VOLUME 96, NUMBER 4 | OCTOBER, NOVEMBER & DECEMBER 2019

VA DENTAL JOURNAL

2019-2020 VDA PRESIDENT
DR. ELIZABETH REYNOLDS

▶PG. 35

DENTAL BENEFITS EXPERT
REJECTED OR MODIFIED CLAIMS?

▶PG. 9

VAPING
WHAT DENTISTS SHOULD KNOW

▶PG. 47

VADENTAL.ORG

DRAKE
LABORATORIES

where conventional & digital connect

THE BDS DUAL ARCH DIGITAL DENTURE

conventionally sent. digitally made. hand perfected.

Call 1.800.476.2771 and ask us about the Baltic Digital Denture. Your 2 appointment denture awaits!

vdj419

IN THIS ISSUE

► Volume 96 | Number 4
► October, November & December 2019

VA DENTAL JOURNAL

VOLUME 96, NUMBER 4 • OCTOBER, NOVEMBER & DECEMBER 2019

VIRGINIA DENTAL JOURNAL (Periodical Permit #660-300, ISSN 0049 6472) is published quarterly (January-March, April-June, July-September, October-December) by the Virginia Dental Association, 3460 Mayland Ct, Ste 110, Richmond, VA 23233, Phone (804)288-5750.

SUBSCRIPTION RATES Members $6.00 included in your annual membership dues.
Members – Additional Copy: $3.00
Non-Members- Single Copy: $6.00 Non-Member outside the US: $12.00
Annual Subscriptions in the US: $24.00 outside the US: $48.00

POSTMASTER Second class postage paid at Richmond, Virginia.

MANUSCRIPT, COMMUNICATION & ADVERTISING Send address changes to: Virginia Dental Journal, 3460 Mayland Ct, Ste 110, Richmond, VA 23233.

Member AADEJ American Association of Dental Editors & Journalists

Managing Editor, Shannon Jacobs 804-523-2186 or jacobs@vadental.org

ALL IN!

Dr. Elizabeth Reynolds

I am sure that you have heard that this is the VDA's sesquicentennial. That's 150 years of existence. So let's take a moment to look back. What was happening 150 years ago?

In 1869 Ulysses S Grant was president. The Golden Spike was driven, completing the Transcontinental Railroad. The 15th Amendment went to the states and was ratified in Wyoming. The voting machine was patented by Thomas Edison, and the Suez Canal was opened. The phone and the automobile were yet to be invented.

In dentistry in the late 1800s the first woman graduated from Ohio State School of Dentistry and Robert Tanner Freeman, the first African American dentist, graduated from Harvard. The first foot treadle dental engine was sold, and the collapsible tube was invented paving the way for the first tube of toothpaste. Gold foil was the restoration of choice. As an aside, my father, who graduated from what was then the Medical College of Virginia in 1930 was extremely disappointed that I did not have to learn gold foils. He considered them one of the best restorations, and I must say that when he passed away at 87 he still had an intact gold foil that had been placed by his lab partner in dental school. I am not sure how many of us can say the same about our composite restorations!

So also in 1869 a group of nine like-minded dentists from Virginia decided that they wanted to protect and advance their profession. They got together and in 1870 the Virginia Dental Association was formed. One of the founding fathers, Dr. James Thompson of Fredericksburg, stated that the purpose of the initial planning meeting was to "organize an association having in mind the cultivation of the science and art of dentistry and all of its branches: also to elevate and sustain the professional character of the dentists, and to promote among them mutual improvement." A bit later, at the eighth meeting, then president Dr. WWH Thackston of Farmville recognized that there were laws to protect other medical professionals but none for dentists. He began the long and arduous process of enacting laws to "assure the public and the practitioner of the necessary protection from the charlatans." Protection of practice issues? Sound at all familiar?

Dr. Sam Galstan passes the torch and official VDA President's pin to Dr. Elizabeth Reynolds making her the VDA's 139th President.

In 1886 it became obvious that the organization needed a Code of Ethics for their membership. This code was developed and presented that year. It addressed the "duties of the profession to the their patients, how to maintain a professional character, the relative duties of dentists and physicians, and the mutual duties of the profession and the public." Responsibility to the public sector? Sound familiar? These are the tenets of our Code of Ethics today.

In 1931, because they were concerned over membership, this group established eight individual geographic constituents throughout the state; they felt this would help attract new members from a grassroots perspective. Membership issues? Sound familiar?

So, what do you think spurred these visionary founding fathers to establish an organization to protect their profession? Do you think any of that has changed since 1870? Shouldn't we as an association strive to represent our members in this same ethical, honorable manner? Shouldn't we all want to be certain that we

► ALL IN - CONTINUED ON PG. 4

► ALL IN - CONTINUED FROM PG. 3

are taking care of our members and taking care of our patients?

Times have certainly changed. I like to think about the differences between the way my father practiced and the way we practice now; so much is different. I have the appointment books/progress notes from his first years in practice. One entry stated: "Monday June 6,1930: 10:00. Extraction, Mrs. Jones, $1.00." I don't know about you, but my entries are a wee bit more detailed than that. My father took radiographs scattering heaven knows how much radiation around the room, dipped them into toxic solutions and hung them up to dry. I am pretty sure there were no lead aprons. I have a cool device that I can carry around from operatory to operatory and snap radiographs to my heart's content and they show up immediately on my computer screen. And my patients are clad from thyroid down with lead, despite the fact that my radiographs are safer than ever. We even have technology to scan and print crowns to deliver that same day. So, yes, the practice of dentistry has certainly changed over the years, but what hasn't changed is that dentists have always been focused on providing the best care possible to their patients, and hoped to make a fair living doing it. Today the procedures are more complicated, the business is more complicated and the money is more complicated, but I maintain that the basic tenets of our profession are exactly as they were in 1870.

When I was privileged to have been elected to serve in this position I was awed and overwhelmed but so honored. I have been preceded by many incredible leaders with incredible visions. After this Virginia Meeting last year I sat down with my dear friend and mentor Dr. Terry Dickinson and I said to him "I don't have a vision for this organization. How can I lead it without a vision?" He looked at me and said simply "Not everyone comes in with a vision. Be patient and listen and the vision will identify itself." And so perhaps it has. We are in an incredible time of change in our organization, and with change comes opportunity. As change averse as I am (and trust me- I am!), I recognize and am going to embrace this opportunity. We are celebrating 150 years of an association that is the leading organization for oral health in Virginia. We are composed of 69% of the dentist population in Virginia, but I argue that we represent 100% of that population. Dentists are by nature kind, bright, giving individuals. They want to do all that is right and the Virginia Dental Association is here to help them with that. Our loyalty is to our fellow colleagues and our patients, is it not? Then let that be our mantra.

We are embarking on an incredible journey together this year. We are developing our strategic plan which will take us through the next five years. It will be all encompassing and will ensure the continued success of our members, of our patients, and of our association. We will strive to be responsive and proactive. We will strive to honor those who formed this organization 150 years ago by continuing to make it stronger and better, and by continuing to make it inclusive and representative of all dentists. Perhaps Terry was correct; perhaps my vision has identified itself to me. Perhaps it is to work in partnership with all of you to set this organization up for the next 150 years of success. I don't know what this year holds but I do know that the VDA is continuing to take the responsibility of protecting the profession and the patients seriously.

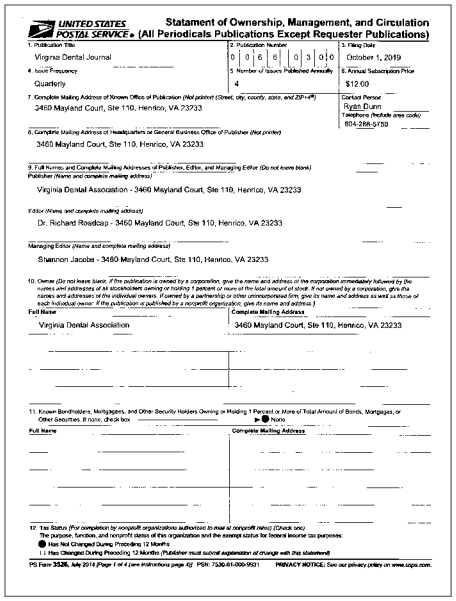
We are all in to define teledentistry to maintain the safety of our patients.

We are all in to work with insurance companies so that our members are fairly compensated and so that our patients get from their insurance companies what they have been promised.

We are all in to ensure that people in need have access to care from our educated and qualified members.

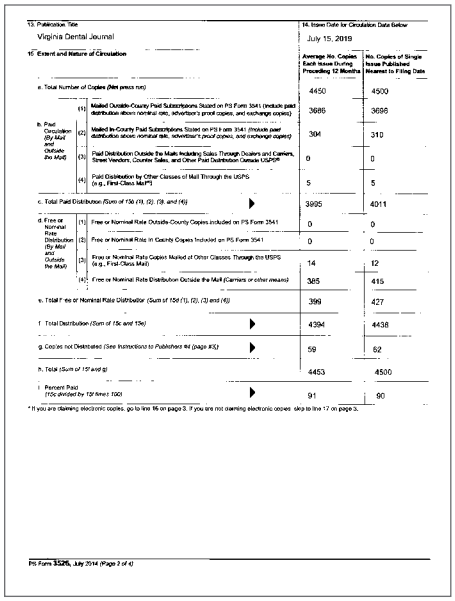
I am asking you to work with me this year to ensure that our Virginia Dental Association continues and strengthens our commitment to our members and to our patients. We have had an incredibly successful past 150 years; let's work together to set us up for the next 150.

USPS REQUIRED POSTING
STATEMENT OF OWNERSHIP



Statement of Ownership, Management, and Circulation (All Periodicals Publications Except Requester Publications)

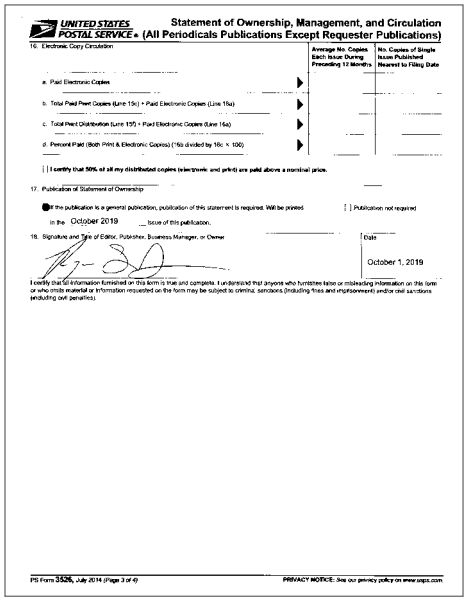
1. Publication Title: Virginia Dental Journal
2. Publication Number: 0066-0310
3. Filing Date: October 1, 2019
4. Issue Frequency: Quarterly
5. Number of Issues Published Annually: 4
6. Annual Subscription Price: $12.00
7. Complete Mailing Address of Known Office of Publication: 3460 Mayland Court, Ste 110, Henrico, VA 23233
Contact Person: Ryan Dunn
Telephone: 804-288-5750
8. Complete Mailing Address of Headquarters or General Business Office of Publisher: 3460 Mayland Court, Ste 110, Henrico, VA 23233
9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor
Publisher: Virginia Dental Association - 3460 Mayland Court, Ste 110, Henrico, VA 23233
Editor: Dr. Richard Rosdeck - 3460 Mayland Court, Ste 110, Henrico, VA 23233
Managing Editor: Shannon Jacobs - 3460 Mayland Court, Ste 110, Henrico, VA 23233
10. Owner: Virginia Dental Association — 3460 Mayland Court, Ste 110, Henrico, VA 23233
11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities: None
12. Tax Status: Has Not Changed During Preceding 12 Months
PS Form 3526, July 2014 (Page 1 of 4)



13. Publication Title: Virginia Dental Journal
14. Issue Date for Circulation Data Below: July 15, 2019

		Average No. Copies Each Issue During Preceding 12 Months	No. Copies of Single Issue Published Nearest to Filing Date
a. Total Number of Copies (Net press run)		4450	4500
b. Paid Circulation (By Mail and Outside the Mail)	(1) Mailed Outside-County Paid Subscriptions Stated on PS Form 3541 (Include paid distribution above nominal rate, advertiser's proof copies, and exchange copies)	3686	3696
	(2) Mailed In-County Paid Subscriptions Stated on PS Form 3541 (Include paid distribution above nominal rate, advertiser's proof copies, and exchange copies)	304	310
	(3) Paid Distribution Outside The Mails Including Sales Through Dealers and Carriers, Street Vendors, Counter Sales, and Other Paid Distribution Outside USPS®	0	0
	(4) Paid Distribution by Other Classes of Mail Through the USPS (e.g., First-Class Mail®)	5	5
c. Total Paid Distribution (Sum of 15b (1), (2), (3), and (4))		3995	4011
d. Free or Nominal Rate Distribution (By Mail and Outside the Mail)	(1) Free or Nominal Rate Outside-County Copies included on PS Form 3541	0	0
	(2) Free or Nominal Rate In-County Copies included on PS Form 3541	0	0
	(3) Free or Nominal Rate Copies Mailed at Other Classes Through the USPS (e.g., First-Class Mail)	14	12
	(4) Free or Nominal Rate Distribution Outside the Mail (Carriers or other means)	385	415
e. Total Free or Nominal Rate Distribution (Sum of 15d (1), (2), (3) and (4))		399	427
f. Total Distribution (Sum of 15c and 15e)		4394	4438
g. Copies not Distributed (See Instructions to Publishers #4 (page #3))		59	62
h. Total (Sum of 15f and g)		4453	4500
i. Percent Paid (15c divided by 15f times 100)		91	90

* If you are claiming electronic copies, go to line 16 on page 3. If you are not claiming electronic copies skip to line 17 on page 3.
PS Form 3526, July 2014 (Page 3 of 4)



Statement of Ownership, Management, and Circulation (All Periodicals Publications Except Requester Publications)

16. Electronic Copy Circulation

	Average No. Copies Each Issue During Preceding 12 Months	No. Copies of Single Issue Published Nearest to Filing Date
a. Paid Electronic Copies		
b. Total Paid Print Copies (Line 15c) + Paid Electronic Copies (Line 16a)		
c. Total Print Distribution (Line 15f) + Paid Electronic Copies (Line 16a)		
d. Percent Paid (Both Print & Electronic Copies) (16b divided by 16c × 100)		

I certify that 50% of all my distributed copies (electronic and print) are paid above a nominal price.
17. Publication of Statement of Ownership
If the publication is a general publication, publication of this statement is required. Will be printed in the October 2019 issue of this publication.
18. Signature and Title of Editor, Publisher, Business Manager, or Owner — Date: October 1, 2019
I certify that all information furnished on this form is true and complete. I understand that anyone who furnishes false or misleading information on this form or who omits material or information requested on the form may be subject to criminal sanctions (including fines and imprisonment) and/or civil sanctions (including civil penalties).
PS Form 3526, July 2014 (Page 3 of 4)

A SUSTAINABLE FUTURE?

