VOLUME 97, NUMBER 1 | JANUARY, FEBRUARY & MARCH 2020

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Check out our FAQs ► PG. 31

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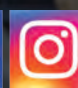

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IN THIS ISSUE

Volume 97 | Number 1
JANUARY, FEBRUARY & MARCH 2020

DENTISTRY IS STRESSFUL!?
Dr. Elizabeth Reynolds gives us some useful advice. **pg. 3**

ALL ABOUT YOU!
ADA 16th District Trustee, Dr. Kirk Norbo, gives us insight on the ADA's latest board retreat. **pg. 5**

PIRATES
Editor, Dr. Richard Roadcap, says history can be our guide to the future. **pg. 7**

SUPERHERO LIFE
A review of issues brought before the dental benefits expert. **pg. 9**

EXTREME PULLIN'
A member spotlight featuring Dr. Dustin Reynolds **pg. 11**

FIVE FREE MARKETING TOOLS
Kelsey Leavey - There's an app for that! **pg. 13**

COMPOUNDING MAGIC
Jimmy Pickert - A spell to boost retirement savings. **pg. 14**

CARING DENTIST
Dr. Bruce Overton explains what this little-known committee is all about. **pg. 15**

YOU HAVE CHOICES IN 2020
Dr. James Schroeder provides some guidance on taking the next step in your career. **pg. 16**

BOARD OF DENTISTRY NOTES
Dr. Ursula Klostermyer details the happenings of the December 13 Board of Dentistry meeting. **pg. 17**

IMPROVING OUR ETHICS
Dr. A. Garrett Gouldin - Can ethical standards be learned? **pg. 18**

YOUR REPUTATION
Dr. Anthony Chillura gives 11 ways to mitigate malpractice claims. **pg. 19**

COMPLYING WITH NEW EPA RULE ON AMALGAM
A reference guide from Dr. Alfred Frost. **pg. 21**

TELEDENTISTRY FAQs
Learn about teledentistry and why our 2020 General Assembly legislation is vital to the future of dentistry. **pg. 31**

PATHOLOGY PUZZLER
Be a life-long learner and test your pathology knowledge with Dr. John Svirsky. **pg. 42**

UTILIZATION OF DENTAL SERVICES AMONG MEDICAID ENROLLED PREGNANT WOMEN IN VIRGINIA
New research. **pg. 46**

PROJECT HOMELESS CONNECT
Sam Page educates us on the importance of this outreach program. **pg. 50**

MARTINSVILLE THANKS YOU!
Dee Joyce recaps the first MOM Project in Martinsville. **pg. 51**

COLUMNS pg. 3
RESOURCES pg. 13
SCIENTIFIC pg. 36
EVENTS/CE pg. 24
ADVOCACY pg. 30
OUTREACH pg. 50
MEMBERSHIP pg. 53
CLASSIFIEDS pg. 57

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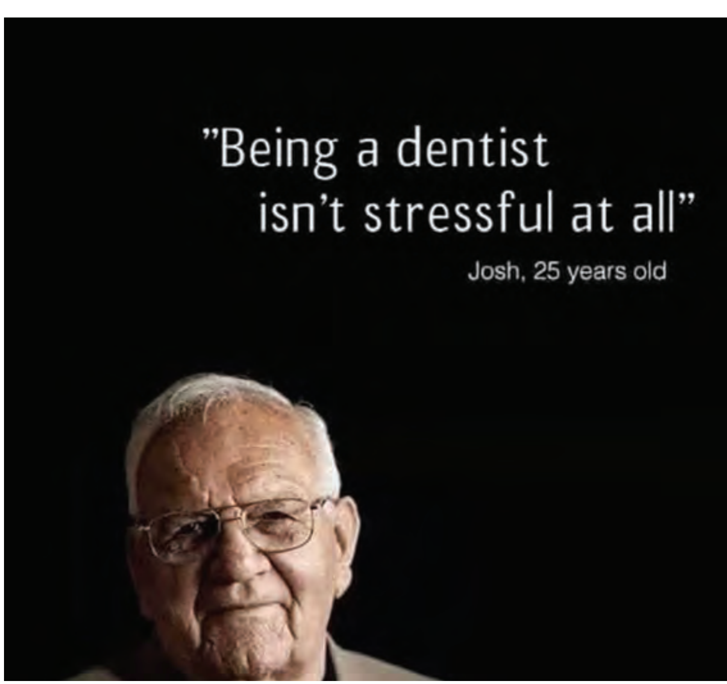
DENTISTRY IS STRESSFUL!?

Dr. Elizabeth Reynolds



Someone texted this photo to me a few weeks ago, and every time I look at it, I laugh. It is so sad but so true, isn't it? Dentistry is stressful. We all have that day when the first patient is late, throwing the schedule off for the rest of the morning. Then the implant bridge for which the patient has been waiting for a year doesn't fit; every hygiene patient has a "little issue" – "could you adjust that night guard or polish that chip or evaluate that loose implant crown while I am here?" Meanwhile, one of the hygienists is sick and your primary assistant has car problems and will be late; the phones are down, and there are four walk-in emergencies. Is it any wonder that Josh has aged so much in his 25 years?

Remember, though, that for every one of those days I just described, there are so many that remind us of the good that we do: a delivery of a denture to a Donated Dental Services (DDS) patient who has been without teeth for years because they just couldn't afford them; a two year old's first visit that ends in joy and a prize from the basket; the delivery of a bridge that replaces congenitally missing laterals on a 15 year old, just in time for prom. Sometimes it is just as simple as getting to see a hygiene patient who has been out of touch of a bit or getting a hug of thanks from a nervous patient who successfully completed their treatment.

We all find ourselves in moments of frustration or exasperation; if we spend too much time in that space, we will look like Josh. Remember to take the time to celebrate the good. Remember to go home and hug your family; remember to call your loved ones to let them know how much you care; remember that every cloud does indeed have a silver lining. Know that in this New Year, we are grateful to you and thank you for the time, energy and money that you contribute to organized dentistry and our profession.

Take some steps to begin or continue your involvement with organized dentistry in 2020. Start by reading the articles in this Journal; get familiar with the issues and our teledentistry bill that is coming in front of the General Assembly this year. Join us in the fight by contacting your representatives. Be vocal! Let us know what we can do for you to make your professional life easier. We don't want you to end up in Josh's situation.

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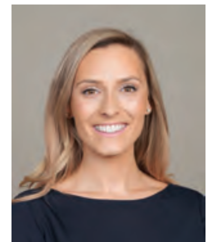

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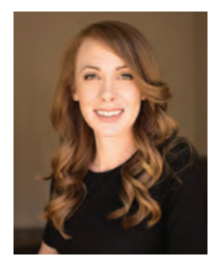

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ALL ABOUT YOU!

Dr. Kirk Norbo, ADA 16th District Trustee

At our most recent ADA board retreat, you the member, were the focus of this meeting. I am excited to report to you that the ADA is working harder than ever to deliver a personalized experience that will surpass your expectations and make you proud to be a member. I repeat, we want to make you proud to be a member of the American Dental Association!

Mr. Robert Stevenson, a well-known corporate speaker, gave a thought provoking presentation that made us all consider the importance change will play in the survival of the ADA. Associations that are experiencing growth have a clear value proposition for membership, are attracting Millennials and are digitally strong.

The board identified the fact that the ADA lacks a well-defined value statement that creates a sense of pride and validates reasons why we are members. Since I have been a member, we have continually addressed our (organized dentistry) inability to tell a story that compels nonmembers to join or members to remain active in the ADA. This fresh value proposition statement will be developed to provide a message that is articulate, concise and enticing to all dentists to join our association.

A strong digital presence in the dental marketplace is a business strategy that is critical to the ADA's potential growth and is essential to its success. There are plans to spend in excess of $5 million this year to accomplish that mission. Moving forward, it is anticipated that this digital marketing expense will be a line item in the ADA budget and provide ongoing support for our members and the public.

By now, most of you are aware of the recent lawsuit filed by the ADA against Delta Dental. The complaint is centered on anti-trust violations – specifically price fixing and market allocation. The ADA leadership has been counseled not to discuss pending litigation at this time and therefore I will not go into any details. There is a recent article in ADA News and some additional information concerning this lawsuit can be found on the web.

Third party reimbursement complaints continue to rank at the top of this list of issues that are most concerning to members. The fourth goal of the new ADA Strategic Plan, Common Ground 2025, opens the door for leadership to shed more light on third party issues and formulate strategies to create a more level playing field in the marketplace. The current ADA board is on a mission to help you stay in business by receiving fair reimbursements for the quality services you are delivering to your patients. We believe that the association will improve its relevancy to members as efforts in this area ramp up.

The Elder Care Taskforce appointed in 2019 has met and is working hard to develop a plan for delivering dental care to the underserved seniors in an efficient and cost effective manner. ADA leadership is hopeful that this group will come up with an alternative system that will prove to be superior to any dental benefit plan being considered in Medicare. This is a tall order but the current board is not shying away from the most difficult issues facing the profession.

In October, the contract ADA had with CVS was finally terminated. As you know, CVS breached the contract by not providing ADA signage in its stores and did not follow through with promises it made to help market our Find-a-Dentist program. During this time Smile Direct Club products popped up on the shelves of CVS stores, much to the dissatisfaction of dental professionals, but this in no way factored into the contract termination decision. At this time, neither the FTC nor FDA have ruled on the complaints lodged by the ADA against SDC. Even though this CVS contract ended prematurely, because of undesirable results, the ADA will continue to look for partnerships that will benefit members as well as the association.

In his presentation, Mr. Rob Stevenson showed several slides of the "Titanic" sinking. He warned us about the number of Fortune 500 businesses that have failed – Kodak, Blockbuster and Radio Shack to name a few. It is imperative for our association to change or risk the possibility of extinction. While change is uncomfortable the current ADA board is full of optimism for the future of our profession. I hope you feel the love coming your way as the ADA continues to find ways to help ALL MEMBERS SUCCEED!

SHE LOST AN EYE

Dr. Henry Botuck

Although this occurred in 2013, I just read an article about a dental office accident that resulted in a patient losing her right eye. As described in the article, a used syringe was passed by the assistant over the patient's face, and the dentist dropped it! It "penetrated" her right eye, introducing oral bacteria into the eye.

There were multiple lapses that contributed to this tragedy (not necessarily in order of importance):

1. Instruments should not be passed over a patient's face.
2. Dental treatment should immediately have been stopped after the accident. (The dentist elected to continue dental treatment.)
3. There was no eyewash station in the office (which may, or may not have made a difference, but should have been used).
4. The patient was not driven to the emergency room.
5. The patient was not wearing protective glasses. (Regardless of the procedure, all patients should be given protective eyewear immediately upon being seated in the chair. In fact, everyone treating patients also should be wearing protective eyewear)

After multiple surgeries, the poor woman lost her eye.

Freak accident? Yes
Avoidable? Yes.

Some OSHA regulations and CDC recommendations may seem unnecessary or overkill. But, whether it is infection prevention or safety, we always need to guard against those "worst case scenarios", because they do happen. Don't let it happen in your office.

AN ARTIFACT?

Dr. Harold Demsko and Dr. Scott Gerard

At a recent Southside Dental Society meeting we discovered that we are both the proud owners of what may be a rare artifact of the 100th anniversary of the Virginia Dental Association. Thanks to the flea markets of Southside Virginia we possess ceramic commemorative ashtrays. Who else owns on of these? Are they indeed ashtrays? There must be some of our more 'seasoned' members that remember receiving one.

As we prepare for the 150th anniversary of the founding of our association, we doubt if an ashtray is on the list of possible commemorative items that our staff and committee members dream up.

THE MOST VULNERABLE

Dr. Mayer Levy

Kudos to Dr. Smith for his insightful article on dentistry and empathy[1]. It is always good to recognize MOM Projects, free clinics, reduced fee clinics, and the DDS Program - but - what about help for indigent kids. The most vulnerable of all - kids.

Under the radar and little publicized is the Delta Dental of Virginia "Smart Smiles" Program, a program specifically designed to provide oral health care for that population least likely to have access to dentistry.

DDVA has partnered with the Boys and Girls Clubs of the Virginia Peninsula and, for over a decade, more than two thousand kids have been involved with multiple oral health issues. Between 150-200 kids participate yearly; and, equally or more importantly, there is a preventive component of the program. The VCU School of Dentistry, the VA Tech College of Science, VIMS of the College of William & Mary, as well as Delta are part of the community involvement in an Annual "Smart Smiles 5K" that raises $20,000 to $25,000 to supplement about half of the "Smart Smiles" budget.

It takes more than a village to provide oral health benefits for our indigent kids.

Reference: Smith, C (2019) The Ethics of Empathy, *Virginia Dental Journal*, 96(4), 43-44

PIRATES

Dr. Richard F. Roadcap

One day in 2000 American heavy metal band Metallica realized their entire catalog of songs was available online, free of charge. A website known as Napster, founded by Shawn Fanning and Sean Parker, had pioneered peer-to-peer sharing of MP3 music files, and subscribers could download copyrighted songs at no cost. At one point Napster had 80 million users, and high speed networks on college campuses were overloaded to the point where colleges blocked access fearing that their servers would crash.

The band thought its days were numbered if fans no longer had to pay for its recordings and performances. They filed suit in federal court, seeking an injunction, and one month later American rapper and record producer Dr. Dre also filed suit, seeking to have his songs removed from Napster's website. Also in 2000, A&M Records sued (*A&M Records, Inc. v. Napster, Inc.*) alleging widespread copyright infringement.

A series of unfavorable court rulings left the website in peril, if not mortally wounded. The Ninth US Circuit Court's 2001 ruling set terms with which Napster was unable to comply. The site shut down later that year, and in 2002, filed for bankruptcy. The Napster brand lives on as an online music store today, having been owned at one point by electronics retailer Best Buy.

More recently, in 2015, the state of South Dakota realized it was losing millions of dollars in sales tax revenues from online purchases. Earlier that year Supreme Court Justice Anthony Kennedy commented that the "physical presence" requirement for sales tax collection no longer made sense. Encouraged by his remarks, the state legislature passed a law requiring internet merchants to collect taxes at the time of purchase. Litigation ensued, and in 2018 the US Supreme Court, in *South Dakota v. Wayfair, Inc.*, ruled that states may collect sales tax from out-of-state sellers, even if the seller has no physical presence in that state. The 5-4 decision overturned a 1992 ruling that involved office products retailer Quill. The earlier ruling exempted sales tax collection from vendors outside the state and online. Online sales have grown exponentially since 1992, and it's been estimated that states have lost $13 billion in tax revenue to online sales.[1] By the end of 2018, 31 states had passed legislation to apply sales taxes to internet purchases. Online retailer Amazon now collects sales taxes in all 45 states that apply taxes to retail purchases.

So what do music downloads and buying online have to do with practicing dentistry? Which one of us doesn't like free music and not having to pay taxes? Some of us may have used Napster in its heyday, and I suspect most of us don't bother to report the tax if the website doesn't ask for it. (A caveat: please remit all sales tax due the State of Virginia for purchases made for your practice, even if the vendor doesn't collect it. Better yet, choose vendors who automatically collect Consumer Use tax at the time of purchase.) Online retailers for years have enjoyed a tax advantage to the consternation of "physical presence" sellers, and states have often made no effort to collect the tax from consumers.

This year the VDA will introduce legislation that seeks to define teledentistry and give guidance to the Virginia Board of Dentistry.

The dental practice acts of Virginia and most states were written before digital formats were first used to examine, diagnose, and treat dental disease. In general, state boards of dentistry have no jurisdiction over dentists who practice in another state. But what if a dentist outside of Virginia uses an online forum to prescribe treatment for a Virginia resident? Does the practice of teledentistry establish a doctor-patient relationship? What redress does a resident of this state have if they are harmed by the actions of a dentist practicing remotely, and often anonymously? These are some of the questions the VDA's legislation hopes to answer.

It's unlikely that teledentistry services will be confined to orthodontics. Digital pirates will skim other services from the ADA Code and offer them to the unsuspecting, free of regulation and any liability for adverse outcomes. Other disciplines, such as prosthodontics, periodontics, and preventive services (use your imagination) stand to suffer. That's why it's so important that we define "teledentistry" now, and what recourse is available for parties who suffer harm. Our board of dentistry has no control over dentists licensed in other states, and most certainly no control over anonymous practitioners.

As we seek to protect our patients from harm, we can use the examples of Napster and Wayfair to remind us that justice may be delayed, but it still is available to us. Free music and tax-free sales held sway for a time, but in the end neither was just nor fair. We hope that, in 2020, legislators and policy makers will realize the VDA's proposal is necessary for the welfare of our patients.

1 https://en.wikipedia.org/wiki/South_Dakota_v._Wayfair%2C_Inc.

BETTER TOGETHER

WORKING TO IMPROVE PATIENT EXPERIENCES

Sarah Bedard Holland; Chief Executive Officer, Virginia Health Catalyst

For providers in Virginia, there is no shortage of motivation to improve the patient experience and offer more comprehensive health care. Yet while the desire to provide comprehensive care is real, augmenting systems and care models to address multiple patient needs is daunting.

Time issues are very real. Appointments are short and packed already and introducing new services like blood pressure screenings or assessments for food insecurity or safety at home requires some flexibility with existing care models. And once you introduce more services and assessments you need a clear process so that you can utilize the information you collect like mechanisms to communicate with primary care providers or referrals for vital social supports. Without the right support and resources, even the most straightforward integration project can become unwieldy. Fortunately, a multitude of resources exist to help; I'll highlight a few:

VIRGINIA HEALTH CATALYST INTEGRATION TOOLKIT:
This guide is built on our experience working with safety-net clinics across Virginia. It offers a framework to integrate care and support for a variety of patient populations and addresses some of the major hurdles you may face in any integration opportunity, like technology, creating referral systems, and getting buy-in from your team.

VIRGINIA HEALTH CARE FOUNDATION TRAUMA-INFORMED CARE RESOURCES:
To support dental providers in taking a trauma-informed approach to care our friends at the Virginia Health Care Foundation developed a resource center for dental providers. Along with fact sheets, the trauma-informed care resource center includes educational webinars and videos so you can find the right ways to integrate trauma-informed care into your practice.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CULTURAL COMPETENCY PROGRAM:
To address the cultural sensitivities of your patients HHS has developed an online learning program centered around culturally competent care. Through the program, you can learn how to address the needs of an increasingly diverse patient group.

I am excited to continue our work together in 2020 and support VDA members in improving the patient experience across Virginia. If you have any specific questions on integrating care, including the implementation of health screenings or beginning a referral process with primary care providers, please don't hesitate to reach out at: sholland@vahealthcatalyst.org.

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SUPERHERO LIFE

A REVIEW OF ISSUES BROUGHT BEFORE THE DENTAL BENEFITS EXPERT

Thomas S. Bridenstine, VDA's Dental Benefits Expert

In these ongoing articles for the Journal, which are designed to provide practical advice to our members, I share information designed to assist your practice regarding insurance authorizations and payments. Previous articles addressed the different types of dental insurance coverage and information on filing an effective appeal when a claim is denied. This time I present a summary of the common types of problems members have asked for help in solving.

