falls victim to an attack

Network Intrusion & Breach Response Protocol (Insured)

In the event of a suspected or confirmed data breach or ransomware attack event, unplug the affected device(s) from internet and power, then immediately contact your MSP and insurance company. Practice and business owners insured under a robust data breach / cyber liability insurance contract can expect to receive prompt contact from a claims consultant who, depending on the nature of the breach event, will assemble and introduce a team of expert consultants. These consultants include all or some of the following:

1. Forensics
2. Legal/Regulatory
3. Finance
4. Public relations/Crisis management

The team of consultants will work with a policyholder and his or her MSP to identify and remedy the source of the breach. In the event of a ransomware attack, the forensic IT specialist and the policyholder's MSP will work together to restore lost data from back-ups and server images if possible. A crisis management professional or attorney will simultaneously communicate with the criminal to negotiate the value and terms of the ransom demand. In some

cases, the negotiator may succeed in persuading criminals to accept a ransom substantially lower than initially demanded and potentially far less than the business interruption and service restoration expenses. In all cases, whether a breach takes the form of a phishing attack, cyber extortion, data/device theft, fraudulent instruction/funds transfer, or other similar e-crime, the most comprehensive breach response/cyber liability insurance policies provide technical and monetary coverage with limits ranging from hundreds of thousands of dollars per incident to multiple millions of dollars for various expenses. Covered expenses may include:

1. Breach response costs (professional services)
2. Business interruption
3. Regulatory defense and penalties
4. Payment card liabilities and costs
5. Extortion/ransom loss

Conclusion

On the timeline of criminality, network intrusion, data theft, and cyber extortion are relatively new evolutions. Similarly, defense technology and the vocabulary that defines cyber-crime are new. But at their essence, cyber-crimes are just new iterations of misdeeds in existence for millennia. Likewise, the core concepts required to manage and mitigate risk are still effective. Risk assessment, risk reduction, and risk transfer (insurance) are old but effective tools to manage risk in the digital age.

References:

1. Beazley Breach Briefing 2020
2. ibid

Editor's Note: This article is not a comprehensive risk assessment and does not constitute specific risk mitigation advice. The author is not an attorney and offers no legal advice or coverage determinations for any past, current, future, or hypothetical insurance claims. Only an insurance claims adjuster is authorized to make coverage determinations on behalf of an insurer in the event of a claim.

THE SECRET(S) TO AN ENGAGED WORKPLACE

Lindsay O'Bar

Patient satisfaction starts with employee satisfaction. But what makes for a truly engaged and satisfied employee? While there may not be one straightforward solution there are several ways that an employer can create a welcoming, inclusive, supportive, and fun environment that's ripe for connection and trust among staff.

Before we get into those tactics, it's important to note that if you're sensing a lack of engagement at the office, you're not alone. Many dental offices have expressed a similar need to revitalize the culture and remember to pause for some reflection and fun. It's important for employers to remember that your employees are also people. They're parents, children, neighbors, and friends who may also be struggling with circumstances outside of work because of the pandemic and just life in general.

When you stop and think about that, it becomes motivating to want to create a positive environment at the workplace where everyone can thrive. All of this will result in an engaged team that delivers a great experience to patients at every touch point.

One office manager in Richmond credits their high retention to their culture of "keeping it light," claiming that with everything going on in the world and the often-serious nature of their work, it is helpful for them to create a place that's uplifting and positive and has a healthy dose of humor.

Whether you're doing a complete re-write on your office culture or need a tune-up, here are some ways to bring that lightness, support, and fun to your dental office.

- **Ask the team.** To get it right, start by asking your employees how you can do better. Ask the tough questions and be prepared for the answers. It's important to know where you stand to improve. Send an anonymous survey to the team and request their honest feedback. Don't overcomplicate the survey, just use SurveyMonkey or create a Google Form.

"At the very least, stopping to acknowledge and thank your employees is a step in the right direction. We all need to slow down and smell the roses."

- **Commit to daily communication.** When it comes to patient scheduling, we know that once the day starts, it's off the races. Which is why a quick, five-minute daily huddle is the perfect way to set the tone. Get the team involved by randomly asking a question, share the outlook for the day and recognize contributions from the team. It should be fast, light-hearted, and positive – and when it's done right it engages employees and helps them feel connected to each other and the practice.

- **Recognize the team.** We'll call it "see something, say something." If you witness an employee going above and beyond for a patient or coworker, then share that. Create a way to show appreciation of your employees during daily huddles, in newsletters, on social media, etc. At the very least, stopping to acknowledge and thank them is a step in the right direction. We all need to slow down and smell the roses.

- **Reward how you can.** It may not be feasible to announce a mid-year bonus, but more than likely there's something you can do to show your appreciation through a reward. Is it a bonus PTO day, gift cards to local businesses, lunchtime chair massages, sweet treats in the break room or regular lunch surprises? These small gifts add up and can go a long way.

- **Support professional growth.** Make it known that you're an office that invests in its employee and encourages continued training and development. Consider creating a training budget for each employee and challenge them to find an opportunity that will help them do their job better.

- **Set the vibe.** Look around – does your office feel energizing and welcoming? Consider hiring a designer or seek input from the staff on ways to freshen up the office. Maybe it's plants, paint colors, more light, more photography or art that could change the overall vibe of the space. And while you're at it, make sure the break room does what it needs to do – give staff a break. Provide snacks, offer coffee/tea, play relaxing music, and furnish with comfortable seating.

- **Invest in the tools.** A major element in employee frustration can stem from people feeling that they don't have the tools to do their job. Don't let this be what impedes your positive culture. Commit to staying on top of solutions that will make both the office staff and dental team more effective at their job. Seek input for the team on their needs, discern what you'll be investing in and then communicate the priorities. This transparency will go a long way and help eliminate any resentment.

- **Celebrate together.** Whether it's a birthday, milestone work anniversary, baby shower or just Friday, create time to celebrate as a team. Encourage a party planning committee to own this part of office engagement and request that they plan something regularly. (Tip: Consider a seasonal birthday approach if there are too many birthdays to celebrate.)

As you can see, there's a lot that goes into creating a workplace where employees want to stay and others want to join. It starts with intention, and then it's all about action. For the good of your practice, it's always worth it to invest in the office culture. After all, a positive patient experience starts with a positive employee.

And if this list looks overwhelming then it might be time to empower some employees to take the lead on some of the initiatives that will enhance the workplace. Chances are they'll be happy to take the lead – and, of course, now you'll know to recognize them for their help.

Editor's Note: Lindsay O'Bar, APR is VP of Client Services and Culture at The Hodges Partnership, a strategic communications firm in Richmond.

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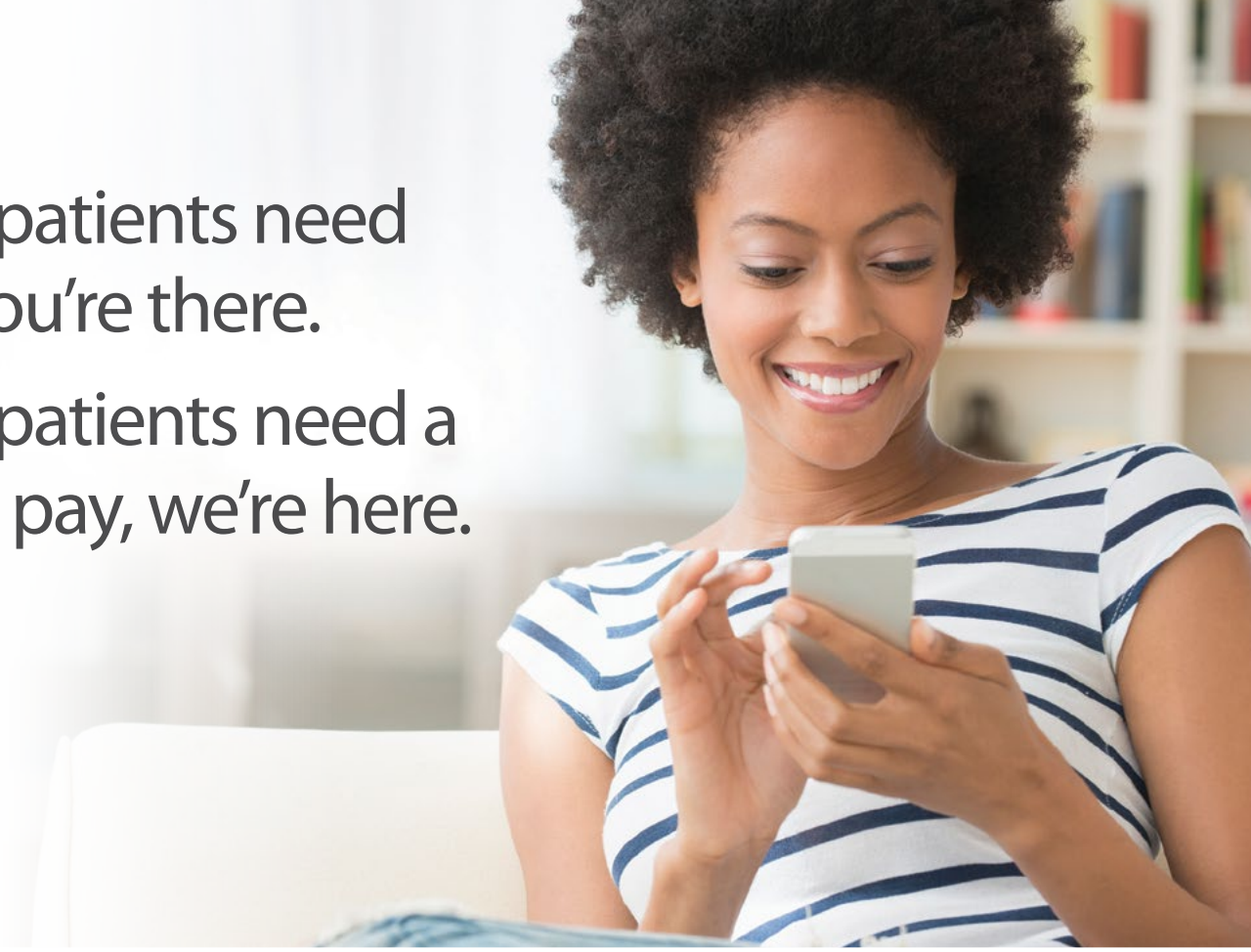

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VADJ2021DA

STEP-UP AND SUPPORT YOUR PROFESSION

Laura Givens, VDA Director of Legislative and Public Policy

This is an important election year, and we urge all members to contribute to the VDA PAC!

The VDA PAC is far from reaching the 2021 goal of $375,000. This should concern you because, if the VDA PAC does not get the contribution support it needs from you and your component colleagues, the VDA is in danger of giving our political foes increased motivation to try an end-around on us in future sessions in Richmond. What foes are we referring to? To list a few: **third-party payers, mid-level providers and DIY dentistry companies**. If you are concerned about these and others infringing on how you provide the absolute best dental care to your patients, you MUST take action NOW.

We must stand together, and we must protect this profession and our patients. **It's easy- all you need to do is visit https://www.vadental.org/advocacy/vda-pac to submit a credit card payment at the level you wish**. If you have questions, you may contact Laura Givens at **givens@vadental.org** or 804-523-2185.

With many potential issues coming our way, 2022 will most definitely be an important General Assembly Session and we urge all members to contribute to the VDA PAC – don't ride the coattails of others who give year after year – step up and stand with them. **Review the chart and see how close your component is to reaching its goal.**

Component	% of 2021 Members Contributing to Date	2021 VDA PAC Goal	Amount Contributed to Date	Per Capita Contribution	% of Goal Achieved
1 (Tidewater)	35%	$45,500	$29,025	$285	64%
2 (Peninsula)	35%	$27,500	$16,425	$299	60%
3 (Southside)	34%	$14,000	$8,457	$287	60%
4 (Richmond)	27%	$67,750	$48,170	$310	71%
5 (Piedmont)	34%	$30,000	$20,775	$286	69%
6 (Southwest VA)	43%	$25,250	$14,740	$295	58%
7 (Shenandoah Valley)	30%	$30,000	$21,770	$305	73%
8 (Northern VA)	27%	$135,000	$64,640	$228	48%
TOTAL	**33%**	**$375,000**	**$224,002**	**$287**	**58%**

TOTAL CONTRIBUTIONS: $224,002

MUST RAISE $150,998 TO REACH GOAL

2021 GOAL: $375,000

VIRGINIA BOARD OF DENTISTRY NOTES

JUNE 11, 2021

Ursula Klostermyer, DDS, PhD

This was the first in-person board meeting since the pandemic began. The agenda was full, and the meeting extended into the afternoon. Due to other commitments, I could not participate for the entire session. Notes on the extended session were taken from the agenda and the hand-out materials.

The meeting started with the usual public comment session:

- Tracey Martin, president of the Virginia Dental Hygienists Association, spoke in opposition to any changes in the duties for dental assistants, especially with regards to the use of scalers.
- Dr. Al Russell, VCU's interim chair of Prosthodontics, expressed the difficulties of the school in hiring new faculty members. He stated that a high percentage of the faculty is over the age of 60 and that there are open positions for three prosthodontists and four general dentists. VCU is looking actively for qualified instructors and would like Virginia follow the instructor's license model of states like North Carolina, Florida, Texas and Ohio to be able to recruit and retain excellent faculty members.
- Dr. Mary Pettiette, Associate Dean for Admissions at VCU School of Dentistry (she was previously at UNC), urged the BOD to change the restrictions for qualified foreign trained dentists and to expand licensure possibilities.
- Three written comments were submitted: Dr. Richard Archer, VCU senior Associate Dean of Clinical Education, asked the BOD to assist the Dental School to find new faculty by establishing a new instructors license. On behalf of the American Association of Orthodontists, Dr. Stuart Robb and Trey Lawrence expressed their concerns regarding the definition of a digital scan technician and teledentistry. They suggested some change of wording. Jack R. Bierig , Legal Counsel to WREB, commented regarding the March 19, 2021 BOD decision to cease recognizing WREB exams.

Dr. David Brown, Department of Health Professions Director, reported that due to the Governor's announcement about ending the current COVID-19 State of Emergency on June 30, 2021, virtual meetings will be less frequent. But due to their convenience for Board members, who must travel and for public participation, some shorter meetings are planned to remain virtual. He stated that the mandatory mask wearing in health care facilities might change at the end of June as well.

Dr. Allison-Bryan and Ms. Ressler, HPMP's Administrative Director, gave a presentation of the **H**ealthcare **P**ractitoners' **M**onitoring **P**rogram: The HPMP offers an alternative to disciplinary action for qualified healthcare practitioners with a substance abuse diagnosis, a mental health diagnosis, or a physical diagnosis that may alter their ability to practice their profession safely. HPMP refers healthcare professionals for appropriate treatment and provides ongoing monitoring for their treatment progress. It does not provide the treatment for the substance abuser patients, but monitors and supports it during the recovery process, and assists with a safe return to productive work. This might help the affected avoid disciplinary actions in the absence of criminal behavior. Participants are responsible for the treatment costs. Data for average treatment costs were not available, but it was mentioned that reduced costs for a 3 to 4-day assessment would be between $2,500-5,000. Concerns from the BOD side included the high expense of 1 to 5-year treatments of a health care professional, which might be 3 times their annual income and are likely not affordable.

Dr. Sandra Catchings reported from the Regulatory-Legislative Committee regarding digital scan technician training. Discussions took place to define the term remote supervision and address the practice of digital scan technicians.

Dr. Jamiah Dawson shared with the BOD her very satisfactory experience about her CODA accreditation site visits in Virginia.

Ms. Elaine Yeatts went through the Regulation and Guidance documents. Regarding the action on requirement of infection control training for dental assistants, Dr. Dag Zapatero and Dr. Perry Jones questioned the reasons for this requirement as there are already training and requirements by OSHA and CDC in place. Dr. Nathaniel Bryant stated that the BOD has no authority to enforce the OSHA and CDC guidelines and that this regulation would give them authority for a required training. The motion passed forward with this regulation with Dr. Zapatero and Dr. Jones voting in opposition.

Ms. Yeatts in addition went thoroughly through the teledentistry legislation for the BOD and made sure that everyone was clear on the established requirements for the training of a digital scan technician. Unanimously the BOD voted to approve the recommended wording in the materials provided. Now this proposed regulation will follow the normal process and go to the Governor's office followed by a public comment phase of 60 days.

>> CONTINUED ON PAGE 57

DID YOU KNOW?

A SERIES FROM THE VIRGINIA BOARD OF DENTISTRY

Decision to terminate the dentist-patient relationship

Did you know that a dentist must give patients at least 30 days written notice of a decision to terminate the dentist-patient relationship?
18VAC60-21-60 (A) (5) of the Regulations Governing the Practice of Dentistry.

False, deceptive, or misleading advertisement

Did you know that publishing an advertisement that contains a false claim of professional superiority, contains a claim to be a specialist, or uses any terms to designate a dental specialty unless the dentist is entitled to such specialty designation under the guidelines or requirements for specialties approved by the American Dental Association (Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists, November 2013), or such guidelines or requirements as subsequently amended is considered false, deceptive, or misleading advertisement?
18VAC60-21-80 (G) (3) of the Regulations Governing the Practice of Dentistry.

Patient Record

Did you know that every patient record shall include the patient's name on each page in the patient record?
18VAC60-21-90 (B) (1) of the Regulations Governing the Practice of Dentistry.