Dr. Kirk Norbo, ADA 16th District Trustee

The ADA recently celebrated its 160th birthday and as many of you know the VDA will turn 150 years old in 2020. Much has changed in our beloved profession during this time and our predecessors as well as contemporaries have been able to adapt to these shifts, keeping organized dentistry relevant to member dentists. Just as important, the ADA, VDA and our state components have been able to stay in business.

In 2015, the ADA hired Frog Design to take an in depth look at its business model. Frog ultimately determined that the ADA would start experiencing financial difficulties in 2027 if changes were not made in its business practices. This brief historical perspective of the ADA and the tripartite system is important to take into consideration when we look at the decisions that were made by ADA leadership this year. We used the financial sustainability of the organization as the most important guiding principle as we deliberated on some very serious issues. Streamlining our dues structure, reorganizing the ADA Foundation, building up our royalty reserves to spin off significant non-dues revenue, the ADA Practice Transitions project and the CVS contract consumed a significant amount of time in the board room. All of these efforts were geared toward making the ADA a stronger association financially.

The ADA House of Delegates (HOD) was faced with difficult decisions this year concerning dues structure. There were four proposed changes. First, incoming dentists will experience a three year phase in to full dues paying status. What that means is for the first year out of dental school (or residency) there will be zero dues, 50% the second year out and after three years there will be a full dues payment expected. In addition, the active life members will no longer be offered a 25% dues discount and will be full dues paying members in 2021. The $30 dues amount expected to be paid by residents will no longer be in effect. The fourth component of this dues restructuring is the addition of a 1.3% CPI increase on an annual basis. The HOD voted in favor of the full dues streamlining package which included these four pieces. These changes are predicted to add $4.3 - $6 million in additional revenue in 2021.

By 2023, the royalty reserve fund at the ADA should reach the $100 million mark. This money has been accrued from royalties paid each year to the ADA by Great West Life as a result of members who are using Great West insurance products. By investing this royalty reserve, the ADA should benefit by receiving revenues in the neighborhood of $6 million annually. This is another addition to our business plan that will take the pressure off of dues income

The ADA Foundation has been discussed for the past several years in the board room because of the amount of money necessary to keep it in business. This year, the board decided to reorganize our foundation in an attempt to position it on solid financial ground. The philanthropic activities of the association will now be housed in the ADA under its 501(c)6 status. The ADA Foundation will still operate as a 501(c)3 entity but will be dedicated to science and research. Existing grants will still be managed by the ADA Foundation but any new philanthropic activities will be administered by the ADA. Our intention for making these changes is to cut administrative costs associated with philanthropic efforts while establishing a science and research foundation that with time will be self-sustaining financially.

The ADA Practice Transitions (ADAPT) program represents a future non-dues revenue source for the ADA but is still in a pilot phase. All start up business ventures have a certain degree of risk and ADAPT is no exception. If this project is successful and can be scaled nationwide, we anticipate a non-dues revenue stream of $5-7 million per year.

We entered into a contract with CVS two years ago anticipating that CVS would be a sound business partner and help us expand our Find-a-Dentist program. In addition, the goal was to develop better oral health care aisles within the stores while providing more exposure for our ADA Seal products. We were all unhappy with CVS's decision to allow teledentistry companies to house technicians within stores but that is not why we terminated the contract. We terminated this relationship because it was determined that CVS breached the contract. They did not provide proper signage within the stores highlighting our Seal products and did not follow through with efforts to publicize the Find-a-Dentist program. The contract we had with CVS was for three years so we forfeited $600,000 by terminating this agreement one year early.

It is imperative that the ADA as well as all levels of the tripartite system have business plans in place to assure financial sustainability. We all expect organized dentistry to deliver quality service and products for the foreseeable future. For this to happen, leadership must be focus on sound business principles and be willing to make decisions that will keep all levels of organized dentistry financially strong.

SURVIVING SEPSIS

Dr. Henry Botuck

Sepsis is an extreme, life-threatening response of the body to an infection. It can lead to tissue damage, organ failure, and death. The Centers for Disease Control (CDC) is promoting a sepsis awareness program to educate the public and health professionals to the need to recognize and treat sepsis aggressively-and early. It is considered a medical emergency.

CDC estimates that about 1.7 Million adults develop sepsis each year, and about 270,000 die. This doesn't count the number who develop permanent damage to vital organs, inability to care for themselves, memory loss, generalized aches and pains, and other disabilities.

Sepsis can happen to anyone who has an infection anywhere in the body. Those at highest risk are those over age 65 and under age one, people with chronic conditions (lung disease, diabetes, cancer, kidney disease), and those with weakened immune systems.

There are a number of symptoms that are present when making the diagnosis of sepsis: fever, low blood pressure, increased heart rate, difficulty breathing, confusion or disorientation, and lab tests that might suggest organ damage. Unfortunately, these symptoms can be a part of other illnesses if the patient has co-morbidities. This makes sepsis a little more difficult to diagnose in the very early stages. A patient with an infection needs to be monitored carefully and treated aggressively if sepsis is even suspected. Quick action is critical.

Does your office call your patient the day after surgery to make sure everything is going as expected? Are patients advised that they should call if infection or pain worsens, or if they have any questions? And, if the patient does call, please don't give advice through your assistant. Do it yourself. Personally! If you can't speak to the patient at that moment, indicate that you will call back later. And, if necessary, have the patient come into the office.

Make sure that all instructions about calling you if there are questions, or if pain or infection worsens, are recorded in the chart and/or are in any handout instructions. If it isn't in the chart, it didn't happen. All patient conversations over the telephone, with you or your assistant, should be recorded in the chart. If it isn't in the chart, it didn't happen.

If your patient has an infection that is getting worse, or if the pain is worsening, don't be bashful about getting a consultation. In those instances, sepsis should always be in your mind. And time is of the essence.

Go online to CDC.com for more information about sepsis prevention, recognition, and how it is treated.

MY GREATEST FEAR

Dr. Marvin E. Pizer

As many of you remember, of my 65 years of practice in oral and maxillofacial surgery (OMS), the last 15-20 years were limited to oncology. Although I used the team approach to treating malignant lesions, my greatest fear was recurrence of this disease in my patients. As most of you know the lips and most any intraoral soft tissue could become malignant by the habit of "smoking and drinking" – you know what I mean. As to oral sex and many other contributors to this I'll never know!

We (our team) could eliminate this cancer, but how could I prevent the dreaded recurrence? Promises by the patient when it comes to a serious habit were easy to receive, but after a hopeful cure, how could I as the surgeon be comfortable? I sent letters to the patient's dentist and physician, advising them to use their influence to break the habits that were the most obvious cause of their OMS cancer. I talked to closest of kin, and to the patients, about the organizations available to treat alcohol and tobacco habits.

To my best knowledge I followed my cancer patients all of their lives and when I retired referred these patients to competent dentists and physicians. While I was in practice I had good follow-up results.

I am confessing my personal fear – with the hope that future recurrences after initial "cures" can be avoided. Recurrences can be more deadly than the original lesion.

EXPOSURE

Dr. Richard F. Roadcap

The antifluoridationists have another arrow in their quiver[1]. A recent study in *JAMA Pediatrics* linked prenatal exposure to fluoride to lower IQ scores in children at ages 3-4. One of the study's nine authors, Dr. Angeles Martinez-Mier, is a faculty member at the Indiana University School of Dentistry. We've become accustomed to "association" studies that link everyday dental practice and preventive dentistry to adverse outcomes. For example, a 2012 study associated bitewing radiographs with a nearly two-fold increased risk of intracranial meningioma[2]. Although the outcry was swift, lead researcher Elizabeth B. Claus, M.D, later commented "These findings should not prevent anyone from going to the dentist."[3]

Public water fluoridation has been a cornerstone of efforts to prevent caries, and was named one of the 20th century's greatest public health achievements by the Centers for Disease Control. Nearly 70 years of research have supported fluoridation as both safe and effective. Yet the publication of a peer-reviewed manuscript of this nature in a prestigious journal has caught many in the profession off guard.

Let's review the findings of Green et. al. The authors studied mothers in six Canadian cities and their children (601 pairs) born between 2008 and 2012. Of these, 41% lived in fluoridated communities. Maternal urinary fluoride was measured in pregnant women, and children were scored for Intelligence Quotient (IQ) at ages 3 and 4. The authors found a significant decrease in IQ scores for boys (but not for girls) who lived in cities with fluoride in public water. Among the authors' conclusions was the "possible need to reduce fluoride intake during pregnancy".[4]

The response from the profession and the scientific community was widespread. Numerous researchers pointed out the shortcomings in the study's methods and its conclusions. Among them:

- Boys appeared to be harmed by fluoride in the water, but not girls.
- The mothers self-reported their intake of fluoride-containing beverages (our patients always remember the date of their last x-rays, right?).
- Fluoride concentrations in tap water were not measured.
- Also, the researchers did not measure exposure between birth and testing to substances such as lead. Alastair Hay, Ph.D., an environmental toxicologist at the University of Leeds in England, commented "We know that lead exposure has devastating effects on IQ in children and this study takes no account of postnatal lead exposure."[5]

What does this study portend for future dentist-patient interactions? Should we tell pregnant women to drink bottled water (often derived from tap water)? We've learned from previous media eruptions that our patients greet the latest scientific study with a shrug. They know, as we will learn too, that another study will soon refute the findings of the earlier one. They trust our professional judgment and will ask us to make sense of this convoluted report. But the risk to community water fluoridation is significant. The anti-fluoride lobby and its sycophants will brandish copies of Green et. al., before aldermen and councilors in their never-ending campaign to deny oral health to those in our communities who have the least access to dental care.

The ADA has a taken a measured response to the dustup. The association released a statement saying it "remains committed to fluoridation of public water supplies as the single most effective public health measure to help prevent tooth decay." Bruce Y. Lee, M.D., a contributor to Forbes.com, and a faculty member at Johns Hopkins School of Public Health, was less sanguine. He remarked "Observational studies, like this one…cannot, cannot, cannot, cannot prove cause and effect."[6] The ADA knows provoking the foot soldiers of the anti-fluoride brigades may not be the best strategy.

As healthcare professionals and practitioners of evidence-based dentistry, we have seventy years of science on our side. If water fluoridation is threatened in our communities we'll be called upon to take a leadership role in its defense. The ADA and its components have a multitude of resources, such as "Fluoridation Advocacy" in the Public Programs section of ADA.org, to support us when the arrows fly.

1 Green R et. al. Association Between Maternal Fluoride Exposure During Pregnancy and IQ Scores in Offspring in Canada. JAMA Pediatr. 2019 Aug 19. doi: 10.1001/jamapediatrics.2019.1729. [Epub ahead of print]

2 Claus EB et. al. Dental x-rays and risk of meningioma. Cancer. 2012; 118(18): 4530-7.

3 https://www.webmd.com/cancer/brain-cancer/news/20120410/dental-x-rays-linked-brain-tumors#1

4 https://www.ncbi.nlm.nih.gov/pubmed/31424532

5 Burger, David and Jennifer Garvin. "Responses to fluoride study flood in from all over the globe" ADA News, September 2, 2019: 8

6 https://www.forbes.com/sites/brucelee/2019/08/20/fluoride-and-iq-what-is-the-link-what-this-study-says/#6935dbea3cc6

NEW NAME, NEW VISION

VIRGINIA HEALTH CATALYST

Sarah Bedard Holland; Chief Executive Officer, Virginia Health Catalyst

Virginia Health Catalyst
The Intersection of Overall Health and Oral Health

The Virginia Oral Health Coalition is now Virginia Health Catalyst!

Good oral health doesn't occur in a vacuum, and to improve the overall health of Virginians, we must address the clinical, environmental, and social factors that impact a person's health. As Virginia Health Catalyst, our mission to ensure all Virginians have equitable access to comprehensive health care that includes oral health remains the same. However, we'll bring a stronger focus on public health issues that impact individual and population health to all of our programs and advocacy efforts and broaden our partner base to ensure all members of the health care community, including community health workers, home visitors, physicians, and policy makers, recognize our shared understanding that good oral health is necessary to achieve good overall health.

A LOOK AT OUR UPDATED STRATEGIC VISION

As Virginia Health Catalyst, we will meet our mission with a new strategic framework that creates a foundation for comprehensive health care based on four interconnected systems, or pillars: public health, policy, clinical and community care, and public awareness.

The pillars will guide our work and shape the lens through which we all can advance health in the Commonwealth:

- Public Health: Community, environmental, and social factors equitably contribute to improved oral and overall health.
- Policy: Laws, policies, and regulations at all levels of government support positive oral and overall health outcomes and health equity.
- Clinical and Community Care: Care provided by all health care providers and lay health workers including clinicians, community health workers, and home visitors, is equitable, high-quality, coordinated, and integrated.
- Public Awareness: Awareness of the importance of comprehensive health and the integral relationship between oral and overall health informs all aspects of the health care system.

WHAT YOU CAN EXPECT FROM VIRGINIA HEALTH CATALYST

Our core programs, (which many of you participate in), like the regional oral health alliances which address community level oral health needs, our learning collaboratives that work with safety net providers to integrate care, and the community water fluoridation rapid response team which we facilitate in partnership with the VDA remain integral to our work. New this fall will be task forces working to ensure water is safe, trusted and fluoridated (and that people drink it) as well as a refreshed clinical advisory board to inform and grow our integration work. I hope you will be on the lookout for more information later this fall and consider participating.