Some members asked for assistance in appealing a denied pre-authorization/pre-treatment plan submitted to a patient's dental insurer. The key element in appealing this type of denial is providing a comprehensive case explaining why the intended treatment is the standard of care. As with all appeals, it is important to address the specific reasons the insurer has denied the claim and refute each reason with solid medical reasoning.

There were a few appeals that involved a patient using the dollar limit of the coverage, such that even though the services may have been medically necessary, the dental plan did not pay the claim.

There were members who performed a service that an insurer denied as not medically necessary, such as a denied crown, which an insurer determined the same result could have been attained with a filling. Another example is a tooth not readily visible, which could have been filled with amalgam but a composite filling was used instead for aesthetic reasons.

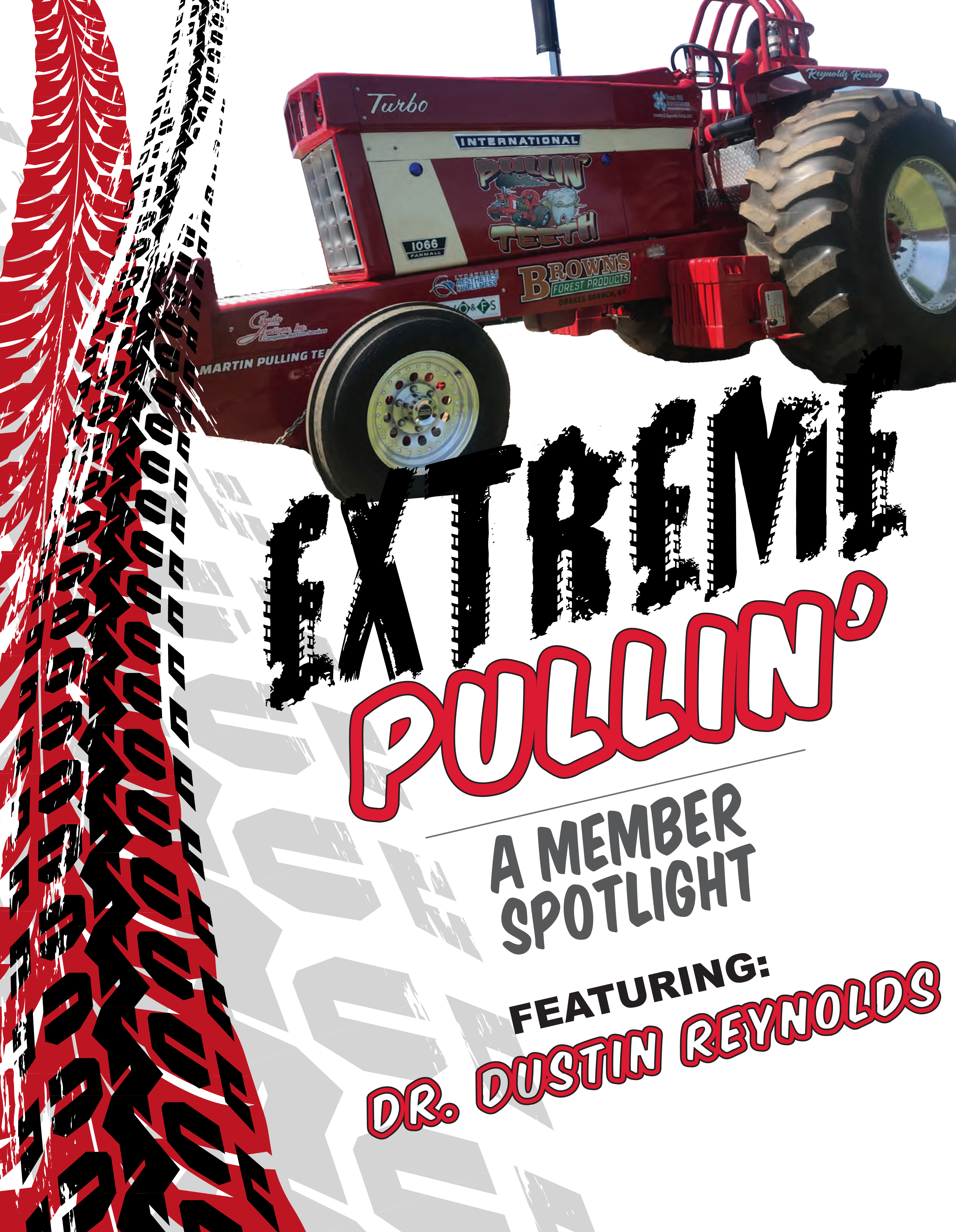
I also received inquiries from members whose patients' entire anesthesiology charges were not paid for the entire duration of the procedure. Another common denial from one particular dental insurer were claims for scaling and root planing due to a lack of radiographs demonstrating loss of attachment. I also encountered some denials for services provided to a tooth, which an insurer rejected because it determined that specific tooth had a poor prognosis.

SUBMIT A CASE AT **vdaexpert.com**

Some members also report problems with down coded claims, such as a composite filling that was down coded to the amount for an amalgam filling. While this is not desirable, at least the insurer paid some of the claim rather than rejecting the entire claim either as not medically necessary or not a covered benefit.

There were also claims involving a provider's contract with an insurer with the issue being whether or not the provider was participating with the insurer. This occurred with some of the out-of-state dental insurers, who claimed that, since the provider was participating with the insurer in Virginia, by default the provider was participating with all of the insurer's plans and products, even those in other states. The key to avoiding this type of problem is knowing the content of your provider contract and any applicable amendments. Importantly, this situation often determined whether or not the provider could bill the patient for the services. Please be aware that, due to diligent work by the VDA, this type of situation should be severely curtailed going forward due to a new law passed by the Virginia General Assembly recently.

If your practice encounters any of these types of problems or other issues, I will gladly provide assistance. Inquiries may be submitted for my review at **vdaexpert.com.**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DR. DUSTIN REYNOLDS

Dr. Dustin Reynolds is a rare breed of endodontist who loves "Pullin' Teeth". To be clear, that's not the treatment of choice at his Lynchburg practice, Forest Hill Endodontics. It is, however, one of his many hobbies when he and his wife Cary aren't busy chasing their two young daughters - Laurel (8) and Pyper (1).

Growing up in rural Appomattox, some of Dustin's earliest memories are spending time outdoors and tinkering under the hood of antique cars and tractors with his father. At school, and in college, he excelled in math and science (in addition to being a varsity athlete), and it was that love of building, of problem solving, and working with his hands, that pushed him toward a potential career in engineering. Dustin and his father spent many hours in their garage, so much so that they made a pact: when they had the time, knowledge and means, they'd build a tractor, together.

In 2015, after establishing his practice and setting up shop in Lynchburg, the two made good on that promise, purchasing a 1976 International Farmall 1066. It was an ordinary 100 horsepower farm tractor, that the two transformed into Pullin' Teeth, a 1200 horsepower modified tractor that in Dustin's words "does things no tractor should be able to do."

And while Pullin' Teeth might be overkill for the Reynolds family farm in Charlotte County, it's perfectly suited for the sport of tractor pulling. Popularized in the Midwest, the sport involves using high-horsepower vehicles to pull a 42,000 lb weighted sled – imagine a flat-bed trailer with moving weights on it. The goal is for your vehicle to create enough power to drag the sled 300 feet: whoever moves it furthest wins. In order to do that, vehicles need to deliver power and speed, motors need to be built strong enough to resist catastrophic failure and tires need to spin fast enough to gain traction while overcoming the resistance of the sled dragging against earth.

Late last year, Pullin' Teeth made its second appearance at the Southern Showdown, in Miller's Tavern, one of the largest truck and tractor pull events on the East coast, where the team placed 2nd, pulling the sled 349 feet at over 30 mph. The team also participates in the popular Field Day of the Past event just outside Richmond. But beyond the fun on the track, Dustin loves being able to use his tractor to promote oral healthcare with fans from Pennsylvania to North Carolina.

It was the desire to have a positive impact on others that first drove Dustin toward a career in dentistry. While at Hampden-Sydney, studying physics, Dustin worried that a desk job as an engineer wouldn't suit his out-going people-person nature. During that time, Dustin also served as a volunteer fire fighter and EMT and while many aspects of those jobs suited his personality, the potential for 3 a.m. pages did not. It was at that point that a fraternity brother suggested dentistry. Endodontics was the cherry on top, playing towards Dustin's steady hand and love of problem solving.

In addition to his family, his practice and Pullin' Teeth, Dustin is an active volunteer with the United Way of Central Virginia, a past president of his local component, a current board member at the VDA, an avid supporter of organized dentistry and a regular volunteer provider at the Free Clinic of Central Virginia. If you'd like to learn more about Dustin or his practice, visit him at www.foresthillendo.com.

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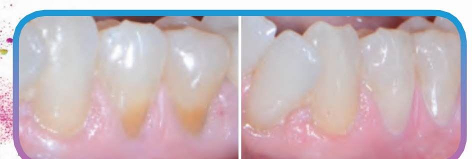
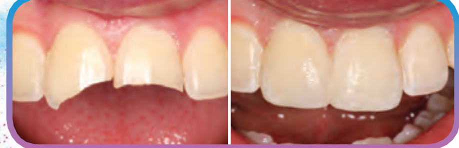


Case image courtesy of Dr. Peter Auster, Pomona, NY



Case image courtesy of Dr. Allan Mohr, Massapequa Park, NY

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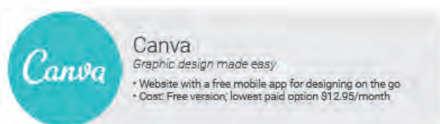
FIVE FREE MARKETING TOOLS

THERE'S AN APP FOR THAT!

Kelsey Leavey

If it seems like the to-do list for marketing your practice is never ending, you aren't alone. There are more channels than ever to communicate with existing patients and potential new patients making it more challenging to get it all done (and to do things well).

Luckily, there are also more free tools out there to help you save time and make your marketing strategies more effective. From helping you create stunning visuals for social media to collecting feedback from your patients, there's an app for that. The following five services offer free versions that will make crossing items off your to-do list easier.

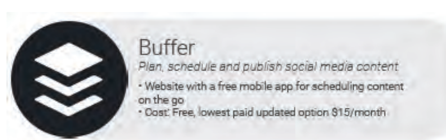


CANVA

Creating graphics for your website, social media channels or printed materials using programs like Adobe Photoshop or InDesign can be a challenge if you don't have a background in graphic design, not to mention the financial investment to access the programs.

Canva is primarily a web app, which means you won't have to download anything to your computer to start creating designs. With over 60,000 free design templates and a library of more than 3 million images, you can use the platform to easily produce graphics to promote your practice. When creating your designs, just select what you're trying to make—Facebook post, Instagram story, poster, etc. — and your design will be correctly sized.

The paid version includes custom fonts to match your practice's branding, save brand colors and gives access to 400,000 free photos, illustrations and templates.



BUFFER

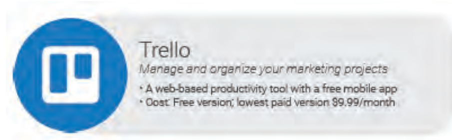
Have you ever gone long stretches of days without updating your Facebook page because you're distracted by other work duties? We've all been there.

Users can plan and schedule Facebook, Instagram, Twitter, Pinterest and LinkedIn content all in one place with Buffer. Scheduling content through Buffer's app or website in advance helps guarantee that your practice's social media channels are active on a regular basis and the handy dashboard gives users a great overview of post content.

GOOGLE ANALYTICS

Marketers use Google Analytics to track the activity of visitors to their organization's website. Want to know how people are finding your practice's website and what pages users spend the most time on? Google Analytics can help with that. The dashboard is broken down into audience insights, acquisition (how people are finding your website), behavior (what users do when they get to your website) and conversions (the actions people are taking on your website).

In order for Google Analytics to collect data about your website and its visitors, you'll need to add a short line of code to your website — note: some content management systems (CRMS) such as Wordpress and Squarespace give you the option of adding Google Analytics tracking without editing the code of your website.



TRELLO

If you're leveraging a variety of marketing tactics for your practice such as sharing regular blog content, posting to social media, responding to patient reviews, sending out direct mail pieces and advertising in the local family magazine, keeping it all of it organized can be a challenge, especially if the marketing responsibilities are split up among multiple staff members.

Trello allows you (and other staff members) to organize the various tasks onto "boards," set deadlines, assign to-dos, create checklists and share documents all in one place. The platform is great for keeping everyone on the same page and streamlining tasks to make marketing more efficient.

It can take some set up on the front-end to define and refine your process to best fit the needs of your practice, but in the long run it will make crossing things off your marketing to-do list easier.

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COMPOUNDING MAGIC

A SPELL TO BOOST RETIREMENT SAVINGS

Jimmy Pickert, CFA, CRPS®; Portfolio Manager, ACG Worldwide

For most freshly-minted dental school graduates, saving for retirement is not the first thing they think about once they're handed their diploma. More likely they are focused on how to turn their new degree into a rewarding career, paying down the sizable student loans they've amassed or even how they should reward themselves after succeeding through several years of difficult study. All of these are worthy considerations, but by letting their retirement savings fall to the backburner they are passing up on one the greatest financial opportunities that they'll see in their lifetime. This opportunity is known as the magic of compounding, and the only way to make the magic happen is by giving it time.

Albert Einstein called compound interest the Eighth Wonder of the World. It's the process in which a fixed amount earns interest, and then that interest earns interest, and so on, ad infinitum. This leads to growth that is exponential, not linear, in the same way that a snowball's growing surface area allows it to accumulate snow faster as it rolls downhill.

Consider this: the average annual return of the S&P 500 over the 40 years ending 2018 was 11.53%. Imagine you invested $100 on January 1, 1979 and let's assume those returns aren't variable, but instead that you get the same 11.53% return each year. After year one, you've only earned $11.53. But in year two, compounding has begun and the same percentage return earns you slightly more-- $12.86. This compounding continues each year so that by year 20 your $100 has grown to $889 and, incredibly, by year 40 your $100 has grown to $7,864. That's not a typo—if you had invested $100 in the S&P 500 on January 1, 1979, today your investment would be worth more than 78 times more than it originally was. This is the beauty of compounding interest, and as you can see, the more time you give your money to grow, the more each additional year of investing will benefit you. While it's great that you grew your investment by a factor of nearly nine in the first 20 years, the vast majority of growth occurred in the latter 20 years. This is why it's important to begin investing for retirement in your 20s instead of waiting until your 30s or 40s.

For dentists that have a large student loan balance, saving for retirement early on can be both financially and emotionally difficult. According to the American Student Dental Association, in 2017 dental students graduated with an average debt balance of over $287,000. Dentists should do what they can to consolidate and refinance these loans so as to pay them down as efficiently as possible. Everyone's optimal payment plan is different—the interest rate, minimum payment and other details need to be carefully considered—but in general, once you're in a place where you're covering any interest accrual and chipping away at principal, it's likely worth shifting more of your income away from debt payments and towards retirement savings. This is counter-intuitive to how most of us are wired—debt is viewed as a burden and the emotional instinct is to get rid of it as aggressively as possible. While this is a laudable goal, still better would be to start building your retirement nest egg now to give the magic of compounding more time to work. Finding the right balance between loan payments and retirement savings is a savvy financial move from a dollars and cents perspective and it also helps establish the habit of saving early on—something that can be difficult to do in your 30s and 40s after lifestyle creep has kicked in.

For many savers, the main hurdle to saving for retirement is uncertainty around where to start. If your employer has a retirement plan, for example a 401(k), saving can be automated and easy—you simply defer money from your paycheck into an account where it can grow tax-deferred. If you own or co-own your practice, you may be interested in other types of retirement plans, like cash balance plans, that enable you to save even more than a 401(k) does on a tax-deferred basis. And if you're not participating in any type of employer-sponsored retirement plan, consider making regular deposits into an Individual Retirement Account (IRA), which also allows for the tax-deferred growth of your investments as well as potential income tax deductions.

After determining where to place your retirement savings, the next step is to figure out the appropriate investment strategy for you. While everyone has a different tolerance for risk, in general you should take more risk in your retirement savings early on in your career and reduce risk as you near retirement. An investment portfolio that consists completely, or mostly, of stocks would not be inappropriate for an investor with 30 years or more until retirement. It's prudent to work with a financial advisor to determine a long-term strategy around where you place your retirement savings and how you invest those funds.

The pace of today's world makes it difficult to focus on goals that are months down the road, let alone the decades-long goal of retiring on your own terms. As a result, the largest benefits of compounding are lost to most retirement savers. Feel like you've already waited too long? The best time to start is now.

CARING DENTIST

A LITTLE-KNOWN COMMITTEE

Dr. Bruce W. Overton; Chair, VDA Caring Dentist Committee

For over ten years I have had the privilege of serving as the Chairman for our Caring Dentist Committee (CDC), a very important committee of the VDA. Even more gratifying is the opportunity of working with energetic representatives from our eight components across the Commonwealth. I believe I speak for everyone on the committee when I say that we get back much more than we put in as far as time and commitment of our group to the dental community.

The purpose of our committee is to help dentists and dental hygienists who are suffering with addiction, alcoholism, or other mental and emotional diseases which could affect the performance of optimal patient care. Our program is available to resident licensed dentists and hygienists of Virginia. However, if any member of your dental team needed assistance, the program would help the impaired member or provide resources for family members.

As many of you are aware, the practice of dentistry can be stressful even on a good day. Occasionally, some of us may choose an outlet for relief of this stress that could become self-destructive over time. These choices could ultimately become pervasive to the provider, their patients, other members of the dental team and family members. Should these habits deteriorate into full blown addiction, loss of a hard-earned career, loving relationships, and loss of life could be the result. This is where the Caring Dentist Committee can help.

I would be remiss in leaving out one very important misconception. The belief that "this could never happen to me" is a very foolish thought. Expanding on this statement is "this could never happen to anyone in my family or practice" is another potentially deadly statement. I once had the same belief, until my intervention on November 30, 1995. I was out of practice for nine months, and sustained board and legal consequences. My salvation was the fact that these consequences saved my life, and have allowed me to help others in my journey.

We are fortunate that the Health Regulatory Board has a very progressive attitude toward the disease of addiction, and other mental illnesses which could impair the dental professional. Gone are the days of making a valuable member of the dental team feel ostracized from the professional community. Though denial and shame go hand-in-hand when the individual is in the throes of the illness, the CDC is there to offer emotional support to the provider and their family. We also serve as a valuable resource and work in cooperation with the Health Practitioners Monitoring program, which is under the auspices of the Health Regulatory Board, serving to protect the public and return a valuable member of our profession to productive practice.

Our program has volunteer speakers to provide education at appropriate functions around the state. The eight components within the Virginia Dental Association each has its own representative. These component representatives can serve as Peer Support Volunteers, offer one-on-one support, and avail themselves for interventions, if needed. Ultimately, we encourage professional reintegration to practice, and recovery. We want to be thought of more as a group for support as opposed to a policing body.

While many of the Peer Support Volunteers are in recovery themselves, some have

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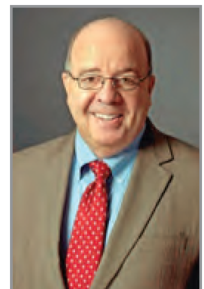

YOU HAVE CHOICES IN 2020

DOING NOTHING IS NOT AN OPTION

Dr. James R. Schroeder

Let's face it, in today's world choices have become more complicated and critical in our professional journey. Information overload, technology, complex staffing dilemmas and new players influencing the systems of delivering dental care, require doctors to be informed and seek counsel outside their area of expertise.