Sedation Patient Record

Did you know that there are additional requirements for patient information and records when a patient is receiving sedation? In addition to the record requirements in **18VAC60-21-90**, when moderate sedation, deep sedation, or general anesthesia is administered, the patient record shall also include a review of medical history and current conditions, including the patient's weight and height or, if appropriate, the body mass index.
18VAC60-21-260 (D) (2) of the Regulations Governing the Practice of Dentistry.

WE'RE BACK!

ATTENDING THE 2021 VIRGINIA MEETING IS GOOD FOR YOUR WELL-BEING

Ryan L. Dunn, VDA Executive Director

In the last year, we have as an association communicated more than ever with our members, sharing updated guidance, launching new online CE and providing members with trusted information to help them successfully practice in changing circumstances. We have, however, seen each other less than ever as in-person events, study clubs and local component meetings were cancelled or moved behind the glow of a laptop or iPad. Those communications served a purpose, and we learned that many of our members valued the flexibility that online CE and meetings can offer. But having worked in associations and for elected officials throughout my career, I know nothing can replace the impact and sense of community you get from connecting with your peers in-person.

I'm glad to report that registration has now opened for the 2021 Virginia Meeting in Williamsburg! I hope that you will join us for a time of renewal, learning, and fellowship with long-time friends in the profession and the opportunity to make new ones. The Virginia Meeting has always been a time to pause and enjoy comradery with fellow dentists, and after this year, I know that we could all use a break.

"Nominate a fellow dentist or staff member who went above and beyond for recognition at the Virginia Meeting."

On top of all the in-person CE, vendors, giveaways, food, and beverages you expect from the Virginia Meeting, it's important that this year's event is also FUN. We will also be including a new dentist reception and career fair, live music, games, an opportunity to hear from statewide candidates for office and more. This will be a great opportunity for dental office staff to join as well, connect with peers and learn about new offerings and ways to make your practice more successful.

We have also seen incredible acts of generosity and leadership from members across the Commonwealth over the last year. From volunteering to administer vaccines, helping fellow dentists who are going through difficult times, donating time, money and talents in your communities, the profession has answered the call to the myriad challenges that came from COVID-19. **I encourage you to nominate a fellow dentist or staff member who went above and beyond for recognition at the Virginia Meeting this year so we can share their story.**

Scan the QR code below or go to https://www.vadental.org/about-us/member-team-recognition to make your nomination today.

We have made it through challenges, both personal and professional since the onset of the pandemic. Some of the changes and adaptations will stay in place and may even be a benefit, while most of the restrictions will be a thing of the past. What hasn't changed and won't change, in the VDA's 150 years of fighting for the profession, is our commitment to strengthening the profession and allowing our members to provide essential dental care in their communities.

Register Now: vadental.org/vam

2021 VIRGINIA MEETING

Virginia Dental ASSOCIATION

Welcome to the Virginia Meeting!

One and Done: New All-Inclusive Registration

We are looking forward to finally meet in-person to reconnect with colleagues, gain in-person CE, and to advance the mission of the Virginia Dental Association.

Over the course of the meeting, you'll hear from new nationally renowned clinicians as well as some respected speakers from our backyard, with a full schedule of live presentations.

There will also be plenty of time for fun, with live music, receptions, games, and options for your family and entire dental team. This year the VDA will be hosting a golf tournament on Williamsburg's acclaimed Green Course.

We are excited to be able to gather once again to grow and learn.

The Virginia Meeting is perfect for dentists, their team members, and for the whole family, as the historic area offers many shops, restaurants and other attractions.

Registration is now open at vadental.org/VAM. We'll see you there!

NOW INCLUDED IN YOUR REGISTRATION:

Friday
- Power Hour in Exhibit Hall with mimosas & snack
- Opening Ceremonies
- Opening Reception
- Late-Night Games

Saturday
- Lunch in Exhibit Hall
- Membership Gala

Register Now: vadental.org/vam

NEW Pediatric Dentistry Track

The Virginia Academy of Pediatric Dentistry is pleased to partner with the VDA for our first joint meeting.

VIRGINIA ACADEMY OF PEDIATRIC DENTISTRY

Friday, September 17, 2021

CREDITS: 4

Noon - 4:00PM
Policies, Politics, and Guidelines: Update for Pediatric Sedation & Anesthesia
Dr. Jonathan Wong

This 4-hour course satisfies the CE requirement for sedation permit holders. The course reviews the updates and changes in professional guidelines that began in 2016 and continue as a response to safety concerns with sedation and anesthesia in the dental office. We will review the source of the public's concern and review the evidence (or lack thereof). Additionally, we will review the guidelines of the numerous organizations (such as the American Dental Association, the American Academy of Pediatric Dentistry, the American Academy of Oral and Maxillofacial Surgery, and American Society of Anesthesiologists) have released regarding sedation and anesthesia in the dental office by non-anesthetists. Through this review, we will look at the evidence base for some of the proposed practices and help the practitioner navigate and understand what practices have been supported by evidence or root cause analysis. Included in this discussion will be the use of checklists and systems to improve safety in sedation. Lastly, we will explore the ever-changing regulatory environment and what dentists can do to help improve safety for our patients.

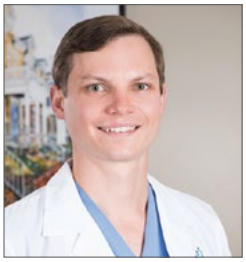
4:00PM – 5:00PM
Virginia Academy of Pediatric Dentistry Business Meeting and Happy Hour (VAPD Members Only)

Saturday, September 18, 2021

CREDITS: 3

8:00AM - 11:00AM
The Times They Are A-Changin': So are the Oral Diseases and Drugs We Use to Treat Them
Dr. Catherine M. Flaitz

Times have changed, and so have the oral diseases that occur in children and adolescents. There are new oral lesions, infectious diseases, treads, habits, and dental anomalies that dentists need to be aware of. This course will share updated facts about common pediatric oral diseases, based on best evidence, and cover topics like behavioral health issues, medication side effects, new drugs, and oral lesions management approaches tailored for kids.



CREDITS: 4

Noon - 4:00PM
Introduction to Pediatric Sleep Disordered Breathing
Dr. William Dahlke and Dr. Ethan Puryear

In 2017 the ADA passed a resolution encouraging dentists to screen for sleep related breathing disorders (SRBD) as part of a comprehensive medical and dental history and provide referrals and evidence-based care when appropriate. This course will provide participants an introduction into sleep disordered breathing and sleep health with a primary focus on obstructive sleep apnea (OSA) in pediatric patients. Participants will learn the definition of sleep, understand sleep terminology, learn the anatomy of the airway and physiology of sleep, the various types of sleep disorders, and the pathophysiology of OSA. We will review the impact sleep disordered breathing has on our patients and the role of the dental professional in the screening for signs and symptoms of OSA. Treatment options and pathways for referral will be introduced.

Register Now: vadental.org/vam

Schedule of Events

Wednesday, September 15, 2021

Code	Event/Course Title	Speaker/Event Host	Time	Cost	Credits
n/a	Registration Check-In: Attendee and Exhibitor	VDA & Vendors	4pm-7pm	$0	0

Thursday, September 16, 2021

Code	Event/Course Title	Speaker/Event Host	Time	Cost	Credits
n/a	Registration Check-In: Attendees only	VDA	7am-5pm	$0	0
T1	Thriving through Technology	David Fidanza, Chris Elley	9am-11am	$0	2
T2	INFECTION CONTROL and OSHA During and After COVID	John Molinari	9:00am-12pm	$0	3
T3	Implant Prosthetic Misadvenures	Wayne Szara	9:00am-11:00am	$0	2
T4	Top of the Heap	Tom Viola	9:00am-12:00pm	$0	3
T5	Beating the Odds: A Story NOT Silenced by Stage IV Oral Cancer	Eva Grayzel	10am-12pm	$0	2
T6	Strategies for a Successful Retirement and Tax Savings Ideas for High-Net-Worth Investors	Robert Moyer	1pm-4pm	$0	3
T7	Lecture - Overdenture Patient Opportunities Good, Better and Best	Wayne Szara	1pm-3pm	$0	2
T8	Golf Tournament	VDA	1pm shot gun start	$150	0
T9	A Patient Can Have as Many Diseases as They Pleases	Svirsky	1pm-4pm	$0	3
T10	Take it on the Run, Baby!	Tom Viola	1pm-4pm	$0	3
n/a	Registration Check-in: Exhibitor	VDA & Vendors	2pm-5pm	$0	0
n/a	Exhibitor Set Up	VDA	2pm-5pm	$0	0
T11	Protect Yourself from Liability and Save A Life: Raise the Bar on Oral Cancer Screenings and Patient Education	Eva Grayzel	2pm-4pm	$0	2
T12	Hands-on - Overdenture Patient Opportunities Good, Better and Best	Wayne Szara	3:30pm-4:30pm	$0	1
n/a	Dinner on your own	Attenddes	5:00pm-10:00pm	n/a	0
T13	Leadership Reception - Invitation Only	VDA Leadership	6pm-7pm	$0	0
T14	VDA-GO!! (VDA Governance Orientation)	Dr. Frank Iurono	7:15pm-8:15pm	$0	0
T15	American College of Dentists Reception and Dinner - Invitation Only	ACD Members	7:30pm-10pm	$0	0

Friday, September 17, 2021

Code	Event/Course Title	Speaker/Event Host	Time	Cost	Credits
n/a	Registration Check-In: Exhibitor	VDA & Vendors	7am-9am	$0	0
n/a	Registration Check-In: Attendees only	VDA	7am-5pm	$0	0
F16	International College of Dentists Breakfast	ICD Members	7:30am-8:30am	$0	0
n/a	16th District (Delegation of the ADA) Meeting	VDA	tbd	$0	0
n/a	House of Delegates Registration	VDA House of Delegates	8:30am-9am	$0	0
F17	Dental Assistant I vs. Dental Assistant II: Auxiliary Power to Increase Production	Ms. Antoinette Kahan	8:30am-12:30pm	$0	4
n/a	Exhibit Hall Open	VDA & Vendors	9am-7pm	$0	0
F18	The Oral Pathology Playhouse: Name that disease and other Oral Pathology Party games	Svirsky	9am-12pm	$0	3
n/a	Business Meeting & House of Delegates Opening Session	VDA	9am-9:45am	$0	0
F19	DENTISTRY'S TOP GAME CHANGERS: 20 innovations for successful teams	Dr. Mark Hyman	9am-12pm	$0	3
F20	Power Hour - Mimosas and Morning Snack Reception	VDA	10am-11am	$0	0
F21	VDA Fellows Lunch	VDA Fellows	11:30am-1pm	$0	0
F22	Policies, Politics, and Guidelines: Update for Pediatric Sedation & Anesthesia	Dr. Jonathan Wong	12pm-4pm	$0	4
F23	Dental Assistant II: Pathway Preparation Program Becoming a Dental Assisting National Board (DANB)	Ms. Antoinette Kahan	1pm-5pm	$0	4
F24	A Day in the Life of Top Gun Dental Teams	Dr. Mark Hyman	1pm-4pm	$0	3

continued >>

Schedule of Events (continued)

Friday, September 17, 2021 (continued)

Course	Event/Course Title	Speaker/Event Host	Time	Cost	Credits
F25	Evaluation, Diagnosis and Treatment of the Worn Dentition	Dr. John Cranham	1pm-4pm	$0	3
n/a	Exhibit Hall Closed	VDA & Vendors	1:30pm-2:30pm	$0	0
F26	Virginia Association of Pediatrics Business Meeting and Happy Hour	Virginia Academy of Pediatric Dentistry	3pm-5pm	$0	0
F27	Welcoming Ceremonies and Awards with Keynote Speaker/s	VDA	4:30pm-5:30pm	$0	0
F28	Opening Reception/Ceremonies in Exhibit Hall	VDA	5:30pm-7pm	$0	0
F29	Career Fair and New Dentist Reception sponsored by The Genau Group	VDA	7pm-9pm	$0	0
F30	Late night games presented by the Apollonia and Governor's Club	VDA	10pm-11pm	$0	0

Saturday, September 18, 2021

Code	Event/Course Title	Speaker/Event Host	Time	Cost	Credits
n/a	Registration Check-In : Attendees only	VDA	7am-5pm	$0	0
n/a	Registration Check-in: Exhibitors	VDA & Vendors	7am-8am	$0	0
S31	Dental Assistant II: Pathway Preparation Program - DANB Radiation Health & Safety (RHS) Exam	Ms Antoinette Kahan	8:00am-12pm	$0	4
S32	The Times They Are A-Changin': So Are the Oral Diseases and Drugs We Use to Treat Them	Dr. Catherine M. Flaitz	8am-11am	$0	3
S33	Million Dollar Lemonade Stand - Lessons Learned from Stirring Lemonade to Running a $100 Million Company	Mr. Ryan Vet	8am-10am	$0	2
S34	Surprising Ways Compliance Laws can Increase Profits and Productivity	David Fidanza, Chris Elley	8am-10am	$0	2
S35	Risk Management	Dr. Robert Peskin	8:00am-12:30pm	$0	4
S36	Fundamentals of Elective Esthetic Dentistry	Dr. John Cranham	8am-11am	$0	3
n/a	Exhibit Hall Open	VDA & Vendors	9am-1pm	$0	0
S37	Closing Reception Buffet Lunch	VDA & Vendors	12pm-1pm	$0	0
S38	Introduction to Pediatric Sleep Disordered Breathing	Dr. Dahlke & Dr. Puryear	1pm-4pm	$0	3
S39	Lecture - Overdenture Patient Opportunities Good, Better and Best	Wayne Szara	1:00pm-3:00pm	$0	2
S40	Digital Dentistry-Protocols for Success	Dr. John Cranham	1pm-4pm	$0	3
S41	Dental Assistant II: Pathway Preparation Program - DANB General Chairside Exam	Ms Antoinette Kahan	1pm-5pm	$0	4
S42	Dentistry Uncorked	Mr. Ryan Vet	1:30pm-4:30pm	$50	2
S43	Hands on - Overdenture Patient Opportunities Good, Better and Best	Wayne Szara	3:00pm-4:00pm	$0	1
S44	Academy of General Dentistry Reception - Invitation only	AGD Members	5:00pm-6:00pm	$0	0
S45	VDAF Reception	VDAF & VDA	6:30pm-7:30pm	$0	0
S46	Membership Gala sponsored by The Genau Group Realty Advisors	VDA	7:30pm-10:30pm	$0	0

Sunday, September 19, 2021

Code	Event/Course Title	Speaker/Event Host	Time	Cost	Credits
Sun47	Past Presidents' Breakfast	VDA Past Presidents Only	7am-8am	$0	0
n/a	VDA Annual Meeting	VDA House of Delegates	8:30am - 9:30am	$0	0
n/a	HODRegistration	VDA House of Delegates	9:15am - 10:00am	$0	0
n/a	Second Session of House of Delegates	VDA House of Delegates	10:00am - 12:00pm	$0	0

Event Lodging

Colonial Williamsburg Hotels

Williamsburg Lodge
$204 (plus taxes & fees)

Griffin Hotel
$169 (plus taxes & fees)

Woodlands Hotel & Suites
$129 (plus taxes & fees)

Reservations
Reserve your room 2 ways:
Online: via https://book.passkey.com/go/5d2e652d
Call: 1 (855) 231-7240

- Check in: 4:00pm
- Check out: 11:00am
- Complimentary Self-Parking for all attendees

Event Dining

Restaurants

Traditions at the Williamsburg Lodge
- Breakfast: Daily 7:00am-11:00am
- Lunch: Friday-Sunday 12:00pm-2:00pm (Buffet option)

Sweet Tea & Barley at the Williamsburg Lodge
- Tuesday-Saturday: 2:00pm-10:00pm

Chowning's Tavern *(Outdoor Garden Snack Bar)*
- Wednesday-Sunday: 11:00am-5:00pm

The Cupboard
(Gourmet Grab & Go, located at the Williamsburg Lodge)
- Sunday-Monday: 7:00am-8:00pm
- Tuesday-Saturday: 7:00am-2:00pm

To view more dining around Colonial Williamsburg Hotels, please visit:
www.colonialwilliamsburghotels.com/dining/

Please READ the following important information prior to completing your registration!

REFUND AND CANCELLATION POLICY
All refunds must be submitted in writing by August 30, 2021. All refunds are subject to a 20% charge per total registration fee that will be processed within 15 business days to the primary registrant. The 20% fee will be calculated based on the original registration total. Refunds will be processed via check to the original payee within 10 business days for receipt of request. No refund requests will be accepted after August 30, 2021.

DENTIST REGISTRATION
Dentists must register as dentists. If registering as a VDA member, membership dues must be paid in full prior to registering. To pay your dues or to inquire about membership status, contact Jill Kelly at the VDA (804) 523-2183.

YOU MUST REGISTER FOR ALL EVENTS/ SESSIONS WHICH YOU PLAN TO ATTEND. Each conference badge will contain a bar code, which tracks all courses and events that you have registered for. Upon entrance to any course or event, your badge will be scanned. By doing so, we are able to eliminate the need for any tickets, as well as track CE credits for each attendee. You may make changes to your registration at any time. If changes are made onsite, VDA staff will print a new badge for you so that the barcode reflects these changes.

REGISTRATION MATERIALS
You will NOT receive registration materials before the meeting. This will allow you to edit your registration preferences during the entire pre-registration period. Materials for registrants will be available for pick-up under the registrant's name at the VDA welcome table.

NON-SOLICITATION POLICY
With the exception of exhibitors operating within their designated booth space, no attendee, exhibitor or speaker may solicit business on the exhibit floor or in any other Virginia Meeting area. Violation of this policy will result in expulsion from the conference.