Additionally, Virginia Health Catalyst now has a resource library which we will continue to grow with new white papers, learning videos, and Virginia specific information. These resources, like our just published white paper on improving patient health by integrating all aspects of the health care system, are meant to serve as guides and tools for all members of the health community to improve oral and overall health.

The VDA is a founding partner of our organization, as we move forward as Virginia Health Catalyst, I hope you will reach out to me directly at sholland@vahealthcatalyst.org with questions or concerns.

Here's to an exciting future!

REJECTED OR MODIFIED CLAIMS?

HELPFUL TIPS ON FILING APPEALS

Thomas S. Bridenstine, VDA's Dental Benefits Expert

In the previous issue, this column discussed the types of dental insurance with an emphasis on fully-insured plans and self-insured plans, especially in the commercial market. Fully-insured plans involve an employer transferring risk (paying claims) to a dental insurer via an insurance contract while self-insured plans involve an employer accepting financial risks (paying claims) and using a third party, which may be an insurer, to manage the plan. The type of coverage influences many aspects of the coverage, including benefits and, if something goes wrong, the best way to address the issue may be to file an appeal.

Fortunately, for all concerned (providers, patients, insurers and third parties), in the vast majority of patient encounters, no problems arise. The patient receives treatment, a claim is submitted, and the provider receives payment. This process occurs thousands of times a day without any problems.

There are, however, situations when a problem arises and a claim is rejected or modified. There also may be a situation when a pre-treatment plan is not authorized by the dental insurance company.

BELOW ARE SOME TIPS TO HELP RESOLVE THESE PROBLEMS.

- Carefully review the reason the claim or service was denied. It will typically be for one of two reasons: not medically necessary or an administrative denial. Be sure you understand the reason, although you may be in disagreement.
- Follow the instructions in any applicable correspondence from the insurer, including denial letters and explanation of benefits. These documents, along with the patient's policy documents, will explain the appeal process and the next step.
- Medical necessity denials will probably include an opportunity to speak with a dental director so take advantage of that opportunity. Administrative denials will probably not provide this option, although thanks to recent efforts made by the VDA, Delta Dental is continuing to provide an opportunity to speak with a dental director when a claim is downgraded.
- The appeal process may include one level or two levels; check the patient's plan documents and correspondence from the insurer.
- For patients whose coverage is self-insured, the patient may be able to submit an appeal to the employer.
- If your practice participates with the patient's insurer, you may be able to obtain assistance from their providers' relation office, and your provider contract will probably include information on appealing.

These principles also apply to dental coverage provided by other types of dental insurance, such as dental insurance provided by the government.

Don't be intimidated by the process and remember that you can always request my assistance through the VDA's Dental Benefits Expert Program at VDAExpert.com.

Dental Benefits EXPERT
vdaExpert.com

Your team has a way to help more patients get care.

It's super **easy** and super **powerful**.

When patients have a patient portion, your team can save the day and fill the schedule by letting them know you have the CareCredit credit card as a financing option — before cost can become a barrier to care. It's a super easy and super powerful way to help more patients get care.

FREE Resource: Discover ways to minimize failed appointments with ***Preventive Appointment Communication Strategies + Scripts***, an eight-page booklet from Rachel Wall, RDH, BS and CEO of Inspired Hygiene

Already accept CareCredit?
Call 800-859-9975, option 1, then 6.

Ready to add CareCredit?
Call 866-246-6401.

CareCredit®
Making care possible...today.

VDA0919DA

HAVING FUN YET?

HOW DENTISTRY KEEPS US HAPPY, HEALTHY

Dr. Al Stenger

Did you have fun today at work? Did you at least enjoy it? Dentistry can be a very demanding profession. But it also can be rewarding in so many ways. Doing our thing should be fun; certainly it has the potential to be that way. Our profession is undergoing some rather serious structural changes. In the thirty or so years I've been in practice we've continually adapted to advances in technology that have made things better for our patients and for us. Technology will continue to advance and we will adapt. The structural changes we are facing require a different kind of adaptation. Do we have to change how we practice? Should we? Are changes in how we practice better for our patients, for society, for us the practitioners? These are the questions I want to explore in this essay because if change doesn't produce betterment, then why change? Furthermore, as we are ethically bound to improve dental care and the dental health of the public, we should seriously consider anything that might put that ethical duty at risk.

Think about your most rewarding experiences as a practicing dentist. What is it that makes our work meaningful? From a betterment-of-society standpoint, if we could be replaced by robots, should we? Can we be left alone to practice the dental arts without having to manage people or a business? What happens to a dentist's ability to diagnose and treatment plan if procedures are accomplished by prescription by mid-level providers? Is there something about seeing a problem through from beginning to end that is better than any other alternative?

Matthew Crawford is an author and a research fellow at the Institute for Advanced Studies in Culture at the University of Virginia. He addresses this very issue:

> "Any discipline that deals with an authoritative, independent reality requires honesty and humility. I believe this is especially so of the stochastic arts that fix things, such as doctoring and wrenching, in which we are not the makers of the things we tend. If we fail to respond appropriately to these authoritative realities, we remain idiots. If we succeed, we experience the pleasure that comes with progressively more acute vision, and the growing sense that our actions are fitting or just, as we bring them into conformity with that vision. This conformity is achieved in an iterated back and forth between seeing and doing. Our vision is improved by acting, as this brings any defect in our perception into vivid awareness"[1]

Crawford would say yes, not only do we become better at what we do by acting in conformity with our vision (treating what we diagnose and treatment plan) but those actions produce pleasure because our vision improves and what we do matters; our actions are fitting and just. Accordingly, it is the act of restoring teeth and other dental treatments we do, where our work is subject to authoritative reality (as professionals we have agreed to standards of excellence) that we experience the pleasure of seeing clearly how our interactions with the physical world produce a result. This seems obvious based on our experiences but maybe we

aren't thinking about the reverse so much. Could separating the seeing from the doing keep us from being the best doctors we could be and make us less happy in our work?

Some interesting work is being done in neuroscience that might provide an answer to that question. Kelly Lambert is a neuroscientist and professor of psychology at the University of Richmond. Her recent book "*Well-Grounded: The Neurobiology of Rational Decisions"* examines the best ways we can protect and preserve our ability to predict the outcomes resulting from the decisions we make. In addition her work provides insight into what happens to us when we don't confront things as they are or when the outcomes of our decisions aren't contingent on our actions.

> "One factor contributing to the rising rates of depression in service oriented, technology driven societies is the removal of contingency training in our day to day lives. Instead of engaging in tasks that our ancestors did, such as cooking, cleaning, building and gardening, requiring

1 Matthew B. Crawford. *Shop Class as Soulcraft: An Inquiry into the Value of Work.* New York: Penguin Press, 2009.pg. 100

► FUN - CONTINUED ON PG. 12

► FUN - CONTINUED FROM PG. 11

> ongoing contingency calculations, we are more likely to sit around and push buttons for our resources to appear as soon as possible. Consequently, I fear that many of us are increasingly becoming the noncontingent trust fund group (in the rat model, those rats that receive a reward of food independent of, not contingent on, their actions), with a diminishing ability to adapt to changes in our environment in effective ways. Regardless of whether we diminish our contingency building activities suddenly or gradually, our sense of control and efficacy also diminishes, leading to emotional and cognitive challenges and in worst cases, psychiatric illnesses such as depression."[2]

Lambert's research suggests that a loss of agency might harm us psychologically. Crawford examining the issue using a different discipline finds the struggle for individual agency to be at the very center of modern life.

> "Both as workers and as consumers we feel we move in channels that have been projected from afar by vast impersonal forces. We worry that we are becoming stupider, and begin to wonder if getting an adequate grasp on the world intellectually, depends on getting a handle on it in some literal and active sense."[3]

> "If occasions for the exercise of judgment are diminished, the moral-cognitive virtue of attentiveness will atrophy. We have to wonder, then, whether degraded work entails not just dumbing down but also a certain unintended moral reeducation."[4]

Notice that Crawford goes further, suggesting that diminished agency might have a negative effect on ethics, as he puts it an "unintended moral reeducation". Much of what we decide to do when we practice dentistry involves some sort of intervention on our part. Generally our evidence base is not like physics where there are "laws" that have been clearly established and agreed upon. It's hard and in many cases unethical to do true double blind studies. The evidence we rely on generally guides us in making our decisions rather than prescribing what we "ought" to do. Should we place a composite on this particular tooth in this patient's mouth or is it better to place a crown or onlay or even an amalgam? Should we do a resective periodontal surgery procedure on this site or should we treat it nonsurgically? Should we do a root canal or extract and place an implant? Our patients are unique individuals and the problems they have are hard to reduce to simple treatment algorithms. To practice ethically, we have to see everything clearly.[5]

Crawford suggests that what we do requires a certain cognitive and moral disposition towards our patients requiring us to practice attentively in the way of a conversation rather than assertively in the way of a demonstration.[6]

If every dental problem were the same, we might become bored and our services reduced to a commodity: our individuality might not matter. But dental problems are rarely the same. There are nuances to the delivery of care, the specific causes and the exact conditions from person to person. It's not only that we didn't make the things we work on (people), but each one is different. Thus getting it right demands that we try to understand the individual who trusts us with their care. It makes what we do cognitive (we have to think) and moral (we have to decide what is the right thing to do) and as such provides the opportunity to practice in the way of a conversation: in this specific patient, what were the causes of this problem we are fixing? When we are deciding what to do, how will our choices be affected by things unique to this individual? Do I understand what this patient needs in terms of prevention and maintenance? Do I have time to know this person? Do I have time to make sure the patient understands her condition and why this course of treatment is the best choice among all others?

Compare that to practicing assertively in the way of a demonstration. A broken tooth becomes a crown. Proximal caries becomes a DO composite. Maybe we do the treatment ourselves or maybe an associate or a mid-level provider actually completes that treatment plan. Maybe we get to follow our treatment to learn if it worked as we thought it would.
A young orthodontist once commented to me that sometimes she is so busy she doesn't feel present. Time pressure gets in the way of "getting it right". Other distractions exist as well. Poorly functioning systems in the office, third parties rejecting payment for what our "conversation" determined to be the best for that individual. In your own experience, what other distractions keep you from practicing attentively or reduce your day to a series of demonstrations?

Did you enjoy your work today?

> "If we follow the traces of our own actions to their source, they intimate some understanding of the good life. This understanding may be hard to articulate; bringing it more fully into view is the task of moral inquiry. Such inquiry may be helped along by practical activities in company with others, a sort of conversation in deed. In this conversation lies the potential of work to bring some measure of coherence to our lives."[7]

Can our actions as dentists intimate some understanding of the good life? I experienced as much at the first MOM

2 Kelly Lambert. *Well Grounded: The Neurobiology of Rational Decisions.* New Haven and London: Yale University Press, 2018. pg 149
3 Crawford, pg. 7
4 Crawford, pg. 101
5 Espelid I, Alanen P, Hofmann B. Evidence-based dentistry and Ethics. Nor Tannlegeforen Tid. 2013; 123: 28-32
6 Crawford, pg. 82
7 Crawford, pg. 197

project 20 years ago and at every other one I participated in. If you experienced the same, I want you to reflect deeply on the cause of that feeling. Did it get you in touch with the life well lived? My experience at MOM was rooted in a feeling of solidarity with my fellow dentists and really every volunteer; solidarity with a group of people who gathered together utilizing their skills and efforts to bring not only dental care but hope to the people of Appalachia who were suffering.

"Obligation to others is the claim made on us by various systems of universal ethics. It has a dreary quality to it, like a summons for jury duty. The Kantians claim to find the source of this obligation in a rigorous argument, but I am not able to follow it. By contrast, solidarity with others is a positive attraction, akin to love. It is not an abstract imperative, but an actual experience we have from time to time. Its scope is necessarily smaller, its grip on our affections tighter, than of any vaporous universal."[8]

Crawford isn't minimizing the good that comes from fulfilling an obligation to others, rather he is recognizing that solidarity is more descriptive of what attracts us to do good. If there were no dental profession and you simply fixed teeth so to speak independent of any universally accepted standards, would your work be as beneficial to you as a person?

> "Only a fellow journeyman is entitled to say "nicely done". A judgment on the finer points can arise only within, and receives its force and justification from, a shared orientation toward the more basic functional ends that are captured by the objective standards of the practice. It is in doing the job nicely that the tradesman puts his own stamp on it. His individuality is not only compatible with, it is realized through his efforts to reach a goal that is common. His individuality is thus expressed in an activity that, in answering to a shared world, connects him to others: the customers he serves and other practitioners of his art, who are competent to recognize the peculiar excellence of his work."[9]

Crawford's comments here would suggest that, no, it wouldn't be the same if we worked on teeth outside of a dental profession. We put our own stamp on what we do for our patients and that is important. But our individuality as a dentist can only truly be realized in how we reach the goal that is common, is shared with our colleagues. Dentists used to gather in associations and study clubs for the so-called intangibles of camaraderie. Maybe that was reason enough. Could a renewal in interest in joining together as professionals strengthen our ethics and focus on excellence?

This essay explored how the work we do with our hands meeting the standards that we know to be true impacts the quality of our decisions and makes our work enjoyable. It further explored some reasons why being in solidarity with our colleagues is actually good for each individual dentist. Even though we can agree to ethical standards and standards of excellence, because each of us is a unique individual with different abilities and interests and behavioral tendencies, we should expect that there would be different means to achieving the same ends. Accordingly we should work to preserve the ability of the individual dentist to find his or her own way.

If we believe practicing dentistry attentively as in the way of a conversation is better for both the practitioner and the patient then we have an ethical duty to defend this. Consolidation of dental practices and large corporate entities running dental practices is a threat if it turns our practice of dentistry into a demonstration. Production goals are a threat if they detach us from seeing things clearly, messing with our contingency calculators. Taking away our management responsibilities is a threat if it reduces our agency. Dentistry by prescription, mid level providers, is a threat if it removes our ability to learn about each particular patient as we do what we do, as we work with our eyes and hands.