"Help! All I want to do is my dentistry!"

Working with hundreds of practice owners throughout our Commonwealth, I encounter practices that range from a healthy state of growing and thriving, to a steady state of decline. What I've noticed over the years is that there are clear differences that separate the "growing and thriving" practices from the barely "surviving" ones. Below are a few of these differences:

THRIVING PRACTICE OWNERS SEEK KNOWLEDGE

Owners of thriving practices tend to realize that what they believed to be true as recently as five years ago, no longer applies today. Staying informed and engaged in what's happening not only in their practices but within the industry is evident in this group.

LEADERS ARE COMMITTED TO GROWTH AND DEVELOPMENT

Leadership teams of growing practices recognize that the skills they started with (following graduation) must be continually developed to a higher level of competency. Example: One client four years out of school has placed over 50 implants. Another is six years out and has never removed a tooth or written a prescription. One sees opportunity and one is plagued by dental school "fearodontics".

GROWING PRACTICES PRIORITIZE PATIENT NEEDS

Doctors of thriving practices understand that their purpose is to serve and meet the needs of the patient - not the insurance companies. Over the past 30 years, there has been a gradual takeover of insurance companies directing and approving standardized treatment, rather than individual treatment plans created by the doctor. This is a pathway our medical colleagues traveled many years ago. How did that impact our healthcare system today?

From graduation to retirement, we are faced with decisions to be made outside of our dental expertise; decisions that impact our professional journey. DSOs have raised the bar on business management of our practices, on marketing, and the operational acumen required to effectively deliver our dental services.

HOW WILL YOU RESPOND TO THE WAVE OF CHOICES IN 2020?

1. An accurate assessment of your dental competencies will help you identify the areas where you can best grow. If you're a recent graduate, expanding your dental competencies beyond dental school is mandatory.
2. A deep look into your P&L in comparison to industry standards can shed new light on areas where you may have previously believed to have had no issues. Be open to asking yourself if you are practicing best business practices. Partner with your accountant by asking questions and listening to suggested advice.
3. The start of a new year is a great time to engage in a leadership program. The lack of solid leadership in medical and dental offices is one of the greatest limiting factors for an office to move from a striving (one foot out of the grave) practice to a thriving (the future looks bright with hope) practice.
4. If you're thinking about retirement and selling your practice, you have options to consider. You can direct sale to a young doctor or sell to a corporate entity and walk away; you can merge your practice and work as an associate while capturing your equity from your patient base; or, you can choose a chart sale to a nearby colleague within a 5 mile radius. Each option requires careful assessment while you are healthy and have choices! Good planning now can avoid closing the doors or a fire sale!

WHERE DO I START?

Do something! If this is a new journey for you, it most likely will require a guide by your side who will prevent you from getting lost in the weeds. Set aside time on your calendar to focus on your business then seek out the expertise to guide you on an exciting journey in 2020.

Editor's Note: Dr. James R. Schroeder practiced dentistry in Richmond for over 30 years and is the founder of Leadership by Design – Practice Transitions. If you have questions for Dr. Schroeder or would like him to address a specific topic in future articles, you can reach him by phone 804-897-5900 or at drjim@lbdtransitions.com www.lbdtransitions.com.

BOARD OF DENTISTRY NOTES

DECEMBER 13, 2019

Ursula Klostermyer, DDS, PhD

The last meeting of 2019 began with some public comments by Misty Mesimer, RDH, who is the Director of the Dental Assisting Program and the Local Coordinator of the Northern Virgnia Community College Dental Hygiene Program of the Germanna Community College. Ms. Mesimer commented that dental assistants should have an official degree and an education which shows their proficiency and knowledge in their field as they deal with public safety, while they work on patients. Sterilization guidelines, infection control, and radiology regulations are important topics that every dental assistant needs to follow. She states that most dental assistants do not have an official degree and that this should be changed. She and the other RDHs, who spoke up, like Ms. Heather Fonda or others, gave a written statement to the board, announcing that a written examination should be discussed to qualify dental assistants and maintain a standard of quality in the dental professional world. They are aware that most dental assistants are not officially qualified and it was stated that a grandfathered-in status (after an exam) might be an answer as well. The BOD referred all the public comments to the regulatory legislative committee for further discussions.

Board member Dr. Nathaniel Bryant had visited the Germanna Community College in November while they held their CODA visit for the Dental Assistant Program's accreditation. The Germanna campus in Fredericksburg has degree programs in Dental Assistant, Dental Hygiene, Physical Therapy Assistant, and Nursing. Dr. Bryant gave a very positive report on his visit. Germanna went through a transition and they seem to be well prepared for an in-house high level of comprehensive education.

In October the Board of Dentistry went through a member training program. Visitors will now need to get ID checked and will then receive a visitor's badge which has to be worn until they leave the building. In the board room panic buttons will be installed on the board members' chairs. The program was successfully closed.

Drs. Sandra Catchings and Augustus Petticolas both reported from the 136th Annual meeting of the American Association of Dental Boards. Both of them stated their disappointment about the conference. They questioned the voting system and feel that AADB is not fitting the bill and seems to be a dysfunctional, floundering organization. The Virginia Board of Dentistry might consider withdrawing support from the AADB. Dr. Catchings and Dr. Petticolas agreed that it is very valuable to network with representatives of other states.

With regard to the change in the licensure renewal schedule, Ms. Elaine Yeatts, Regulatory Coordinator for the Department of Health Professions, stated that the proposed change might not happen during 2020 as previously planned and will begin in 2021. Executive Director Sandra Reen knows that this change is initially a big internal adjustment, but in the long run a change to the licensure renewal from the month of March to members' birth month will be helpful.

In 2019 the BOD received 426 cases of which the Board closed 400 cases with no violation. There were 29 cases closed with violations consisting of the following: 10 cases were standard of care issues – the diagnosis or treatment was improper, delayed or unsatisfactory. In 4 cases patients were treated by unlicensed individuals, which could include: practicing on a revoked, suspended, lapsed, or expired license, as well as aiding and abetting the practice of unlicensed activity. There were 4 malpractice care reports. In 2 cases drug-related patient care was reported. Individuals were treating patients while under the influence of alcohol, illegal substances or prescriptions drugs or were incapacitated due to mental, physical or medical conditions. In one case patient care was violated due to abuse, abandonment or neglect. In one case falsification/alterations of patient records was reported and another where a standard of care issue came up while performing improper/unnecessary surgery on a patient. There were 5 non-patient care related violations reported like business practice issues, violation of a Board order or probation violation and record release failures and charging excessive fees for these record requests.

To demonstrate the difficulty Board members undergo while discussing violations or recognizing improper care, Ms. Reen initiated a case calibration exercise with a photograph of teeth with restorations, which demonstrated to all the board members the difficulty of discussions while individual board members observed photos and had differing judgments about a possible violation. The difficulty of objective observations was recognized but more practice sessions with different cases were announced by Ms. Reen for the Board members to judge fairly and objectively.

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.

IMPROVING OUR ETHICS

Dr. A. Garrett Gouldin

Reprinted with permission from the Northern Virginia Dental Society - Newsletter

Former American Medical Association (AMA) President Dr. Elmer Hess said "If a man is good in his heart, then he is an ethical member of any group in society. If he is bad in his heart, he is an unethical member. To me, the ethics of medical practice is as simple as that." Perhaps ethics is just that straightforward. Or, could it be that we are simply thinking small, and not looking closely enough for the nuances in our own approach – our own practice's ethical standards.

The mindset that ethics cannot be taught, and that a person's ethical compass is set at a young age and cannot be effectively altered, is not supported by experience and research in the circles that concern themselves with such issues. In fact, "the study of dental ethics can have a direct influence in the moral and professional development of the dentist"[1]. Dentists often face ethical problems that are unique to the dental profession that otherwise would not occur in day to day interactions in other fields and workplaces. Research shows that, like many ongoing processes throughout humans' lives, moral development does occur over time, and it can be taught and learned successfully. Being an ethical dental professional is a complex and powerful skill that we should all seek.

And how much time do we spend as dentists striving to find the answers to improve and grow our practices, or to identify the silver bullets that can help us in the many challenging areas of practice we face day to day? Well, if you accept the premise that ethical behavior can be improved, then you might be happy to learn the following: "business research has shown that organizations that strive for high ethics enjoy greater productivity, innovation, employee loyalty, customer satisfaction, and profitability." (https://www.dentalethics.org/pead/)

Short of inclusion of technical excellence, the five areas of improvement listed above comprehensively cover the goals of most dental practice owners. Nevertheless, as dentists, we tend to focus the majority of our energy on acquiring new procedural techniques and refining existing skills – both worthy goals. But exploration of our ethical and moral growing edges, as well as our team members' positions on such matters, could be an area to expand if you have not done so already.

The American College of Dentists website has a variety of resources to foster learning in the area of dental ethics. One example, the Practice Ethics Assessment and Development (PEAD) program (https://www.dentalethics.org/pead/), is set up in easily digestible sections, in a format that would support brief office meetings and lead to valuable exchange among team members. American writer and historian Will Durant said, "Education is a progressive discovery of our own ignorance." Exercising a little courageous leadership by sharing this tool with your team could very well generate a host of valuable discoveries regarding the ethical dimensions of your dental practice. Might we all look closer at our own approach, and make note of the ways in which we can evolve into more ethical dental professionals.

1 https://www.acd.org/wp-content/uploads/Dental-Ethics-Primer-2017_Peltier-and-Jensen.pdf

YOUR REPUTATION

11 WAYS TO MITIGATE MALPRACTICE CLAIMS

Dr. Anthony E. Chillura

Regardless of the reason, the best defense in claims mitigation is to prevent them from happening in the first place. Some basic suggestions in that regard are below.

1. COMMUNICATE CLEARLY WITH YOUR PATIENT BEFORE TREATMENT

Patient dental education regarding their treatment is vital to the overall success of the case. The informed consent process is mandatory before treatment is started by providing the patient with options, considerations, and complications and risks of treatment, benefit of treatment, alternative treatment and no treatment. The patient questions must be completely satisfied. Don't take for granted that your patient has some background knowledge of dental procedures. You should require your patients sign a consent form that states they understand the treatment and its risks. Risks Benefits of Treatment and No treatment - RBA or BARN can be used as chart notation.

2. ALWAYS FOLLOW UP WITH MISSED OR CANCELLED APPOINTMENTS

At the new patient experience, the patient should be advised of the office policy on scheduled appointments and providing the delivery of proper treatment. Your office should have written protocol in place for following up with patients who miss or cancel an appointment – even if it's just a six-month recall exam and cleaning. A missed appointment means you might miss the opportunity to diagnose a condition as soon as possible, which leaves you vulnerable to claims of negligence. The missed appointment must be entered into the patient's chart to document the patient not fulfilling their responsibilities or duties. It also confirms the patient's contributory negligence which would possibly reduce the dentist's liability in an alleged malpractice lawsuit.

3. STAY IN YOUR COMFORT ZONE

Treat patients using your specific training, experience, and education. If a patient comes to you with an issue that is outside your level of care, always refer them to a specialist that you trust. If you decide to go ahead with an extraction that ends up failing, a patient (and his lawyers) can argue that a specialist would have been a safer route and that you should have known better. It should be noted that extraction complications are a leading cause of claims.

4. PROPER COMMUNICATION

This will be discussed in detail later, so suffice it to say that without proper communications between patient and doctor or staff, there is potential for disputes between all parties that can easily lead to a claim.

5. REALISTIC EXPECTATIONS

If you are presented with a patient who does not understand or comprehend realistic goals of treatment, this poses increased risk and potential for a claim. If the patient cannot be educated to accept the realities of dental treatment, it may be prudent to consider separating yourself from that patient.

6. UNEXPECTED EVENTS

Even the most dedicated and skilled dental practitioner who has practiced for many years can experience an unexpected event. A tooth can fracture during an extraction and have much difficulty completing the procedure producing increased trauma afterwards, a reamer can separate during a root canal, a simple restoration can morph into a root canal, or any number of unexpected events most difficult to predict.

7. RETRIBUTION

Motivation for filing a claim can come from a number of non-clinical events. These could include collection efforts for a past due account, dismissing a patient from your practice, disregarding patient requests, rude or disrespectful behavior from the staff to patient, and many other situations.

8. TREATMENT FAILURES

Much of what we do is highly technique sensitive, which invites failure. In addition, unexpected events made occurring early in a procedure or case, and not realized, often get magnified to being a mistake at the outcome. This can make a small situation result in a tremendous failure! Also, in this category you would include such problems as, the shade is off, the shape is not right, the bite is off, the porcelain cracked, it's gotten very sensitive, to name a few complications.

9. KEEP ACCURATE RECORDS

Your first line of defense is accurate recollection of the events that occurred during treatment documented in the patient chart. They must be comprehensive and truthful rendition of everything that happened. Included here should be adverse or unexpected events, unmet expectations, poor treatment outcomes, complications of the treatment, statements made by the patient, and anything you deem appropriate to treatment. If there is a complication or if the patient finds out about it later, they may be surprised, angry, and ready to file a claim against you and your practice.

► CONTINUED ON PAGE 28

Does Your Office Need an Amalgam Separator?

Special Pricing Available for VDA Member Dentists!

The EPA's final rule for amalgam separators requires that most dental offices that place or remove amalgam restorations must have an ISO 11143 certified amalgam separator installed in their practice by **July 14, 2020**. To help members with this new requirement, VDA Services is working with two companies to offer members special pricing and benefits on amalgam separators.

DRNA is your complete 360-degree solution for amalgam separators and waste management. While the EPA rule makes installing an amalgam separator mandatory, paying for one is most definitely not!

As a benefit of membership, the VDA has arranged for its dentists to receive a **FREE amalgam separator** ($850 value[1]) when signing up for DRNA's low-cost recycling service with a 3 or 5-year service agreement.[2]

The service agreement is $500/year for the BU10-5 unit (1-8 chairs) and $750/year for the BU10-30 (9-16 chairs). As part of the DRNA's annual services contract, you will receive your Annual Replacement Kit automatically that includes a replacement canister, on-demand pick-up of existing canister, pre-paid shipping, recycling and all compliance documentation.

Please go to **drna.com/vda** or call **800-360-1001 Ext. 2** to sign up for your FREE amalgam separator.

[1] *Retail price of the unit has, from time to time, been less because of promotions.*
[2] *Receive a free unit when you sign a 3- or 5-year recycling agreement at $500/year for the BU10-5 and $750/year for the BU10-30, inclusive of all costs.*

Solmetex provides the 'Complete Solution' to the EPA Dental Rule on the handling of dental amalgam waste. Our product line contains all the necessary components to keep your practice in compliance:

- Award-winning ISO 11143 certified NXT Hg5 Amalgam Separator meets or exceeds all requirements of the EPA regulation.
- No contracts required.
- The NXT Hg5 includes a Practice Waste Solutions Amalgam Bucket for the recycling of all 'dry' amalgam waste (required by the regulation).
- The new PowerScrub Vacuum Line Cleaner by Solmetex that has a neutral pH between 6 and 8 (required by the regulation).
- Proof of Compliance: Solmetex.com houses all Certificates of Compliance, accessible online 24/7.

Solmetex has all the EPA regulation elements covered, so you do not have to worry about it. Recycling included in the product cost.

And as a VDA member benefit, Solmetex is offering a **FREE container and $30 gift card** with purchase of an NXT Hg5 Amalgam Separator – a total value of $368!

Receive your exclusive member benefit at **solmetex.com/endorsements/virginia-dental-assn/**.

Peer-Reviewed. Members-Only Benefits.

VDA Services is a service mark of the Virginia Dental Association. VDA Services is a program brought to you by the Virginia Dental Services Corporation, a for-profit subsidiary of the Virginia Dental Association.

COMPLYING WITH NEW EPA RULE ON AMALGAM

A REFERENCE GUIDE

Dr. Alfred L. Frost, III; Vice President for Clinical and Scientific Affairs, DRNA

BACKGROUND
On July 14, 2017 the US Environmental Protection Agency (EPA) finalized its new Rule regarding the handling and recycling of amalgam and its wastes.

According to the Agency, EPA issued pre-treatment standards under the Clean Water Act (CWA) for discharges of pollutants into publicly owned treatment works (POTWs) from new and existing dental practices that discharge dental amalgam waste. Mercury is a persistent, bio-accumulative pollutant with well documented neurotoxic effects on humans. Dental amalgam contains mercury in a highly concentrated form that is easy to collect and recycle. Dental offices are the main source of mercury discharges to POTWs[1].

The Rule aims to ensure that all dentists who either place or remove amalgam properly collect and recycle the wastes generated from those activities. Emphasis is placed on compliance, documentation and enforcement. Previous mandatory programs (in some states) emphasized only equipment purchases and did not provide for inspection of offices or mandate other types of enforcement. This Rule is far more onerous as its emphasis is on demanding both compliance with proper recycling and documentation as well as establishing mechanisms to inspect those offices suspected of non-compliance.

While not comprehensive, this brief article cites the KEY aspects of the Rule which will impact your practice.

The Rule applies to anyone who either places OR removes amalgam.
The Rule covers permanent and temporary dental offices, hospitals, schools, clinics, mobile units and facilities owned by federal, state or local governments.
The Rule requires the installation, maintenance, monitoring and recycling of an amalgam separator in addition to requiring compliance with all ADA Best Management Practices (BMPs) regarding the recycling of “scrap amalgam” (which includes excess mix or carvings, empty capsules from pre-capsulated alloy, extracted teeth containing amalgam, in line disposable traps and vacuum traps from wet vac systems).[2]

AMALGAM SEPARATORS MUST:
Be 2008 ISO 11143 certified to operate at a minimum of 95% efficiency.
Be properly sized to incorporate all the wastewater that may pass through it.
Have canisters, cartridges or other collecting units changed when full, as recommended by the manufacturer, or annually - whichever comes first.
Be maintained so as not to allow for unprocessed wastewater to bypass the system and enter a drain.[3]

SCRAP AMALGAM HANDLING, COLLECTION AND RECYCLING:
All items considered to be “scrap amalgam” (previous list) must be properly recycled in containers both designed and designated for this purpose. These wastes must never be co-mingled with regular trash or bio-hazardous (red bag) wastes.
The Rule requires the use of only non-chlorinated line cleaners in the pH range of 6.0 to 8.0.[4]

MONITORING, REPORTING AND RECORD KEEPING:
Monitoring and enforcement will be conducted by the local POTWs. Dentists will be categorized as Dental Industrial Users (DIUs), a less stringent category than Significant Industrial User (SIU).[5] To maintain this DIU status, the office must certify, among other things, that:

It has installed and is properly maintaining, inspecting and recycling an amalgam separator which meets the ISO certification standard previously noted.
It adheres to all BMPs and recycles all scrap amalgam (previously described).
It maintains a written log of amalgam separator inspections as well as all notes related to that unit’s servicing.
It is recycling all canisters, cartridges or separator units at least annually.[6]

Failure to comply with the above may result in loss of the DIU status and reversion of the dental office to more intensive inspections as an SIU.

Baseline reports, containing a significant amount of information about the practice including the names of all dentists practicing there, along with their Dental License Numbers, must be filed within 180 days of the effective date of the Rule in order to establish a DIU status.