CLASSROOM COMFORT
Per fire codes, once a course is full, attendees will not be allowed to sit on the floor or bring chairs in from other rooms. Lecture space is limited and available on a first come first served basis. No children are permitted in lectures or workshops. Set cell phones and pagers to "silent" during courses.

LIABILITY WAIVER AND RELEASE
In consideration of being allowed to participate in any way in The 2021 Virginia Meeting, I, the participant, acknowledge, appreciate, and agree that I am voluntarily undertaking participation in The 2021 Virginia Meeting; by doing so I assume all risk and take full responsibility for my own well-being. I am fully aware that possible property damage, physical injury, illness or death may occur as a result of my participation in these events and activities. I forever release The 2021 Virginia Meeting and The Virginia Dental Association, its directors, officers, employees, volunteers, agents, contractors, and representatives (collectively "Releases") from any and all actions, claims, or demands that I, my family or heirs now have or may have in the future related to my participation in these activities.

PHOTO AND VIDEO RELEASE
I agree and acknowledge that The Virginia Meeting plans to take photographs and video at The 2021 Virginia Meeting and reproduce them in news or promotional material, whether in print, electronic or other media, including the VDA website. By participating in VDA Meeting, I grant The Virginia Meeting the right to use my name, photograph and biography for such purposes. I am aware this is a release of liability and rights of use related to photographs and video; a contract between myself and The Virginia Meeting. I have read, understand and agree to these terms and I am entering into this agreement of my own free will.

COURSE DISCLAIMER
The VDA makes every effort to present high caliber speakers in their respective areas of expertise. Speaker presentations in no way imply endorsement of any product, technique or service presented. The VDA specifically disclaims responsibility for any materials presented. Speakers may be subject to change due to circumstances beyond our control.

ONSITE REGISTRATION HOURS
Wednesday, September 15, 2021
4:00 pm - 7:00 pm
Thursday, September 16, 2021
8:00 am - 5:00 pm
Friday, September 17, 2021
7:00 am - 5:00 pm
Saturday, September 18, 2021
7:00 am - 5:00 pm

VIRGINIA MEETING MAILING LIST OPT OUT
The Virginia Meeting will be compiling a mailing list of attendees. The lists will include only mailing addresses provided to the Virginia Meeting when you register. Lists will be available to any Virginia Meeting Exhibitor for a small fee. These lists are strictly to be used to send out pre-conference promotions to you. If you would like to opt out of this mailing list, simply select opt out on the registration form in the brochure. Doing so will opt out all registrants on your registration form. However, if you choose to register online, you will have the option to opt out for each person who registers with your group. Note: This mailing list is strictly information provided to the VDA during meeting registration. It is entirely separate from our membership database.

SAVE MONEY
Save money by registering during our "Early Bird" Registration. Any attendee who registers on or before July 26, 2021 will automatically receive our early bird pricing discount. Please be aware that your registration must be at the VDA Central Office, or completed online by July 26, 2021 to receive the discount. Post marked registration will not be accepted under this pricing so please allow ample time if you choose to mail your registration.

VIRGINIA DENTAL ASSOCIATION (VDA) - GUIDELINES REGARDING COMMERCIAL SUPPORT AND CONFLICT OF INTEREST:
The VDA, in planning continuing education programming for the Virginia Meeting, will adhere to the following policies:

1. Program topic selection will be based on perceived needs for professional information and not the purpose of endorsing specific commercial drugs, materials, products, treatments, or services.
2. Funds received from commercial sources in support of any educational programs shall be unrestricted and the Council on Sessions shall retain exclusive rights regarding the selection of presenters, instructional materials, program content and format, etc.
3. Any and all commercial support received shall be acknowledged in program announcements, brochures, and the on-site program.
4. Commercial support shall be limited to: (a). the payment of reasonable honoraria (b). reimbursement of presenters' out of pocket expenses; and (c). the payment of the cost of modest meals or social events held as part of an education activity.
5. Presenters shall be instructed to avoid recommending or mentioning any specific product by its trade name, using generic terms whenever possible. When reference is made to a specific product by its trade name, reference shall also be made to competitive products.
6. Speakers will be required to disclose any potential bias to commercial supporters of any activity related to the Virginia Meeting.

The Virginia Dental Association (VDA) shall:

1. Be responsible for the content, quality, and scientific integrity of all CE activities.
2. Assure that presentations give a balanced view of all therapeutic options.
3. Assure that commercial exhibits do not influence planning nor interfere with the presentation of CE activities.
4. Be responsible for making ultimate decision regarding funding arrangements for CE.
5. Assure that commercially supported social events at CE activities do not compete with nor take precedence over, the educational events.
6. Have a policy on conflict of interest and assure that all CE activities conform to this policy.

FREE COURSE POLICY CHANGE
IMPORTANT: The VDA is pleased to offer many courses at the Virginia Meeting free with your registration cost. We are also delighted to offer the service of tracking all CE credit that you receive at the Virginia Meeting. This has led to some changes. Please read the following policy carefully.

In order to receive CE credit, you must:

- Register for the course. In the past, attendees had the option of attending free courses without registering for them, provided that there were remaining seats available 10 minutes prior to the course. You MUST register for any course that you plan to attend. This will allow you to earn CE credit for your time in the course.
- Check in with the course monitor. Upon entrance, present your badge and the course monitor will scan it. All registered attendees will be granted immediate access to the course. If you are not registered, you will be asked to return to the registration table where you will be allowed to register if the course has space available. Please wear your badge at all times while in the conference center or at Virginia Meeting events as this badge will be used as your "ticket" to all courses and events.

A record of your total Virginia Meeting CE credit will be emailed to you. Please contact Megan Wyman at **wyman@vadental.org** with any questions.

Register Now: vadental.org/vam

HUMAN TRAFFICKING IN VIRGINIA

WHEN WILL THE DENTAL PROFESSION BE CONSULTED?

Vanessa Sturz, Associate Editor; Class of 2022, VCU School of Dentistry

VCU School of Dentistry

Background

My interest in this topic began during a rotation through the oral surgery emergency clinic last semester. I witnessed an 18-year-old female patient accompanied by her mother. She came in with the chief complaint of pain due to a broken tooth. Upon looking at her panoramic x-ray, the patient appeared to have less than 50% of her remaining adult dentition. Her mother's account was that the patient was having some pain and that she had not been to a dentist in several years. When asked about what her pediatrician thought about her dental issues, the mother replied that she hadn't been to the doctor in a couple of years. Technically, since the patient was 18, this wasn't a potential Child Protective Services case, but something just seemed odd to me. The way the mother was answering for her, and why she entered the dental or medical care field just as the patient turned 18 (when clearly these issues had been going on for a while), didn't seem to make sense to me. I wasn't sure if this patient was being trafficked or that the patient and her family were having issues with access to care. I couldn't help but think: Shouldn't her medical and dental care have been covered by Medicaid? I am sure as you read this article you may recall a patient you have encountered where the patient's story just didn't seem to add up. What resources do you have to identify these patients? Who do you call, and if the patient does admit to being trafficked, what resources can you provide?

I asked the attending that day if oral surgeons receive training in identifying human trafficking victims. He said that there are medical continuing education credits, but he was aware of nothing that was dental specific, or oral surgery specific. He later called me that evening after a brief review of literature and asked if I would be interested in conducting a systematic review on the topic and then put questionnaires in place in the emergency clinic. I jumped at the chance because this was a topic where I felt I knew very little about and had received no training during my three years of dental education.

Figure 1: Locations of Human Trafficking Situations in the U.S. (Situations of trafficking can involve more than one location.

I am happy to report that we will be submitting the review for publication in the next couple of weeks. Upon my review of the literature, I have educated myself on the subject of human trafficking and quite frankly how ill-equipped the dental and medical communities are on handling the subject.

The topic of human trafficking appears in dental journal articles as early as 2012 with a systematic review published in JADA reporting no articles on dentistry and human trafficking.[1] The article does a great job of discussing the issue and makes suggestions for recognizing and dealing with the problem, but doesn't provide the dental professional with the resources to address this issue in their own office. There isn't a publication that discusses the experiences of a dental practice deploying screening tools, things learned, what works, and what doesn't. Health systems often find themselves ill-equipped to deal with identifying victims and providing resources, even though there are more publications and resources for physicians.

Nationally

The Polaris Project is a great resource for self-reporting of human trafficking. Taken from the most recent report dated 2019, Figure 1 shows a heat map

>> CONTINUED ON PAGE 76

ELIZABETH REYNOLDS

Candidate for ADA Second Vice President 2021

"We are Dentists"

Dr. Elizabeth Reynolds Announces Candidacy for American Dental Association Board Seat

Past president of Virginia Dental Association seeking ADA Second Vice President post

Dr. Elizabeth Reynolds, immediate past president of the Virginia Dental Association, is running for a seat on the Board of Trustees of the American Dental Association.

In seeking the Second Vice President post in the 163,000-member professional organization, Dr. Reynolds emphasized the ADA's role in helping ensure that public policy continues to support dentists' capacity to provide quality, accessible care to their patients.

"Serving as the ADA Second Vice President, I will work to ensure that every ADA member can focus on patients first, knowing that the ADA has their backs," Dr. Reynolds said. "Among my priorities, I will fight for fair insurance reimbursement and government policies that recognize the important work that dentists perform in communities across the country."

Dr. Reynolds has held leadership posts within the VDA and the Richmond Dental Society for close to two decades, most recently serving as VDA's president and overseeing growth within the association during her term, even as she helped navigate the Commonwealth's dental profession through the uncertain times of the pandemic. She worked closely with Governor Northam's administration in setting forth policies that helped ensure the safety of dental patients while at the same time enabled dental offices to carry out their critical work. While it was a difficult year to lead the VDA, Dr. Reynolds stated, "the entire organized dentistry community really came together to meet the challenges presented by the pandemic and I am proud of the work we all did to continue to focus on providing patients with safe and essential dental care."

A 1991 graduate of the School of Dentistry at the Medical College of Virginia, Virginia Commonwealth University, Dr. Reynolds has been a practicing dentist for three decades and is currently a partner at Brown, Reynolds, Snow and LeNoir Dentistry which has two offices in Richmond. For Dr. Reynolds, dentistry has always been an important part of her life as she grew up watching her father and his passion for his profession and his patients in his small-town dental practice. "Being a part of organized dentistry allowed my father to pursue the profession he loved and enabled him to have an impact on so many lives in the community." Following his example, Dr. Reynolds works hard, takes joy in the work, and devotes herself to supporting others in the profession that have encouraged her throughout her career.

In addition to her volunteer work with the VDA, she is a Fellow of the American College of Dentists, the International College of Dentists, and the Pierre Fauchard Academy. She currently serves as a Delegate for the 16th District of the ADA and is the proud recipient of the Harry Lyons Award, the most prestigious honor bestowed by the Richmond Dental Society. Her numerous volunteer activities, including Mission of Mercy, Donated Dental Services, and Give Kids a Smile, date back almost 20 years.

For her ADA Second Vice President campaign, Dr. Reynolds has outlined four platform priorities:

- **Protect the Doctor-Patient Relationship.** It is essential to work with insurance companies to foster a strong, trusted exchange that will support continued long-term alliances between dentists and their patients. The ADA must take necessary action, from continued monitoring to legal action to improve third-party payer concerns. The doctor-patient relationship is sacred and must be protected.

- **Address Workforce Shortages.** Dental hygienists and assistants are vital to a successful dental team. Collaboration with the American Dental Hygienists Association and other key stakeholders to establish training programs and address shortages will ultimately benefit the profession and most importantly, patients.

- **Facilitate Practice Transition Success.** Providing new members with a solid foundation for a successful dental career is the responsibility of a profession. The ADA's ADAPT practice transition program is an ideal opportunity to assist members in finding the practice of their dreams and to ensure that members find someone who will take good care of their patients as they retire from practice.

- **Diversify and Grow the ADA Membership.** It is crucial to embrace similarities and not let differences push members of organized dentistry apart. The strength of the organization is that dentists always put patients first. Building on what makes members similar, and embracing members differences, will create a diverse organization that is strong, educated and unified in its dedication to patients and oral health.

Dr. Reynolds stated "We are dentists, first and foremost, and as dentists it is key to remember that above all else, we have a shared passion for our profession and our patients. If I have the honor to be elected to serve as ADA Second Vice President, I will enthusiastically represent the House of Delegates and Membership to keep you engaged and informed of the great work of the ADA and its component and constituent organizations."

Editor's Note: Dr. Elizabeth Reynolds can be reached at **elizabethvadental@gmail.com**

EFFECTS OF ACTIVE REMINDERS AND MOTIVATIONAL TECHNIQUES ON ORAL HYGIENE AND GINGIVAL HEALTH IN ORTHODONTIC PATIENTS: A RANDOMIZED CLINICAL TRIAL

Jennifer Shim, DDS, Bhavna Shroff, DDS, Steven Lindauer, DDS, Caroline Carrico, PhD and Christel De Ocampo

ABSTRACT

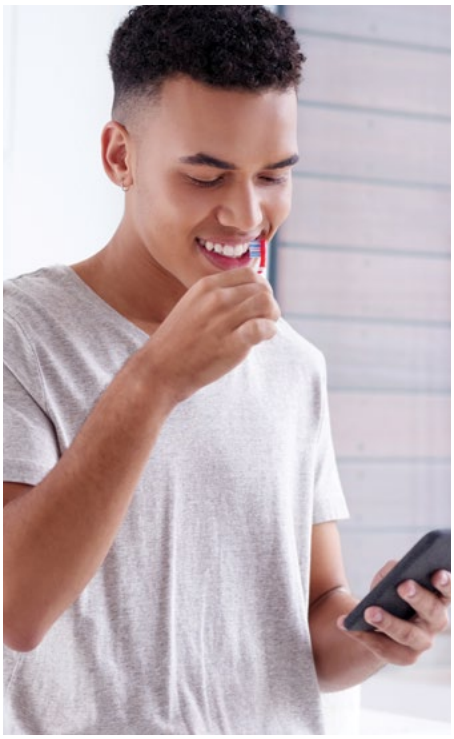
Purpose: To determine effect of oral hygiene instructions and text message reminders on measures of oral hygiene for patients undergoing orthodontic treatment.

Methods: Patients were randomly assigned to one of four groups using a block randomization protocol generated by a statistician. Group 1 served as a control. Group 2 received weekly text messages reminders. Group 3 received oral hygiene instructions at each visit. Group 4 received both text messages and in person oral hygiene instructions. The primary outcomes were oral hygiene measures using bleeding index (BI), modified gingival index (MGI), and plaque index (PI). Baseline measurements were obtained at the day of bonding (T0) and then at the subsequent 3 adjustment visits. Study measurements were all performed by a blinded examiner. Changes in oral hygiene status were assessed using repeated measures ANOVA.

Results: A total of 67 patients were enrolled and 64 were followed for an average of 4.8 months. Changes in PI (p-value=0.28), MGI (p-value=0.89), and BI (p-value=0.22) across the four visits were not significantly related to the intervention. All patients had optimal levels of oral hygiene at baseline and were able to maintain throughout the study period.

Conclusions: The use of text message reminders and oral hygiene instructions did not result in significant differences in oral hygiene among the study subjects who presented with high levels of oral hygiene at the study onset.

This study was registered with ClinicalTrials.gov under the study identifier: NCT03841825 (https://clinicaltrials.gov/ct2/show/NCT03841825).



INTRODUCTION:

The use of fixed appliances makes normal oral hygiene practice difficult and increases plaque accumulation around the brackets.[1] A change in periodontal health indices can be detected immediately after placing brackets and bands.[2] Prolonged plaque accumulation can lead to gingival inflammation and enamel demineralization, which can eventually lead to white spot lesions.[3] They can quickly develop within one month after placing fixed appliances.[4,5] The incidence of at least one white spot lesion per patient during orthodontic treatment was found to be 50% on average.[6] Oral hygiene compliance remains a consistent challenge during orthodontic treatment.

In both medicine and dentistry, the use of reminders has improved appointment attendance and reduced the no-show rates.[7-11] Studies in dentistry have demonstrated the use of text message reminders or mobile applications to improve compliance, especially for oral hygiene.[11-15] Text messages sent weekly were able to significantly improve plaque removal in as short as 3 months.[12] Increased frequency of text messages were more effective in improving compliance.[16]

Effective oral hygiene requires a combination of frequency and proper technique. Previous studies showed that repeated oral hygiene instruction and motivation with a hygienist significantly improved plaque scores in orthodontic patients.[17-20] Using verbal technique to instruct followed by self-application by the patient was effective for plaque elimination and improving periodontal health.[21]

The aim of this study was to compare repeated oral hygiene instructions and motivation to text message reminders in improving oral hygiene compliance. The hypothesis is that there was no difference in oral hygiene status if interventions begin at the same time treatment begins. The results from this study will help clarify the most effective way to obtain compliance with toothbrushing in patients with fixed appliances.

METHODS:

This was a randomized, active controlled trial. Approval was granted by the Virginia Commonwealth University Institutional Review Board (IRB HM20014910). Inclusion criteria consisted of patients between the ages of 11 and 20, were ready to start treatment involving full fixed appliances in both arches, who owned a cellphone with a plan allowing for text messaging, and no significant medical or dental history. Any patients that required antibiotic prophylaxis for dental procedures and patients with intellectual disabilities were excluded.