The changes that are occurring in our profession aren't necessarily good or bad from an ethical standpoint unless we allow them to be. Hopefully this essay has caused you to think differently about what it is we need to fight for and preserve as we move into the future. Maybe it's worth considering. if only as a way to talk about these issues. Perhaps the work presented here is getting closer to the true causes of problems we see so that we don't focus our remedies solely on the symptoms. Hopefully it will stimulate each of you to have conversations with your colleagues and the people who work with you about what it is that makes the practice of dentistry rewarding to both our patients and every provider.

Editor's Note: Dr. Stenger, a VDA member, practices general dentistry in Richmond.

8 Crawford, pg. 201

9 Crawford, pg. 207

TAPERED VERSUS CYLINDRICAL IMPLANT: WHICH SHAPE INFLICTS LESS PAIN AFTER DENTAL IMPLANT SURGERY? A CLINICAL TRIAL

Samieirad S, Mianbandi V, Shiezadeh F, Hosseini-Abrishami M, Tohidi E.
J Oral Maxillofac Surg. 2019; 77(7): 1381-1388

One of the most common surgeries to replace missing teeth is the placement of dentoalveolar implants. For the most part, postoperative pain from dental implant surgery is mild to moderate and the level of pain varies depending on how difficult the surgery is, the expertise of the provider, and the patient's baseline pain threshold. This article aims to assess if implant shape has any effect on patients post-operative pain. There are many implant designs including threaded vs non-threaded, platform switch vs standard platform, and implant diameters. This randomized control trial aimed to determine whether tapered implants or cylindrical implants caused less postoperative pain.
This study had a total of 50 patients, with an average age of 43.7 years, who were edentulous in the posterior maxilla. None of the patients required grafting and all of the patients had at least 6-7mm of bone width and 12mm of bone length. Patients with periodontal disease, sensitivity to NSAIDs, smokers or alcohol users were excluded from the study. All surgeries were completed by a single surgery and both implant types were manufactured by the same company. Patients were randomly assigned to either the tapered implant or cylindrical implant group. All implants were completed in 2 stages. The first stage was for implant placement, and the second stage was for uncovering of the implant. All patients were given an antibiotic and an NSAID preoperatively and postoperatively for 2 days. The visual analog scale was used to assess postoperative pain. Patients' pain levels were measured at 30 minute, 3-hours, 6-hours, 12-hours, 1-day, 2-day, 3-day, and 1-week postoperatively. At every interval the cylindrical implant had increased pain compared to the tapered implant.
The differences were statistically significant at the 3-hour (2.64 vs 1.20) , 6-hour (4.84 vs 2.32) , 12-hour (3.80 vs 1.76), and 24-hour (2.40 vs 0.96) marks. There was no statistical difference at the 30-minute, 48-hour, 72-hour, and 1-week marks. All implants were successful 6 months post-operatively. Providers can use this study to help guide implant types to help decrease patient's discomfort after implant placement.

DAN TRAN, DDS; CHIEF RESIDENT, DEPARTMENT OF ORAL AND MAXILLOFACIAL SURGERY, VCU MEDICAL CENTER

MARGINAL BONE LOSS ONE YEAR AFTER IMPLANTATION: A SYSTEMATIC REVIEW OF DIFFERENT LOADING PROTOCOLS

Sommer M, Zimmerman J, Grize L, Stubinger S.
Int J Oral Maxillofac Surg. https://doi.org/10.1016/j.ijom.2019.03.965

In the realm of implant dentistry, there are multiple techniques commonly used in practice regarding loading of implants. As first described by Branemark over 40 years ago, conventional implant loading requires a healing period of 3 to 6 months between extraction and implant placement, followed by an additional 3 months of healing prior to placement of a crown. Though thought to be potentially safer for the successful osseointegration of the implant, the lengthy healing time required for this protocol is not without negatives for both the patient and provider. In efforts to decrease time between extraction and restoration, other protocols have been described. Currently, immediate restoration involves restoring an implant within 48 hours of placement without any opposing occlusal contact while in immediate loading the restoration is subject to opposing occlusal forces. Placement of a restoration into contact between 48 hours and 3 months after implant placement is considered early loading.

Marginal bone loss around implants typically occurs rapidly during the first year then stabilizes, and has been correlated with poor hygiene, smoking, and periodontal disease. This systematic review set out to evaluate the relationship between loading protocols and marginal bone loss at one year after implant placement. Of 889 reviewed studies, 22 were included in the analysis. From the papers included, a total of 2336 implants were placed in 1253 patients; it should be noted that nearly half of the implants were loaded immediately. The meta-analysis showed an average marginal bone loss of 0.390mm for immediate restoration, 0.457mm for immediate loading, 0.488mm for early loading, and 0.852mm for conventional loading. Given these findings, it is more than reasonable to consider immediate or early loading protocols for implant dentistry in practice. It is important to remember however, that this study does not evaluate relationship between marginal bone loss and implant success.

SEAN ECCLES, DDS; RESIDENT, DEPARTMENT OF ORAL AND MAXILLOFACIAL SURGERY, VCU MEDICAL CENTER

BONE LEVELS ARE PRESERVED AFTER SIMULTANEOUS SINUS ELEVATION AT TIME OF IMPLANT PLACEMENT

Block MS.
J Oral Maxillofac Surg. doi: 10.1016/j.joms.2019.06.177

Posterior maxillary implant placement can be challenging given pneumatization of the maxillary sinus. Select cases may be placed without complication; however many require augmentation. Studies have indicated long-term success with implants greater than 9mm in length which frequently require sinus augmentation prior to or at the time of placement. This study aimed to identify differences in bone height in the posterior maxilla following implant placement in patients that required sinus augmentation and those who did not. This longitudinal study compared posterior maxillary vertical bone height measurements after 2 to 3 years following implant placement with and without simultaneous sinus lift. Bone heights were measured and compared utilizing cone-beam computed tomography performed prior to, immediately after, and 2-3 years following surgery.

Findings indicated that sinus augmentation with simultaneous implant placement utilizing a crestal approach resulted in stable bone levels 2 and 3 years following surgery. The average preoperative bone height for first molar sites in the no-graft group was 12.1mm, compared to 11.4mm in the post-augmentation group. Following implant placement in the augmentation group, the bone level at first molar sites was unchanged. All procedures were performed using a crestal approach. Sinus augmentation was performed through the osteotomy site, with a total of 98 augmentations compared to 157 in the opposing group. Comparable bone heights were obtained at the time of surgery and maintained for 2 to 3 years following simultaneous augmentation supporting the use of a crestal approach and augmentation performed through the osteotomy site to gain bone height. Limitations of this study included a small sample size, and a variance of 0.3mm during bone height measurements.

CHRISTOPHER LOSCHIAVO, DMD; RESIDENT, DEPARTMENT OF ORAL AND MAXILLOFACIAL SURGERY, VCU MEDICAL CENTER

MANDIBULAR CANAL-RELATED PARAMETERS INTERPRETED IN PANORAMIC IMAGES AND CBCT OF MANDIBULAR THIRD MOLARS AS RISK FACTORS TO PREDICT SENSORY DISTURBANCES OF THE INFERIOR ALVEOLAR NERVE

Matzen LH, Petersen LB, Schropp L, Wenzel A.
Int J Oral Maxillofac Surg. 2019; 48(8): 1094-1101

Predictive values for radiographic risk factors associated with sensory disturbances in panoramic and cone beam computed tomography images have not previously been studied. The aim of this prospective study was to determine whether obtaining a CBCT prior to odontectomy of mandibular third molars can improve the risk assessment for sensory disturbances of the inferior alveolar nerve compared to panoramic image. One hundred and six mandibular molars had panoramic images and CBCTs obtained prior to extraction. Patients' inclusion criteria included superimposition of roots of third molar on the mandibular canal in panoramic image and neurosensory test performed on side to be operated on via the Semmes-Weinstein monofilament set.

Radiographic risk factors in panoramic and CBCT images were assessed. Twenty cases had some temporary disturbance of the IAN and one case had permanent disturbance. The values looked at included positive predictive values (PPV), negative predictive values (NPV) and positive and negative likelihood ratios for all risk factors. The highest PPV and positive likelihood ratio for the CBCT obtained was when the IAN was positioned between the roots and for the panoramic image was when the roots were positioned inferior to the lower border line of the canal. In general, the PPV and positive likelihood ratio were similar for both panoramic and CBCT images. This suggests that for the most part, CBCT does not provide a significant improvement in assessment of neurosensory disturbance. This is important because CBCT imaging has been used to justify treatment planning of coronectomy instead of full removal of tooth causing alteration of the original treatment plan.

In conclusion, although CBCT does show higher PPV and positive likelihood when nerve is located in between the roots, the authors of the study do not believe that this radiographic assessment justifies performing such imaging and should only be reserved for rare complicated cases. It should be the practitioner's responsibility to know when such imaging is required.

SOHEIL ROSTAMI, DDS; RESIDENT, DEPARTMENT OF ORAL AND MAXILLOFACIAL SURGERY, VCU MEDICAL CENTER

EFFICACY OF SODIUM BICARBONATE BUFFERED VS. NON-BUFFERED LIDOCAINE WITH EPINEPHRINE IN INFERIOR ALVEOLAR NERVE BLOCK: A META-ANALYSIS

Guo J, Yin K, Roges R, Enciso R.
J Dent Anesth Pain Med. 2018; 18(3): 129–142.

Background: modern local anesthetics contain two main portions: uncharged base molecules and cationic element. The uncharged free base form of the solution is designed to diffuse through the nerve sheath, revert to the charged form within nerve, and block the sodium channel to induce nondepolarizing nerve block. Diffusion is affected by pH. With higher pH values the uncharged anesthetic isomer is the dominant form present. The pH of local anesthetics is kept low to prolong shelf life. Lidocaine with epinephrine yields a pH of approximately 4. This results in the cationic form of the anesthetic to predominate and presents as an obstacle to efficient diffusion of the anesthetic through the neuronal membrane. This acidity causes increased discomfort upon injection and time until onset for local anesthetic injections, as the acidic anesthetic must be buffered in vivo above the pKa of the drug so that more of the basic form can predominate and diffuse across the neuronal cell membrane.

Methods: In the studies assessed, 1-2% lidocaine buffered with 8.4% sodium bicarbonate was used alongside a control of non-buffered lidocaine. All were randomized controlled trials on healthy volunteers, asymptomatic patients in need of bilateral dental treatment, or symptomatic patients in need of non-surgical endodontic treatment. Outcomes were the primary time to anesthesia, pain on injection as measured by a VAS score, anesthetic success rate of inferior alveolar nerve block (IANB), and percentage of painless IANB.

Results: Five studies including healthy volunteers requiring bilateral dental treatment showed statistically significant decrease in injection pain with buffered vs. non-buffered lidocaine of ~minus 4.95 units on the VAS score (0-100). Of the eleven studies and 508 participants, one study had high risk of bias, and remaining ten studies had unclear risk of bias. Meta-analysis showed faster onset of anesthesia by 48 seconds on average and a decrease in injection pain of 5 units on VAS score.

Strengths: Two independent reviewers were used to assess risk of bias for the 11 studies used in the meta-analysis. Eight of the 11 studies used split mouth technique to control for variation between patients. Overall strength of evidence, according to GRADE system, was moderate for injection pain for IANB using VAS scores and percentage of patients with painless IANB injection

Potential confounders: varying anesthetic concentrations (1% to 4%), dosage (1.7 mL to 4 mL), difference in concentration of epi (1:80k to 1:200k), small sample size of 508 total patients across all studies, and inconsistent method of outcome assessments.

Clinical applications and further questions: Will buffered lidocaine reduce the injection pain and onset of IANB in patients with symptomatic irreversible pulpitis or acute apical abscess? (Here mostly healthy volunteers were used). Future studies may look at the effectiveness of buffered lidocaine in both symptomatic and asymptomatic patients with different routes of anesthetic administration.

Conclusion: There is moderate quality of evidence to support the use of buffered lidocaine in IANB local anesthesia to decrease injection pain by 5 units on a scale of 0–100 and low quality of evidence to support the effectiveness in reducing onset time. Due to the small sample size and the small number of included studies, further studies are needed to confirm these results. Thus, there is inadequate evidence at this point to recommend the buffered lidocaine for IANB local anesthesia in patients in need of dental treatment.

TYLER HILL, DDS; RESIDENT, DEPARTMENT OF ORAL AND MAXILLOFACIAL SURGERY, VCU MEDICAL CENTER

EFFICACY OF CORTICOSTEROIDS VERSUS PLACEBO IN IMPACTED THIRD MOLAR SURGERY: SYSTEMATIC REVIEW AND META-ANALYSIS OF RANDOMIZED CONTROLLED TRIALS

Almeida RAC, Lemos CAA, de Moraes SLD, Pellizzer EP, Vasconcelos BC
Int J Oral Maxillofac Surg. 2018; 49(1):118-131

Among general dentists and oral and maxillofacial surgeons, there is significant variation with regards to steroid use and third molar extractions. The aim of the study was to perform a systematic review of the literature to determine the efficacy of corticosteroids in the control of postoperative pain, edema, and trismus after extraction of impacted mandibular third molars.

The meta-analysis compared 17 randomized control trails and included 730 patients ages 15-35. Each of the studies compared the administration of a steroid during the pre-operative or post-operative period against a placebo group. There was variation between the studies with regards to route of corticosteroid administration, dose of corticosteroid, and duration of treatment. Additionally, there were varying degrees of impaction of the third molars within the studies. The corticosteroids included dexamethasone (9), betamethasone (2), methylprednisolone (5) and prednisolone (1). In 16 of the 17 studies, it was found that the use of corticosteroids had a positive effect with regard to the control of the pain, edema, and trismus associated with the surgical removal of impacted mandibular third molars.

With the exception of the submucosal route, the route of administration did not seem to influence the results, making the oral route an easy and cost effective option. The administration of a corticosteroid in the preoperative phase was superior to its use in the postoperative phase for the control of trismus. A single preoperative dose of dexamethasone was the most commonly utilized intervention among the trials.