Other reports, including 90 day compliance reports and periodic monitoring reports, will also need to be filed going forward.[7]
All reports listed above, along with service, maintenance and inspection logs, plus dates of canister or cartridge changes, etc., must be kept on file for at least three years.

CONCLUSION
Dentists must report the type of amalgam separator devices installed, when it was installed, how it is maintained, and

► CONTINUED ON PAGE 22

► FROM PAGE 21

perform two Best Management Practices (BMPs). The compliance date is July 14, 2020, however, it is suggested to install your device and report sooner rather than later. Compliance is mandatory if you are applying or removing amalgam.

The DEQ webpage with the Virginia Dental Rule Compliance form and FAQ can be found at https://www.deq.virginia.gov/DentalRule.aspx. There is a link to the rule and background information there as well.

REFERENCES:

Environmental Protection Agency. Effluent Limitations Guidelines and Standards for the Dental Category. Accessed October 19, 2017. pg 1.
Ibid. pgs 32, 38, 97-99, 101.
Ibid. pgs 27, 34, 38-39, 71, 100-101.
Ibid. pgs 18, 23, 31, 38, 101.
Ibid. pgs 83-84
Ibid. pgs 16, 74-75, 78-79, 83, 96, 100-101.
Ibid. pgs 103-106.

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DID YOU KNOW?

A SERIES FROM THE VIRGINIA BOARD OF DENTISTRY

► Every Patient Record

Did you know that every patient's record shall include for every treatment the diagnosis and options discussed, including the risks and benefits of treatment or nontreatment and the estimated cost of treatment options?

18VAC60-21-90(B)(3) of the Regulations Governing the Practice of Dentistry.

► Requirements for Direction and General Supervision

Did you know in all instances and on the basis of his diagnosis, a licensed dentist assumes ultimate responsibility for determining with the patient or his representative the specific treatment the patient will receive, which aspects of treatment will be delegated to qualified personnel, and the direction required for such treatment, in accordance with this chapter and the Code?

18VAC60-21-120(A) of the Regulations Governing the Practice of Dentistry.

► Opioid Prescriptions

Did you know that due to the higher risk of fatal overdose when opioids are prescribed with benzodiazepines, sedative hypnotics, carisoprodol, and tramadol, the dentist shall only co-prescribe these substances when there are extenuating circumstances and shall document in the patient record a tapering plan to achieve the lowest possible effective doses if these medications are prescribed?

18VAC60-21-103(C) of the Regulations Governing the Practice of Dentistry.

► Moderate Sedation Record Requirements

Did you know that a dentist who administers moderate sedation shall document in the patient's record, the patient's height and weight or, if appropriate, the body mass index?

18VAC60-21-260.D(2) of the Regulations Governing the Practice of Dentistry.

Save the Date

September 23-27, 2020
Norfolk

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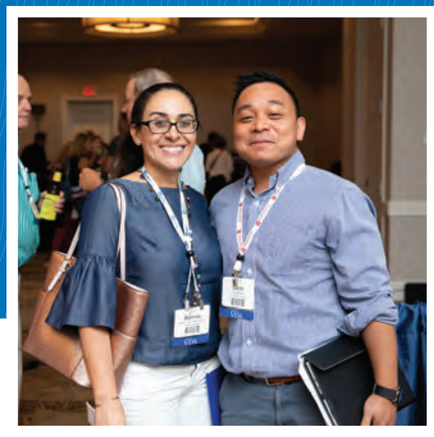
2020 Meeting Agenda



Thursday, September 24

- Continuing Education Courses
- Apollonia & Governor's Club Reception *(invitation only)*
- American College of Dentists Dinner *(invitation only)*

Friday, September 25

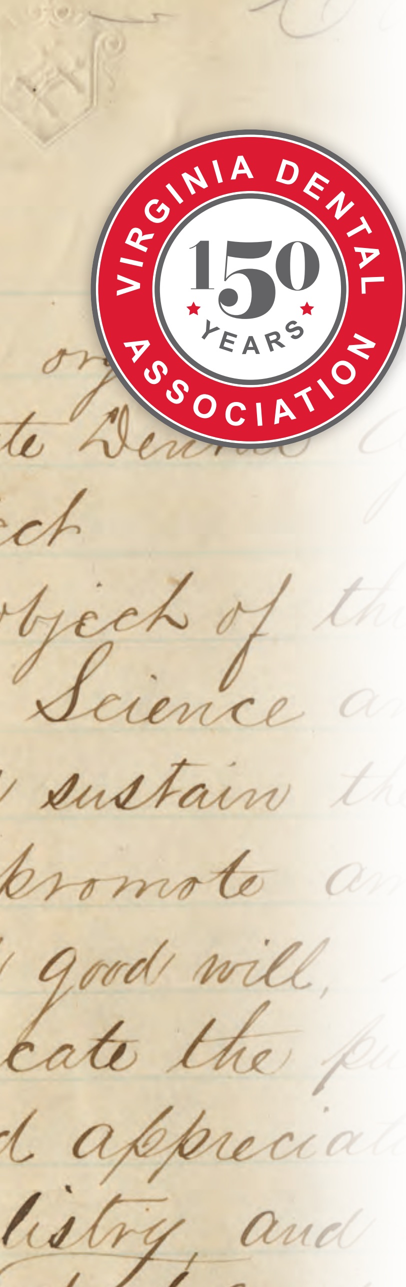
- Opening Session/Annual Business Meeting
- Continuing Education Courses
- Exhibit Hall Open: *9:00 a.m. – 7:00 p.m.*
- First Session of House of Delegates
- VDA Fellows Lunch
- President's Reception in Exhibit Hall: *5:30 p.m. – 7:00 p.m.*

Saturday, September 26

- International College of Dentists Breakfast
- Continuing Education Courses
- Exhibit Hall Open: *9:00 a.m. – 1:00 p.m.*
- Pierre Fauchard Lunch & Student CE
- Exhibit Hall Closing Lunch Reception: *12:00 p.m. – 1:00 p.m.*
- VDA New Dentist & Dental Student Reception
- Academy of General Dentistry Reception
- VDA Foundation Silent Auction Reception
- VDA 150th Anniversary Gala

Sunday, September 27

- Past President's Breakfast
- Annual Business Meeting
- Second Session of House of Delegates



From

9 to 3,842

VDA Celebrates 150 Years of Organized Dentistry in Virginia

Elise Rupinski, VDA Director of Marketing and Programs

On November 3, 1870, nine dentists met in Richmond to form the Virginia State Dental Association. At a time when the practice of dentistry faced many challenges, the association sought to "cultivate the science and art of dentistry and… elevate and sustain the professional character of dentists…"[1] What began with just nine members is now the largest dental association in Virginia, representing 3,842 dentists today. This year, the Virginia Dental Association will be celebrating its 150th Anniversary and members and the entire Virginia dental community are invited to join us in Celebrating Our Progress, Building Our Future.

Conditions of membership in the early years were not so different than they are today: dentists who resided in Virginia, were at least 21 years of age, were professionally qualified and possessed a good moral character were able to become members. Education and the sharing of knowledge was among the first priorities of the new organization. Almost immediately, the association set out to develop standards for the practice of dentistry in Virginia and to regulate the profession to protect the public from poorly-trained individuals. In 1886, due to the work of the members of the Virginia State Dental Association, the Commonwealth passed the first legislation that would govern the practice of dentistry and created the State Board of Examiners. That year also saw another important milestone for the new organization, the adoption of a Code of Ethics.[2] As part of a growing trend to establish professional associations nationwide, the early work of the VSDA would shape the practice of dentistry in Virginia for many years to come.

The Virginia Dental Association celebrated its centennial in 1969 with a brunch, honorary luncheon and banquet and ball.

VIRGINIA STATE DENTAL ASSOCIATION FOUNDING MEMBERS[3]

- **Dr. James F. Thompson**, Fredericksburg, President
- **Dr. Hugh M. Grant**, Abingdon, 1st Vice President
- **Dr. William M. Dorset**, Ballsville, 2nd Vice President
- **Dr. T.M. Henley**, King and Queen County, 3rd Vice President
- **Dr. George B. Keesee**, Richmond, Secretary
- **Dr. Judson B. Wood**, Richmond, Treasurer
- **Dr. Hugh M. Grant**, Executive Committee
- **Dr. Jas. A. Chapman**, Executive Committee
- **Dr. F.A. Jeter**, Executive Committee

THE ESTABLISHMENT OF A TRIPARTITE ORGANIZATION[4,5]

American Dental Association (est. 1859)

- Virginia Dental Association (1870)
  - Tidewater Dental Association – Component 1 (1880)
  - Peninsula Dental Society – Component 2 (1934)
  - Southside Dental Society – Component 3 (1925)
  - Richmond Dental Society – Component 4 (1894)
  - Piedmont Dental Society – Component 5 (1916)
  - Southwest Virginia Dental Society – Component 6 (1917)
  - Shenandoah Valley Dental Association – Component 7 (1914)
  - Northern Virginia Dental Society – Component 8 (1931)

2020 will be an exciting year for the VDA and all members are invited to share in the celebration of the VDA's sesquicentennial. We started the celebration with the Legislative Reception in Richmond where members and legislators marked the occasion and discussed the important VDA legislative agenda for this year. Each quarter the *Virginia Dental Journal* will have an article dedicated to the 150th Anniversary so please keep reading to learn more about the association and the members that make this organization outstanding. We are also working collaboratively with the Tomkins-McCaw Library at VCU to digitize important documents from the VDA's history that will be accessible to all through an online archive.

Just like the centennial celebration held in Richmond in 1969, the sesquicentennial celebration will culminate with a gala at the 2020 Virginia Meeting in Norfolk. Mark your calendar now to attend the Annual Meeting so that you can be a part of this historic celebration of the VDA.

What started as a very small group of dentists working to elevate the profession has grown into the Virginia Dental Association that we know today. And while many things have changed, many things have stayed the same. For members of the tripartite, high quality continuing education is available in person and online to further dental education and practice through the national, state and local level organizations. The VDA today continues to protect patients and actively advocates for the profession with the Virginia legislature. Members of the tripartite voluntarily commit to adhere to a Code of Ethics that to this day holds members accountable to the highest ethical standards. And the VDA continues to be a community of professionals who represent the voice of dentistry in Virginia. Please join us in celebrating all that the VDA has accomplished in the organization's first 150 years and help us to build an organization that will last another 150 years and beyond.

Editor's Note: If you have a special memory about the VDA or a piece of memorabilia that you would like to share with the VDA as the 150th Anniversary gets underway, please reach out to Elise Rupinski at Rupinski@vadental.org or via phone 804-523-2184.

REFERENCE:

1 - Virginia State Dental Association. *Constitution and Bylaws* (1870).
2 - Powell, H.W. *100 Years of Dentistry in Virginia* (1969), 16-17.
3 - Powell, H.W. *100 Years of Dentistry in Virginia* (1969), 15.
4 - *Presidents and History of the ADA*. https://www.ada.org/en/about-the-ada/ada-history-and-presidents-of-the-ada.
5 - Powell, H.W. *100 Years of Dentistry in Virginia* (1969), 19.

VDA's 150th Anniversary Gala

Please join us on
Saturday, September 26, 2020
for the culminating celebration of the VDA's sesquicentennial.

Hilton Norfolk | The Main
Part of the 2020 Virginia Meeting

► FROM PAGE 19

10. NEVER ERASE ANYTHING IN A PATIENT'S PAPER CHART.

Not even mistakes! If you do mistakenly record incorrect data or information record a mistake in a chart, simply cross it out with a single line drawn through it and note that it is an error. If that patient sues later and your records are examined, it's going to look suspicious if entries have been rubbed out or transformed. For the same reasons, you should never add information to a chart (if only to clarify) once a patient has filed a claim. Don't even touch the chart.

11. THE LETTER FROM THE STATE DENTAL BOARD

In some states, a claim filed with your insurance carrier may be reported to the state dental board. Normally is it not reported if the verdict/damages are below the reporting limits of the state. Claims are normally not reported, just judgments above the reporting limit of the state. It is mandatory and as such the board must investigate all these complaints. Even if the complaint is baseless, the board has a duty to adjudicate the case. Being contacted by the state board is very serious and you must contact your insurance carrier immediately to seek legal advice. Providing them all the information requested is the first step towards having the case dismissed. And if your insurance has not been notified, you would be prudent to advise them of the issue so it is on record they have been apprised of the event or incident.

Editors Note: Dr. Anthony Chillura is the Director of Dental Risk Management for the Professional Protector Plan (PPP) For Dentists. He is responsible for the overall risk control assessment, evaluation, consulting and technical support of risk exposures for insurance products for the dental profession. His dental and risk management experience allows him to manage the unique risk exposures related to the delivery of dental services and partner with insured dentists in their mission to improve patient safety and minimize risk. Dr. Chillura is a member of the American Dental Association, the Academy of General Dentistry and a Fellow of International College of Dentistry. To learn more about VDA Services endorsed partner Professional Protector Plan (PPP) for Dentists, please visit protectorplan.com or contact Virginia state administrator, RK Tongue Co., Inc., at 800-683-6353.

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Our Success is Your Success!

Don't be a spectator in the political process. You control the future of your profession and your practice through political action—which involves making political contributions and forming relationships with legislators. Don't assume your colleagues' contributions are enough.

Your contribution WILL make a difference.

Still have questions? We have the answers.

Call or email Laura Givens, Director of Legislative and Public Policy: **(804) 523-2185** or **givens@vadental.org**.

Virginia Dental Association

January 1, 2020

So, what exactly is Teledentistry and why does the VDA have bills (HB165/SB122) in this year's General Assembly? We hear this and other questions quite often, so we developed some FAQs to help answer them. Take a look at our Teledentistry FAQs post (next page).

N.E. Anderthal

TELEDENTISTRY FAQS

WHAT IS TELEDENTISTRY?

Therein lies one of the biggest issues we are seeking to address. There is no official definition of teledentistry in Virginia. This is important because without a definition, the Virginia Board of Dentistry (BOD) does not have the express authority to regulate it. Many dentists believe that teledentistry means providing dental care to a patient using technology to communicate information so that the patient can be at a different location. Officially, however, a BOD guidance document states that the term "teledentistry services" means:

the use of electronic technology or media, including interactive audio or video for the purpose of diagnosing or treating a patient or consulting with other healthcare providers regarding a patients diagnosis or treatment (Virginia BOD guidance document 60-23 adopted 12/11/2015).

IS IT THE SAME AS DO IT YOURSELF (DIY) DENTISTRY?

Some DIY or direct to consumer (DTC) companies use teledentistry to provide a platform for dentists to provide dental care to patients. Unfortunately, these companies do not require a dentist to see the patient in person, which means there is no head and neck exam, no thorough oral cancer screening, and no standard review of x-rays. Without appropriate radiographs the treating dentist could be putting the patient at risk. Members are seeing cases both personally and via referral which include patients who were treated with undiagnosed impacted teeth (canines especially with resorption of central and lateral incisors), patients with undiagnosed active periodontal disease, bone loss, and other pathology.

WHAT MAY BE SOME OF THE BENEFITS OF TELEDENTISTRY?

There are some wonderful benefits to teledentistry. When used judiciously and properly, it allows dentists to provide services to many patients who may not otherwise have such an opportunity. Some of the benefits are:
Access - It can be a great tool to used to treat established patients in remote locations.

Case Monitoring - Dentists can monitor patients more closely and make treatment much more convenient. It is not always feasible for patients to come to an office daily or even weekly, but patients can easily scan their teeth with their phones periodically which allows dentists to catch a problem very quickly and act accordingly to remedy the problem in a timely manner.

IS THE VIRGINIA DENTAL ASSOCIATION (VDA) OPPOSED TO TELEDENTISTRY?

We are certainly not opposed to teledentistry or innovation. As mentioned above, it can be a wonderful option for patients with less access or busy schedules. Though this is the intent of teledentistry, what we are seeing is that some practitioners, often living outside of the Commonwealth, are treating patients in Virginia without regard for the standards of practice to which Virginia licensed dentists are held. These standards have been established for the protection and safety of our patients and should be followed by anyone practicing in Virginia. Our goal is not to outlaw teledentistry, but to decisively define it so that it can be practiced safely and effectively.

WHY IS THERE A NEED TO DEFINE TELEDENTISTRY?

With no definition, there is no understanding of the rules of the road. The BOD uses those rules to ensure quality of care and to protect patients. At this point there is no true understanding of what is encompassed by technology so it is imperative that the definition of teledentistry be clear and precise. Without it, there is a risk of misinterpretation that could allow for orthodontics (the movement of teeth through the bone) to be considered a non regulated cosmetic procedure. We all know that there are some very significant health risks that can be associated with moving teeth haphazardly or without a proper examination/diagnosis and without a safe treatment plan. Otherwise teeth could be pushed out of bone and bites can be compromised.

HOW CAN ORGANIZED DENTISTRY HELP DIRECT INNOVATION IN THIS AREA OF TECHNOLOGY?

Organized dentistry is the gatekeeper of our profession. We can help move dentistry in the right direction by getting legislation passed! It is not only appropriate but imperative that organized dentistry establish and then support this definition. We all need to chip in to do it, whether it's through letters or phone calls or going to Lobby Day. Organized dentistry needs to define teledentistry and set the basic guidelines to protect patients. Then hopefully the BOD will be able to set and maintain this level of care.

WHAT ARE THE RISKS OF THE PRACTICE OF TELEDENTISTRY WITHOUT REGULATIONS?

The risks are great, both in number and in consequences. If oral pathology is missed, it can be devastating. Inappropriate or aggressive movement of teeth out of bone could result in periodontal issues that may not manifest themselves until much later, and could eventually result in tooth loss.

The most common case for patients seeking orthodontic care past adolescence is a Class I deep bite with mandibular anterior crowding. If you correct these cases and straighten the teeth without proper technique, the result is that the mandibular teeth are pushed forward in the bone and the deep bite is not corrected. Consequently, the anterior teeth will contact prematurely, resulting in fremitus. What happens to teeth that are forward in the bone and experiencing fremitus? We all know the answer to that one!

If an ectopic canine is missed, it can resorb the roots of the incisors which could possibly lead to loss of one or more of these teeth. Losing teeth can be a life altering event that could easily be mitigated through appropriate standard of care.

WHY SHOULD ALL DENTISTS (NON-ORTHODONTISTS) BE CONCERNED ABOUT TELEDENTISTRY WITHOUT REGULATION?

Ten years ago it would have been hard to imagine that patients would be able to take their own impression or scan their teeth without being in a dental office and three weeks later begin orthodontic treatment, never having seen a dentist or orthodontist in person. What is the future of this process? Does anyone think that this will stop at aligners? What will this evolve into?

We are seeing evidence that this is evolving quickly into anything that is possible. Our imagination cannot keep up with the progress. What about the patient who loses his crown and goes to a scanning area, has the tooth scanned, and then receives a new crown three weeks later, along with instructions and the necessary "glue"? This DIY scenario is already reality in other countries. Other modalities include producing partial dentures, full dentures, sleep apnea devices, retainers, and occlusal guards.