Group 1 served as the control group and received brief home care instructions the day of bonding appliances. Group 2 received an SMS text message once weekly at 5:15 PM (Eastern time) from an automated messaging service. The two different text messages were scripted as follows and were sent every week in an alternating order: "This is a friendly reminder to brush your teeth after every meal. Cleaning your teeth will help keep them healthy and beautiful," "Don't forget to brush your teeth for 2 minutes after each meal!" Group 3 received standardized oral hygiene instructions at each visit, including demonstration of proper brushing and flossing technique on a typodont model followed by patient demonstration on his or her own teeth. Group 4 received both the text message reminders and oral hygiene instructions.

Subjects received a text message through an automated patient communication system (Groups 2 and 4). The message consisted of a short reminder to brush their teeth that was sent once a week at the same time. Subjects receiving oral hygiene instruction received standardized, scripted instructions where their doctor demonstrated proper brushing and flossing technique on a typodont, then had the patient demonstrate it back on the typodont. The patients were then asked to demonstrate it on their own teeth, and corrections were made as needed.

Table 1: Oral Health Indices

	Score	Description
Bleeding Index (BI)	0	Absence of bleeding after 30 seconds
	1	Bleeding observed after 30 seconds
	2	Immediate bleeding observed
Plaque Index (PI)	0	No plaque
	1	Isolated areas of plaque at gingival margin
	2	Thin band of plaque at gingival margin (≤1mm)
	3	Plaque covering up to 1/3 of tooth surface
	4	Plaque covering between 1/3 and 2/3 of tooth surface
	5	Plaque covering ≥2/3 of tooth surface
Modified Gingival Index (MGI)	0	Absence of inflammation
	1	Mild inflammation – slight change in color, little change in texture of but not entire marginal or gingival unit
	2	Mild inflammation – criteria as above but involving entire marginal or papillary gingival unit
	3	Moderate inflammation – redness, edema, and/or hypertrophy of marginal or papillary gingival unit
	4	Severe inflammation – marked redness, edema, and/or hypertrophy of marginal or papillary gingival unit, spontaneous bleeding

Starting at baseline, readings of the Ramfjord teeth were recorded. The Ramfjord Index Teeth or Ramfjord Teeth (maxillary right first molar, maxillary left central incisor, maxillary left first premolar, mandibular left first molar, mandibular right central incisor, mandibular right first premolar) are a group of teeth used to describe the periodontal health of an individual. By measuring the gingival index, modified bleeding index and the plaque index of these teeth, we can obtain a reliable assessment of one's periodontal health. Descriptions of these three indices, which were the primary outcome measures are presented in Table 1. Measurements were taken using a University of North Carolina probe.

The baseline visit (T0) was the initial appointment where patients received full fixed appliances. At this visit, all patients received an oral hygiene kit, which included a pamphlet with written instructions and photos on proper brushing technique. Measurements were then taken at the following three adjustment appointments, typically ranging 4-8 weeks apart. Each patient had elastomeric ties and wires removed and instructed to brush prior to being examined.

Bleeding Index was measured according to Saxton and van der Ouderaa by probing the mesio-buccal, straight buccal, and disto-buccal sulci of the teeth.[22] One PI measurement was scored according to a modified scoring system from Quigley and Hein and measured the buccal surface of each Ramjford tooth.[23] One measurement for MGI was recorded on the buccal surface using an index developed by Lobene et al.[24] The average of each tooth was calculated, followed by an average of all the teeth.

Subjects received a text message through an automated patient communication system (Groups 2 and 4). The message consisted of a short reminder to brush their teeth that was sent once a week at the same time. Subjects receiving oral hygiene instruction received standardized, scripted instructions where their doctor demonstrated proper brushing and

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Table 2. Mean duration from T0 to T3 (months) and ranges (p-value=0.22)

	Mean duration (months)	Range (months)
Control (n=17)	4.65	3.50, 7.00
Text Only (n=14)	5.07	3.50, 7.23
OHI Only (n=16)	4.90	3.27, 6.87
Text and OHI (n=16)	4.77	3.73, 6.30

**OHI=Oral Hygiene Instructions*

Table 3. Mean (SE) BI, PI, and MGI baseline (T0) measurements

	Mean PI	Mean MGI	Mean BI
Control (n=17)	0.10 (0.10)	0.25 (0.09)	0.02 (0.04)
Text Only (n=14)	0.24 (0.12)	0.14 (0.09)	0.02 (0.05)
OHI Only (n=16)	0.35 (0.11)	0.28 (0.09)	0.13 (0.04)
Text and OHI (n=16)	0.36 (0.11)	0.36 (0.09)	0.11 (0.04)
p-value*	0.2492	0.4048	0.1570

**P-value from ANOVA model testing for differences across 4 groups at baseline; OHI=Oral Hygiene Instructions*

flossing technique on a typodont, then had the patient demonstrate it back on the typodont. The patients were then asked to demonstrate it on their own teeth, and corrections were made as needed.

A sample size of 8 was suggested for each of the four groups based on a prior study.[13] This would allow for at least 80% power to detect a difference in the trends across the 4 visits for average bleeding index. This was chosen since it demonstrated the greatest changes in previous studies. Power calculations assumed a 5% reduction in scores at each time point for the addition of OHI. Patients were randomly assigned to one of four groups using a block randomization protocol generated by a statistician as patients were sequentially enrolled. Study measurements were all performed by a single blind examiner who was calibrated.

Changes in mean BI, PI, and MGI were compared across the four visits using repeated measures analysis of variance. Significance level was set at p=0.05. The software used for all analyses was SAS EG (v.6.1).

RESULTS:

A total of 67 patients were recruited for the study. Four patients were lost to follow-up. There were total 37 females and 26 males with a mean age of 14.2 (SD=2.4) years, ranging from 11-20. Patients received full fixed appliances at T0 and were measured at the subsequent three adjustment visits (T1-T3), which ranged at least 4-6 weeks apart. The time from T0 to T3 ranged from 3.2 to 7.2 months and averaged 4.8 months (Table 2). The elapsed time did not differ among the four groups (p-value=0.2187).

Table 3 summarizes the baseline values for Bleeding Index (BI), Plaque Index (PI), and Modified Gingival Index (MGI). Although there were some differences between the groups at baseline, none of the differences were statistically significant or clinically relevant.

The average plaque index remained less than 0.5 (out of 5) across all visits indicating good oral hygiene. The changes in plaque index across the four visits were not associated with the intervention (p-value=0.2755). For all study subjects combined, the change in PI across the four visits was not statistically significant (p-value=0.5417).

The average modified gingival index remained less than 0.5 (out of 4) across all visits indicating good oral hygiene. The changes in modified gingival index across the four visits were not associated with the intervention (p-value=0.8940). For all study subjects combined, the change in MGI across the four visits was not statistically significant (p-value=0.2008).

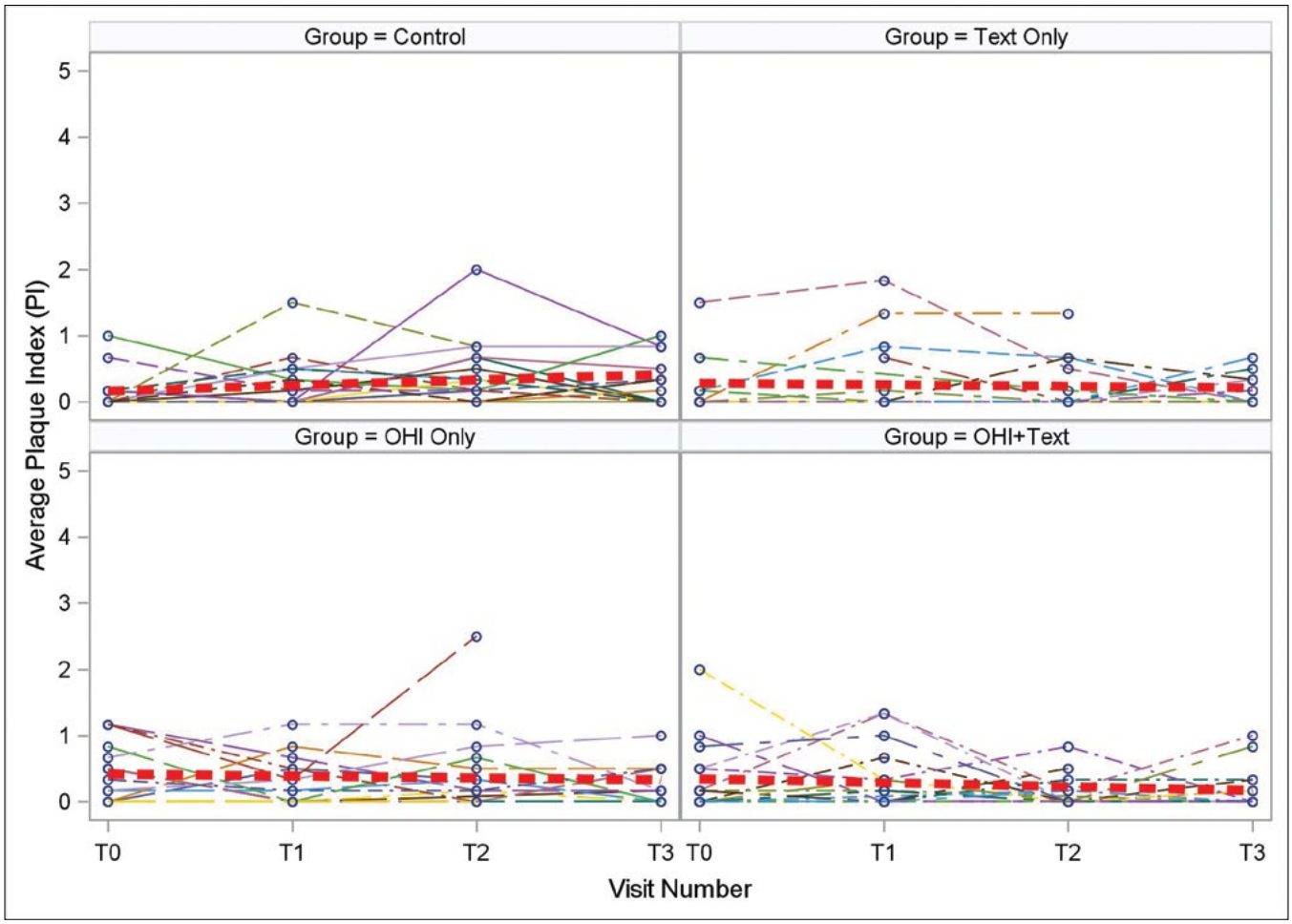
The average bleeding index remained less than 0.15 (out of 2) across all visits indicating minimal bleeding on probing. The changes in average bleeding index across the four visits were not associated with the intervention (p-value=0.2204). For all study subjects combined, the change in BI across the four visits was not statistically significant (p-value=0.7156).

Figures 1-3 display the trendlines for all the individual patients in the study across the four visits for each of the three oral hygiene measures. Visually, these demonstrate that the differences in the subjects across time were predominantly within the same range that was seen at baseline.

DISCUSSION:

Oral hygiene compliance is an important factor for successful orthodontic treatment outcomes. Oral health decreases as a result of fixed appliances and patients are more at risk of developing white spot lesions.[2,25] This can cause many problems during orthodontic treatment, ranging from gingival inflammation to white spot lesions and active decay.[1,5] A previous study showed that white spot lesions worsen the final esthetic outcome of orthodontic treatment.[26] Many methods have been tested to improve oral hygiene compliance, such as text reminders or

Figure 1



the use of cellphone applications. Some studies emphasize the importance of the frequency of reminding patients to brush and demonstrated that reminding patients at least once a week can increase oral hygiene compliance compared to no reminders.[11-16,27]

Proper oral hygiene requires not only frequency of brushing, but correct technique since fixed appliances impede the ability to brush. Repeated oral hygiene motivation and verbal instructions can decrease plaque levels and improve gingival health.[17,20,21] This study compared the use of weekly text message reminders and motivational oral hygiene instructions on improving oral hygiene. Patients were assigned to a control, text message only, oral hygiene instruction only, or combination of text and oral hygiene instruction group. Bleeding index (BI), plaque index (PI), and modified gingival index (MGI) have been used in previous studies to measure oral hygiene compliance and have high sensitivity and specificity for assessing periodontal health.[28,29] These indices were used in the present study to evaluate patients' oral hygiene.

No significant differences in BI, PI, or MGI were found between any groups at the end of the study. These results are inconsistent with previous studies. The following factors may have contributed to the differences observed in the present study: timing of intervention, initial oral hygiene status, a patient's self-efficacy, and possible behavioral modifications from participants in the control group.

Previous studies tested interventions at variable times during orthodontic treatment. Acharya et al started at the beginning of orthodontic treatment, but the baseline and follow-up measurements were significantly higher than those reported here.[17] The higher baseline measurements indicate that oral hygiene started off with signs of inflammation

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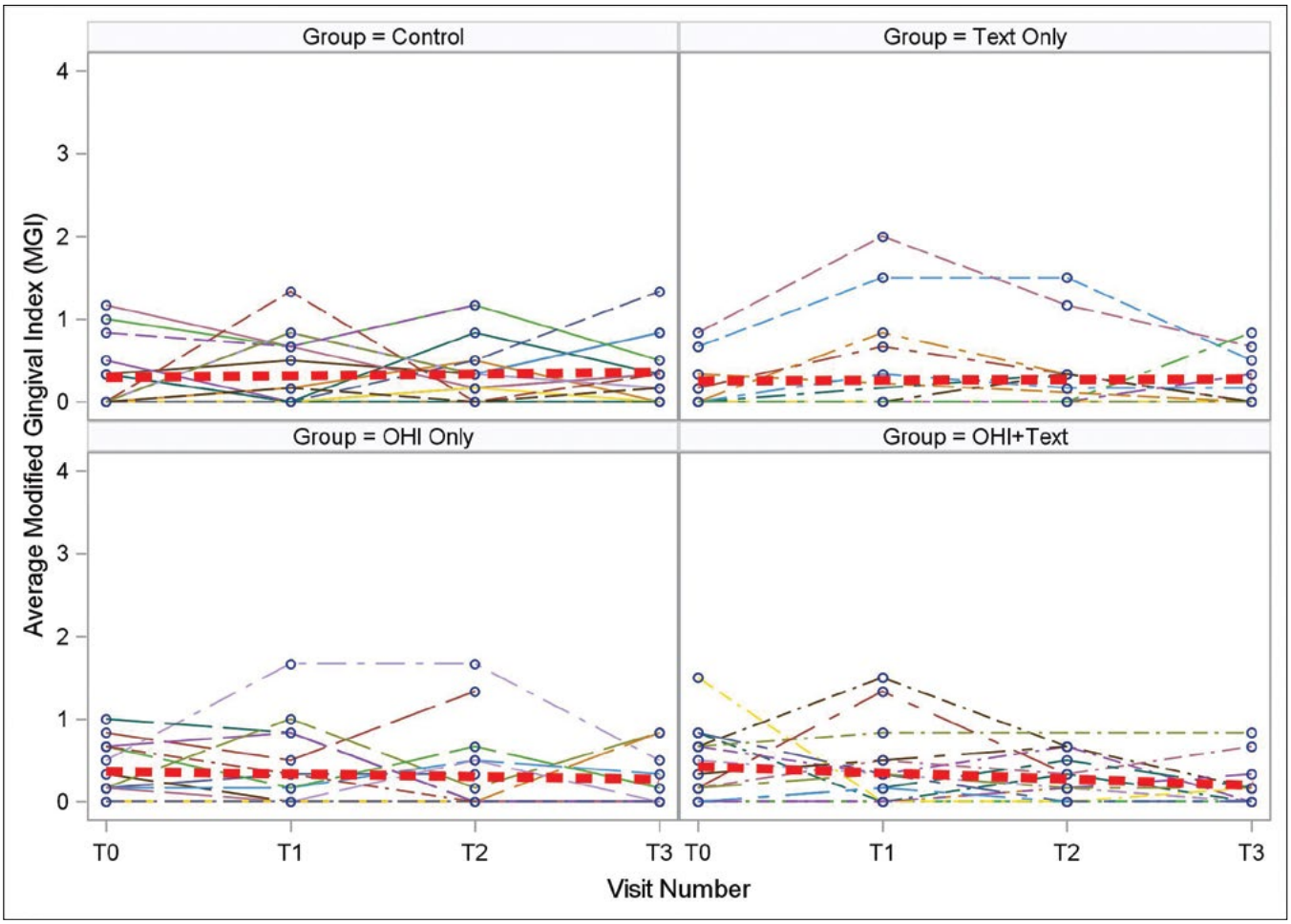
Figure 2



and were not controlled before starting orthodontic treatment. Other studies started at least four months after orthodontic treatment was initiated and the baseline measurements were also higher than in the present study, with the control groups worsening with time.[12,13,16,21] Patients in the present study were enrolled at the start of their orthodontic treatment in an effort to see if they could maintain their initial oral hygiene status. The treating providers are responsible for only initiating treatment when patients can demonstrate that their oral hygiene has improved to an acceptable level. The time range from T0 to T3 was 3.2 to 7.2 months and averaged 4.8 months. This would have allowed sufficient time for hygiene to decline. The results indicate that all patients, including those in the control group, were able to maintain adequate oral hygiene regardless of the intervention during the first four months of treatment.

Measurements at all timepoints were clinically significantly lower than those reported in other studies.[13,14,16,17,20] Patients have higher motivation and interest in their treatment early on. As treatment progresses, patients' motivation and cooperation decreases and patients are less willing to brush than they were at the start of treatment.[30,31] Mei et al reported that patients who were self-motivated for orthodontic treatment were more cooperative during treatment and had significantly less biofilm formation than patients who were family-motivated or both family and self-motivated.[32] Studies have found that patients who are motivated to start orthodontic treatment have a positive correlation with their reported cooperation during treatment.[30,31] The baseline measurements of this study were obtained when the patients were the most motivated and this could explain the discrepancy between previous studies, many of which enrolled patients in later stages of their treatment.