LAUREN KAPLAN, DDS; RESIDENT, DEPARTMENT OF ORAL AND MAXILLOFACIAL SURGERY, VCU MEDICAL CENTER

IBUPROFEN AND/OR PARACETAMOL (ACETAMINOPHEN) FOR PAIN RELIEF AFTER SURGICAL REMOVAL OF LOWER WISDOM TEETH, A COCHRANE SYSTEMATIC REVIEW

Bailey E, Worthington H, Coulthard P.
Br Dent J. 2014; 216(8): 451-455

Removal of wisdom teeth is an extremely common surgery performed by both general dentists and oral and maxillofacial surgeons. Research suggests that wisdom tooth removal can have an immediate negative affect on both the patients' social and work life. One study showed that patients averaged 1.6 days off of work, with over one third of the patients reporting a negative impact on their work performance. For many patients, quality of life is reduced for one to two weeks following surgery. Postoperative complications include swelling, bruising, and limited mouth opening. However, patients are mostly concerned with postoperative pain. Ibuprofen and acetaminophen are commonly prescribed for pain management following extractions.

This study aimed to statistically compare the efficacy of ibuprofen, acetaminophen, and the combination of ibuprofen and acetaminophen in management of postoperative pain.

The study was completed as a systematic review and meta-analysis looking into the optimal dose of ibuprofen versus acetaminophen by direct comparison, taking into account the side effects of different doses of drugs. All included studies were randomized controlled double-blinded clinical trials. Crossover studies were included provided there was a wash out period of at least 14 days. Participants of the studies were patients of all health states without intolerances or allergies to the study drugs who required surgical extraction of a lower wisdom tooth or teeth that required bone removal. Surgery was completed under local anesthesia, sedation, and general anesthesia. Patients taking concurrent analgesia were excluded from the study. Search criteria included Cochrane Oral Health Group's Trials Register, The Cochrane Central Register of Controlled Trials, MEDLINE, EMBASE, and MetaRegister of Controlled Trials. Seven studies were included in this review. The studies contained data on 2,241 participants with a 16-40 age range. Each study included a direct comparison of 400 mg of ibuprofen to 1000 mg acetaminophen or the combination of both agents at 2 hours and 6 hours postoperative.

The studies showed that, for greater than 50% pain relief over 2 hours, the overall risk ratio was 1.30 (95% CI 1.09-1.55 p<0.00001). This indicates that 30% more patients achieved at least 50% of the maximum pain relief over 2 hours in the 400 mg ibuprofen group when compared to the 1000 mg acetaminophen group. However, the studies also showed that, for a greater than 50% pain relief over 6 hours, the overall risk ratio was 1.47 (95% CI-1.28-1.69 p<0.0001), which indicates that 47% more patients achieved at least 50% of the maximum pain relief over 6 hours in the 400 mg ibuprofen group when compared to the 1000 mg acetaminophen group. The combination of the two drugs did show an overall relative risk of 1.77 (95% CI 1.32-2.39). However, only two of the included studies observed the effects of the two medications taken together. Thus, this cannot be considered a meta-analysis.

The evidence in this study suggests that 400 mg of ibuprofen is superior to 1000 mg of acetaminophen in postoperative management of pain following surgical extraction of mandibular third molars. The study shows promising results for combining both 400 mg ibuprofen and 1000 mg of acetaminophen for postoperative pain management. Based on the evidence of this study, the authors recommend that since most patients are able to tolerate both Ibuprofen and acetaminophen, prescribing both analgesics would take advantage of their different mechanism of actions and achieve adequate pain relief for patients following the surgical removal of mandibular third molars.

MICHAEL BOARD, DDS; RESIDENT, DEPARTMENT OF ORAL AND MAXILLOFACIAL SURGERY, VCU MEDICAL CENTER

SAFETY OF TOOTH EXTRACTION IN PATIENTS RECEIVING DIRECT ORAL ANTICOAGULANT TREATMENT VERSUS WARFARIN: A PROSPECTIVE OBSERVATION STUDY

Yoshikawa H, Yoshida M, Yasaka M, Yoshida H, Murasato Y, Fukunaga D, Shintani A, Okada Y
Int J Oral Maxillofac Surg. 2019; 48(8): 1102–1108

Due to the recent FDA approval of direct oral anticoagulants (DOAC) as an alternative to warfarin, Oral and Maxillofacial surgeons encounter an increased number of patients on this new antithrombotic treatment. DOACs are divided into direct thrombin inhibitors (Dabigatran) and factor Xa inhibitors (Rivaroxaban, Edoxaban, Apixaban). Traditionally therapeutic monitoring of Warfarin is achieved via INR that is taken 24 hours before extraction. If the INR is controlled within therapeutic range then warfarin is usually not stopped prior to extractions, reducing the risk of an adverse thromboembolic event. In contrast, coagulation screening assays (PT/APTT) are considered unreliable for DOACs, and routine therapeutic monitoring in clinical experience is available to guide perioperative care, including need for cessation of DOACs prior to extraction. Thus, the goal of the study was to compare the safety of tooth extraction in patients receiving DOAC or Warfarin without their antithrombotic treatment.

The study was a prospective observational study which included 367 patients, broken down into two groups: patients taking DOAC and patients taking warfarin. Of the 390 tooth extractions 128 were DOAC patients and 262 extractions were warfarin patients. International normalized ratio (INR) was obtained within 24 hours for all warfarin patients. Based on the report by Stangier et al. a protocol was created for patients taking Dabigatran in which all extractions on patients taking DOACs were performed more than 6 hours after the last dose. This protocol is based on the statistic that on average APTT prolongation declined to half of the maximum within 6-8 hrs of dosing. This was applied to all DOACs due to the fact that all of their half-lives are similar. Extractions were performed under local anesthesia under an established set of clinical protocols. Hemostasis was achieved by placing an absorbable gelatin sponge into extraction sockets and suturing with (3-0) silk suture, patients were instructed to bite on gauze for one hour after surgery. Bleeding was defined as oozing or marked hemorrhage that could not be stopped by wound compression with gauze, and hemostasis that required medical intervention. Out of the 128 extractions of the DOAC group postoperative bleeding occurred in 4 extractions (3.1%). Postoperative bleeding occurred in 23 out of the 262 (8.8%) extractions of warfarin patients. However, this study found that there was no statistical significance between the groups. Based on these results the study concluded that it is not necessary to stop DOACs before extractions if the extractions are performed at least 6 hours after the last dose. It is clear that more studies are needed to confirm these results and to investigate the perioperative management of patients taking DOACs before official guidelines can be implemented.

JENNIFER VAN HOOK, DMD; RESIDENT, DEPARTMENT OF ORAL AND MAXILLOFACIAL SURGERY, VCU MEDICAL CENTER

CLINICAL OUTCOMES OF BOTOX INJECTIONS FOR CHRONIC TEMPOROMANDIBULAR DISORDERS: DO WE UNDERSTAND HOW BOTOX WORKS ON MUSCLE, PAIN, AND THE BRAIN?

Connelly J, Myung R, Gupta GM, Tartaglia A, Gizdulich J, Yang R, Silva R.
Int J Oral Maxillofac Surg. 2017; 46(3): 322-327

Botox (onabotulinumtoxin A) has historically been used to treat a wide number of clinical problems such as movement disorders, chronic migraines, focal hyperhidrosis, strabismus, facial rhytids and more. It exerts its effects at the neuromuscular junction to block the release of acetylcholine, resulting in a local paralytic effect. Botox has played a valuable role in the contemporary treatment of temporomandibular joint disorders (TMDs), although existing randomized control trials fail to demonstrate superiority of Botox over other conventional therapeutic options.

The aim of this retrospective review was to identify the efficacy of Botox injections for the reduction in TMD symptoms in patients with or without concomitant stress-related psychiatric comorbidities and/or history of bruxism. The authors also investigated the relationship between the follow-up visit interval and overall self-reported efficacy of Botox treatment. A total of 71 patients being treated for TMD between 2002- 2013, without any benefit from conventional therapy (i.e. psychological support, splint therapy, physiotherapeutic support) were included in this review. Subjective responses to the Botox treatment were categorized as "beneficial" or "not beneficial" based on a documented reduction in pain and/or improvement in function. All subjects received a one-time treatment with a total of 100 units of Botox that was injected into the bilateral temporalis and masseter muscles. Ten units of Botox were delivered at each injection site using a 5 cc syringe with 30 gauge needle. The patients then followed up for evaluation at 5 and 10 week intervals.

Results demonstrated that subjects with a history of bruxism were significantly more likely to benefit from Botox treatment compared to those without bruxism (P= 0.042). Also, those patients with stress-related psychiatric comorbidities (such as depression, anxiety, PTSD etc.) who also had bruxism, showed significantly greater benefit from Botox treatment compared to those with stress-related psychiatric comorbidities but without bruxism (P=0.027). Lastly, the authors found that at 5 weeks after treatment, subjects were less likely to report an improvement in their TMD pain compared to those queried at 10 weeks after treatment (P= 0.009).

Although the use of Botox for the treatment of TMDs is controversial and a standardized approach to treatment has yet to be formulated, these retrospective clinical findings showed that a significant proportion of TMD patients who were resistant to conventional treatments reported Botox treatment to be beneficial (77.5% of patients). The increase in efficacy seen at the 10 versus 5 week timepoint may be due to the fact that maximal effects of Botox are observed at 5 to 6 weeks post-injection. Taking these findings into consideration, practitioners can have better insight on optimal patient selection and timing for post-procedural evaluation when considering Botox treatment for TMDs.

DR. BALRAJ S. KANG; RESIDENT, DEPARTMENT OF ORAL AND MAXILLOFACIAL SURGERY, VCU MEDICAL CENTER

IN VIVO TOOTH-SUPPORTED IMPLANT SURGICAL GUIDES FABRICATED WITH DESKTOP STEREOLITHIOGRAPHIC PRINTERS: FULLY GUIDED SURGERY IS MORE ACCURATE THAN PARTIALLY GUIDED SURGERY

Bencharit S, Staffen A, Yeung M, Whitley D, Laskin DM, Deeb GR
J Oral Maxillofac Surg. 2018; 76 (7): 1431-1439

It is well agreed upon among surgeons and the restoring clinicians that the ideal implant placement takes into consideration the ultimate location and angulation of the final restorative prosthesis. Through previous studies, it is also now known that implant guides fabricated from cone beam computed tomography (CBCT) and computer treatment planning software demonstrate superior accuracy compared to traditional implant guides fabricated from clinical impressions alone. It has also been demonstrated that even for experienced clinicians, implant guided surgery has proven to be more accurate than non-guided implant placement. Because of this, most clinicians continue to use out-sourced surgical guides which are fabricated in laboratories at different locations. This can be quite costly and it may take several days to receive the manufacturers implant guide. Recently, in-office intra-oral scanning combined with implant planning software and stereolithographic 3D printers has allowed for accurate and cost-effective implant guide fabrication. However, there is little data to prove the accuracy of the in-office based 3D-printed implant guided systems. This study compared the accuracy and deviation of in-office based fully guided and partially guided 3D planned and printed implant surgical guides. Fully guided implant surgery is

defined as the implant and fixture mount being placed through the surgical guide and partially guided is defined as the implant osteotomies alone being used through the surgical guide. In addition to comparing accuracy of fully guided versus partially guided implant surgical guides, this study also sought to define trends in misplacement of implants in regards to angulation and position.

In this study, sixteen patients were used requiring a total of thirty-one dental implants. The patients also had to have at least four natural remaining teeth in the respective arch. All implant plans were approved by the same oral and maxillofacial surgeon and the same prosthodontist. A total of 20 implants were placed using fully guided protocol while 11 were placed using partially guided surgical protocols. All implants were placed flapless unless the amount of keratinized gingiva prohibited this. Post-operatively, a CBCT was taken and deviations in implant angulation and bodily positioned were measured.

Overall, the results demonstrated a statistically significant difference in fully guided implant placement having superior accuracy compared to partially guided implant placement. In the mesiodistal dimension, the partially guided protocol had deviation range average of ~0.5mm and the fully guided protocol had average deviation of ~ 0.3mm. There was no significant difference in buccal lingual deviation comparing partially and fully guided placement. Of note, when placing partially guided implants the position of the implant was more distally positioned and angulated. This has clinical significance and the operator should be aware of this tendency. Finally, it is important to note that the deviations from the present study were similar to those published in previous studies using laboratory manufactured guides. This may provide promise for the same quality of 3D printed surgical guides to be fabricated in-office potentially saving time and cost.

Although fully guided implant surgery does appear more accurate than partially guided surgery there are some limitations that should be realized. One example, is a single anterior implant site where the space between the adjacent teeth is too narrow to fabricate the surgical sleeve for the fully guided implant. Additionally, one must be very confident in the pre-operative implant plan as no intra-operative changes can be made with a fully guided system which at times may be disadvantageous. Also, it should be noted that the planned surgical guides in this study were tooth-supported guides and none were partially supported by mucosa. Overall, fully guided implant surgical guides, which can be fabricated in-office, should be utilized for the most accurate implant placement given the appropriate clinical situation.

DR. DANIEL HAWKINS; RESIDENT, DEPARTMENT OF ORAL AND MAXILLOFACIAL SURGERY, VCU MEDICAL CENTER

MULTIPLE SUPERFICIAL MUCOCELES CONCOMITANT WITH ORAL LICHEN PLANUS: A CASE SERIES

Kejia L, Jianhua L, Weija Y, Guohua W, Hua Y.
Oral Surg Oral Med Oral Path Oral Rad. 2019; 127(4): e95-e101

Superficial mucoceles are a relatively rare variant of the common mucocele which have an unclear etiology and are often misdiagnosed as pemphigoid, bullous lichen planus, herpes lesion, or venous lake when concomitant with oral lichen planus (OLP). It is thought that these lesions are induced by an inflammatory mechanism related to OLP. On exam, along with the classic presentation of OLP, this variant of the common mucocele will present as multiple small, translucent, subepithelial vesicle affecting the oral mucosa most commonly in the retromolar, lower labial, buccal, and soft palate regions which are subepithelial extravasations of mucous occurring at the epithelial-connective tissue junction. These lesions were most commonly noted in females over the age of 30 years old in this case series and other documented case reports. In general, they are significantly smaller than the traditional mucoceles and can cause some discomfort when they burst and leave behind small, shallow ulcerations. However, most patients report no symptoms and the ulcerations generally heal within a few days after formation. In order to optimize patient care and achieve the correct diagnosis, it is important to be familiar with this variant of the common mucocele.