Some scanners claim that they have a caries detection feature that can find decay. Other companies are close to being able to scan your dentition with your phone or with a small inexpensive scanner. Is it possible that patients will go to a scanning area or scan their own teeth and send it to a service in lieu of a dental appointment and cleaning? Do you have any patients that would do this? Orthodontics is just the beginning. This technology will affect every aspect of our profession. Our bill is paramount in setting the precedent for maintaining the health and safety of our patients and the respect of our profession. Obviously, this is not just orthodontics, and it all starts from this moment. That is why this bill is so important to you!

IF A PATIENT FEELS THEY HAVE BEEN HARMED BY THE PRACTICE OF TELEDENTISTRY, WHAT RECOURSE DO THEY HAVE NOW?

Unfortunately, this is a nebulous area. At least one of the DTC companies requires its patients sign a binding arbitration, limiting where they can complain about their treatment. Does this mean that the patient cannot complain to the BOD? We don't know the answer to this and certainly the patients do not either. If you go to the Better Business Bureau (BBB) and look up one of these companies, you will see that they have hundreds of complaints. Also, you will note that almost all of the positive reviews for these companies are based on the initial experience.

WHAT SHOULD WE EMPHASIZE TO OUR LEGISLATORS ABOUT THE SUBJECT OF TELEDENTISTRY?

Most importantly that this is for the protection of the patients. Everything comes back to that. Under the current model, patients are at risk for health concerns.

WHAT CAN YOU DO?

We are at a major crossroads in our profession. It is up to us to protect the standard of care and proper dental treatment. And by us, I mean you! This is a call to action and you need to be part of it!

First, answer the VDA's call to action by contacting your legislators using our Action Center tool. It's so easy… simply following the steps on page 34. Get in touch! Let them know how much this bill means to you! Second, an endeavor this size requires funding. Please consider contributing to the VDA PAC www.vadental.org/vda-pac. These contributions will give the us the resources we need to make sure that our profession is protected. We have already put tremendous time and financial resources into making this happen, but we cannot do it alone. We need you!

Now is the time to act! 10 minutes could change the future of dentistry. Your patients need you! Your profession needs you! YOU need you!

The VDA continues to lead the way in advancing and protecting the profession of dentistry. There is no Association in the Commonwealth that is counted on to speak with one voice for its profession and its members, like the VDA. The VDA continues to be the premiere and trusted voice for all things related to the overall oral health and practice of dentistry in Virginia.

That voice needs to be heard now as the VDA advances our agenda in the 2020 Virginia General Assembly. The VDA has introduced comprehensive legislation (HB165/SB122) to define teledentistry, thus creating the clear nexus and direct oversight with the Virginia Board of Dentistry. Our common-sense legislation is designed to ensure patient protections and to require equal application of the practice of dentistry. The legislation will establish requirements and guidelines to ensure a dentist-patient relationship is formed and valued.

As the advances in technology continue to impact every part of our lives, dentistry must balance - being proactive and ensuring that technology is embraced, while safeguarding the profession's top priority: healthy outcomes for patients. Take the VDA's call to action! **See page 34** of the *Virginia Dental Journal* to learn how easy it is to make an impact.

N.E. Anderthal

WE MADE IT EASY FOR YOU

TAKE THESE STEPS TO MAKE AN IMPACT FOR OUR **TELEDENTISTRY LEGISLATION**

STEP 1 - LOCATE OUR ACTION CENTER

There are two ways to easily locate our action center.

- Go to www.vadental.org and click on "teledentistry legislation" on the homepage.
- TEXT "vadental" (that's the text of the message you're sending) to 52886 (use that number as you would a phone number). You'll receive a text in return that will provide a link directly to our action center item for our teledentistry legislation.

STEP 2 - CHOOSE AN OPTION TO CONNECT WITH YOUR REPRESENTATIVES

PHONE - Click the phone icon at the top of the page. Our action center will ask you to enter your address and phone number to locate your representative and begin the call. Enter that information then click "Find Legislator". Next you will be able to read our talking points. After reviewing those, click the button at the bottom of the page that says "Call Me". The system will call you at the number you provided. Listen to the prompts to be connected to your representative.

EMAIL - Click the email icon at the top of the page. Our action center will ask you to enter your contact information to locate your representative. Enter that information, then scroll down to the email text template. You can change any of the wording in this email. Once you have the text the way you want it, click "Send Email".

TWITTER - Click the Twitter icon at the top of the page. Our action center will ask you to enter your contact information to locate your representative. Enter that information, then click "Find Legislator". The next page will give you a tweet template (if you representative has a Twitter account). You can change any of the wording in this tweet. Once you have the text the way you want it, click "Post Tweets".

STEP 3 - SELECT TO SEND A SECOND OR THIRD MESSAGE USING ANOTHER OF OUR ACTION CENTER METHODS (PHONE, EMAIL, TWITTER)

GIVE YOURSELF A PAT ON THE BACK!

YOU'RE MAKING AN IMPACT FOR THE FUTURE OF YOUR PROFESSION.

N.E. Anderthal

January 1, 2020

I'm making an impact in 2020. Are you? BTW, how awesome are smartphones!?

THANKS VDA...

VDA

Thanks for taking action and supporting the VDA's Teledentistry Legislation.

FOR MAKING IT SIMPLE!

Virginia Dental Association

MANAGING MOLAR-INCISOR HYPO-MINERALIZATION: A SYSTEMATIC REVIEW

Molar incisor hypomineralization (MIH) is a common developmental condition often seen by pediatric and general dentists in clinical practice. Clinical management and treatment of patients presenting with MIH proves to be one of the toughest challenges practitioners face. Due to the extensive variability in clinical presentation and severity of MIH, a wide variety of treatment options exist. Treatment modalities range from prevention, remineralization, and restoration with the most severe cases requiring extraction of affected teeth with or without subsequent orthodontic intervention. Decisions regarding appropriate treatment must be made on an individual basis, taking into consideration MIH severity, symptoms, age of the patient, and patient/parental expectations. In addition, suitability of the varying treatment options in regards to treatment success, survival, subjective evaluation, and cost-effectiveness is needed to make the most comprehensive clinical assessment.

Numerous studies have been conducted reporting on available treatment options; however, none have been performed systematically. The aim of this systematic review was to determine which treatment modalities have been evaluated by clinical studies and how these particular treatments performed in children diagnosed with MIH.

A literature search of electronic databases (PubMed, Embase, Cochrane CENTRAL, Google Scholar) along with hand searches and cross referencing was conducted to identify clinical trials reporting on various MIH treatment options that had taken place from January 1, 1980 to May 1, 2016. Only clinical trials conducted on humans with ≥ 1 MIH molar/incisor were included. Sample-size-weighted annual failure rates were estimated where necessary, and the risk of bias assessed using the Newcastle-Ottawa scale.

The initial literature search identified 2420 studies. Titles of the identified studies were then screened independently by two authors. After comparison and discussion of their findings, 64 full text articles were evaluated for eligibility of which 14 (mainly observational) were included for the study. Of the 14 included clinical trials, 10 investigated various treatment options for MIH affected molars. A total of 381 participants (720 molars) were treated with a mean follow-up of 3.6 years. The remaining 4 studies investigated various treatment options for MIH affected incisors. A total of 139 participants (274 incisors) were treated with a mean follow-up of 0.5 years.

Successful treatment for MIH molars included remineralization therapies, restorative approaches, and extractions. Effective remineralization and desensitization therapies of MIH affected molars was shown in one study through the improvement of molar surface morphology following the use of casein phosphopeptide-amorphous calcium phosphate (CPP-APP). Mean annual failure rates were used to determine the success of the various restorative approaches. Fissure sealants and glass ionomer restorations were shown to have the highest mean annual failure rates, while indirect restorations, preformed metal crowns, and composite restorations were shown to have the lowest. Extraction of MIH affected molars and subsequent spontaneous alignment of the second molars in children (mean age 8.2 years) was evaluated in one study. This study found spontaneous alignment of second molars was more frequent in the maxilla compared to the mandible.

Success of treatment for hypersensitivity and improvement of esthetics were investigated for MIH affected incisors. One study found improvement of hypersensitivity following the use of a desensitizing agent on MIH affected incisors. The use of micro-abrasion and composite veneers were found in two studies to improve aesthetics for MIH affected incisors.

In terms of bias of the 14 included studies, 4 showed high risk for bias, 6 showed moderate risk, and 4 showed low risk. Taking into account the moderate to high risk bias of these studies, in less severe cases of molar MIH and/or hypersensitivity associated with molar MIH remineralization or sealants may be suitable treatment options. In more severe cases of MIH, molars treated with composites or indirect restorations or preformed metal crowns should be considered. Extraction of MIH affected molars should only be considered as a last resort, and should take into account an individual's age, malocclusion, and condition of neighboring teeth. Due to the limited amount of studies included in this review on treatment modalities for MIH affected incisors, the ability to provide a definitive treatment regimen is not possible.

Reference: Elhennawy K, Schwendicke F. Managing Molar-Incisor Hypomineralization: A systematic review. J Dent. 2016; 55:16-24

Submitted by: Courtney Tremmel Brashier, DDS; Resident in Pediatric Dentistry, Virginia Commonwealth University

MANAGEMENT OF CHILDREN WITH AUTISM SPECTRUM DISORDER IN THE DENTAL SETTING: CONCERNS, BEHAVIORAL APPROACHES AND RECOMMENDATIONS

Everyone can relate to being in a dental chair, hearing the whistle of the drill, the overhead light shining in our eyes, and the strong (usually unpleasant) tastes of the various medicaments. Now imagine feeling the drill vibrating at its most extreme level; the light beaming like brights on a new car; and the smells and tastes feeling so extreme as they pass through your nose and mouth that you feel your nostrils burn and your taste-buds sizzle. Furthermore, imagine that you cannot communicate these intense sensations to anyone in the room. This scenario is a reality for many patients with autism.

Autism spectrum disorder (ASD) pertains to a group of neurodevelopmental disabilities with a set of defining criteria that relate to impaired communication skills and social interaction, and restricted or repetitive behaviors. Additionally, many patients with autism have sensory impairments, intellectual disabilities and epilepsy. Sometimes a complete lack of linguistic development is present.

When peering inside the patient's mouth, the dentist often will find poor oral hygiene, an anterior open bite, class II malocclusion, reverse overjet, and signs of bruxism, tongue thrusting and lip biting. These patients typically have a preference for sweetened and soft foods and tend to retain food in their mouth for long periods of time, both of which can increase the rate of dental decay.

If a dentist can understand what these patients are experiencing at a given dental visit, they may more effectively treat and communicate with them. These patients often lack curiosity for the world around them and furthermore, they are often unable to use spoken language, gestures or eye contact. Additionally, these patients exhibit impaired sensory perception and they may have aberrant responses to visual, auditory, tactile, olfactory and gustatory signals.

Whether it be due to behavioral management challenges or a lack of comfort in treating the unique dentition and complications associated with a medical condition, more than 60 percent of general dentists do not feel prepared to treat the subgroup of patients with special needs and intellectual disability. Further complicating the issue, the majority of special needs patients have an aversion to dental treatment.

Behavior management techniques that can prove effective for autistic patients include tell-show-do, using short and clear commands, verbal reinforcement and recommending parental presence in the operatory. In addition, patients with autism are often receptive to visual pedagogy, a technique in which custom-made photo books are used to teach patients about dental instruments and skills required for the dental examination. Often, photographic step-by-step explanations help to enhance their understanding of oral hygiene.

The dentist should keep in mind that patients with autism often have extreme sensitivity to the sensory environment, particularly, lights, sounds and touch. The patients may prefer toothbrushes with different textures, various toothpastes, or even a washcloth to introduce tooth-cleansing. As such, protective stabilization and nitrous-oxide inhalation are less popular with these patients. They may also prefer to wear noise-cancelling headphones or other similar devices to help distract themselves.

An interdisciplinary approach to patients with special needs, and in particular autism, can prove very beneficial for both the patient and the dentist. The dentist should seek to understand the patient by clear and open communication with not only the patient, but also the patient's parents and physician, keeping in mind the various aforementioned behavioral techniques. With this approach, along with a sense of patience and understanding, hopefully more general dentists will become more comfortable treating patient with autism.

Reference: Delli K, Reichart PA, Bornstein MM, Livas C. Management of children with autism spectrum disorder in the dental setting: Concerns, behavioral approaches and recommendations. Med Oral Patol Oral Cir Bucal. 2013; 18(6): e862-8

Submitted by: Jennifer Waters, DMD; Resident in Pediatric Dentistry, Virginia Commonwealth University

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PREDICTING SUCCESSFUL DENTAL EXAMINATIONS FOR CHILDREN WITH AUTISM SPECTRUM DISORDER IN THE CONTEXT OF A DENTAL DESENSITIZATION PROGRAM

Autism Spectrum Disorder (ASD) occurs in 1:68 children and is one of the most common developmental disorders worldwide. Although most children diagnosed with ASD have visited a dentist, the prevalence of unmet dental needs in this population is about 12-15%. The impairment in communication and sensory modulation in children with ASD decrease the effectiveness of basic behavior guidance techniques. The goal of this study was to evaluate the effectiveness of a dental desensitization program for children with ASD. This retrospective cohort study examined 168 patients with ASD that participated in a dental desensitization program at the Center for Pediatric Dentistry at the University of Washington. Researchers used extensive chart review to quantify a child's ability to sit for a minimal threshold exam (MTE) – an exam with an intraoral mirror while seated in a dental chair – which was used as the standardized exam procedure throughout the study. The researchers also examined the number of appointments required to achieve MTE. The study found that within 1-2 visits, 77% of patients were able to receive an MTE. 87% of patients received an MTE by the fifth visit. When the statistics were analyzed using mild, moderate, and severe ASD severity, a statistically significant difference was found in ability to receive an MTE in patients diagnosed with moderate vs. patients diagnosed with severe autism. Other significant factors included the ability to be involved in group activities, verbal communication, understanding of language, and ability to perform self-care. Through participation in a dental desensitization program, most children in this study were able to complete an MTE. This study emphasizes that many children with ASD may benefit from desensitization prior to dental visits. Specifically, children with increased social engagement and ability to perform self-care are great candidates for desensitization therapy. This therapy is an effective way to teach children with ASD to not only receive a dental exam but learn dental skills such as brushing at home. This may also allow patients the opportunity to accept radiographs, more in depth preventive care, and potentially simple restorative procedures at subsequent appointments.

Reference: Nelson T, Chim A, Sheller BL, McKinney CM, Scott JM. Predicting successful dental examinations for children with Autism Spectrum Disorder in the context of a dental desensitization program. J Am Dent Assoc. 2017; 148(7): 485-492.

Submitted by: Dr. Elizabeth Hering; Resident in Pediatric Dentistry, Virginia Commonwealth University

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► FROM PAGE 15

academic backgrounds and personal experience with chemical dependency and/or substance abuse in their family. In other words, each component representative has useful insight to assist the dental professional in need.

Another unfortunate misconception of our Committee is the belief that we can shield an individual from any legal or Dental Board action. Though we offer advocacy in Dental Board hearings, or legal proceedings, the assistance of the Caring Dentist Committee cannot prevent or erase any decision made by the Board of Dentistry, or legal sentence imposed by the State or Federal Court Systems. We can strive to bring awareness to the dental community before an individual has sustained any permanent consequences, and direct the individual to professional treatment programs, avoiding altogether loss of their career, relationships, or their life.

Addiction, alcoholism, and other mental illnesses can be treated, and those who are afflicted need no longer feel like they are labeled as outcasts. They deserve to live a life free of this disease. Please make no mistake, this is a disease, and not a defect of character or personal weakness. Though it was a frightening time in my life, the revelation that I had this disease was a first step in my recovery, and overall a liberating experience.

In upcoming issues of the *Journal*, I look forward to contributing useful information so that you, or anyone you might know in the dental community who is in need of help, may benefit from the services of our Committee. Meanwhile, if you have any further questions about the Caring Dentist Committee, please feel free to call me directly at 804-221-3228, or my e-mail at drbruceoverton@comcast.net.

EFFICACY OF RESIN INFILTRATION OF PROXIMAL CARIES IN PRIMARY MOLARS: 1-YEAR FOLLOW UP OF A SPLIT-MOUTH RANDOMIZED CONTROL CLINICAL TRIAL

Non-cavitated caries account for a large portion of carious lesions in children. Current evidence supports the use of conservative treatment for non-cavitated lesions, as the placement of traditional restorative materials leads to the removal of sound tooth structure. Literature currently supports non- invasive strategies which are primarily aimed at arresting lesions through the use of fluoride treatments, plaque control and use of pit and fissure sealants. This randomized control trial seeks to evaluate the effectiveness of caries infiltration as an alternative technique of conservative caries control.

In a split mouth design, 50 healthy patients aged 5-9 years old presenting with at least two pairs of adjacent primary molars with proximal carious lesions sized E2(radiolucency confined to the inner half of enamel) to D1(radiolucency on the outer third of the dentin) were selected and treatment randomly assigned. Study participants and their parents were instructed to floss once per day and brush twice daily with fluoridated toothpaste. Treatment of the test lesions was completed by a single trained investigator with Icon® caries infiltrant (DMG America, Ridgefield Park, NJ). For the application of the infiltrant, isolation was achieved with rubber dam, surface was prepared using 15% HCl gel etch for 120s. Lesion was then washed with water spray for 30 sec., and 100% ethanol applied and dried for 30sec. Infitrant was then applied using the Icon Kit interproximal applicator tool for 180 sec. Excess material removed through flossing and air drying. Infitrant was then cured for 40sec and a second application of Icon infiltrant was applied for 60 sec. Infiltrant was then cured again for 40 sec. Excess infiltrant was then polished and rubber dam was removed.

This study was structured so that patients were evaluated at 6 month and 1 year follow ups. Digital bitewing radiographs were taken at baseline and again at the 1 year follow up. The goal of this study was primarily to evaluate the progression of test and control lesions and secondarily to evaluate both the mean time for treatment and the anxiety level induced by treatment in patients.

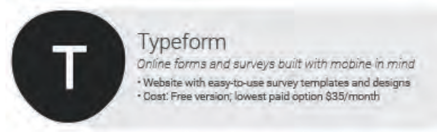
The results revealed 11% of test lesions and 33.3% of control lesions progressed at reevaluation at the 12 month follow up. It was concluded, the therapeutic effect after 1 year was 21.4% and the relative risk reduction with treatment was 64.3 %. Five control and three test lesions progressed to the middle 1/3 of dentin and were restored. No side effects were observed in subjects. Additionally, it was noted that anxiety levels of the treatment were low and mean time of treatment was 11.29min (+/- 1.16 mins).

In conclusion, this study shows that caries infiltration of proximal carious lesions in primary molars is significantly more effective in stopping the progression of caries than current standard therapy (fluoride tooth paste and brushing alone). As a result, this study presents caries infiltration as an alternative conservative, micro-invasive technique for caries control in children.

Reference: Ammari MM, Jorge RC, Souza IPR, Soviero VM. Efficacy of resin infiltration of proximal caries in primary molars: 1-year follow up of a split-mouth randomized control clinical trial. Clin Oral Investig. 2018; 22(3): 1355-1362.

Submitted by: Kathryn Skarda, DDS; Resident in Pediatric Dentistry, Virginia Commonwealth University

► FROM PAGE 13



TYPEFORM

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Editor's Note: Kelsey Leavey is a public relations and social media specialist formerly at The Hodges Partnership, a strategic communications firm based in Richmond that excels in public relations, content management and social media. Hodges works with clients to tell their stories through traditional and digital media. They can be contacted at info@hodgespart.com.