Certain risk factors can indicate that some patients are more likely to develop white spot lesions with fixed appliances than others. Patients who have fair or

poor oral hygiene pretreatment had three times the risk of developing white spot lesions compared to those who had good pretreatment oral hygiene.[33] Knowing this risk factor, doctors may be more apprehensive to start treatment on patients that present with poor oral hygiene. If a patient presents with poor hygiene at their initial exam, orthodontic treatment should be deferred until there is significant improvement of the oral hygiene. Requiring good oral hygiene before initiating treatment could have contributed to the low measurements in this study and may explain why oral hygiene was sustained for those that started treatment.

Oral hygiene-related self-efficacy has been shown to be positively correlated to important hygiene parameters.[34] Self-efficacy can be defined as an individual exercising control over his or her own health habits.[35] Patients that reported being confident that they could brush, clean interproximally, or attend their dental visits in different taxing situations positively predicted their behavior in the outcomes assessed.[34] Patients that possess self-efficacy might not be influenced by any kind of intervention or motivation induced by the orthodontist since the patients are inherently self-motivated already.

The control group consistently had good hygiene, not differing from any of the intervention groups.[13,16] This could result from patients being aware that they were involved in a scientific study. Subjects in a study may alter their behavior as a result of their awareness of the study. The Hawthorne effect describes that individuals may change their behavior upon being observed or assessed.[36] The John Henry effect describes that the control group's behavior changes resulting from fear of being outperformed.[37] During the consent process, patients were informed that they would be randomly assigned to one of four groups and each group was described. Patients may have guessed that they were assigned to the control group since they did not receive a text or oral hygiene instructions at each visit.

One main limitation of the study was the timing of the intervention. If patients were in fixed appliances for at least six months before beginning the study, oral hygiene may have declined and then interventions could have shown statistical differences from baseline. However, it should be considered that maintaining good hygiene for the first six months of treatment is commendable. Potential bias could have resulted from the patients not being blinded.

CONCLUSION:

Patients who presented with good oral hygiene initially were able to maintain it during the first four months of treatment regardless of the intervention.

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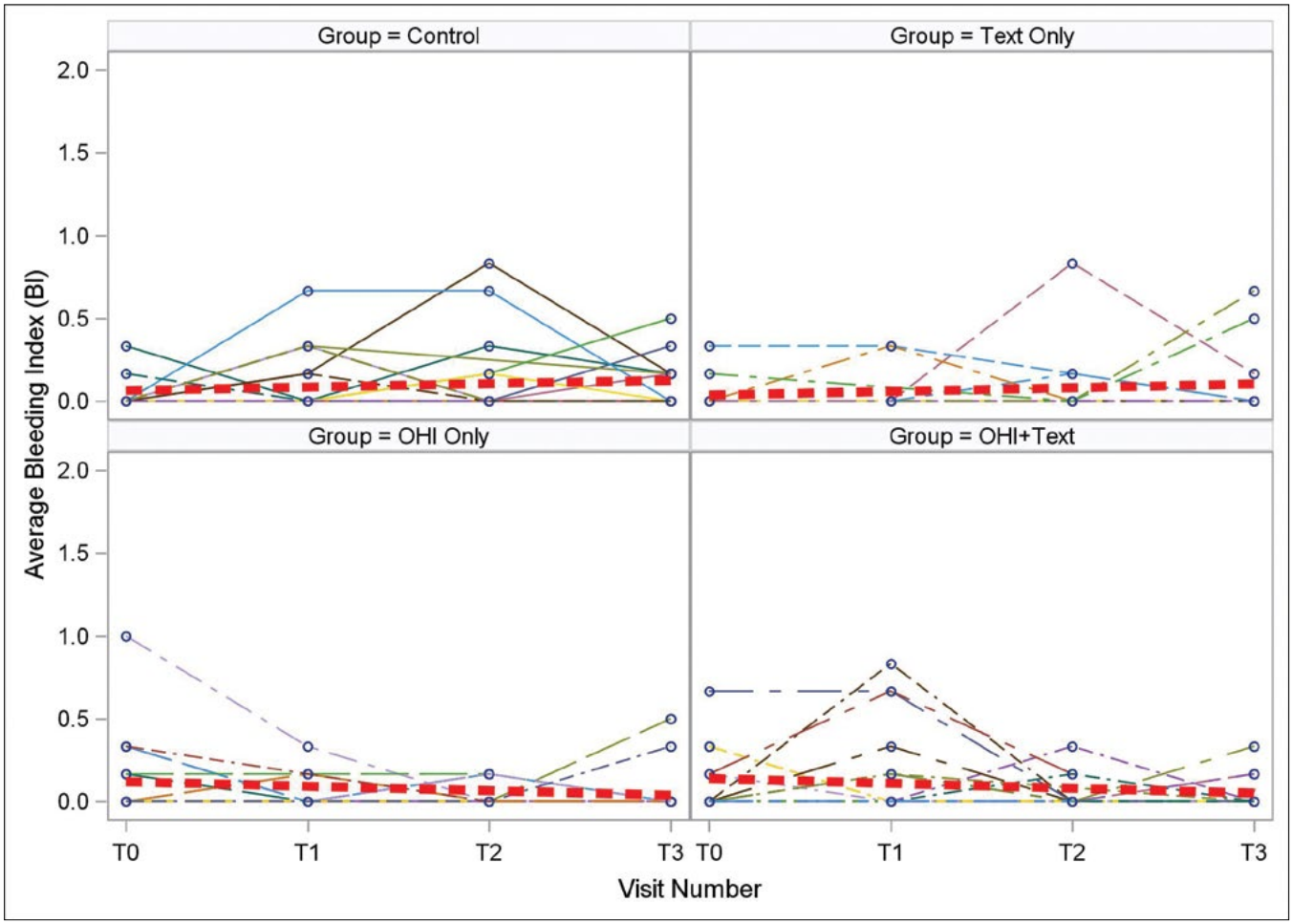
Figure 3



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Authors:

1. Jennifer Shim, D.D.S., Virginia Commonwealth University School of Dentistry, Resident, Department of Orthodontics
2. Bhavna Shroff, D.D.S., M.D.Sc., M.P.A., Virginia Commonwealth University School of Dentistry, Graduate Program Director, Department of Orthodontics
3. Steven Lindauer, D.M.D., M.D.Sc., Virginia Commonwealth University School of Dentistry, Department Chair, Department of Orthodontics
4. Caroline Carrico, PhD, Virginia Commonwealth University School of Dentistry, Biostatistician, Associate Professor, Dental Public Health and Policy
5. Christel De Ocampo, Virginia Commonwealth University School of Dentistry, Doctoral Student

Corresponding Author:
Bhavna Shroff, DDS, MDSc, MPA
Virginia Commonwealth University
Orthodontics
520 N 12th Street
PO Box 980566
Richmond, VA 23298-0566
(804) 828-0843
bshroff@vcu.edu

CLOUD TECHNOLOGY LIGHTS THE WAY FOR THE FUTURE OF DENTISTRY

Robert McDermott; President/CEO, iCoreConnect

There's never been a better time to leverage technology in dentistry. It's more accessible, secure, and efficient than ever before. No matter how long you've been in dentistry, it's likely dental school didn't teach much in the way of computer software and programming or offer a Master of Business Administration. Fortunately, what you need to know is simple. It's all about integrating cloud-based software to speed up clinical workflow and enhance patient care. This process is easier than it sounds, and the long-term benefits have tremendous payoff in both time and money.

Cloud-based technology and services are rapidly becoming the preferred backbone to run any business. The technology model, Software-as-a-Service or SaaS, is a term you may have heard pronounced "sass". SaaS is commonly referred to as 'cloud-based', 'web-based', 'hosted' or 'on-demand' software. For example, Amazon, Spotify, and Netflix are all SaaS platforms and are all accessed through the internet. Think of the ease and convenience of these services. Now imagine translating this model of cost savings, convenience, and capability into your practice.

Here's how it works. Cloud-based software replaces traditional servers, hard drives, and daily processes in the clinical workflow. For example, if you are using a traditional server system, which lives at your office, you most likely had a large cash outlay when you purchased the system. Installation and setup is labor intensive and time consuming. The server gets updated, often at a cost to the practice, infrequently and inconveniently. The data on the server needs to be backed up to physical hard drives and stored at different locations outside your office. And, eventually, that server will need to be replaced.

On the other hand, a cloud-based service, whether it's your practice management system, your e-Prescribing service, or the way you check insurance, is charged on a monthly recurring basis (just like Netflix). There is no physical installation to make your cloud services work. All practice data is backed up continuously to multiple servers in multiple, highly secure locations across the country, protecting your critical practice records from loss. Updates are automatic, frequent and free. These are all examples of the SaaS benefit.

Here are four key areas where cloud-based products and services will immediately improve your business.

Verify insurance benefits immediately

When the doctor discovers a patient needs a crown, a staff member needs to check the patient's insurance. That patient may walk out the door without a follow up appointment because she is waiting to find out what, if anything, she will owe out of pocket. But here is great news for the staff member who usually spends countless hours checking patient insurance. Today, there is specialized software that checks insurance benefits immediately. The staff member gets answers while the patient waits for just a moment or two. Armed with the actual insurance information needed for next steps, a patient is more likely to book the appointment and show up for it. Anxiety over financial surprises no longer lingers. The patient gets needed treatment, and the practice remains financially on track.

e-Prescribe all medications

Electronic prescribing is another big deal for better clinical workflow. You've already taken the first step toward a faster workflow now that you are e-Prescribing

"Software-as-a-Service, or SaaS, is a term you may have heard pronounced "sass". SaaS is commonly referred to as 'cloud-based', 'web-based', 'hosted' or 'on-demand' software. Amazon, Spotify, and Netflix are all SaaS platforms accessed through the internet."

any controlled substance containing an opioid. The next step is to move every prescription to electronic. Eliminating the multiple other steps including phone calls, handwritten scripts, pharmacy clarifications or faxing will significantly speed up your workflow.

By simply streamlining insurance checks and the prescription process, time is saved, and patient care is kept on track. The next two steps add to the security, peace of mind and efficiency of running a practice.

Move data to the cloud

If practice data is stored in a physical server in the office and then backed up to a physical hard drive, trouble may await. Backing up to a hard drive in the office, or one that travels home with the dentist or a staff member, puts Protected Health Information (PHI), financial information

and all practice information at risk of being stolen or accidentally destroyed. The strongest protection comes from using a cloud-based backup service. PHI and all other data is backed up every time a key is clicked on the keyboard. The sensitive data lives on servers across multiple locations, protected at the highest level of cyber and physical security.

Take IT off Your Plate

Even though you may be savvy to technology, your first love and priority is dentistry. It is prudent for a practice to engage the services of a Managed Services Provider or MSP. An MSP takes care of everything IT at a predictable monthly rate, eliminating surprise costs. An MSP team doesn't even need to be in the same city as the practice. That's the beauty of running your business on cloud-based software. The MSP experts diligently maintain, update and prioritize security and compliance of the practice's computers and secure email. IT and security issues are immediately mitigated or simply don't happen.

In conclusion, leveraging cloud-based technology at any stage of a dentist's career is the economical, practical and proactive way to do business. The dental industry needs a fresh approach to speed up clinical workflow and make dentistry even safer and more convenient for patients while increasing security and revenue for the practice. Doing business the same way as always may be comfortable but it will keep a practice stuck at "status quo" at best. Your business has a bright future in cloud-based technology.

iCoreConnect

Editor's Note: iCoreConnect, a VDA Services Endorsed Partner, develops cloud-based software that improves and protects your practice, including e-Prescribing software, full IT/MSP services, insurance verification and revenue analytics. VDA members receive special discount pricing on iCoreExchange HIPAA-compliant email and iCoreRx e-Prescribing software. Visit **http://land.icoreconnect.com/VA06** or 888.810.7706 for a no obligation demo to see how iCoreConnect's products speed up workflow and increase revenue.

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FEEL FREE TO HAVE YOUR VOICE HEARD! Take the time to log into the website and leave a comment. In addition, the BOD approved templates for dental appliances work order forms as well as dental appliances subcontractor disclosure and sub-work order forms.

The calendar for 2022, with the proposed meeting schedules, was discussed in the extended session. Authorizing dentists to allow a DA1 or DA2 to use a scaler to remove cement from the coronal surface of teeth was also covered.

The disciplinary report shows for the period of January 1, 2021 through May 31, 2021, 182 cases were received and 181 cases were closed. Most cases had to do with a neglect of the standard of care, diagnosis and treatment. There was one case of abuse/abandonment/neglect and one for unlicensed activity. There were two suspensions for inability to safety practice and one summary suspension for inability to safely practice imposed.

On March 21, 2021, the Department of Defense announced the approval of a series of grants that will help military spouses with the issue of professional license portability.

Editor's Note: Dr. Klostermyer, a VDA member, practices prosthodontics in Richmond. Information is presented here for the benefit of our readers, and is deemed reliable, but not guaranteed. All VDA members are advised to read and comprehend all Board of Dentistry regulations and policies.

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WHAT ARE THE RMDS FOR BENEFICIARIES IN QUALIFIED RETIREMENT PLANS?

David J. Kupstas, FSA, EA, MSEA

When an employee in a qualified retirement plan dies, the employee's account balance must be distributed to the beneficiary at a certain rate over a certain timeframe. The money cannot stay in the plan forever. What is that timeframe? When do distributions have to start?

A lot of people are familiar with the rule calling for living employees to begin receiving required minimum distributions (RMDs) at age 70½ (now age 72). The RMD rules also address distributions after an employee has died, whether before or after age 72. This article addresses some of the death RMD rules that apply to qualified defined contribution plans, including 401(k)s and profit-sharing plans. Distribution rules governing defined benefit plans and IRAs are not covered here.

Distribution Periods

The maximum period over which distributions may be made to the beneficiary depends on several factors:

- **Whether the employee had attained their required beginning date (RBD) or not**. The RBD for most employees is the April 1 following the calendar year in which the employee retires or attains age 72, whichever is later. For more-than-5% owners, it is the April 1 following the calendar year he attains age 72, even if they are not retired. Until 2020, the beginning age was 70½ instead of 72.
- **Whether the beneficiary is an "eligible designated beneficiary,"** which means the employee's surviving spouse or minor child or someone who is disabled, chronically ill, or no more than 10 years younger than the employee. The concept of "eligible designated beneficiary" was introduced as part of the SECURE Act in late 2019.
- **Whether the sole beneficiary is the employee's surviving spouse.**
- **Whether the beneficiary is a "designated beneficiary" at all.** A "designated beneficiary" must be a person. Trusts, estates, and organizations are not designated beneficiaries. While it is true that a trust, estate, or organization may be "designated" by an employee to be their beneficiary, these entities are not "designated beneficiaries" as the term is defined.

The SECURE Act added a rule specifying that, in many cases, the account balance of an employee who died must be distributed in full by the end of the tenth calendar year following the employee's death. The addition of the 10-year limit under the SECURE Act curtailed what was known as the "stretch IRA," which allowed beneficiaries to stretch their withdrawals over many years, sometimes well past the expected lifespan of the employee whose money they inherited. The stretch concept applies to qualified plans as well.

Here are the distribution periods that apply under various scenarios:

If the employee dies after attaining their RBD:

If an employee dies after attaining their RBD, then there must have been an RMD in the year of death. If the employee took the RMD before they died, nothing further needs to be distributed that year. If the employee did not take the RMD before they died, then the RMD needs to be paid to the beneficiary before the year is up. The RMD amount is the same whether the employee took it before death or not.

After that, it depends on who the beneficiary or beneficiaries is/are:

1. Distributions to an eligible designated beneficiary may be made over the beneficiary's remaining life expectancy or the deceased employee's remaining life expectancy, whichever one is longer. "Remaining life expectancy" is discussed below. It could be different depending on whether or not the spouse is the sole designated beneficiary.
2. For non-eligible designated beneficiaries, the 10-year rule generally applies.
3. If there is no designated beneficiary, then distributions must be made over the deceased employee's remaining life expectancy.

If the employee dies before attaining their RBD:

The employee's full account balance must generally be paid out by the end of the tenth calendar year following the employee's death. Exceptions are as follows:

1. Distributions to an eligible designated beneficiary that is not the employee's surviving spouse may be made over the beneficiary's remaining life expectancy. However, if these distributions do not begin in the calendar year following the employee's death, either by the beneficiary's election or because of the plan's terms, then the 10-year rule applies.
2. If the surviving spouse is the sole designated beneficiary, then the surviving spouse must start taking RMDs when the employee would have attained age 72. The spouse's RMD amounts are

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based on the spouse's remaining life expectancy. If the surviving spouse dies before starting RMDs, distributions shall be made as if the surviving spouse was the employee.

3. If there is no designated beneficiary, then distributions must be made by the end of the fifth calendar year following the participant's death. Before the SECURE Act, the five-year rule applied in more instances, but now it applies only when there is no designated beneficiary. The five-year rule works the same as the new 10-year rule, other than the shorter time period.

Remaining Life Expectancy

The "remaining life expectancy" is determined differently depending on whether the surviving spouse is the sole designated beneficiary or not. If the spouse is the sole designated beneficiary, then the remaining life expectancy is the life expectancy based on the spouse's current age in the year of each distribution.