Other case reports describe superficial mucoceles found in conjunction with Graft Versus Host Disease, Head and neck radiation, cytotoxic chemotherapeutic agents, and allergic reactions to some dental agents and alginate impression material. Of importance, none of the 9 patients in this case study experienced relief of the superficial mucoceles in response to anti-inflammatory and/or immunosuppressive treatment directed at the OLP.

Most superficial mucoceles resolve spontaneously and do not require treatment, which is significantly different from the common oral mucocele which requires surgical removal of the lesion and underlying traumatized salivary gland tissue for resolution. Surgical excision or laser ablation can cause significant mucosal soft tissue damage and scarring and is most likely more irritating to the patient than the lesions themselves. One case report has described successful treatment with betamethasone mouthwash; however, there is not enough scientific literature regarding this treatment for the authors in this case series to recommend it. It is for these reasons listed above that the authors of this case series and authors of numerous other case reports cited in this article recommend no treatment for superficial mucoceles. However being aware of this entity is important to prevent misdiagnosis and unnecessary patient treatment.

MARK GARDNER, DDS; RESIDENT, DEPARTMENT OF ORAL AND MAXILLOFACIAL SURGERY, VCU MEDICAL CENTER

COMPARISON OF THREE ANXIETY MANAGEMENT PROTOCOLS FOR EXTRACTION OF THIRD MOLARS WITH THE USE OF MIDAZOLAM, DIAZEPAM, AND NITROUS OXIDE: A RANDOMIZED CLINICAL TRIAL.

de Moares MB, Barbier WS, Raldi FV, Nascimento RD, dos Santos LM, Loureiro Sato FR
J Oral Maxillofac Surg. https://doi.org/10.1016/j.joms.2019.06.001

One of the most difficult aspects of providing excellent patient care is the management of anxiety. Patients worldwide will avoid seeking treatment due to fear. Currently there are several local anesthetic medications administered to provide pain control. However, this does not eliminate the factor of anxiety. Various sedation techniques are available to reduce patient anxiety; this study compares three different anxiety management protocols via oral and inhalational sedation.

The study was performed as a randomized clinical trial that compared the effects of diazepam, midazolam, and nitrous oxide on anxiety levels, vital signs (including heart rate, blood pressure, oxygen saturation), and retrograde amnesia on patient's requiring extraction of fully impacted maxillary third molars. A total of 120 patients were included in the study with moderate to severe levels of anxiety determined by the Corah Dental Anxiety Scale, and were divided randomly into 3 groups. The inclusion criteria also incorporate that the patient be categorized as an American Society of Anesthesiologists (ASA) classification of I and are 18 to 30 years of age. The three groups included patients sedated with 5 mg of PO diazepam 30 minutes prior to the start of surgery, patients sedated with 7.5 mg of PO midazolam 30 minutes prior to the start of surgery, and patients sedated with 40% nitrous oxide and 60% oxygen via inhalation 5 minutes prior to the start of surgery. The same oral and maxillofacial surgeon performed the extractions with equivalent doses of local anesthesia per patient.

The anxiety level, vital signs and retrograde amnesia were evaluated prior to surgery, 15 minutes after sedation, at the end of surgery, and 15 minutes after surgery. There was no statistically significant difference found in patients' heart rate, oxygen saturation, and retrograde amnesia for all 3 groups, however there was a significant difference in systolic and diastolic blood pressure after 15 minutes of nitrous oxide sedation. The administration of nitrous oxide had resulted in decreased systolic and diastolic blood pressures. Upon evaluating anxiety, the differences in preoperative to postoperative anxiety levels were statistically significant for all techniques.

The evidence provided by this study gives the practitioner several effective options in managing anxiety for the fearful patient when extracting third molars; however, it does not include patients with complex comorbidities. Every provider should consider the variability in anxiety level from patient to patient and therefore should contemplate the use of anxiolytics to enhance patient care.

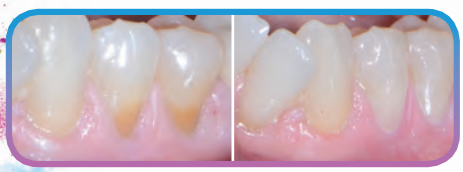
MICHAEL THEISS, DDS; RESIDENT, DEPARTMENT OF ORAL AND MAXILLOFACIAL SURGERY, VCU MEDICAL CENTER

OMNICHROMA **One-Shade Universal Composite**

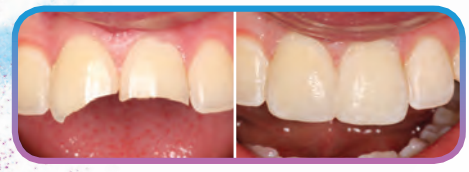
Why Are Thousands of Doctors Trusting OMNICHROMA?

"OMNICHROMA is GROUNDBREAKING—
a win-win for all offices. No need to stock 30 composite shades that expire and take up space. So economical and it works great!**"**
-Dr. Peter Auster

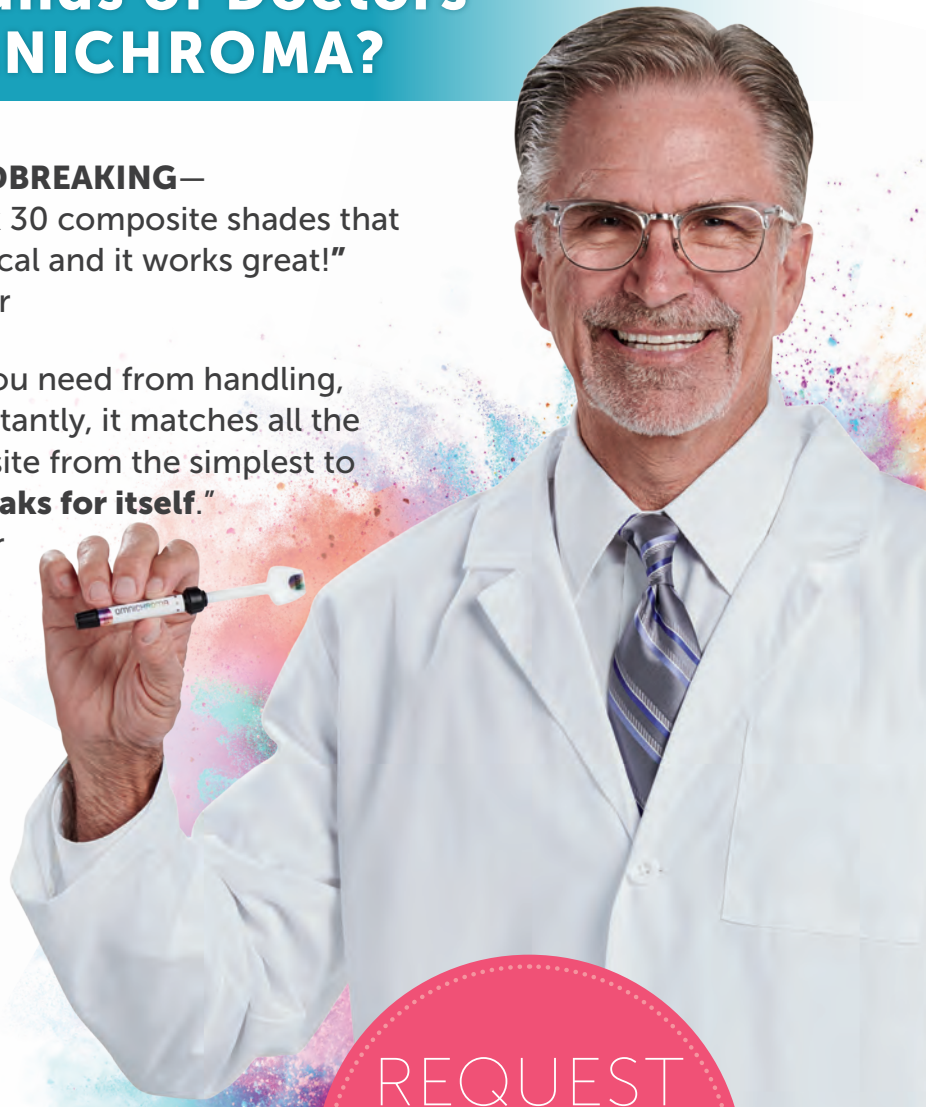
"OMNICHROMA has all the features you need from handling, strength, polishability, and, most importantly, it matches all the tooth shades. This is my go-to composite from the simplest to the complex... **The result speaks for itself**."
- Dr. Allan Mohr



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



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



REQUEST **YOUR SAMPLE** TODAY
OMNICHROMA.COM/US
USE CODE: **TVDA**

Innovated to color-match like you've never seen before, Tokuyama's unique dental composite matches every shade from A1 to D4 with just one shade of composite. By streamlining the restorative process, OMNICHROMA simplifies day-to-day dentistry and saves you time and money.

Tokuyama

Call us at +1 (877) 378-3548

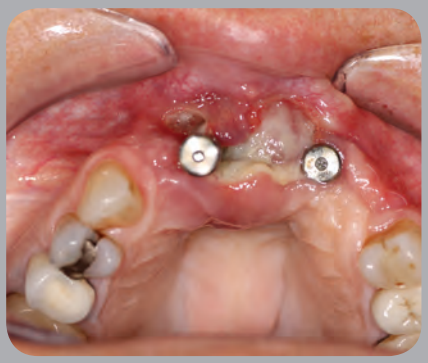
*Limit one sample kit per doctor. While supplies last. Offer valid until 12/31/19. Please allow 4-6 weeks for delivery of complimentary goods. Offer valid in US and Canada only. For evaluation purposes only. Participating doctors or dentists are obligated to properly report and reflect any bonus product, rewards, rebates, discounts or other benefit they receive on their submissions to Medicare, Medicaid, state or federally funded healthcare program and/or private insurance.

PATHOLOGY PUZZLER

DR. JOHN SVIRSKY

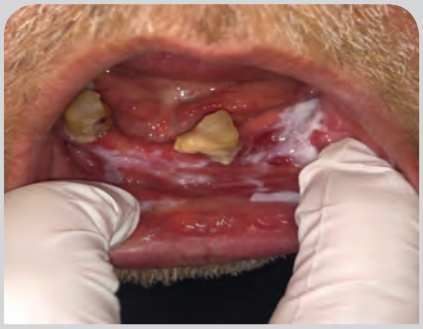
INSTRUCTIONS: *What is your clinical impression of each of the following cases? Answers are revealed on page 25.*

► CASE ONE



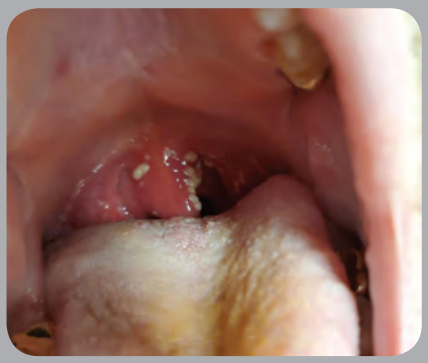
A sixty-two-year-old white female presented with a non-healing lesion between two implants.

► CASE TWO



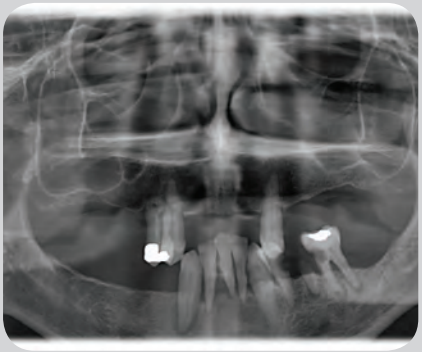
A sixty-seven-year-old white male presented with a history of white lesions of the oral cavity that were increasing in size, areas affected and thickness. He had a history of smoking and drinking. A biopsy was performed in oral surgery.

► CASE THREE



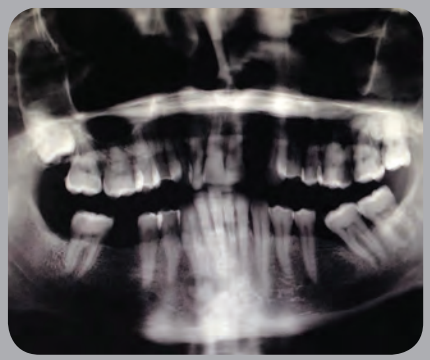
A seventy-two-year-old white male presented with lesions of the uvula that did not readily wipe off

► CASE FOUR



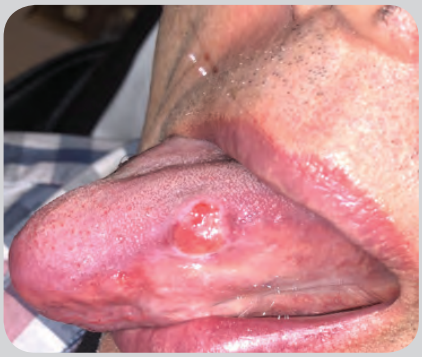
Incidental finding on a panoramic radiograph in a seventy-year-old black male.

► CASE FIVE



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

► CASE SIX



Lesion found on a sixty-seven-year-old white male.

DRNA Offering a *FREE*[1] Amalgam Separator to VDA Members

DRNA is endorsed by:

VDA Services
VIRGINIA DENTAL ASSOCIATION

Why pay more?

EPA compliance is mandatory, but paying more for your amalgam separator is not. Reduce your office overhead and put money in your pocket.

As a member of the VDA, you can get a ***FREE*** amalgam separator from DRNA while locking in the current annual recycling rate for three or five years.[1]

DRNA offers a complete recycling solution for your office. Recycling services include on-demand pickup, pre-paid shipping, recycling, and all necessary compliance documentation required under the EPA rule.

[1] Receive a free amalgam separator 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.
[2] Retail price of the unit has, from time to time, been less because of promotions.

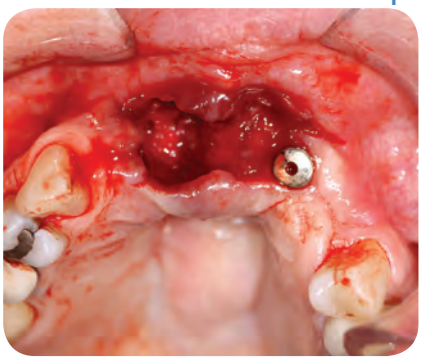
Visit **www.drna.com/vda** or call **(800) 360-1001, ext. 2** to sign up and receive your free amalgam separator.