EVIDENCE-BASED DENTISTRY ON LASER PAEDIATRIC DENTISTRY: REVIEW AND OUTLOOK

This article summarized the available literature and clinical applications of the uses of laser in pediatric dentistry. Areas of literature included articles of laser utilization on soft and hard tissue. It also reviews some of the controversies surrounding the use of different types of laser energies to allow the reader to be aware of problem areas, and areas where further research is needed.

One of the clinical applications in oral surgery is precise cutting of soft tissue, tissue ablation and decontamination, which allow for better healing, bleeding control and hemostasis, hence, less use of local anesthetics. When used in conjunction with air-water jet, the erbium laser decreases temperature on operation site, providing an area with less tissue necrosis and therefore more accurate soft tissue biopsies. Patients also prefer the laser route due to reduced post-operative discomfort and less use of pain medications. Ease of handling of equipment allows periodontists and orthodontists to utilize laser in performing gingivectomies, gingivoplasties and operculectomies without need for local anesthesia. Moreover, laser is commonly used in maxillary and mandibular frenectomies such as in releasing ankyloglossia in a newborn, with significant reports of reduced post-operative discomfort and complications. The chief concern in pediatric patients is to use the least applicable laser energy.

Argon laser and CO_2 laser as well as erbium laser and other laser combinations in conjunction with acid treatment of enamel surfaces were studied in terms of caries prevention and reduction of white spot enamel lesions and increased acid resistance of enamel layer, however, literature shows conflicting results in clinical significance. In contrast, many articles seem to focus on Fluorescence light at 655nm (LF) in caries detections, especially in primary dentition, showing promising results with high specificity, sensitivity and reproducibility. Currently, it can be used as an adjunct tool to visual examination and bitewing radiographs, with some studies even showing superiority of LF in caries diagnosis. Erbium laser (Er:YAG and Er:YSGG) radiation has been used to pretreat enamel surfaces prior to sealing pits and fissures, yet results showed poor seal and increased microleakage or clinical insignificance; it also did not eliminate the need for acid etching prior to seal. Currently, in pediatric dentistry, cavity preparation and caries removal in primary teeth, mainly using erbium laser, is an area of interest as in theory it seems optimal due to association with less intra-operative discomfort (eliminating vibrations, noise, and reducing pain). Using laser dentistry shows good results in minimally-invasive cavity preparations but a main disadvantage is longer working time to achieve caries excavation in comparison with other methods. On the other hand, a debate concerning bonding strength to laser-treated hard tissue, yielded inconsistent results with a general recommendation to acid-etch tooth surfaces after laser therapy to produce better composite bond to tooth surfaces. Some of the factors that influenced the strength of bond were laser output energy and fluence, output angulation and air-water jet as well as mode of focus. Endodontically, a limited number of studies discussed laser therapy in pediatric dentistry, while literature relating to adult endodontics achieved good outcomes in decontamination and providing a superficial layer of pulpal coagulation allowing high success rates in pulp capping. Similarly, only a few studies were found discussing pulpotomies in primary dentition, with most focusing on vigilance when applying laser energy in root canal systems and keeping in mind difference in shape of apices. In comparison, eodymium (Nd:YAG) laser system has been documented to be successful in decontaminating root and lateral canals in permanent dentition.

Few studies investigated the utilization of laser in trauma but in theory, laser therapy can be used on oral soft and hard tissue to decontaminate tooth surfaces and root canals, direct and indirect pulp capping, as well as, sealing dentinal tubules and providing less post-operative sensitivity. In addition, laser can be used in managing periodontal and soft tissue defects following a trauma while achieving tissue decontamination, hemostasis and reduced pain perception. A new emerging area of interest in research is Lower Level Laser Therapy (LLLT), which is a helium-neon laser. For example, some orthodontists use LLLT to attain rapid orthodontic movement in stimulating local inflammatory modulation, while others have used it to reduce pain perception in patients.

Reference: Olivi G, Genovese MD, Caprioglio C. Evidence-based dentistry on laser paediatric dentistry: review and outlook. Eur J Paediatr Dent. 2009; 10(1):29-40.

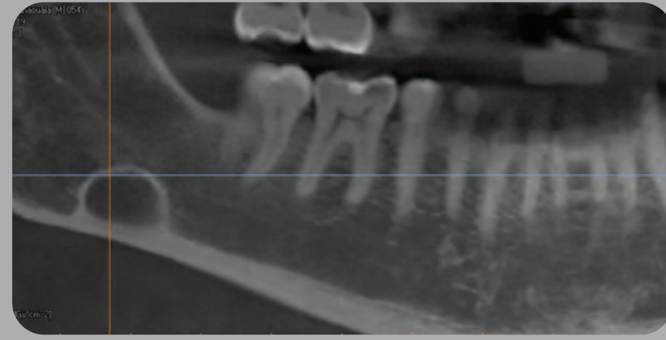
Submitted by: Dr. Taibah AlBaker; Resident in Pediatric Dentistry, Virginia Commonwealth University

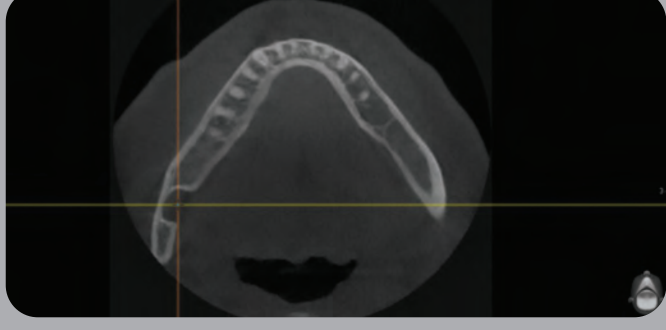
PATHOLOGY PUZZLER

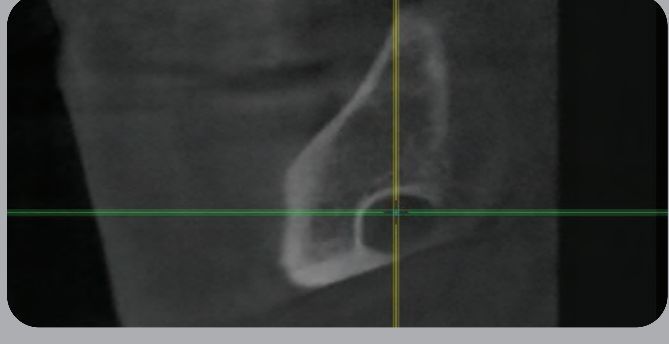
DR. JOHN SVIRSKY

INSTRUCTIONS: *What is your clinical impression of each of the following cases?* *Answers are revealed on page 55.*

▶ CASE ONE

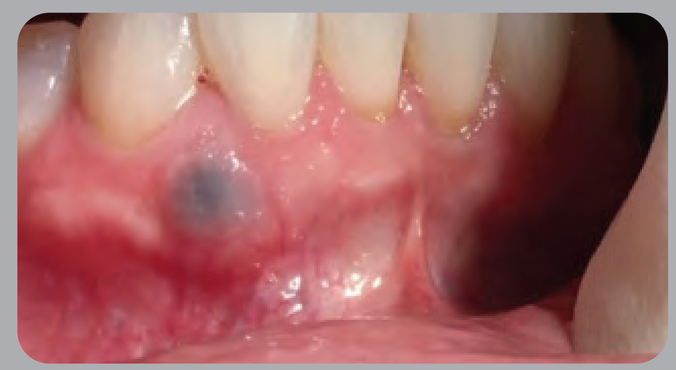


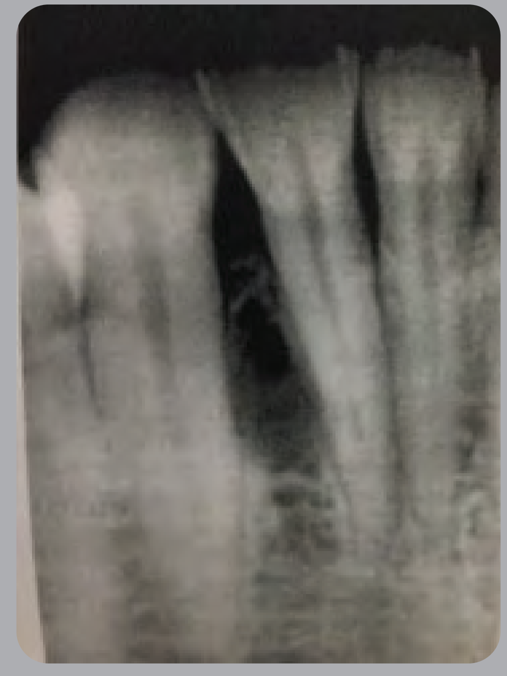




Incidental findings in a 54-year-old male

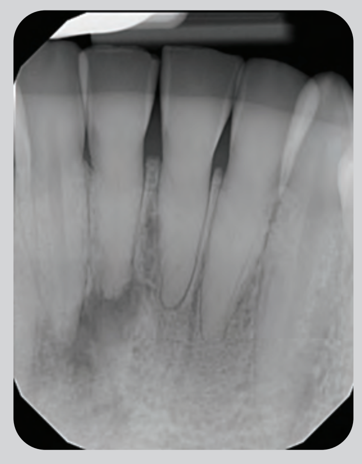
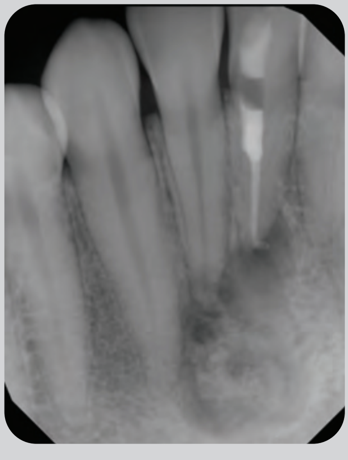
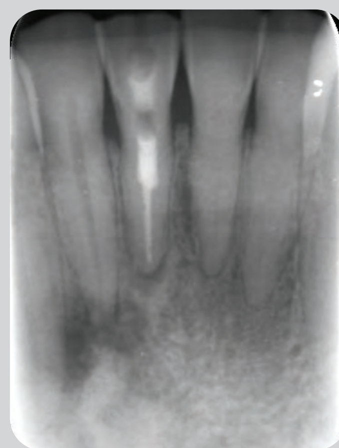
▶ CASE TWO





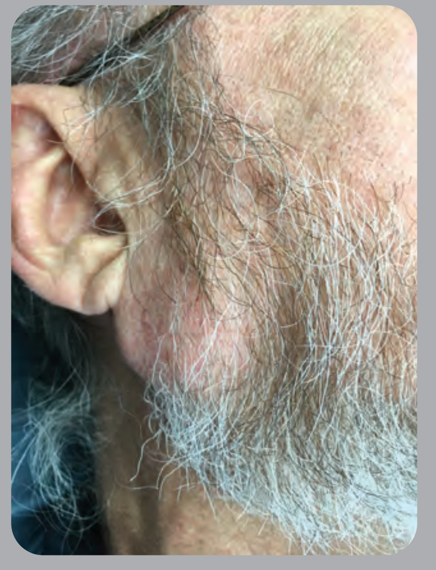
An asymptomatic lesion found in a 48-year-old Caucasian female.

▶ CASE THREE

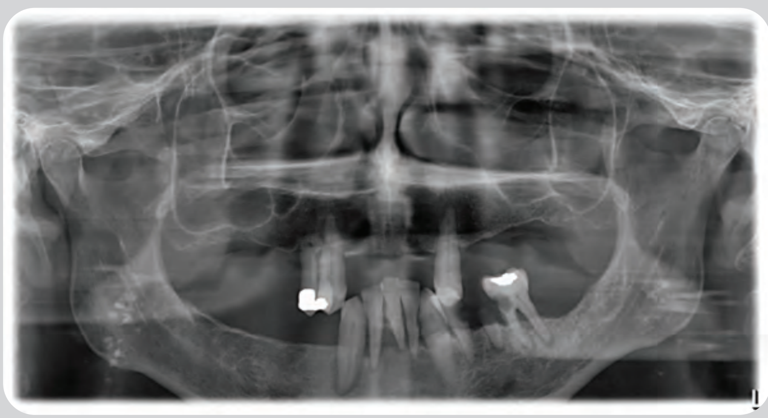
I am not sure of the history but hopefully the endo treated tooth number 25 in this 45-year-old African-American male was symptomatic. What condition do the radiographic findings suggest

▶ CASE FOUR



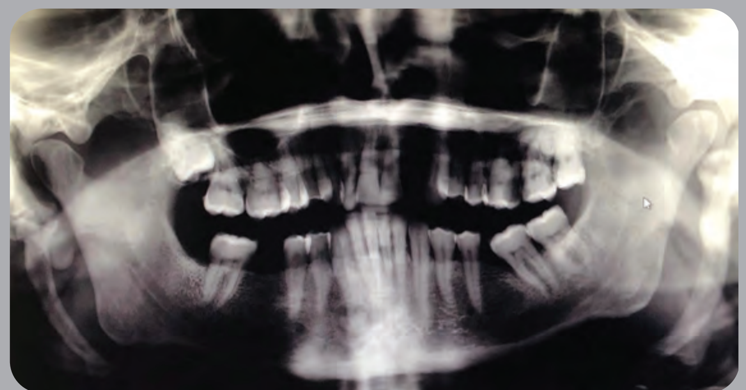
Incidental finding of the right parotid gland below the ear in a 73-year-old Caucasian male that had been slowly increasing in size. The lesion was firm to palpation.

▶ CASE FIVE



Incidental finding on a panoramic radiograph in a 70-year-old African-American male.

▶ CASE SIX



Surprisingly asymptomatic lesions found on panoramic radiograph. There are two separate entities.

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PATHOLOGY PUZZLER ANSWERS:

► CASE ONE

This is an excellent example of a lingual mandibular salivary gland defect/Stafne bone cyst/defect. It is found in .08% to .48% of panoramic radiographs with a striking male predilection (80-90%). Most cases represent a focal concavity of cortical bone on the lingual aspect of the mandible. Treatment is not indicated. However biopsied lesions represent salivary gland tissue. If diagnosis is in question, CT imaging studies can confirm the cupped out nature of the defect.

► CASE TWO

The clinical appearance suggests a gingival cyst with its blueish appearance and mandibular bicuspid location. However, the radiographic appearance is that of a lateral periodontal cyst. In most probability it is a lateral periodontal cyst that involved both soft tissue and bone. These lesions rarely occur in individuals younger than 30.

► CASE THREE

The radiographic findings are suggestive of periapical cemento-osseous dysplasia. In this case if tooth number 25 was not symptomatic, no treatment was indicated. These lesions are most commonly found in the mandibular incisor area and are not symptomatic. The lesions vary from radiolucent to radiopaque and early lesions are typically radiolucent and can be confused with a periapical pathosis. However, the lack of symptoms and clinical appearance are enough for a diagnosis. There is a marked female predilection (90%) and 70% affect blacks. Lesions are typically diagnosed between 30 and 50 years and rare before 20.

► CASE FOUR

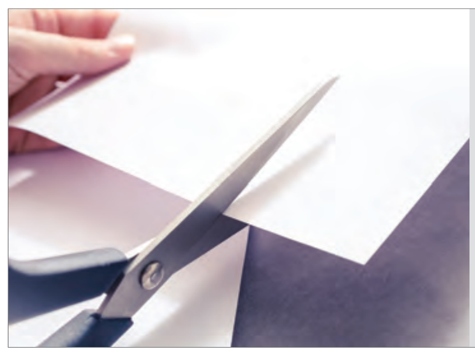
This lesion is most likely a benign salivary gland tumor. In this location the most common salivary gland tumor is the pleomorphic adenoma, which accounts for almost 75% of parotid tumors. The second most common benign salivary gland tumor is the Warthin tumor which accounts for approximately 10% of tumors and associated with a male predilection (90%) and smoking.

► CASE FIVE

These are most likely tonsilloliths. They are seen at the angle of the mandible on both sides. There is also quite advanced periodontal disease in the remaining teeth.

► CASE SIX

The stylohyoid ligaments are markedly calcified. Surprisingly, the patient was asymptomatic. If the patient had pain on swallowing or turning her head, I would have diagnosed Eagle syndrome. There is also an odontoma/supernumerary tooth in the apical area of tooth 27 but not associated with the tooth.



CORRECTION: If you're an avid Pathology Puzzler reader, you might have noticed that cases five and six are repeated from the October 2019 issue. We got crop-happy and cropped off too much of the radiographs for these cases. Our online issue has been corrected but we wanted to reprint these in this issue to be sure everyone sees them. Thanks to our readers for getting in touch with us about the error. Please feel free to contact our managing editor to discuss any aspects of the *Virginia Dental Journal*. We love hearing from you.

Managing Editor: Shannon Jacobs jacobs@vaental.org.

UTILIZATION OF DENTAL SERVICES AMONG MEDICAID ENROLLED PREGNANT WOMEN IN VIRGINIA

Shillpa Naavaal BDS, MS, MPH[1,2,*], Tegwyn Brickhouse DDS, PhD[1,2], Jonathan W. Yu[3], MA, JoAnn Wells, BSHS, RDH[4]

ABSTRACT

The study evaluated the impact of the Virginia Medicaid dental benefit on dental services utilization among pregnant women enrolled in Medicaid. Data from a total of 10,395 women who had at least one dental claim during the 2015-2017 period were included in the study. The number of dental visits and dental services utilized per person grew from an average of 2.2 visits and 7 services in 2015 to 3.1 visits and 10.5 services in 2017, respectively. In 2017, of all dental services used, 6% were for preventive services and 59% were for treatment services. Continued efforts and targeted interventions are required to improve the oral health of pregnant women enrolled in Virginia Medicaid.

INTRODUCTION

Oral Health is an integral part of prenatal health care for pregnant women (1). Poor oral health has been associated with poor quality of life (2). When left untreated, dental problems such as dental caries and its sequelae can cause pain, infections, and lead to complex and additional treatment needs (3). Furthermore, evidence suggests that gingival bleeding and periodontal disease are associated with poor pregnancy outcomes and can impact maternal as well as infant birth outcomes (4, 5). However, dental use among pregnant women is very low. Nationally, one out of two women did not have a preventive dental visit during pregnancy (6). These oral health disparities are further widened among low-income and minority women as they carry a disproportionate burden of dental disease and have limited access to dental care (7, 8). In 2011, women in the low-income group were nearly three times more likely to report a dental problem and eight times less likely to seek dental care compared to their high-income counterparts (9). According to a recent study, 33% of pregnant women in Virginia reported having no dental insurance during 2012-2014 (10). Moreover, women who were of Hispanic ethnicity had high school or less education, had no dental insurance, and those with low family income were much less likely to have a dental visit during pregnancy compared to their respective counterparts.

One of the National Performance Measures (NPM) for the Maternal and Child Health program (MCH) is to increase the number of women who had a preventive dental visit during pregnancy (NPM 13.1) (11). At least 18 states including Virginia have selected this measure as their programmatic priority. To support this national measure and improve the oral health of women and their children, professional organizations such as the American College of Obstetricians and Gynecologists (ACOG) and the American Dental Association have developed recommendations for oral health care during pregnancy (12, 13). However, despite available recommendations and guidance, oral health care often goes unattended during pregnancy and disparities remain (10, 14).