If the spouse is not the sole designated beneficiary, then the remaining life expectancy is determined using the "subtract one" method, which is the life expectancy as of some initial date minus one year for each calendar year that has elapsed since the life expectancy was first determined. If the life expectancy at age 71 is 16.3 years, then the remaining life expectancy under the subtract one method at age 72 is 15.3 years, at age 73 is 14.3 years, and so on. Compare this to the fresh life expectancies from the life table: 15.5 years for age 72 and 14.8 years at age 73.

In most of the situations we have described, the initial life expectancy for the employee is based on the year of death, while for the designated beneficiary it is for the calendar year following the year of death. This distinction comes into play if the employee and beneficiary are the same age. In that case, the beneficiary's remaining life expectancy would be used since his life expectancy in the year after the employee's death will always be greater than the employee's year-of-death life expectancy minus one.

Other notes on distribution periods are as follows:

- If the non-spouse beneficiary dies before receiving the deceased employee's full account balance, payments will continue to a contingent beneficiary for the same distribution period (i.e., with the same life expectancy factors that were being used for the original beneficiary).
- If there is more than one designated beneficiary, the life expectancy used is based on the oldest beneficiary.
- Under the five-year rule or 10-year rule for deaths before RBD, the account balance may be distributed in chunks over the applicable period, or it can be distributed all on the very last day of the fifth or tenth year – however the beneficiary wants to do it as long as it's completely distributed by the deadline. This is in contrast to distributions under the life expectancy method which must be made each year.
- Once a minor child reaches the age of majority, he then has 10 years to receive the remaining account balance of the deceased parent/employee, meaning the distribution period for someone who starts getting distributions as a minor child may end up being more than 10 years.
- If an eligible designated beneficiary dies, the 10-year rule applies to the beneficiary of such eligible designated beneficiary. That beneficiary doesn't get to use the life expectancy method.
- Be aware that the distribution period will usually get shorter when an employee dies. When living, the distribution period is often based on the Uniform Life Table, which is a joint life expectancy that is longer than the life expectancy of a single person. After the employee's death, distributions are based on the life expectancy of just a single person.
- An updated mortality table will be used in RMD calculations for 2022 and beyond. In some cases, the remaining life expectancies being used under the subtract one method will be reset.

Rolling Over

Let's switch gears and talk tax. A beneficiary receiving RMDs must pay taxes on the distributions in the year the money was received. The annual

distributions under the life expectancy method are subject to income tax, as would a big lump sum distribution paid within five years or 10 years of the employee's death.

A beneficiary might think, "Ah, let me roll the account balance over to an IRA so I can avoid paying income taxes until a time far off in the future." Unfortunately, that's not going to work. Even if the money is rolled into an IRA for a non-spouse beneficiary, it still must be distributed under the rules governing the plan from which the rollover came. There is no tax-deferral advantage for a non-spouse beneficiary to roll over to an IRA, although there may be other reasons to move the account from the qualified plan to an IRA. For what it's worth, the IRAs in these cases are to be treated as inherited IRAs and should be titled thusly.

"A beneficiary receiving RMDs must pay taxes on the distributions in the year the money was received."

The rules are different when the sole beneficiary is the spouse. A surviving spouse may be able to postpone RMDs until the employee would have attained age 72 by rolling to an inherited IRA. Likewise, a surviving spouse may be able to roll over the deceased employee's account to the spouse's own IRA and avoid taking RMDs until the spouse's own age 72.

Prior to 2007, a nonspouse beneficiary was not able to do a direct rollover of a qualified plan account balance.

Missing the Required Beginning Date

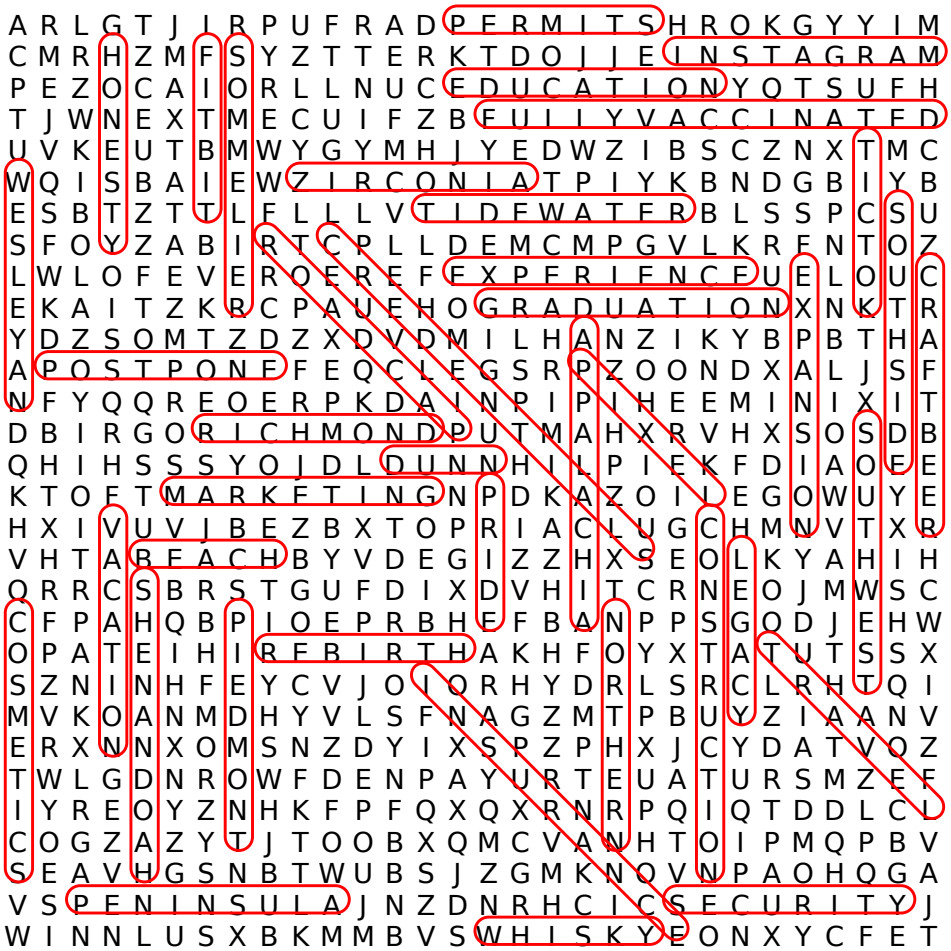
It is easy to miss RMDs when an employee dies prior to attainment of age 70½ or 72. Plan sponsors may simply not be aware that distributions must be made relatively soon if the beneficiary is not the spouse. They might think the beneficiary can wait until he turns 72 or until when the employee would have turned 72. Or they may be well aware of the rules but never be notified that a terminated employee has died. Plan sponsors often lose track of employees who have not worked at the company in a number of years. We had one instance where there was a change in personnel and a change in recordkeepers, a beneficiary was inadvertently coded as a terminated employee, and no one knew RMDs were owed until quite a while after the actual employee's death.

Suppose an employee with a non-spouse beneficiary died 10 years ago, and no RMDs were ever made on their behalf. Either partial distributions should have started in the year after death, or the whole account balance had to be distributed within five years (under the pre-SECURE Act rules). Since neither of these happened, there is a big problem. A missed RMD is subject to a 50% excise tax payable by the beneficiary.

In lieu of paying the tax, the beneficiary can write a letter to the IRS asking for mercy and for the tax to be waived. The letter might actually work if there is a good reason the RMD was missed. Alternatively, the plan may file under the IRS Voluntary Correction Program and potentially get the taxes waived. There are fees for utilizing this program, though. Once the error is discovered, a makeup distribution has to be made. This would be the sum of all the missed distributions plus earnings. An interesting question is, can the makeup payment and subsequent distributions be based on the life expectancy rule if the beneficiary originally had that option, or must the entire account balance be distributed because the beneficiary missed his chance at the life expectancy rule by not taking a distribution in the year after the employee's death? The IRS issued a Private Letter Ruling (200811028) indicating the life expectancy method is still available under these circumstances. A PLR is valid only for the taxpayer who requested it, but PLRs do give some indication that the same approach taken by someone else might be considered reasonable.

Editor's Note: The content of this article is for general informational purposes only and may not be construed as tax advice. Readers weighing options with respect to retirement plan distributions will wish to contact their own advisors qualified in tax planning.

>> WORD SEARCH ANSWERS CONTINUED FROM PAGE 15



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STARTING OVER IN A PANDEMIC

Julie Ericksen; Program Manager, Donated Dental Services

Through the Virginia Dental Association Foundation's (VDAF) Donated Dental Services (DDS) program, we connect hundreds of folks each year with one large treatment plan to restore their mouth to good oral health. The treatment our clients receive is life-changing, promoting improved health and well-being. They feel the incredible relief of access to formerly unattainable dental care, from dentists and labs who generously donate their time and materials to support them. Our clients are either elderly or disabled and low income.

One such case is Gregory, who was diagnosed with Laryngeal Squamous Cell Carcinoma and consequently had a total laryngectomy. The entire journey from his diagnosis, three surgeries, chemo and radiation, and dental care has occurred during the pandemic while living in a homeless shelter; a combination of conditions undoubtedly difficult for most of us to imagine.

The pandemic, of course, created special challenges for Gregory: isolation, difficulties with transportation, vulnerability to infection, covering his face as well as tracheotomy site. Chemo and radiation caused a burning throat and secretions which stimulated coughing. We all know that coughing during a pandemic raises eyebrows…

In many cases of head and neck cancers, any teeth that are not completely healthy will be removed before radiation, often very abruptly due to the necessity of the impending treatment. This was the case for Gregory, who not only lost his ability to speak with vocal cords but lost his teeth and ability to eat normally. Consequently, he had a feeding tube as he went through chemotherapy and radiation treatments. Managing the challenges of such a visible cancer is daunting, though groups like the "Lost Chord Club," where folks with similar issues can share life experiences, are deeply supportive. The hottest topic among this population is often food, highlighting the importance of eating in our lives – it's connection to sustenance, community, and pleasure.

"Gregory struggled to communicate using his new voice prosthesis, but I clearly understood the level of gratitude he feels for our support facilitating his dental care."

Despite these incredible challenges, his case manager describes him as resilient, appreciative, humble, and adaptable. He is a man of strong faith who hopes to sing again in a church choir with the aid of his vocal prosthesis.

Gregory would have been in greater distress without the support of people like his Oncology Social Worker, Paul Bennett. Paul discovered the VDAF's DDS Program in his quest to help Gregory get dentures, and has aided him in getting a vaccine, his stimulus checks and is currently helping him with housing. I was deeply moved by Gregory's story and thrilled when Dr. Amy Baluyut of Virginia Beach and Lab One Dental Laboratory of Norfolk, Virginia agreed to take on this case to provide Gregory with dentures. He received close to $3,000 worth of free care.

Dr. Baluyut commented, "What a sweet man. I'm always happy to help when I can, and I love what I do because I have the ability to help people smile...and hopefully he will flash those 'pearly whites' for a long time."

As the case neared its completion, I had a conversation with Gregory. He struggled to communicate using his new voice prosthesis, but I clearly understood the level of gratitude he feels for our support facilitating his dental care. He thanked me over and over again from the bottom of his heart. I had tears in my eyes simply for the fact that without the voice box, he would not have been able to communicate that to me over the phone, and it was a joy for me to share my understanding of his words and how it made me feel to hear them.

As rewarding as our work is for the clients, it is often equally rewarding to the dentists and labs who support their neighbors to return to good oral health and enjoy the relationships they have with their patients. One of our volunteer dentists said it best: "Some days, our DDS patients give us our 'Best' smiles of the day!" If you would like to join our Donated Dental Services team, feel free to give me a call at (804) 523-2182 or email me at **ericksen@vadental.org**.

10 YEARS OF ORAL CANCER AWARENESS

Deborah Owusu, Class of 2022, VCU School of Dentistry; President, VCU SNDA, 2021-22

On Thursday April 8, 2021, VCU SNDA held its 10th Annual Oral Cancer Walk and its first Virtual Oral Cancer Walk. The Student National Dental Association (SNDA) originated from concerned dental students at Meharry Medical College in 1970. SNDA was formed to give a structured mechanism to promote contact between minority dentists and dental students. Since its humble beginning, SNDA has grown to approximately 1,100 minority dental student members across the nation. Our mission has been to promote, support and encourage recruitment and retention of minority dental students. We are committed to engaging in outreach efforts, providing oral hygiene education, and improving access to care, emphasizing our efforts on minorities and the underserved.

The purpose of the Oral Cancer Walk Event is to promote oral cancer awareness and to raise money for oral cancer research. A portion of the proceeds are donated to the Philips Institute for Oral Health Research. This event has been very successful, and we raised close to $9,000 through the Oral Cancer Walk in the past.

We were pleased to have several authorities on oral cancer join us for this event. SNDA and VCU are grateful for their participation in this very successful event.

About Oral Cancer

Oral cancer is the ninth most common cancer in men. According to the Oral Cancer Foundation, approximately 43, 250 people will be diagnosed with oral cancer this year. More than 25% of the 30,000 Americans, who get oral cancer, will die of the disease. Approximately 75% of oral and pharyngeal cancers are attributed to tobacco and heavy alcohol use. Less than 60% of patients will survive 5 years, and only 40% will survive in 10 years. The good news is that early detection significantly reduces the risk of death.

2019 Event

This year's virtual event included several speakers that were able to share important stories and information. The speakers at the event were Dr. Iain Morgan, Dr. Sarah Glass, Mrs. Dania Luby, and Mrs. Cindy Cheely.

IN MEMORY OF:

Name	City	Date	Age
Dr. Gary R. Arbuckle	Newport News	5/4/21	86
Dr. Wendell H. Butler	Roanoke	11/5/20	95
Dr. Irwin S. Feldman	Falls Church	5/1/21	78
Dr. Philip S. Ferris	Bellevue, WA	4/4/21	80
Dr. Thomas R. Golden	Monroe	1/29/21	85
Dr. Robert F. Graham	Radford	8/20/14	76
Dr. Matthew J. Howell	Portsmouth	10/11/20	93
Dr. John R. Kiser	Erwin, TN	3/14/21	85
Dr. Charles H. Miller	Portola Valley,CA	1/4/21	90
Dr. Robert V. Perkins	Richmond	1/9/21	90
Dr. John Salmon	Richmond	12/16/20	80
Dr. Charles L. Smith	Virginia Beach	10/23/20	82

MEET THE CANDIDATES

VOTING BEGINS JULY 9, 2021 AT **VADENTAL.ORG/VOTE**

PRESIDENT-ELECT *(1 position available)*

Dr. Cynthia Southern

I am running for President-Elect. I have served the Virginia Dental Association for the last 15 years. My experience from serving on the Board as Component VI director and as Treasurer has led to my desire to run for President-Elect. We are coming out of a difficult year. The VDA has been the leader throughout the pandemic to guide dentists and their practices through the emergency guidelines and reopening. I am proud of this association and would like to help the president this upcoming year to keep moving us forward and to continue that movement through 2023.

ADA DELEGATE *(4 positions available)*

Dr. David Anderson

Being a Delegate to represent the VDA at the ADA has been a challenge and a joy. With dentistry rapidly changing and the landscape that we are in now is adding another layer of complexity. Having been an ADA committee chair and being appointed to three ADA reference committees has given me the requisite knowledge base to put forth the VDA's ideals and positions. While this will be my last election, I bring to the table a wealth of experience to help younger delegates thrive for years to come.

Dr. Samuel Galstan

The VDA and the ADA need to hear all of our voices, and our representative to the ADA needs to represent all of our components and members, and I have the ability, the energy, the desire and the skill set to be able to do this. I have had the opportunity to serve on the Virginia delegation to the ADA, as well as being a VDA Past President and a Southside Dental Society Past President, and this is most helpful to be effective in this position. The VDA and the ADA are facing a number of challenges, and we need to put the effort in to ensure organized dentistry's sustainability and viability. I am here to serve you, and respectfully request that you vote for me for ADA Delegate.

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ADA DELEGATE continued *(4 positions available)*

Dr. Ralph Howell

As things slowly return to a post pandemic state, it reminds me of the absolute need to continue to be involved in the dental profession. As a member of the ADA Council on Dental Practice, I have had the opportunity to see the many valuable services and resources that the ADA was able to produce to assist members in their return to work. Yet there is still much to do. I would like to continue my service on the ADA Delegation to further promote the profession and assist in making our association the trusted source for oral health. With the added pressures on the practice with the constant changing regulatory environment and pressures from third party carriers; it is extremely important to have proven leadership to help tackle these problems. I ask for your vote as ADA Delegate. Thank you.

Dr. William "Vince" Dougherty

Dentistry has always been a part of my life. I watched my father practice without all of today's technological advancements. So much change has occurred. I want to continue to help direct the change in a way that benefits the practice of dentistry and our patients. I have the will, the confidence, and the passion for the position. I promise to represent you in the best way possible. Serving as ADA Delegate, as past president of NVDS, and past president of VDA, I have acquired leadership and decision-making skills to act confidently on your behalf. I am currently serving as chair of the Virginia Dental Association's Covid "Back to Work Task Force" and a member of the ADA's Council on Dental Benefits. The VDA has been extremely successful in helping all of us get back to work safely in our current pandemic. The task force worked diligently to develop clear concise guidelines to help all of membership thrive during difficult conditions. There are still obstacles, but the guidance has been extremely important for many members. My experience on the CDBP enables me to understand that there are many other threats against our great profession, including the ability to practice quality dentistry while delivering exceptional patient care without insurance interference. I respectfully ask for your vote. I understand that in fulfilling the position, it will be an ongoing responsibility to our profession. I hope to continue to serve you in this capacity and look forward to continuing to represent our great state on a national level.