DRNA™
Dental Recycling North America

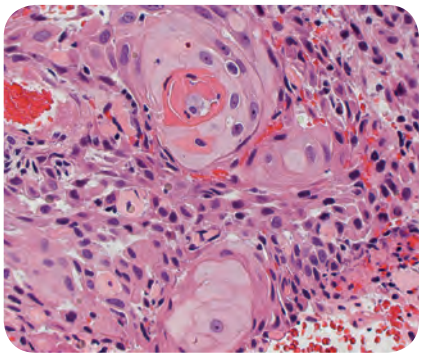
PATHOLOGY PUZZLER ANSWERS:

► CASE ONE

1



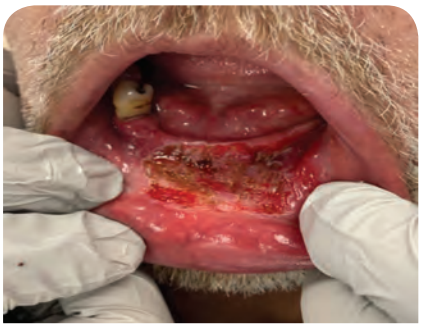
2



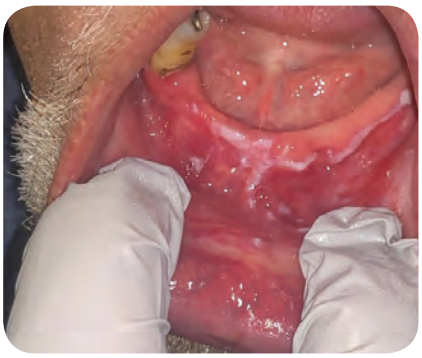
This case clinically looked reactive/inflammatory but lesions are not always as they seem. When the lesion was biopsied, there was a surprising amount of bone loss (image 1). It turned out to be a squamous cell carcinoma (image 2).

► CASE TWO

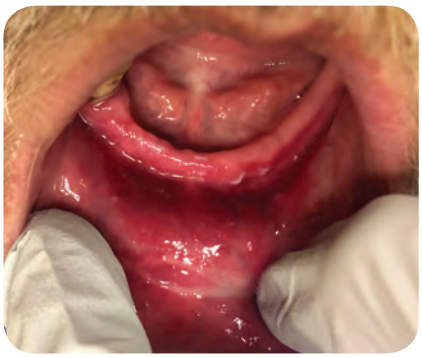
1



2



3



This patient has a difficult management condition termed clinically proliferative verrucous leukoplakia. These patients have a tendency to develop squamous cell carcinomas within ten years of diagnosis This is a progressive condition that is multifocal and can develop multiple carcinomas. The biopsy can show hyperkeratosis, dysplasia or squamous cell carcinoma. They need to be kept on close follow-up protocol. Laser is a good way to address the lesions, however they often recur. In this case image 1 is following the initial laser removal by the “Laser Master” Dr. Robert Strauss. The histology showed moderate dysplasia. Within four months the leukoplakia returned (image 2) and was lasered a second time (image 3). My philosophy is that it cannot become cancer if the lesions are no longer present.

► CASE THREE

This has the appearance of oral candidiasis and was treated with clotrimazole 10mg troches up to 5 times a day for up to two weeks. Sometimes the white plaques can be difficult to rub off.

► CASE FOUR

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 FIVE

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.

► CASE SIX

This lesion turned out to be a squamous cell carcinoma. There was minimal induration and the differential diagnosis would have also included a pyogenic granuloma and trauma.

A Model of Group Practice for Dentists by Dentists

CENTRAL VIRGINIA DENTAL CARE, PLC

SERVING RICHMOND AND CENTRAL VIRGINIA

112 Dentists | 62 Practices
1 Common Vision

A group practice model that allows us to take control of our future. Not content to remain in the business practice model of the past, we have chosen to build upon our strengths, confront the market threats, address our weaknesses, and seize the opportunity to advance the care we deliver. Whether you're an owner operator or looking for an ownership opportunity, know Central Virginia Dental Care has the model for your success.

Hundreds of Virginia Dentists are forging control of their own futures

CENTRAL VIRGINIA DENTAL CARE, PLC

Visit us at:
www.centralvirginiadentalcare.com

ATLANTIC DENTAL CARE, PLC

SERVING SOUTHEASTERN VIRGINIA

117 Dentists | 74 Practices
1 Common Vision

A group practice model that positions us to thrive in the future and maintain control of our destiny. Dentistry is changing and the practice model of the past must evolve and adapt to meet today's market challenges. Whether you're an owner operator, recent graduate or dental student, know Atlantic Dental Care is an equity ownership model of practice designed to position you for success.

Imagine Corporate Dentistry Without Compromise

ATLANTIC Dental Care, PLC

Visit us at:
www.atlanticdentalcare.net

VCU STUDY ABROAD PROGRAM

INTERNATIONAL CONNECTIONS

Sebastian Viski, Associate Editor; Class of 2020, VCU School of Dentistry

Each year, the VCU School of Dentistry selects four rising senior students for a study abroad grant. Two students are immersed in two weeks of clinical sciences at the University of Ljubljana, School of Dentistry, in Slovenia. The other two students travel to Qingdao Stomatological Hospital, China, for a similar trip. The study abroad program has become a tradition at VCU. While VCU sends its own students to universities across the world, the institution also accepts students from abroad who experience our educational system.

As one of the recipients of this grant, I was one of the guests at the University of Ljubljana, Slovenia in May 2019. Their training is based on a 6-year program following high school. The first three years are oriented on heavy medical sciences followed by clinical dentistry in the fourth year of studies. My host was Dr. Ksenija Rener Sitar, associate professor at the University of Ljubljana and Diplomate of the American Academy of Orofacial pain (picture 1). The experience permitted me to rotate through each specialty clinic during the first week and in the second week, I was granted the opportunity to learn more about prosthodontics, my area of interest, in their particular department.

Each program exposes knife-edge technology, techniques and materials to the guest students. This year, the University of Ljubljana took me on a tour of Fotona Medical and Dental Laser Dispach and offered me hands-on experience with their new dental lasers. During the visit, the company scheduled us for a small-class training with one of their top dentists who focuses on laser technology within their practice. The dentist showed us a live demonstration and walked us through the major settings of the dental laser. The laser company is not only based in Europe, but has a great market opening within the US.

This program not only allowed me to be among the students, but also offered me the opportunity to follow some of the professors within the faculty practice. The entire staff, faculty, and students were very welcoming and eager to answer any questions.

Even if we come from two different educational systems, our differences make the experience exceptional. Dentistry is amazing because we see beyond the limits of the cavity preparation. Both countries see the patient as a whole and seek customized treatment to each country's population needs and customs.

L-R: Dr. Rener-Sitar, Vice-Dean Dr Janja Jan, and Sebastian Viski (VCU Class of 2020)

IS IT TIME FOR A COURSE CORRECTION?

Dr. James R. Schroeder

The American Dental Association compares the life cycle of a dentist's career in private practice to that of a bell shaped curve. The "x" axis represents the years in practice from graduation to retirement, and the "y" axis represents revenue produced. Nobody can escape the curve. Or, can they?

A modification of the curve seems to exist for those with a sharp awareness of internal and external factors that impact the shape the curve. Through measurements and honest self-assessments it's possible to discover where an individual dentist's road map is trending.

Please recognize there is a wide range of variables. But the elephant in the room is the question about where we're spending the majority of our time and energy. It's easy to be driven by the tyranny of the urgent in dentistry. An average day is largely occupied by a focus on delivering exceptional patient care and clinical skills. Unless you have an appetite for business and leadership, those skills simply don't get fully developed and the practice will never operate at maximum efficiency and productivity.

Dentistry is no longer about honing your technical skills. A generation ago that may have been acceptable - but today, the dental owner feels squeezed by corporate entities, large insurance companies, and government regulations - including very difficult HR regulations. Today, consult outside the dentists' wheelhouse is often critical and saves a great deal stress and heartache.

As I look at our dental colleagues of all ages, I see many different responses to our changing health care world.

Many recent graduates have a degree in "fearodontics" which is an important discussion for another day. Further along in the dentist's journey, many will acquire diversified skills and talents to make the necessary course corrections. Others will recognize a need to develop their business acumen and leadership skills. And others will remain in the comfortable circle – starting in graduation and holding steady for the next 40 years, unchanged yet very satisfied.

There is enormous diversity when it comes to the chosen path of our colleagues. But no matter where one is on that path, all can benefit from self-examination. Below are three areas of growth to consider reflecting on as you reach the various stages of the dental journey:

DENTAL SKILLS

General dentists have enormous opportunities to expand their skill base - from surgery to cosmetics to sleep apnea. I encourage a thorough engagement as opposed to a weekend course to learn these often complex procedures. There also has to be a commitment to skill application shortly after you return from your training. This can serve as an exciting addition to your day and boost your income by meeting an unmet need or demand in your market. It's exciting to know that you're meeting the needs of your patients and improving their health!

BUSINESS SKILLS

Evaluate your relationship with your accountant. Many colleagues do not track expenses and revenue in a methodical manner. There are industry standards that provide you with a compass, allowing you to better discover if you are "off course". Recently, a client told me that his staff salaries were at 48%, wondering why he had so little take home. Was he under producing or was he over paying? Another young client was producing $900,000 and collecting $500,000 due to the many insurance contracts. Basic understanding of the numbers is important to know, but the more difficult road to take is developing the business skills to execute the changes necessary. Knowledge without application is useless.

LEADERSHIP SKILLS

These are an absolute must to execute growth, change and enjoyment in today's world of health care. I encourage you to develop a continuous growth plan for yourself followed by learning skills to develop your diversified team. Most of us have discovered that simply "informing a team member" about a necessary behavior change that's needed is not always the best strategy. The truth is that if you are interested in business ownership, leadership is part of the package. You can't expect to delegate everything without oversight.

In summary, consider taking time to check where you are in your journey. For those of you who fall in the beginning of the bell-shaped curve, school provided you with a start. It is up to you develop your road map. For those of you who fall on the end of the bell shape curve, take the time to plan and look at your choices. There is an exciting next chapter that you can shape. Don't wait for a crisis.

Editor's Note: Dr. Schroeder practiced dentistry in Richmond for 30 years and is the founder of Leadership by Design - Practice Transitions. He can be reached at 804-897-5900 or drjim@lbdtransitions.com www.lbdtransitions.com

BOARD OF DENTISTRY NOTES

SEPTEMBER 13, 2019

Ursula Klostermyer, DDS, PhD

A public comment was made by Dr. Alex Vaughan, a general dentist in Richmond, asking that the Board of Dentistry should consider keeping a broad regulatory definition of teledentistry and clarify the use of it, as he warns that a tightening of the regulations would limit dentists in their ability to diagnose and treat patients. The Board will discuss the regulations of digital teledentistry and has referred this issue to the Regulatory-Legislative committee. Further, Dr. Vaughan stated the need for the public to be made aware of the different dental specialties. He wants the Board to write a letter to the ADA with respect to a specialty recognition of oral medicine and oral facial pain. The Board accepted this as a request.

The Virginia Association of Orthodontists sent a representative to state the importance of digital scanning as a practice of modern dentistry. He stressed the importance of a physical, face-to-face, examination before treatment to check for periodontal disease, tooth decay, and oral cancer. This should be performed by a dentist with a Virginia license. His intent was to obtain clarification on these topics. The Board directed these topics to their Regulatory-Legislative committee.

The revised "Sanctioning Reference Points Instruction Manual" was approved. Dr. Augustus Petticolas reported from the Southern Board Testing Agency (SRTA) meeting in August 2019 on how dental proficiency testing could be performed with a non-patient-based exam. Currently patient based exams are given in dental schools. Students would appreciate a more cost effective non-patient based exam. The Board is open to discuss this issue and Dr. Perry Jones commented that it would be important to hear these new structures not only from the testing agency perspective, but as well from the educators' side, from representatives of US Dental Schools. Dr. David Sarrett, Dean of VCU School of Dentistry, reported that the students have a format on how to treat patients and are supposed to follow this closely through the exam phase. Even though patient examinations are the regular curriculum, a mannequin exam would be possible as well. He states that there are more often problems with judgment issues than with practical ability issues of dentists.

Beginning July 2020, a prescription for a controlled substance that contains an opioid shall be issued as an electronic prescription as consistent with paragraph 54.1-3408.02 of the Code of Virginia. Upon written request, the Board may grant a one-time waiver of the requirement of above described section, for a period not to exceed one year, due to demonstrated economic hardship, technological limitations that are not reasonable within the control of the prescriber, or other exceptional circumstances demonstrated by the prescriber.

Ms. Jennifer Deschenes, the Deputy Executive Director of the Board of Medicine, presented a hearing protocol to the Board. "The purpose of disciplinary proceedings is to protect the public by regulating professional conduct and provide fair and impartial consideration of the matter before the Board. The goal is to strive for fairness to the respondent and also to the public"

The Board's Regulatory-Legislative Committee was scheduled to meet October 19, 2019 to discuss the points above referred to them.

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

ARE YOU ONE OF THE 38%?

VIRGINIA DENTISTS ARE MAKING A DIFFERENCE

Dr. Bruce Hutchison, Chair, VDA PAC

The VDA PAC collects donations from dentists across Virginia to help ensure that our profession and our patients are protected. Virginia dentists have always pushed for legislation that benefits our patients. We want the citizens of Virginia to have access to the best quality dental care available anywhere in the world. Legislators, who make the decisions that affect how we practice, often don't know which direction to move because they simply do not understand dentistry or know what is best for their constituents, our patients.