To address the health inequalities and improve the oral health of pregnant women in Virginia, Governor McAuliffe, under the 'Healthy Virginia plan', directed the Department of Medical Assistance Services (DMAS) in September 2014, to issue emergency regulations to provide comprehensive dental coverage to all pregnant women age 21 and older who

Characteristics	Count (%)
Total	**10,395 (100%)**
Fiscal Year	
2015	1,133 (10.9 %)
2016	3,954 (38.0 %)
2017	5,308 (51.1 %)
Age	
21 – 29 years	6851 (65.9%)
30 – 39 years	3321 (32.0%)
40 – 49 years	221 (2.1%)
50 years and above	2 (0.02%)
Race	
White	5,824 (56.0%)
Black	3,841 (37.0 %)
Hispanic	46 (0.4 %)
Other	684 (6.6%)
Citizenship	
US citizen	8,847 (85.1 %)
Non-US citizen	1,548 (14.9 %)
SES Index	
Lowest	1,949 (18.8 %)
Second	1,866 (18.0 %)
Third	2,421 (23.3 %)
Highest	4,159 (40.0 %)
DMAS Region	
Central Virginia	2,795 (26.9 %)
Winchester/Northern Virginia	2,744 (26.4 %)
Tidewater	2,314 (22.3 %)
Far Southwest	667 (6.4 %)
Halifax/Lynchburg	372 (3.6 %)
Roanoke/Alleghany	881 (8.5 %)
Charlottesville	622 (6.0 %)
Number of Months Enrolled	
>1 and <=3 months	1,018 (9.8 %)
<=12 month	5,931 (57.1 %)
12+ months	3,446 (33.2 %)

Table 1. Characteristics for women who had at least one dental service claim and were enrolled for more than one month

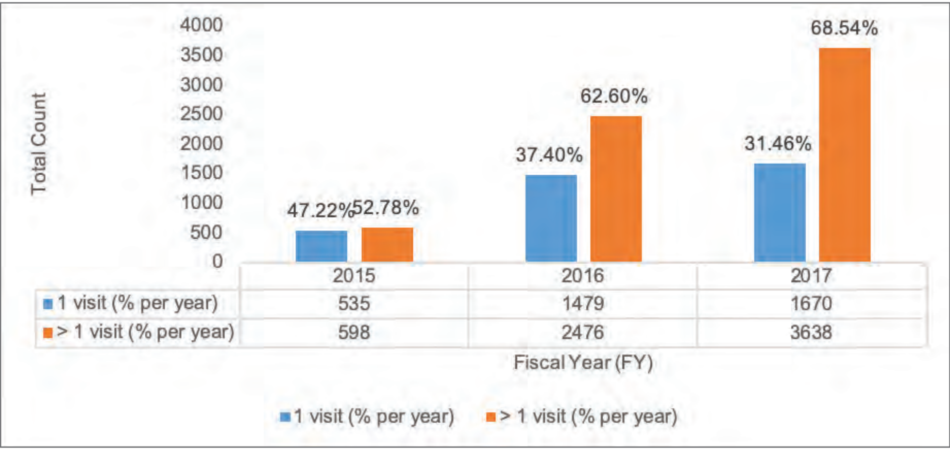


Figure 1. Proportion and number of women who had 1 or more than 1 dental visit by year

were eligible for Medicaid and Family Access to Medical Insurance Security (FAMIS) (15). This newly implemented Medicaid dental benefit for pregnant women went into action on March 1,2015, covered comprehensive dental services, including diagnostic, preventive, restorative, and operative procedures. In the same year, the Virginia Department of Health (VDH), Dental Health program (DHP) received Perinatal and Infant Oral Health Quality Improvement Expansion grant funding from the Health Resources and Services Administration (HRSA) and started developing several initiatives to advance oral health among Virginia women and infants. VDH DHP collaborated with several key partners in the state including the VCU School of Dentistry. One of the objectives of the VDH and VCU collaboration was to conduct research to increase VDH's data evaluation capacity. This study was one of many that were undertaken to understand the impact of the new dental benefit policy on oral health utilization among Medicaid enrolled pregnant women.

Using Virginia Medicaid claims data, the primary aim of this descriptive study was to examine the use of dental benefits among Medicaid-enrolled pregnant women during the early implementation period (2015-2017). Additionally, the study also estimated the average number of dental visits and dental services and examined the type of dental services used by pregnant women.

METHODS

The 2015-2017 Medicaid claims data from the Virginia Department of Medical Assistance Services (DMAS) was obtained. Data sharing agreements were completed and the project was approved by the IRB as exempt. The data from eligibility and claims files were merged and grouped by fiscal year (FY) to compare the utilization of dental care by year (for example, July 1, 2015 – June 30, 2016 is FY 2016). Since the dental benefit was implemented in March 2015, the data for the FY 2015 only included claims between March 1-June 30, 2015.

For the final data set, pregnant women who were enrolled for less than 30 days were excluded (N=1,199). Sample characteristics were summarized by race/ethnicity, age, socio-economic status (SES) index. The SES index was created for each participant's (woman's) geographic locality using the Area Health Resource Files (AHRF) with the 4th quartile having the highest SES (16). Additional variables included citizenship status, region as designated by DMAS, and number of months enrolled. Each dental service represents a separate claim in the data. Total number of unduplicated service claims was counted for each year. Type of services was categorized into three groups: diagnostic (included all codes between D0100-D0999), preventive (codes between D1000-D1999), and treatment (codes between D2000-D9999) (17). Average per person number of visits, services, cost per visit, and type of services received was examined by year. Descriptive analysis was conducted, and associations were tested by chi-squared tests and t-test depending on the type of data. P values<0.05 were considered statistically significant unless specified otherwise.

RESULTS

A total of 10,395 women who had at least one dental service during 2015-2017 time-period were included in the study. A total of 1,133 women used dental services in 2015, 3,954 in 2016, and 5,308 in 2017. Three-year data was aggregated to examine the sociodemographic characteristics of the study population. The majority of women who had dental visits were between 21-29 years of age (65.9%), White (56%) and had US citizenship (85.1%). Only 0.5% of all women were Hispanic. When categorized by SES index, 40% of women were from the highest SES index, and 18.8% were from the lowest. Geographic location showed wide variation with more than 75% of women who used dental services were from Central Virginia, Winchester/Northern Virginia, and the Tidewater region; the remaining four regions constituted less than 25% of the women (Table 1).

The number of women who had more than one visit also grew during the study period from 52.8% in 2015 to 68.5% in 2017 (Figure 1).

The number of dental visits increased from an average of 2.2 visits per person in 2015 to 3.1 visits in 2017, and dental services increased from 7 services per patient to 10.5 services during the same period. The average cost per person, per visit and per service, increased significantly from 2015 to 2017. In 2017, the average cost per patient was $978, per visit was $313, and per service was $93 (Table 2).

The number of dental service claims grew exponentially during the three-year period. During the partial year 2015, there were 7,922 service claims, 35,408 in 2016 and in 2017, a total of 55,814 dental service claims were made, 58% more than in the previous year (Table 3). The distribution of types of dental services was examined by each year at person level and services level. The use of all types of services

saw an increase from year to year with a substantial increase in treatment services. Only 50.4% of the women used preventive services compared to 77.5% of women who used treatment services. At the services level, in 2017, 6% of all dental services provided were preventive, 35% were diagnostic, and 59% were treatment related (Table 3).

DISCUSSION

In Virginia, the number of pregnant women who utilized dental care under the newly available Medicaid benefit increased from 2015 to 2017. The data suggests increased uptake and improved awareness of the available pregnancy dental benefit among Medicaid eligible women.

According to recent Virginia PRAMS data, dental visits among Hispanic women were much lower than non-Hispanic White and Black women (10). Our study findings suggest a similar but more extreme pattern among Medicaid enrolled women. Nearly 56% of women who utilized dental care were White, 37% were Black, and only 0.4% were Hispanic. According to 2014-2016 data, Hispanic women made up 10.6% of the total female population between the ages of 15-44 years in Virginia, and of all live births in Virginia, 13.5% were Hispanic (18). Our results suggest wide differences in the use of dental benefit by race/ ethnicity groups and emphasize the need for increasing awareness among these subgroups. One of the reasons for the low use of dental care among Hispanic women may be misconceptions about the use of dental care during pregnancy. A study among pregnant women found that Hispanic women had significantly lower oral health knowledge and belief score compared to White or African American women (19). Additionally, barriers such as transportation, provider and appointment availability, cultural beliefs, or difficulty navigating the healthcare system can impact the use of dental care (8, 20). Since low-income minority populations are at high risk of dental problems and poor maternal and birth outcomes (20), it is crucial to understand the differences in the use of care by various groups and develop targeted interventions to improve dental care utilization among them.

The average number of visits and the number of dental services per person who utilized Medicaid dental benefit increased in 2017 compared to 2016, suggesting that access to and use of dental care improved. A recent DMAS report showed an increase in the number of inquiries by both members and providers regarding the pregnancy dental benefit program (CHIPAC dashboard), which suggest improved awareness of the dental benefit. Another reason could be early use of and awareness of the dental benefit by pregnant women during the eligibility period compared to previous years providing them more time for scheduling visits and getting dental services. However, we did not have information on the delivery date to determine the timing of first dental visit in relation to the dental benefit eligibility period to test the early use and awareness hypothesis. Other reasons could be that due to better awareness of the benefit among providers, dental providers were able to accommodate more patients in their schedule, and medical providers referred more Medicaid enrolled pregnant women who previously did not have dental coverage. This data, however, did not have information on provider awareness of the benefit by year.

The percentage of treatment services and diagnostic services during all three years were much higher compared to preventive visits suggesting that there was a high demand for treatment services in this group. Recent data suggests that nearly 20% of all pregnant women in Virginia needed to see a dentist for a dental problem (21). Furthermore, low-income women were three times more likely to report a dental problem compared to their higher income counterparts, suggesting high demand of dental treatment among low-income women (9). The results support previous findings and shows that treatment services claims increased by more than eight percentage points from 2015 to 2017. Another reason for high demand for treatment services could also be a result of no dental coverage for the adult Medicaid population suggesting significant pent-up demand in this group. Recent Virginia Medicaid expansion that went in effect on January 1, 2019 has limited dental service coverage depending on the managed care organization, but the majority of adults enrolled in Virginia Medicaid do not have dental coverage.

Good oral health during the perinatal period is essential for both maternal and infant's health and wellbeing. Routine

	Mean (SD)	P-value*
Average number of visits		<0.0001
2015	2.20 (1.7)	
2016	2.73 (2.1)	
2017	3.13 (2.4)	
Average number of dental services per person		<0.0001
2015	6.99 (7.2)	
2016	8.95 (8.5)	
2017	10.52 (9.5)	
Average cost per patient		<0.0001
2015	$564.44 ($880.4)	
2016	$781.79 ($1127.2)	
2017	$977.77 ($1336.2)	
Average cost per visit		<0.0001
2015	$256.73 ($336.3)	
2016	$286.19 ($349.3)	
2017	$312.67 ($389.5)	
Average cost per service		<0.0001
2015	$80.73 ($100.1)	
2016	$87.32 ($115.5)	
2017	$92.99 ($123.1)	

*Satterthwaite T-test between FY 2016 and FY2017

Table 2. Average per person number of visits, services and cost by fiscal year

preventive and restorative dental procedures are safe throughout pregnancy, can prevent progression of dental diseases and are supported by dental and medical organizations (9,10,18). All health professionals should educate women about safety and importance of oral health during pregnancy to improve oral health utilization among this group.

LIMITATIONS:

This was the first study to evaluate the impact of the newly implemented dental benefit on improving utilization of dental care among pregnant women. However, there are a few limitations to this study. The study used claims data and information was available only for those women who had dental claims. This limits our analysis to only a subgroup of all benefit eligible women and we do not know how these women differ from those who were eligible for the dental benefit but did not have a dental visit. To further enhance our understanding of this population's oral health needs, access and utilization of dental care, our next steps will include exploring data for all benefit-eligible women, provider characteristics, geographic differences, specific types of dental treatment services, and association of oral health visits with maternal and child health outcomes.

CONCLUSIONS:

- There was a significant increase in the number of pregnant women using dental care through the Medicaid dental benefit during 2015-2017.
- Consistently higher numbers of treatment services claims during each year suggest the high need for dental care in this group.
- Targeted interventions and outreach is needed among racial subgroups, especially Hispanic women, to understand the barriers they face in using the available Medicaid dental benefit and improve dental care access and utilization among pregnant women.

Financial disclosures: None to declare.

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3. Department of Biostatistics, Virginia Commonwealth University, Richmond Virginia
4. Dental Health Program, Virginia Department of Health, Richmond, Virginia

	Pregnant Women			P-value*	Dental Service Claims			P-value
Year	2015	2016	2017		2015	2016	2017	
Total number	1133	3954	5308		7922	35391	55814	
Type of service								
Preventive	44.6%	45.4%	50.4%	<0.0001	7.6%	6.5%	6.0%	0.014
Diagnostic	88.7%	90.3%	93.6%	<0.0001	35.9%	36.4%	35.1%	<0.0001
Treatment	69.3%	74.1%	77.5%	<0.0001	56.5%	57.1%	59.0%	<0.0001

*Proportion-test between fiscal years for each respective categories

Table 3. Distribution of types of services at the person level and the claims level

PROJECT HOMELESS CONNECT

WHAT IT IS AND WHAT IT MEANS

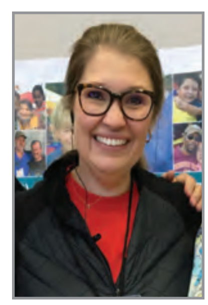
Sam Page, Project Homeless Connect Coordinator

Homeward is the planning and coordinating organization for homeless services in the greater Richmond region.

On November 12th, Homeward hosted the 13th annual Project Homeless Connect. This event is designed to match clients and volunteers in a one to one partnership and connect those clients to as many on-site vital services as possible in one day. The work is hard. We seek to break down some pretty high barriers that most of our neighbors face while experiencing homelessness. Principle of those barriers is simple access. To begin the process of taking back your power, whether that power takes the form of employment or permanent housing, you need certain pieces of the puzzle. Some things many of us may take for granted (i.e. an ID or trip to the dentist) which could mean the difference between living and merely existing to someone in crisis. This event takes those important facets and, for that day, puts them under one roof.

With the help of 40+ service providers and over 400 volunteers, we connected 502 of our neighbors to services need to potentially end their homelessness. These services included dental treatment, housing, benefits, clothing and so much more. With partners like the VDA Foundation's Mission of Mercy, Virginia Dental Association and VCU School of Dentistry and Dental Hygiene, we provided dental care to 59 individuals. That means everything from extractions to cleanings and x-rays. These services provide a clear restoration of dignity and confidence back to clients and give them space to focus on their housing and other needs. To smile and be proud of that smile is so important to the healing and affirming one's self in a time of need.

This being my first time as an event coordinator, Homeless Connect served as both a humbling experience and a call to action. As I walked through the sections, I was reminded of how we sometimes get stuck -stuck in the feeling of hopelessness and helplessness. For a long time, it felt like I wasn't doing anything. With this project, I truly felt the impact of the countless emails and meetings and phone calls. I knew the purpose of the invoices and long hours. In this role I have learned that it is possible to change the seemingly fixed course of someone's life. Even if by a small margin or for but a moment, we are called to make a change. Whether that is with a new coat, an ID or even a trip to the dentist.



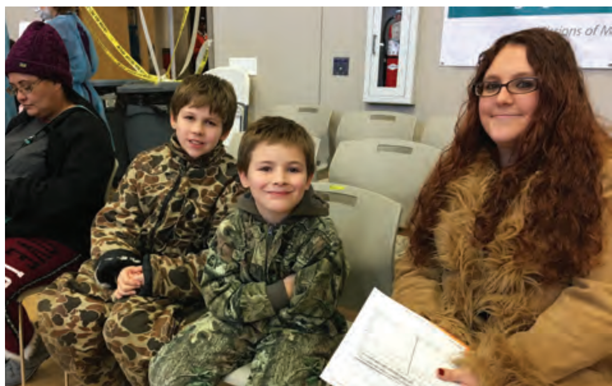
MARTINSVILLE THANKS YOU!

Dee Joyce, VDA Foundation, Community Dental Health Coordinator

As we start a new year, it is time to reflect on the previous year with thankfulness and gratitude. I am truly thankful for each of the MOM volunteers that helped out in Martinsville this year and your giving spirit. You all made this event a successful one! People began to line up early on Friday afternoon to return on Saturday for treatment. Over 200 patients received free dental services (which included exams, x-rays, cleanings, fillings, extractions and root canals) valued at over $147,000! This is phenomenal, especially for the first MOM held at this site. Our community is blown away by the MOM volunteers and what all you accomplished on Saturday.

As a Community Dental Health Coordinator (CDHC), it was my pleasure to help coordinate the Martinsville MOM and give patients the opportunity for care. When going out in the community (to the local health department, congregate meal sites for seniors, Head Start, and many other places) I would come across patients with limited access or means to dental care. To tell our community about this event, was truly a gift…faces would light up with joy because it was their chance to be seen for dental care they would otherwise be unable to access. Thank you all for making this possible!

I especially want to thank Dr. David Jones and Dr. Nicole Deshon for sponsoring the Martinsville MOM and their work in coordinating the dental triage onsite. I appreciate your support in our community!