ADA ALTERNATE DELEGATE *(5 positions available)*

Dr. Scott Berman

I'd like to continue to serve our Association and focus my energies as an Alternate-Delegate on strengthening membership. In particular, I'd like to firm up the membership numbers for specialists. I have several ideas that may enhance that. I would like to suggest a different dues structure for specialists who are full members of their specialty organizations, if those specialty organizations would "require" ADA membership.

Dr. Bradley Hammitt

Representing the VDA at the national level is an incredible responsibility and honor, and a job that requires attention to detail. I would love to utilize my skills in reading the fine print to further Virginia's goals and desires at the ADA House of Delegates. I will make sure to use this opportunity to represent our constituency of excellent dentists with the dignity and proficiency you all deserve. Thank you for your consideration of my candidacy.

Dr. Elizabeth Reynolds

I would be excited and honored to represent the Virginia Dental Association at the national level again. I was so honored to have been president of the association last year and would love the opportunity to continue that leadership at the ADA. I feel that I am in a position to help bring all of our successes from the VDA to the ADA, simultaneously highlighting our accomplishments as a state and contributing to and strengthening some of the ADA positions and programs. I humbly ask for your vote and support as your ADA Alternate Delegate.

Dr. Jeena Devasia

Serving on the delegation for the last two years has given me the opportunity to see first-hand the amount of time and dedication required for our national organization to operate as efficiently as it does to serve the interests of its members. It has allowed me to network with colleagues from other states to see other programs and initiatives that we might be able to benefit from here in Virginia. I am honored by this opportunity to serve and look forward to learning more through my involvement.

Dr. Benita A. Miller

It has been an honor and a pleasure to serve as an ADA alternate delegate over the past two years, and I am hoping you will allow me to serve a second term as your alternate delegate. We have seen incredible events that have rocked our world in ways we could never have anticipated, and never have I appreciated more the backing and support from the VDA and ADA. We have learned to be flexible, to pivot on a moment's notice, and to do what it takes to adapt to "changing change". The lines of communication from ADA to VDA have strengthened, and I will work with our 16th District delegation to further strengthen those relationships. Our profession has become increasingly diverse, and never has it been more critical for all our grassroots voices to be heard nationally as we traverse the ever-changing environment we now face. I hope to be a good mentor to my new practice partner as she starts her career and to my daughter as she enters the profession as a first-year dental student. They help me see their perspective and the challenges (and opportunities) they face. They and their contemporaries will be our future leaders! I am so appreciative of your support over the years, and I humbly ask for your vote to allow me to continue to serve and represent your voice on a national level.

WELCOME NEW MEMBERS

THROUGH JUNE 1, 2021

Tidewater DENTAL ASSOCIATION

Dr. Karan Oza – Norfolk – Midwestern University College of Dental Medicine/ Illinois 2019

Dr. Estelito Santos – Chesapeake – West Virginia University School of Dentistry 2001

Dr. G. Lee Wright – Portsmouth – University of Colorado Denver School of Dental Medicine 2016

Richmond DENTAL SOCIETY

Dr. Nicholas Broccoli – Henrico – Virginia Commonwealth University School of Dentistry 2017

Dr. Emma Moredock – Richmond – Virginia Commonwealth University School of Dentistry 2017

Dr. Matthew Pelais – Midlothian – Virginia Commonwealth University School of Dentistry 2013

Dr. Chelsea Tolbert – Richmond – Virginia Commonwealth University School of Dentistry 2019

Dr. Conway Upshur – Henrico – Virginia Commonwealth University School of Dentistry 2002

Piedmont DENTAL SOCIETY

Dr Aimn Abbasi – Martinsville – Marquette University School of Dentistry 2017

Southwest Virginia DENTAL SOCIETY

Dr. Carolyn Kelly-Mueller – Bland – University of Pittsburgh School of Dental Medicine 1988

Dr. David Marshall – Abingdon – Virginia Commonwealth University School of Dentistry 2020

Shenandoah Valley DENTAL ASSOCIATION

Dr. Brandon Coleman – Winchester – Baylor College of Dentistry 2007

Dr. Mohamed Rezk – Charlottesville – University of Kentucky College of Dentistry 2017

Northern Virginia DENTAL SOCIETY

Dr. Sharon Choi – Fairfax – Rutgers School of Dental Medicine 2011

Dr. Isra Elrayah – Fairfax – Virginia Commonwealth University School of Dentistry 2009

Dr. Marcus Emad – McLean – University of Maryland Dental School, Baltimore College of Dental Surgery 2018

Dr. Ayesan Hemati – Vienna – The Dental College of Georgia at Augusta University 2020

Dr. Katherine Ong – Fairfax – University of Maryland Dental School, Baltimore College of Dental Surgery 2020

Dr. Allie Tran – Falls Church – Virginia Commonwealth University School of Dentistry 2000

Classifieds

VIRGINIA DENTAL ASSOCIATION

VDA Classifieds allows you to conveniently browse and place ads on the VDA website and in this publication. VDA Members can advertise with VDA Classifieds for FREE. Nonmembers are also welcome to place ads for a fee. Please visit vdaclassifieds.org for details on advertising with us.

JOBS: Dentists

6971 - Associate Dentist
30k sign on bonus!
Roanoke
Willis & Associates Family Dentistry is seeking a motivated, quality-oriented associate dentist for our offices. We provide the ultimate in quality general dentistry to the entire family in a modern, technologically advanced setting with experienced support staff. Average compensation of full-time dentists in excess of $220,000/ per annum. Benefits include: health insurance, malpractice insurance, retirement plan, continuing education, and more! Visit our website at **www.willisdentistry.com**
Contact: Justin Gilbert 540-487-4871
justin@willisdentistry.com

7026 - Associate Dentist
Loudoun County
Award winning well established cosmetic and family practice! The right candidate will join our dynamic team with a commitment to excellence and practice growth. We are a privately owned practice with attention to detail, customer service, and community involvement. Our team uses a comprehensive approach to dentistry and believes a beautiful, functional smile is an essential part of one's overall oral and physical health. Only PPO insurance and FFS reimbursement accepted. A competitive full benefits package includes health insurance, malpractice, CE allowance, 401k, and more! Five years experience required as you will hit the ground running with a full schedule while checking hygiene. Experience with endodontics, oral surgery and a AEGD/GPR residency program is welcome.
Contact: Please email your resume and cover letter to **dentistryinloco@gmail.com**.

7029 - Oral and Maxillofacial Surgeon
Verona
Shenandoah Dental Specialists offers a generous benefits package including licensure reimbursement, Malpractice, Medical, 401K matching and a CE stipend. A route to ownership/partnership is also available. Hours negotiable- Full or part-time contract options available. We are offering a commission of 35% of net production. We also have General Anesthesia capabilities in office, with trained/certified anesthesia assistants.
Contact: Dennis Calvano 540-569-2523
drcalvano@mydha.net

7030 - Partnership Opportunity
Piedmont Area of Virginia
We are a well-established and busy multidisciplinary comprehensive general practice located in a small town in the Piedmont area of Virginia. 20 minutes from Charlottesville, 50 minutes from Short Pump. Our office is relaxed and patient centric, with a very low staff turnover rate. Currently a solo practice, we are expanding to a second small town location and offering a partnership opportunity with training and mentorship to the right person. The right dentist will always put the patient's best interests first, will strive to provide the best dentistry possible with honesty and integrity, constantly seeking to improve themselves and learn new skills. This dentist will enjoy educating and getting to know our patients to provide them with a great customized dental experience. Send resume and cover letter to the below email.
Contact: Jack 540-223-3985
jfthompson3@yahoo.com

7033 - Dentist
Yorktown
Full time associate position. Busy modern, practice with a great staff. Competitive compensation package including 401k and medical insurance. Email CV to the below.
Contact: Anthony 757-886-0300
martindentistry@gmail.com

7037 - Associate Dentist
Charlottesville
Our group practice has a position open for an experienced general dentist. Are you interested in having a small dentist & hygienist-oriented practice suite within a larger group practice? You may be just the team member we are seeking. Our group has three doctors, a hygienist and 6 team members in one suite and another suite of three chairs just waiting for the right person to occupy the job.
Contact: Dr. Hodges 434-293-9044
jhodges2250@gmail.com
www.getaperfectsmile.com

7059 - Associate Position with Partnership Track
Emporia
Come join a thriving, state-of-the-art practice in small-town Virginia. We're looking for a part time or full-time associate with a potential track to partnership. Long established two doctor practice with comprehensive care for the whole family. Cone beam CT, implant placement, intraoral scanner and crown milling in house, RCT, cosmetics, surgical extractions, experienced hygiene team with exceptional Periodontal knowledge. Mentoring available for new grads; guaranteed base salary. Retiring dentist will mean a ready to go patient pool. One hour commute from Richmond, just 30 minutes to beautiful Lake Gaston.
Contact: Brenda 434-634-4164
emporiadds@gmail.com

7063 - General Dentist
North Chesterfield
Looking for part-time or full-time dentist to join our team. $750-$850 per day with tremendous potential to bonus. Should be comfortable doing extractions, pulpotomies and RCT. We are also looking to expand into implants and currently have modern 3D pan and willing to pay for CE courses for implants if necessary.
Contact: 804-901-7855
gddentist@aol.com

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JOBS: Dentists

7064 - Part Time Dentist - Wonderful Opportunity
Midlothian
Wonderful opportunity to work in a long-established practice and be mentored by a seasoned dentist. Dedicated team, have fun working together, focus on education. Mondays to start, 2nd day added later. Please email your resume and cover letter.
Contact: Dr. Janine Randazzo
drrandazzo@jrdentistry.com

7065 - Work in Nature's Paradise!
Chincoteague
Do you want to run your own office with support with potential for ownership? Morrison Dental Group is looking for a motivated Doctor interested in unlimited earning potential. The office is nestled on Main Street & located on the harbor. It consists of 5 operatories with new equipment in an all-digital office including Extra-oral radiography, iTero, Sensors & Implant Motor & Surgical Kits. The ideal candidate would have 2+ years experience &/or GPR or AEGD Residency. Chincoteague is located near Maryland & next to the NASA Wallops Island Space Center. It offers the small-town experience, good schools & reasonable cost of living. Established patient base- be busy right away! Salary guarantee vs. commission; Health Benefits, CE allowance, Malpractice paid, 401K.
Contact: Alison Morrison 757-719-2237
amorrison@morrisondentalgroup.com

7067 – Associate Dentist
Falls Church
An established patient centered dental practice is seeking for a general dentist to join our team. PT or FT. Good staff support, flexible hours, some Saturdays. Candidates must have excellent communication and clinical skills, good chairside manners; desire to deliver high quality dental care to our patients. Minimum of two-year private practice experiences preferred. Please respond with resume for consideration.
Contact: Iris 703-663-8859
bestdentist4you@gmail.com

7069 - Dentist
Virginia Beach
The Foleck Center is actively seeking a motivated, quality-oriented Associate Dentist for our practice. We are a state-of-the-art office with an in-house lab offering Emax and Zirconia crowns and bridges as well as some removable. From Cone Beam, to Cerec, to Biolase, if you are looking for a practice that will help you grow as a clinician and allow you to interact with other like-minded people, this is the place for you. Benefits include health insurance, malpractice insurance, 401K with a matching program, continuing education, dental insurance for associates and immediate family members, and two weeks vacation.
Contact: Andrea Bridges 757-965-7696
Andrea.Bridges@gmail.com

7072 - Dentist
Yorktown/Williamsburg
Quality focused, four doctor private practice is seeking a dentist to join our group as an associate. With over 30-years in Yorktown and over 20-years in Williamsburg, we have a substantial, dedicated patient base, with a healthy new-patient flow and minimal insurance participation. We offer a full range of services including, Invisalign, Implants, IV Sedation, Endo, complex crown and bridge treatment, as well as cosmetics, and restorative/preventative care. Two modern offices and a wonderful staff of over 20. Associate will have four experienced doctors to learn from/consult with, as they build their skills, as well as having the ability to buy-in as an owner/partner. Ideal candidate should have 2-3 years of experience and/or an AGD/GPR. Please send resume/CV.
Contact: Josh **cathyjosh@cox.net**

7082 - Associate Dentist
Hampton Roads
Seeking an enthusiastic dentist to join this private practice owned by dentists who love what they do, enjoy excellent benefits, and value high quality patient care. This is a large dental practice that collects well over $1 million and remains busy with a large and growing patient base. Associates earn exceptional pay, ranging from $150k-$250k depending on skill set. Benefits include 401K, Health Insurance, Profit Sharing, Phantom Stock. You will be working side-by-side with devoted dentists who are willing to mentor. Build an extraordinary career by joining this thriving dental family who will keep you on the road for success.
https://www.lbdtransitions.com/dentist-profile-form.html
Contact: Elizabeth
elizabeth@lbdtransitions.com

7090 - Associate Dentist - 30k sign on bonus!
Rocky Mount
Roanoke Dental Center is seeking a motivated, quality-oriented associate dentist for our offices. We are privately owned and provide the ultimate in quality general dentistry to the entire family in a modern, technologically advanced setting with experienced support staff. Our highly valued Associates enjoy top tier compensation, which includes a 30k sign on bonus. Average compensation of full-time dentists in excess of $220,000/ per annum and a full benefit package. Visit our website at **www.roanokedentalcenter.com**. Also visit our sister company at **www.willisfamilydentistry.com**.

7091 - General Dentist
Alexandria
An established large multi-generational patient based cosmetic, and family dental practice is seeking a general dentist to join our team full time. Good staff support and flexible hours. Candidates must have excellent communication skills, good chairside manners, and a desire to deliver high quality dental care to our patients. Minimum of two years private practice experiences preferred. Please respond with resume for consideration.
Contact: Lina 540-809-9183
nvadentist@yahoo.com

7093 - General Dentist
Charlottesville - Pantops
J.C. Wolfe & Associates is currently seeking a General Dentist to join our Charlottesville practice location on Pantops Mountain near Martha Jefferson Hospital approximately 3-4 days per week. The ideal candidate would be proficient in E4D/ Planmeca, one appointment crown treatment, cone

beam digital dentistry and scanning, comprehensive restorative care and 2 years experience in private practice would be helpful. Our practice boasts little or no AR, long term team members and patients, in a state-of-the-art environment. Possible future partnership potential. 401k plan, health insurance and comfortable hours.
Contact: Kelly Breeden 434-242-8888
kbreeden@drjcwolfe.com

7100 - Dentist
Yorktown
Full time Dental Associate position available immediately. Busy, family practice with a great staff. Please send resume or CV.
Contact: Anthony Martin 757-886-0300
martindentistry@gmail.com

7103 - Associate Dentist Wanted
Virginia Beach/Norfolk
Well established holistic family dental practice is seeking a full-time associate. This practice is geared for the patient looking for a dentist who is progressive and holistic minded. We are here to teach the new associate the techniques and ideals of holistic dentistry. We cater to adults and children. We offer a daily guaranteed rate with the opportunity to earn more plus benefits. We are looking for an enthusiastic and compassionate person willing to provide comprehensive patient care.
Contact: Dean E. Kent DDS
757-373-6486 **drdeandds@aol.com**

7105 - Dentist
Harrisonburg
Healthy Community Health Centers seeks a Dentist to provide dental care services to patients of the HCHC dental clinic. Dentist must have unrestricted license to practice Dentistry in the Commonwealth of Virginia and DEA license to prescribe medicine. Cannot be sanctioned under Medicaid or Medicare. This position requires a comprehensive knowledge and application of primary dental care in outpatient settings and of the principles and practice of modern dentistry as related to public health organizations and community health programs as well as current social and economic problems pertaining to public health and their impact on primary health care.
Contact: Jenny Toth CHRO
540-214-5015 **jtoth@hburgchc.org**

7111 - Full Time Dentist
Suffolk
Solo Practitioner practice. Are you ready to be the clinical director of your own office? A great opportunity awaits. Looking for a self-sufficient, confident provider to lead the office. Stand-alone office, with a 37-year history. Fully booked hygiene, fully staffed, and 100% fee for service. Guaranteed base pay, with no paybacks, plus a 30% pay commission beyond the guarantee.
Contact: Renee Johnson 757-357-4121
miltoncook@smithfield-dds.com

7115 - Calling All Dentists!
Williamsburg/Hampton
Morrison Dental Group is seeking a motivated doctor interested in unlimited earning potential to work with experienced staff. The ideal candidate would have 2+ years experience and/or GPR or AEGD Residency. Established patient base- be busy right away! Salary guarantees vs. commission; Health Benefits, CE allowance, Malpractice paid, 401K. Visit us online **MorrisonDentalGroup.com**, Facebook & Instagram!
Contact: Alison Morrison 757-719-2237
amorrison@morrisondentalgroup.com

7121 - General Dentist
Chester
Looking for an experienced General Dentist who is comfortable in all aspects of General Dentistry. We have three offices with many existing and new patients. We see an average of 120 new patients per office. Great salary and benefit, we consider future partnership/ buyout opportunities. We are opening our new location soon. We are locally owned and operated. Immediate opening please send your resume or contact the below or visit **www.unitedsmiles.com**.
Contact: Dr. Varkey 804-874-2333
richmonddentist@gmail.com

7123 - General Dentist
Williamsburg
Join a busy growing practice, work with a great dentist, and enjoy great support from experienced staff and efficient office systems. Looking for a Virginia licensed dentist who can perform all aspects of general and cosmetic dentistry, with a friendly personality, commitment to continuous improvement and strong clinical skills and great attention to details. Must have great communication skills and committed to the best for their patients. Must be outgoing and confident. Ability to get along in a team is very important. Income potential is HIGH and the opportunity to grow along with the practice's growth.
Contact: Maria Amador 757-220-9492
amadordentistry@gmail.com

7133 - Associate to Traditional Private Practice
Hampton Roads
Atlantic Dental Care has multiple opportunities for General Dentists. We are a unique group 100% owned by our dentists, preserving the private practice of dentistry. Our 130 dentists have a shared vision of delivering quality care in the communities (Williamsburg to Virginia Beach) we serve through our 80 locally owned offices. We are a group practice for dentists by dentists. Tired of working for someone else? Come join us and begin your pathway to ownership of your own practice. Benefits include 401k, health insurance, and HSA. Tired of working for someone else or a recent graduate, ADC is designed to provide you with the clinical and business mentoring to ensure your success. Meet us at **https://youtu.be/D1LBEvGglu8** and **http://www.atlanticdentalcare.net/**. Confidentiality Assured.
Contact: Marina 757-455-5554
atlanticdentalcare@cox.net

7136 - Associate General Dentist
Ashburn
Come join a busy growing practice, work with an experienced team that will allow you to focus just on being a great dentist! Qualified candidates will have a friendly personality, commitments to continuous improvement and providing the best care for our patients. Income potential is high as well as the opportunity to grow along with the practice.
Contact: Vincent Adriance 703-858-4222
office@riosdentistry.com

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JOBS: Dentists

7137 - Pediatric Dentist
Richmond
Come join our busy, growing practice as a full or part-time associate working with an experienced and highly committed team. You will have the opportunity to devote yourself to what you love most, Pediatric Dentistry and making a difference in the lives of young people rather than spending hours on the business side of the practice. We are looking for a Virginia licensed dentist who can perform all aspects of Pediatric Dentistry, with an outgoing personality, commitment to teaching excellence among your team and strong clinical skills. Must have great communication skills, and a commitment to outstanding care for your patients. Great Income potential and the opportunity to grow as our practice continues to grow.
Contact: Reid Sowder 804-386-9655
reid@drbyrddds.com

7145 - Associate General Dentist
Midlothian
Our well-established busy office is looking for a driven, self -motivated full time dentist who wants the best out of the practice of dentistry to join our amazing team. This immediate position is for a full time doctor who enjoys the challenges of dentistry and can perform well in restorative, endo, oral surgery and implants. Work well together with associate doctors and team Provide unsurpassed dental care to our patients Excellent communication skills Ability to “connect” with patients Current valid license to practice dentistry as a General Dentist in Virginia 1 year experience preferred Great pay Percentage of collections Potential for great earnings $200k-$350k.
Contact: Oksana Plotkin 804-379-7855
chesterfield@happysmiles.com

7147 - Dentist
Wytheville
Nestled in the Appalachians, Bland Ministry Center has tended to the spiritual and physical needs of the community for forty years. Our organization is searching for a compassionate dentist to serve the residents of SW Virginia, at Big Walker Dentistry. This facility is a new, state-of-the-art complex, with 5 operatories. The position offers a 4-day work week, competitive salary and benefits. In addition, the dentist has an opportunity to serve as Adjunct Dental Faculty at Wytheville Community College via an established hygiene student rotation at Big Walker Dentistry. It is a chance to enjoy a relaxed lifestyle with easy access to a myriad of outdoor activities such as hiking, biking, fishing and hunting.
Contact: Dr. Kelly or Carolyn Kelly-Mueller, DMD, MPH
dr.ckm@blandminstrycenter.org

7149 - General Dentist Part-time Needed Immediately
Manassas
Established, doctor-owned, general practice is seeking a dentist to work 2-3 days. Practice has been in business since 2016. Seeking an experienced and personable dentist. Office is paperless with digital x-rays, Pano/CT and chair-side monitors. Speaking Spanish, a plus but not necessary. Opportunity to expand days, if desired. We have a fantastic patient base and excellent team members. Candidate must have at least five years of clinical experience with a strong background in implant placement, surgical extractions, and Root canals to include 1st and 2nd molars. We are looking for an outgoing dentist with interest in forming a long-term relationship. For additional information and to schedule an interview respond with a cover letter and resume.
Contact: Lisa 703-369-9100
lisa.smdc@gmail.com

6738 - Williamsburg Dentist
Williamsburg
Active general dentistry practice -1700 sq. ft. dental office. Five treatment rooms - expandable (plumbed) to eight if needed. Opportunity to purchase 6800 sq. ft. building for rental income in addition to practice. Owner will finance over years with proper financials. Seller will transition to new dentist over a limited period of time. No onerous buyout agreement of patients, just take over practice and enter into rental agreement with owner dentist. High quality practice with no aggressive treatment of patients. Send Resume/CV to PO Box 1199 Williamsburg, VA 23187.

Practice Transitions

7035 - Awesome Practice Transition Opportunity
Augusta County
Unique established private practice for sale in beautiful Augusta County. Located perfectly between Richmond, Charlottesville, and Northern Virginia. Owner flexible on sale of practice with or without real estate. Owner willing to stay for short transition.2 ops, fully equipped and well maintained, Dentrix, digital x-rays, 4 working days with very loyal patient base. Room to expand when ready. Practice perfect for an honest, energetic patient-oriented dentist that wants control of their work life and plenty of time to enjoy the rest! Don't miss this great opportunity.
Contact: Carl 434-996-7589
Happytooth88@gmail.com

7040 - Very Profitable General Dental Practice for Sale
Roanoke Region
Very busy and profitable general dental practice for sale. This practice is 30 minutes from Roanoke and has four operatories, digital pano, intraoral sensors, and EagleSoft. This FFS/ PPO based practice collecting $960K+ annually with low overhead and very strong hygiene program. 2500 square foot free standing building is also available for sale. This will be a tremendous opportunity for a dentist who would like to have ownership of a very profitable dental practice that has been very successful for a long time. Seller will provide great support for a buyer to have a very smooth transition. Mentorship can be available for recent graduates, if desired.
Contact: Young Park 540-492-0893
yparkdds@hotmail.com

7120 - Looking to Buy Larger Office
Vienna
Existing dental practice looking to expand! We are looking to buy a larger dental office or practice with 4-5 ops in the Northern VA area.
Contact: Matt 571-969-8908
bolducms@gmail.com

7131 - Practice for Sale
Virginia Beach
Dentist Retiring $400,000 collected pre-covid working 3 days a week. Approximately 31 new patients a month. Six equipped operatories, large reception room and lab. Each operatory equipped with prophy jet, intra oral camera, Casey, Dentrix, Dexis (3 sensors), 2,088 sq feet. Rent is $4,801.00 per month. Can take over my lease and options (great rent) or landlord willing to work with new tenant for leasehold improvements. For more information, contact Dr. Randall Furman at (757)270-3890 or at the below email.
Contact: Randall Furman 757-468-4684
iricfurman@gmail.com

7132 - Private Practice Ownership
Hampton Roads
Atlantic Dental Care has multiple purchase opportunities for general dentists. ADC is a group practice 100% owned by its dentists. Our 130 dentists have a shared vision of delivering quality care in the communities (Williamsburg to Virginia Beach) we serve through 80 locally owned offices. We are a group practice for dentists by dentists. Tired of working for someone else? Come join us and begin your pathway to ownership as we preserve traditional private practice. Benefits include 401k, health insurance, 125 plan, and HSA. Whether you're tired of working for someone else, a recent graduate or student ADC has opportunities for outright purchase as well as mentorships. Meet the dentists of ADC at **https://youtu.be/D1LBEvGglu8** and **http://www.atlanticdentalcare.net/**. Confidentiality Assured.
Contact: Marina 757-455-5554
atlanticdentalcare@cox.net

7139 - D.C. Metro Area General Practice for Sale
Washington, DC
The nation's capital has a lot going on! Including this newly on the market general dental practice in the heart of downtown! The current doctor is interested in exploring transition options, most notably affiliating with a group for continued growth. The practice is in an office building with high pedestrian traffic. 9 operatories Collections of $1.6 million EBITDA of $245,000 2,700 active patients 40 new patients per month
https://professionaltransition.com/properties-list/d-c-metro-area-general-practice-for-sale/
Contact: Kaile Vierstra 719-694-8320
kaile@professionaltransition.com

7142 - General Dental Practice for Sale
Henrico
Retiring dentist has been serving patients for over 27 years at this well-established practice located in Richmond's west end on a major thoroughfare that has over 23,500 daily traffic. Location is centrally located and highly accessible to all areas of the greater Richmond DMA. Practice has paper charts but well-maintained. No advertising or dental marketing software yet solid year-over-year increases. This opportunity is ripe for growth with significant mixed-use development underway within 1 mile radius. **Real Estate (Lease): 1,600 sqft **Operatories: 4 ops **Location: Daily street traffic of 23,500+ **5-Yr Avg. Collections: $507,600 **Practice Hours: Monday-Thursday Active Patients: 1,100 (24 months) Primary Insurance: Anthem, Delta Dental Premier
Contact: Elizabeth Schroeder Craig 804-787-4829
elizabeth@lbdtransitions.com

7143 - General Dental Practice for Sale
Kilmarnock
This gem of a practice is in the Northern Neck near the splendors of the Chesapeake Bay and Oyster Trail. Very little competition within a 60-mile radius and Kilmarnock is considered the hub for medical/ dental services for surrounding counties of Lancaster, Northumberland, Middlesex and Westmoreland. Great investment as satellite location for any solo or group practice. Real Estate (Lease): 2,000 sqft (expandable to 3,600); Avg 25 New Patients Per Month; Dentrix software. Practice collections for 1st quarter (2021) $107k working just 2 days a week.
Contact: Elizabeth Schroeder Craig | 804-787-4829 |
elizabeth@lbdtransitions.com

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Practice Transitions

7144 - Hanover Dental Practice for Sale
Hanover
Well-established modern and immaculately cared for dental practice north of Richmond. Three fully equipped operatories are beautifully appointed with updated equipment. Located in the heart of a charming small downtown area with ample parking and outdoor cafes just around the corner. **Real Estate (Lease): 1,100 sqft **Operatories: 3 ops **5-Yr Avg. Collections: $387,000 **Practice Hours: Monday-Thursday **Active Patients: 1,400 (24 months) Real Estate for Sale
Contact: Elizabeth Schroeder Craig 804-787-4829
elizabeth@lbdtransitions.com

7150 - Dental Practice for Sale
Danville
Owner retiring. Private Practice. Avg. gross 3 years, 300+K on 3–4-day week, 5 operatories, Reception, Front Office, Lab, Private office, smaller office, 2 bathrooms, high traffic area. Cosmetic, C & B, Removable, Implant Restor. Eaglesoft, digital equipment. Loyal staff, growth potential with Casino opening 2023. Sincere & reasonable offers considered.
Contact: Owner **rsat@mebtel.net**

JOBS: Office Staff

6908 - Registered Dental Hygienist
Scottsville
$5,000.00 sign on bonus!!! Scottsville Family Dentistry is seeking a full or part time Registered Dental Hygienist. If you are dedicated to providing the highest quality dental care, we would invite you to consider joining our team! Experience with Eaglesoft, digital radiographs, and intra-oral camera preferred, but not required. New graduates are welcome to apply! Full PPE provided and COVID protocol in place. Benefits include very competitive pay, health/prescription drug insurance, paid time off based on tenure, paid holidays, simple IRA retirement plan, free dental services for you and your dependents. Visit our website at **www.scottsvilledds.com**. Please provide resume/CV.
Contact: Justin Gilbert 540-487-4871
justin@willisdentistry.com

7061 - Dental Hygienist
Chesapeake
Exciting office in Chesapeake seeking licensed hygienist to join our team. We are a modern, established office where the well-being of patients is the priority. Hourly appointments with additional time for SRP if needed. 3 1/2 days/week. Please send resume/CV via email.
Contact: Michelle 757-407-5169
mchelle58@outlook.com

7098 - FT Dental Hygienist Needed
Stafford
A GP dental office is looking for a Full-Time Dental Hygienist. Must be a team player, professional, knowledgeable with a positive attitude, and familiar with Dentrix and Dexis. If interested, please forward your resume. Our ideal candidate for the Hygienist position and Assistant will focus on the patient experience, possessing the ability to provide outstanding, comprehensive care and patient education with a personal touch. The preferred applicant will be comfortable with treatment planning and co-diagnosing. If you are a team player, we invite you to join us. Benefits • Medical insurance • Paid time off • 401K
Contact: James D. Graham 540-720-8630

7107 - Registered Dental Hygienist
Glen Allen
Our state-of-the-art office is looking for an experienced Dental Hygienist, part time/ full time. Benefits offered, please contact with your resume.
Contact: Manik Khisti 804-874-5005
manik_khisti@yahoo.com

7127 - Hygienist
Near West End Richmond
Looking for a team oriented RDH for our small general practice office. We see patients from age 3 to 103. Full time or part time position available. We are looking for a motivated Dental Hygienist who is focused on delivering quality care as well as respect and professionalism for our patients.
Contact: **twothdoc97@yahoo.com**

7135 - Pediatric Dental Hygienist
Richmond
Immediate opening for a Dental Hygienist to work with our pediatric patients. Great compensation and benefits package. We are a growing practice that has served our community for more than 20 years.
Contact: Reid Sowder 804-386-9655
reid@drbyrddds.com

Office Space: Sale/Lease

6864 - Dental/Orthodontic Office Condominium for Sale
Manassas
Approximately 1,700 sq. ft. Excellent, centralized location with easy access to Rt. 66. Turnkey operation for primary or satellite office. New equipment including state of the art 3D digital Pan/Ceph unit. Currently set up for orthodontic practice with five chairs and plumbed for two additional. Office could easily be transitioned to treat patients for a general practitioner or specialist of any type with some minor modifications. All furniture, equipment, and supplies are negotiable for sale, as well as the real estate. Great opportunity for a quick practice start!
Contact: **toothuniverse@gmail.com**

6896 - Practice and Real Estate for Sale
Hampton
Located on a busy 4 lane roadway, with a highly visible corner lot. Practice owner wants to sell the real estate with the practice. Owner is flexible with financing both the practice and real estate. Also, willing to rent with option to purchase. Dental office is located on a large lot with room for expansion. Practice has been in this location for the last 31 years. Please email inquiries to the below.
Contact: Wayne Oplinger 570-760-1069
familydentistryusa@yahoo.com

6936 - Five Chair Dental Office for Sale or Lease
Charlottesville
Office condo 1480 sq feet space is equipped with five treatment rooms is ready to go. Choose your software and X-ray system. Hardwired for secure data transmission. This office provides a quiet space in a busy place, Rio and 29 north.
Contact: Alan 434-242-1848
alan.bream@gmail.com

7092 - Two Operatories for Rent
Fairfax
Two fully equipped operatories available for rent. X-ray and Panorex machines, lab, and sterilization area. Great opportunity for a young or retiring dentist. Please call or text 571-460-6785 for more information.
Contact: 571-460-6785

7119 - Office Condo For Sale
Tysons Corner
Office condo for sale. 1500 sq. ft. First floor. Patients do not convey.
Contact: 703-508-1468
nvperiodoc@yahoo.com

7146 - Turnkey dental office for sale
Arlington
A beautiful office in great condition, in the heart of Arlington is up for sale. It's 1,180 Sq. It has 3 ops fully equipped & ready to use. But it's originally plumbed for 4 rooms. It has PANO & digital charting (EasyDental). Everything works perfectly fine & in great condition. Patient charts are included with the sale. Email if you are interested.
Contact: **dentaloffice97@gmail.com**

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of self-reporting sex and labor trafficking victims, and Figure 2 demonstrates the self-reported age at the time that trafficking began.[2] As seen below, it is clear that the I-95 corridor remains one of the highest volume human trafficking areas in the US. It is also reported to be one of the fastest growing criminal enterprises in the US.

Medical

The Virginia Hospital and Healthcare Association released a manual January 26, 2021 for healthcare professionals.[3] I contacted the communications director to inquire whether anyone in the dental profession or the VDA was contacted for input or participation. Unfortunately, to date, I have not received a response to my email. On page 16 of the report the first listed item under "health ailments" trafficking victims may present with is "Oral Health and Dental Conditions." There wasn't a single dental professional on the advisory committee.

Dental

Currently the states of Texas and Florida have specific CE courses on human trafficking in dentistry. Unfortunately, no other state's dental association is taking proactive measures. An inquiry was made to the VDA. It was reported that this subject was not currently on their radar. A news story came out in 2018 about a sex trafficking case from a suburb in Dumfries, Virginia.[4] This story demonstrates how these cases may be hiding in plain sight. Often a minor may be accompanied by a "parent" to seek dental or medical treatment. In this case the minor suffered a traumatic injury to her face affecting her lip and dentition.

VCU School of Dentistry

I reached out VCU Dean Dr. Clara Spatafore to inquire whether the school had the bandwidth to create the infrastructure on screening patients for trafficking and then setting up referral services if a patient identifies as a victim. She immediately jumped at the chance and coordinated with Dr. A. Omar Abubaker, the chair of the Oral and Maxillofacial Surgery Department to begin talks on screening and creating infrastructure with the emergency clinic at

Figure 2: Age at Time Sex or Labor Trafficking Began

VCU. The resources and experiences will be shared in a future publication. I believe VCU School of Dentistry's exploration of this topic and creation of infrastructure will allow dental professionals in Virginia to have a seat at the table.

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