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WELCOME NEW MEMBERS

THROUGH DECEMBER 1, 2019

Dr. Ahmad Alalwan – Norfolk – Tufts University School of Dental Medicine 2019

Dr. Gail Silveira – Virginia Beach – Virginia Commonwealth University School of Dentistry 2011

Dr. Ayman Suliman – Virginia Beach – Jacksonville University School of Orthodontics 2018

Dr. Emmanuel Amoah – Hampton – University of Connecticut School of Dental Medicine 2007

Dr. Hafiz Sharawi – Hampton – Howard University College of Dentistry 2018

Dr. David Hunt – N Chesterfield – Virginia Commonwealth University School of Dentistry 2000

Richmond DENTAL SOCIETY

Dr. Susie Goolsby – Richmond – Virginia Commonwealth University School of Dentistry 1993

Dr. Keerthi Kamreddy – Mechanicsville – Marquette University School of Dentistry 2016

Dr. Vinny Karia – Glen Allen – Virginia Commonwealth University School of Dentistry 2016

Dr. Richard Long – Mechanicsville – Howard University College of Dentistry 2018

Dr. Jennifer Matika Wood – Richmond – Virginia Commonwealth University School of Dentistry 2019

Dr. Shawn McMahon – Glen Allen – University of Minnesota School of Dentistry 2005

Piedmont DENTAL SOCIETY

Dr. Khaled AlSharif – Roanoke – University of Texas Health Science Center/San Antonio Dental School 2018

Dr. Paul Henny – Roanoke – University of Michigan School of Dentistry 1984

Dr. Jacqueline Lapin – Roanoke – Case Western Reserve University School of Dental Medicine 2007

Dr. Christian Lassen – Lynchburg – University of the Pacific Arthur A. Dugoni School of Dentistry 2011

Dr. Harry Tatoian, Jr. – Roanoke – University of Pennsylvania School of Dentistry 1972

Dr. Supneet Wadhwa – Roanoke – University of Colorado Denver School of Dental Medicine 2018

Southwest Virginia DENTAL SOCIETY

Dr. Harini Chitta – Christiansburg – Temple University the Maurice H. Kornberg School of Dentistry 2019

Dr. Andrea Hoke – Cabell – Huntington, WV - West Virginia University School of Dentistry 2016

Shenandoah Valley DENTAL ASSOCIATION

Dr. Esra Salihoglu Yener – Charlottesville – Herman Ostrow School of Dentistry of USC 2016

Northern Virginia DENTAL SOCIETY

Dr. Mielad Abady – Fairfax – Howard University College of Dentistry 2015

Dr. Neha Agarwal – Loudoun – Rutgers School of Dental Medicine 2019

Dr. Yousif Al Najafi – Fairfax – Boston University Goldman School of Dental Medicine 2019

Dr. Aws Altameemi – Woodbridge – University of California at Los Angeles School of Dentistry 2012

Dr. Nomin Aomin – Fairfax – University of Washington Medical Center Department of Dentistry 2019

Dr. Ehesar Caffroni – Fairfax – University of Florida College of Dentistry 2017

Dr. Deborah Chung – Reston – Virginia Commonwealth University School of Dentistry 2018

Dr. Kourosh Dinyarian – Falls Church – New York University College of Dentistry 2019

Dr. Salar Ebrahimi – Leesburg – Howard University College of Dentistry 2019

Dr. Ruhee Jaffer – Falls Church – University of Southern California 2019

Dr. Aya Jawad – Great Falls – University of Maryland School of Dentistry 2019

Dr. Min Sung Kang – Fairfax – Temple University The Maurice H. Kornberg School of Dentistry 2018

Dr. Mohammad Kashif – Springfield – Howard University College of Dentistry 2016

Dr. Vidur Katyal – McLean – University of Pennsylvania School of Dental Medicine 2016

Dr. Sohaib Khan – Springfield – Howard University College of Dentistry 2018

Dr. Hanwool Kim – Fairfax – Virginia Commonwealth University School of Dentistry 2018

Dr. Sammi Kim – Fairfax – Temple University The Maurice H. Kornberg School of Dentistry 2019

Dr. Peter Markov – Arlington – Case Western Reserve University School of Dental Medicine 2017

Dr. Laila Ochana – Fairfax – Marquette University School of Dentistry 2019

Dr. Ji Yon Oh – Falls Church – Howard University College of Dentistry 2016

Dr. Daniel Ribeiro – Fairfax – Columbia University College of Dental Medicine 2018

Dr. Suman Sethi – Clifton – Virginia Commonwealth University School of Dentistry 2015

Dr. Amro Shihabi – Fairfax – University of Pennsylvania School of Dental Medicine 2006

Dr. Jessica Thai – Chantilly – Virginia Commonwealth University School of Dentistry 2016

Dr. Gina Valdivieso Chiang – Gainesville – Howard University College of Dentistry 2012

IN MEMORY OF:

Name	City	Date	Age
Dr. Bernard T. Carr	Annandale	10/31/2019	86
Dr. Ann-Marie Funda	Virginia Beach	10/21/2019	71
Dr. John W. Goering	Richmond	4/27/2019	88
Dr. William T. Green	Newport News	10/17/2019	88
Dr. Arnold Hecht	Fairfax Station	12/16/2019	82
Dr. William A. McClellan	Orange	12/24/2015	90
Dr. Vernon A. Sellers	Portsmouth	10/4/2019	64
Dr. Harding L. Thomas	Culpeper	4/27/2019	98

HOUSE OF DELEGATES

ACTIONS IN BRIEF

September 29, 2019

1.	Approved:	Amend the VDA Policy Manual as follows: Miscellaneous Section (Pages 22-24). Add language to the section between smoking in public and fluoridation. The VDA seeks to educate and inform its members and the public about the many health hazards attributed to the use of traditional, and non-traditional tobacco, and other inhaled products, including but not limited to e-cigarettes, e-cigarette cartridges, snus, dissolvable tobacco, tobacco gels, and other products made or derived from tobacco. These health hazards include the inhalation of any substance that is smoked or vaporized.
2.	Approved:	The Council on Government Affairs recommends that the VDA pursue legislation to be presented to the 2020 VA General Assembly that would define teledentistry.
3.	Approved:	The Council on Government Affairs recommends that the VDA pursue legislation that would allow dentists to administer vaccines, and recommends that the already formed subcommittee begin working on specific content and language for the proposed legislation several months prior to introducing.
4.	Approved:	To approve the 2020 Budget as amended by the Board of Directors.
5.	Approved:	Resolved, that in consideration of existing policy on standards for dental benefit plans, the challenge of a treatment plan by a third-party claims analysis is considered diagnosis. This constitutes the practice of dentistry, which can only be performed by a dentist licensed in the Commonwealth of Virginia who has equivalent training with that of the treating dentist, and carries with it full liability. Be it further resolved, that the formulations or alteration of a treatment plan without a dental clinical examination of the patient by a dentist legally authorized to practice in Virginia should be prohibited, and be it further resolved, that the VDA urges the Virginia Board of Dentistry to pursue legislation and/or regulations to meet this end.
6.	Approved:	Whereas the Virginia Dental Association will mirror the American Dental Association dues structure and refer it to the Constitutions & Bylaws and Finance Committees and for those Committees Treasurer. The Treasurer then will present its work back to the VDA Board for approval and to serve proper notice to the membership prior to the 2020 House of Delegates meeting.
7.	Approved:	Resolved, that the Virginia Dental Association will follow the American Dental Association's recommendation and sign onto the Coalition for Modernizing Dental Licensure at the supporter level, to be reviewed annually.

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Dental Health Associates is a well-established, Community focused Practice looking for a Periodontist to help manage its busy interdisciplinary case load. We are looking for a well-trained, highly skilled Periodontist with exceptional people skills. A good candidate will be well versed in all areas of surgical and non-surgical periodontal care including implantology and Oral Surgery including extraction of 3rd molars. A great opportunity to get into a growing group! Opportunities throughout the Shenandoah Valley in Lexington, Staunton, Harrisonburg, Fishersville and Dayton. Contact: Dennis Calvano 540-569-2523 shenndyr@mydha.net

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Contact: Alvin C Amante 206-427-2977
dentist@culpeperkidsdentistry.com

6561 - Full Time Associate for 2020 Charlottesville
South Side Dental Center is looking for a Full Time Associate Dentist for the spring/summer of 2020. Located in Charlottesville Virginia, our established practice continues to grow and expand. This is an awesome opportunity that can't be missed for an established dentist or a soon to be graduate. Concentrating on Cosmetic, Sedation, and Implant Dentistry for the whole family, our office requires a dentist with a great personality and well rounded skills. Send your resume today to
DrSpano@southsidedentalcenter.com

6564 - Associate Dentist Full Time/Part Time - Just outside Lynchburg, VA
Established dental practice privately owned; looking for a motivated dental associate with future ownership potential. This practice has a great family atmosphere and has recently moved into a new office, offering a great opportunity for growth. We are committed to giving patients great care. We offer a wide range of services including, implant restoration, cosmetic dentistry, cerec restorations, root canals, and extractions as well as routine dentistry. Retirement and healthcare package available.
Contact: Nikki McCullough 434-332-5919
wefixteeth5919@gmail.com

6568 - Dentist Wanted - Chester, VA
Well established dental practice, locally owned and operated, looking for a motivated dental associate. We have three fully digital, technologically advanced state of the art dental offices. We offer future partnership opportunities for the appropriate candidate. Our practice has five general dentists and an Orthodontist. We see an average of more than 100 new patients per month in each location. We are committed to give great customer service and best treatment possible. Great benefit and bonus packages. Immediate opening please send your resume.
Contact: Dr. Varkey 804-874-2333
richmonddentist@gmail.com

6573 - Associate Dentist - Chantilly, VA
Fast paced, quality-oriented Cosmetic and Family General Practice seeks motivated, compassionate dentist in Chantilly, VA. Established non-corporate practice with experienced support staff provides room for growth in a well-structured environment. PPO insurance and FFS only. Four day work week with one ½ Saturday/month. Competitive full benefits package includes health insurance, malpractice and disability insurance, CE allowance, 401k with match, and paid lab bills. Two years of experience or AEGD/GPR residency program required with oral surgery and endo skills preferred. Veterans are encouraged to apply. Please email your CV to
dentistryinloco@gmail.com.

6574 – Dentist Needed - $25,000 Sign on Bonus
Smile Virginia is seeking a caring dentist to join our program and provide comprehensive dental care to kids in need, who would otherwise not receive the care they need and deserve. Full and part-time positions available with competitive compensation and a sign-on bonus. Our doctors work a flexible schedule, no nights and weekends, and have the summers off. Contact Silvana Ayar at (586) 823-0037 or sayar@mobiledentists.com for more information.

6579 - Associate Dentist - Staunton, VA
Willis & Associates Family Dentistry is actively seeking a motivated, quality-oriented associate dentist for our offices in Augusta County, VA. We 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. Compensation: - Sign on Bonus up to $30,000 - Average compensation of full-time dentists in excess of $220,000/ per annum Clinical Practice: - Complete autonomy over treatment planning - Full patient schedule - Fully digital and paperless office - Itero scanner - Discretion over dental supplies and instruments - Friendly and efficient staff Benefits: - Health insurance - Malpractice insurance - Simple IRA retirement plan - Gym membership - Continuing Education - Dental coverage for associates and immediate family members - Clinical hours that support a healthy work / life balance Make this opportunity a reality for you. Please contact us to learn more about rewarding associate dentist opportunities with Willis & Associates Family Dentistry. We offer full-time, and part-time positions.
Website: www.willisdentistry.com
Contact: Dr. James Willis 304-906-5300
drwillis@willisdentistry.com

6582 - General Dentist - Blacksburg, VA
Want to have a CLINICAL MENTOR to increase clinical knowledge, skills and learn how to run a dental practice? We have an amazing mentorship program with a focus on improving general dentistry and expanded services to our patients. Our state of the art office integrates new technologies like Cerec, iTero, digital X-ray and Implant training. You will be training and working with this equipment within weeks of joining us. Our mentorship program extends into personal growth, marketing and the operations of the office. We are growing well established privately owned dental office in Blacksburg, Virginia looking to add associates Summer 2020 with option for future partnership. We have plenty of space to work with 13 operatories. As an office that provides all aspects of dentistry, we are looking for a candidate that is highly motivated, eager to learn and has an amazing chairside manner. This is an amazing practice. Visit at www.reallifedental.com We look forward to hearing from you!
Contact: Tom Williams 540-449-1555
tom@reallifedental.com

6589 - General Dentist - Chester, VA
Our state-of-the-art dental practice is searching for a skilled and experienced Dentist with excellent communication skills to join our professional team. The ideal candidate for this position has worked with patients of all ages, is proficient in performing regular checkups and complex dental procedures and is committed to the highest quality of patient care. Those who are qualified and in search of a long-term career opportunity in a cutting-edge practice are encouraged to submit an application today. D.D.S. or D.M.D. from a school accredited • Licensed to practice in the state of Virginia • Certified in CPR • Good interpersonal skills and communication • Computer skills and experience • Accurate and precise attention to detail • Compassionate and caring of patients • Excellent written and verbal communication skills • Able to work in an intense, concentrated environment • Calm and cool-headed with a positive attitude • Complies with all office, local, state, and American Dental Association regulations, protocols, and procedures
Contact: Sheila 804-717-5100
dentistoffice03@gmail.com

6594 - Associate Dentist Wanted Smithfield, VA
Full time associate dentist wanted in a growing practice located in Smithfield, VA. Non-corporate owned Smithfield Family Dentistry is actively looking for a new member to our family. Enjoy all the benefits of practicing in a small town environment, but have the amenities of the nearby cities of Hampton Roads and Norfolk. Very modern, 100% digital practice with 3 full time hgyienists. Good communication skills and a great bedside manner a must. Please email your interest and resume to:
Contact: Milton Cook, DDS 757-357-4121
miltoncook@smithfield-dds.com

6595 - Calling All Dentists!
Williamsburg, VA
Be paid like an owner, without the risk! Great Benefits!: 401K Health Insurance Doctors paid for hygiene exams Office pays for all lab fees Continuing education paid for annually Relocation allowance First year of malpractice paid for Virginia dental license paid for Recent graduates encouraged to apply as well as those with several years of experience We offer training, development and mentorship opportunities Short commute and near the beach Family-focused environment Core values: patient care and employment retention This is the opportunity you have been waiting for! Apply today! Contact: Alison Morrison 757-719-2237
amorrison@morrisondentalgroup.com

6547 - RICHMOND PROSTHODONTIC PRACTICE FOR SALE Richmond, VA
Specializing in Sleep Disorders, TMD, and Craniofacial Pain Successful fee for service practice with collections over $1.1 million (2018) is located in highly sought-after residential/commercial district in Richmond, VA (pop. over 1 million). This specialty practice is well-known throughout Central Virginia for diagnosing and treating temporomandibular joint disorders (TMD), as well as head, neck and facial pain patients. Retiring doctor is board certified in dental sleep medicine and has strong base of patients suffering from sleep apnea. 2200 sqft beautifully designed office with 4 operatories. Doctor has broad referral network and is willing to remain on part-time to mentor (if desired) and help new doctor with successful transition. Complete confidential Buyer Registration Form for details.Contact: Dr. Jim Schroeder 804-897-5900 drjim@lbdtransitions.com

6570 - Family Practice for sale or lease Pennington Gap
Busy rural family practice 35 years. Four operatories, digital x-rays, Pan, vertical bitewings, cone beam, operative microscope. Sale or Lease building. Retiring. Contact: James Roberson 276-546-3121 or 276-220-6462 skjmroberson@hotmail.com

6577 - Private Practice Ownership Hampton Roads
Atlantic Dental Care has multiple purchase and associateship opportunities for general dentists. ADC is a group practice model 100% owned by its member dentists. Our 124 dentists have a shared vision of delivering quality care in the Hampton Roads communities (Williamsburg to Virginia Beach) we serve through 76 locally owned dental 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 as we preserve traditional private practice. Benefits include 401k profitsharing, health/disability insurance, pretax childcare, flexible spending, and health savings accounts. 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/. Forward inquiries/resume for opportunities. Confidentiality Assured. Contact: Marina 757-455-5554 atlanticdentalcare@cox.net

6578 - Associate to Traditional Private Practice - Hampton Roads
Multiple full and part-time opportunities for general dentists. Atlantic Dental Care is a unique group practice 100% owned by its member dentists. We are preserving the private practice of dentistry. Our 124 dentists have a shared vision of delivering quality care in the Hampton Roads communities (Williamsburg to Virginia Beach) we serve through our 76 locally owned dental 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 profitsharing, health/disability insurance, pretax childcare, flexible spending, and health savings accounts. 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/. Forward resume/inquiry to receive opportunities listing. Confidentiality Assured.
Contact: Marina 757-455-5554 atlanticdentalcare@cox.net

6584 - Oral/Maxillofacial Surgery Practice for Sale - Richmond, VA
Well-established oral surgery practice providing implants, wisdom teeth extractions, pathology, facial cosmetic and reconstructive surgery, as well as full scope anesthesia (local, oral sedation, IV sedation and general). Serving patients for over 25 years with two locations within driving distance from each other. Dentist planning out retirement, looking for right individual to take over successful practice serving broad market area. Collecting close to $2 million (both locations, 2018). Great opportunity for group practice purchase or by individual with interest in ownership. Dentist willing to remain 1-2 years for introductions to broad, diversified referral network.
Contact: Dr. Jim Schroeder 804-897-5900 drjim@lbdtransitions.com

6585 - Dental Practice for Sale Kilmarnock, VA
There's nothing quite like the charm of a small town. This gem of a practice is located in Lancaster county and has collections over $670k (2018) with a 43% avg. net profit. Currently operating just 3 days a week - you can easily move to full-time. 1600 sqft (expandable to 3,600 sqft) with 5 operatories, digital x-rays, paperless, and Dentrix software. Kilmarnock is THE hub for medical/dental services from surrounding counties of Lancaster, Northumberland, Middlesex and more. Over 280 miles of shoreline to enjoy - and just over an hour's drive from Newport News, Richmond and Williamsburg. Enjoy small town living at its best! Contact: Dr. Jim Schroeder 804-897-5900 drjim@lbdtransitions.com

6592 - Associate Dentist to Owner Wise, VA
Associate position in general dentistry with transition to ownership. One owner and two hygienists working four days per week, eleven months per year produced $1.4 million. Up to date equipment, loyal patient base, beautiful, safe area to rear a family. Owner desires to decrease responsibility and work load so energetic, ambitious individual is preferred. Contact: Robert Kilgore 276-328-5291 rdk_clk@yahoo.com

6553 - OFFICE SPACE TO SHARE Falls Church, VA
Great location practice, Seven Corners area, close to 495/Rt 50/DC, equipped with the latest technology, Cerec machine, 3D Cone-beam . Perfect for established dentist/specialist to expand or new- graduate to start out. Available two days of the week. Contact: Fadwa Nassar 703-534-7900 Fallschurchcomprehensive@msn.com

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We are pleased to announce...

Adam S. Foleck, D.M.D.
has acquired the practice of
Robert A. Dreelin, D.D.S.
Hampton, Virginia

Hisham M. Barakat, D.D.S.
has acquired the practice of
Ashley S. Nguyen, D.D.S.
Alexandria, Virginia

We are pleased to have assisted in these transitions.

Practices For Sale

Excellent Opportunity in Norfolk
This 2,040 sq. ft. practice is located in a stand-alone professional building with plenty of parking and great road-side visibility. The office has 6 ops, digital X-rays, and utilizes Dentrix. The practice has an abundant patient base of over 6,600 patients and averages 59 new patients a month. The majority of patients are PPO with some Medicaid. Real estate is also available.
Opportunity ID: VA-5987

Grossing Over $1.3M in Alexandria
This opportunity is in a great location of Old Town Alexandria, which is nationally recognized for its rich history and beautifully preserved architecture. The 2,500 sq. ft. office is located in a free-standing building with excellent road-side visibility. This 4-op office has digital X-ray, Pan, and utilizes Dentrix software. The practice has approximately 1,400 active patients who are all FFS. If you are ready to practice in a town filled with old world charm, call AFTCO today!
Opportunity ID: VA-5960

Fantastic Opportunity South of Richmond
This is a well-established general practice that is located south of Richmond. The office is in a multi-tenant professional building with 4 equipped ops and an additional op that is plumbed. The office is digital and utilizes SoftDent software. The practice is currently open 4 days a week, and it is grossing over $400K. The seller is relocating to another area, so he is motivated to sell.
Opportunity ID: VA-5957

Just Listed - South of Roanoke Practice
This practice opportunity is located in a free-standing professional building right off of the I-81 corridor. The practice is digital and has Eaglesoft software. It is 100% FFS with 1,875 patients and averages 25 new patients a month. This opportunity has tremendous growth potential with low overhead. There is also room for expansion and the possibility of a real estate purchase. Seller is very motivated to sell. **Opportunity ID: VA-5917**

Go to our website or call to request information on other available practice opportunities!

800.232.3826 *Practice Sales & Purchases Over $3.2 Billion* **www.AFTCO.net**