Over the past 20+ years, Virginia dentists have been successful in educating legislators on bills that have made a positive difference in making sure that we can continue to provide the best care for our patients. Several successes are below:

- A new definition of dentistry was enacted after the medical community tried to dictate how dentists and oral surgeons practice in Virginia.
- Virginia dentists helped the General Assembly see fit to secure $11.7 million for the expansion of the VCU School of Dentistry.
- The Medicaid dental program was separated from the medical part of Medicaid so that money targeted for dentistry could be used on dental care. Fees were increased, a fee for service program was developed, and Medicaid dental in Virginia became a model for other states to copy.
- In 2016, legislation was passed that closed the loophole in the non-covered services law (originally passed in 2010) by inserting what is often called a "de minimis" clause that says reimbursement rates must be reasonable and not trivial.
- In 2017, remote supervision for hygienists legislation broadened the types of facilities in which a hygienists can practice under general supervision allowing for better hygiene care of patients in mental health facilities, nursing homes and rehabilitation facilities.
- In 2017, the Virginia Mission of Mercy (MOM) Project Funding allocated $282,560 in each year of the two year budget, including $50,000 earmarked towards the Wise MOM projects as the move to a new location required additional funding.
- This year (2019), at the urging of the VDA and its dentists, the general Assembly passed a Silent PPO Bill, which provides fairness and transparency when third party payers rent or sell their networks of providers.

Dentistry is better in Virginia because of these laws. It is, however, inevitable that we will continue to face challenges every year. There are those out there who think they can improve dentistry for our citizens but who know absolutely nothing about providing that care. If you want the good to win- we have to fight back and continue fighting back.

VDA PAC remains a key element in keeping dental care in Virginia at the forefront with our legislators. Many Virginia dentists (62%) sit back and let things happen while others (38% of Virginia dentists) contribute to VDA PAC to help keep dentistry the great profession it is.

38%

38% of us are making a difference for all dental care in Virginia- thanks so much to those members! Wouldn't it be great if every dentist who benefits from these laws helped a little?

If you haven't yet made a contribution to VDA PAC this year, it's not too late to help preserve the best dental care in the world for our patients. A BIG shout out to the Southside Dental Society for surpassing their annual goal by 66%.

Make your contribution today by visiting vadental.org/vda-pac or contacting Laura Givens at givens@vadental.org or 804-523-2185.

You also can expect your 2020 VDA dues statement in the mail very soon and we ask that you please make your 2020 PAC contribution when sending your dues payment.

As a final note, Election Day is November 5 so please get out and vote. If you have questions about voting, you can visit https://www.elections.virignia.gov for information.

Thank you in advance for your support! It truly will make a difference.

YOU'LL WANT TO BE THERE!

VDA LOBBY DAY AND LEGISLATIVE RECEPTION

Laura Givens, VDA Director of Legislative and Public Policy

We are pleased to announce that we have elevated the format of our past 'Day on the Hill' event. The VDA has added a special legislative reception to be held the evening before what was formerly called the VDA 'Day on the Hill' and that we now present to you as the 2020 VDA Lobby Day. We will look forward to welcoming VDA member dentists, dental students and others from the dental community to Richmond on January 16-17, 2020 at the Omni Richmond Hotel.

The excitement begins with an evening cocktail party on January 16th- all 140 legislators will be invited to join VDA members and guests to celebrate the VDA's 150th anniversary. The next morning, January 17th, will include a breakfast program with special guest speakers and a briefing on the issues followed by meetings down the street with members of the Virginia Senate and House of Delegates.

Let's approach our 150th year together by doing what we do best: advocating for the profession of dentistry and patients!

A room block has been held at the Omni Richmond Hotel for VDA Lobby Day attendees.

Go to vadental.org/Lobby-Day to register and for hotel information.

Visit **vadental.org/Lobby-Day** to register!

We build our reputation by protecting yours.

At MedPro Group, we believe your good name is worth protecting. That's why we've committed to defending the reputations and assets of dentists for the past 119+ years.

400K+

400,000+ CLAIMS HANDLED NATIONALLY

We have more experience defending malpractice claims than any other carrier.

95%

95% TRIAL WIN RATE

We win 95% of dental claims that make it to trial.

PURE

PURE CONSENT

We won't settle a lawsuit without your written consent.

"It's not about the money. It's about something else: my dignity and professional reputation."

DR. K, MEDPRO GROUP INSURED DENTIST

Don't wait for a claim to change your malpractice insurance. Contact us today for a quote.

800.4MEDPRO x119660 | medpro.com/**VDAOct**

1 OPEN CAMERA
2 SCAN
3 GET QUOTE

MedPro Group
a Berkshire Hathaway company

2020 GENERAL ASSEMBLY...

TELEDENTISTRY IS ON OUR AGENDA

Roger A. Palmer, DDS; Chair, VDA Council on Government Affairs

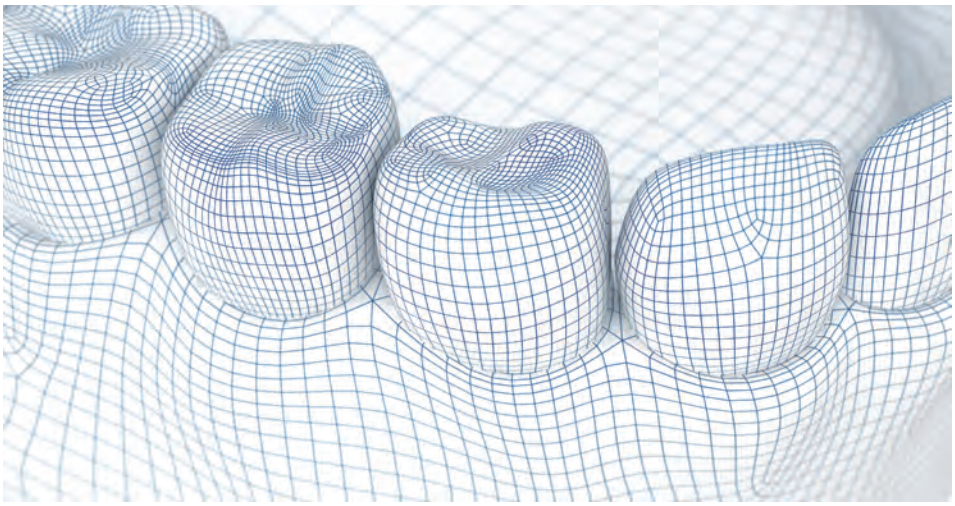
The VDA plans to introduce legislation in the next session of the Virginia General Assembly to address the growing problem of "Do it Yourself Dentistry." At present, a person may go to a kiosk or a booth in a major pharmacy chain, have an intra-oral scan done and receive aligners to correct an orthodontic condition. There is no requirement that the person have an in-person exam with radiographs, etc. Nor is there even a requirement that there be a face-to-face exam through teledentistry. In effect, we feel that there is no direct dentist-patient relationship established. Furthermore, there is a requirement that the patient sign an agreement that limits the patient's ability to file a complaint with the Board of Dentistry.

We have approached the Virginia Board of Dentistry and their position is that, since there does not appear to be a Virginia Licensed Dentist involved, they are powerless to get involved. The only way to correct this problem seems to be by legislation.

The ADA has filed a petition with the FDA regarding this but we are unsure if they will do anything.

The ADA offers these talking points:

- The American Dental Association and member dentists across the country are dedicated to the health and safety of the patients they serve.
- ADA policies oppose Do-It-Yourself Teeth Straightening and Direct to Consumer Dental Laboratory Services because dentists are concerned about the potential for irreversible harm to patients.



- For example, orthodontic treatment, if not done correctly, could lead to potential bone loss and receding gums, changed bites, and other issues.
- The ADA believes that for the health and well-being of the public, patient supervision by a licensed dentist is necessary for all phases of treatment.
- You can find more information on MouthHealthy.org, the ADA's website for the public at MouthHealthy.org/DIYdentistry.

The VDA House of Delegates passed a resolution in September to proceed with legislation that would define teledentistry.

If this legislation is to be successful, we all must get involved and contact our Delegates and Senators in the Virginia General Assembly to make them aware of how important this legislation is for patient safety.

What would the legislation do?

- Address patient safety by requiring an examination and establishment of dentist patient relationship
- Have universal application of the regulations of dentistry
- Provide access to patient records
- Require that patients being treated in VA to be treated by a VA licensed dentist

The last issue of the Journal included a great article on Do It Yourself Dentistry and Ethics by Elizabeth Stapleton, Class of 2020, VCU School of Dentistry. This can be found in that edition on page 35.
We will be sending out additional information prior to the next session of the General Assembly, which begins on January 8, 2020.

2020 Virginia Meeting

Sept. 23-27, 2020
Norfolk

THE MAIN | HILTON NORFOLK

LET'S GET PERSONAL

MEET DR. ELIZABETH REYNOLDS, 2019-2020 VDA PRESIDENT

Dr. Elizabeth Reynolds's dental roots run deep. As early as age ten, Dr. Reynolds could be spotted setting teeth for dentures, helping out in the lab and pouring models at her father's country practice in Chatham, Virginia. And while she loved the early exposure to "real work," what she enjoyed most was the time it afforded her with her dad, Dr. Randall O. Reynolds, who in addition to providing dental services to the local community for 60 years was also its Mayor and representative in the Virginia House of Delegates. "I remember him working quite a bit as we were growing up, so it was nice to be able to spend that time with him and be a part of that piece of his life," says Dr. Reynolds.

If the time spent working in her father's office solidified her interest in dentistry, then her senior project internship with Danville orthodontist Dr. Wilford Cocke sealed the deal. "I just loved the way he practiced. Dad graduated in 1930 so his practice was older and very established as a small town general practice - some of Dad's patients would barter with veggies, and he was just fine with that. I recall Dr. Cocke's office being so modern and exciting, and yet his demeanor with patients was so kind. That comparison helped me realize how much a dentist's personality plays into their practice."

After obtaining a double degree in English and Biology from the College of William & Mary, Dr. Reynolds spent a gap year in Reston working at the office of Drs. Tim Kirkpatrick, Tom Eichler and Joe Richardson, where she decided to go into general dentistry. That experience helped her understand the role of patient relationships, the power dentists have to help patients in so many different ways and how the variety of cases meant that each day was a little different from the days prior.

The following year, Dr. Reynolds began as a D1 at VCU's School of Dentistry, where she learned an important lesson about herself while she appreciated the science and production of dentistry, she's passionate about the clinical aspect – working with patients to find a solution that meets their individual needs. Her time at VCU was the culmination of everything she'd been working toward. It became who she was, what she did and what felt like her entire life. She remembers those years fondly and the great friendships she collected along the way, many of which she still maintains.

Following graduation, Dr. Reynolds went back to Northern Virginia and worked at several private practices, including in the Pentagon on the Concourse. And while those experiences validated her love of dentistry, her longing for a sense of home (and distaste for Northern Virginia traffic) brought her back to Richmond, where

► PERSONAL - CONTINUED ON PG. 36

► PERSONAL - CONTINUED FROM PG. 35

she could be closer to family. Soon after making that decision, Dr. Reynolds was introduced to Dr. Stephen Brown, who was in the midst of an exhaustive search for an associate, and it became clear that the two were well matched. Since joining the practice in 1997, Drs. Brown and Reynolds have added two partners – Drs. Snow and LeNoir - and - one new associate, Dr. Barta, expanded their Patterson Avenue office and added a second location in Richmond's Far West End.

When Dr. Reynolds is not at her practice, you'll find her and husband John running around Richmond carting daughters Anne Randall (12) and Cabel (10) to school and their bevy of sports activities: field hockey, lacrosse, horseback riding and basketball.

Dr. Reynolds is also a *huge* music fan with an eclectic taste that ranges from the Grateful Dead all the way to Brandie Carlyle and the Avett Brothers. But her favorite – the person she jokingly wants to be when she grows up – is Kenny Chesney, whom she makes a point to see in concert annually.

And when the Reynolds family wants to relax, you'll find them at their Buggs Island lake house, which has been in the family for two generations. "It's a family gathering spot. It's where we grew up and the place where I come back to catch up with family and the friends I've known most of my life. We ski, we swim and we enjoy the people around us - that house is like home to me."

Dr. Reynolds will be serving as the Virginia Dental Association president for the 2019-2020 year. If you'd like to learn more about her, or her practice, you can visit them at www.brsdentistry.com. If you have a programming idea or priority you'd like to share, please let her know! You can contact her at elizabethvadental@gmail.com.

LET'S TALK DENTISTRY

AN INTERVIEW WITH DR. ELIZABETH REYNOLDS

TELL US WHY YOU WANTED TO BE VDA PRESIDENT.

I truly am invested in the VDA. I think it is a wonderful organization and I am hopeful to have a hand in leading it into the future. Dentistry has been part of my life for as long as I can remember so being given an opportunity to give back to a profession that has been so wonderful to me is such a gift and an honor.

IF YOU COULD CHANGE ONE ASPECT OF THE VDA (AND ORGANIZED DENTISTRY) WHAT WOULD IT BE?

I would be to make it more nimble. That is such a trite word, and used so often, but, for example, at the ADA this year we discussed vaping policy. Had we not passed something it would have been another year before we had an official policy on vaping. Vaping is an epidemic NOW- it is imperative that we, the leading oral health care organization, let everyone know that it is dangerous. That is a perfect example of our need in this age of technology and immediate gratification that we have the ability to move quickly.

WHAT IS ORGANIZED DENTISTRY'S GREATEST STRENGTH? ITS GREATEST WEAKNESS?

Organized dentistry's greatest strength is in its volunteer members' and team's commitment to our amazing profession. Its weakness is perhaps in its inability to let people know what we do- our inability to successfully tell our story. We do so many amazing things; I would love for the world to know that. We do need to be sure we are a group of like minded professionals with our patients' best interest at heart. I feel the other "noise" can be superfluous and impede our primary focus.

BURGEONING STUDENT DEBT HAS CHANGED THE LANDSCAPE OF THE DENTAL PROFESSION. WHAT SHOULD WE DO TO ADDRESS THIS PROBLEM?

I honestly feel that student debt has affected our profession in so many ways. We see it in the ability of new dentists to go into the practice style that they choose as well as in the retiring dentist being unable to find a perfect partner to buy them out at retirement age. I think unfortunately we see it influence practice decisions. I honestly don't know the answer. I do not feel the burden is entirely on one component. I think the schools need to do a better job of educating their students on the ramifications of borrowing astronomical amounts of money and need to assist them in learning to live their lives within their means. I also feel that we established dentists need to provide these debt laden new students opportunities that take into consideration their debt load. A bit of investment in the beginning will pay off many times over in the end. We all need to work together to ameliorate this issue. One of my favorite opportunities which I do not see often enough is the ability to work in underserved areas to pay back student debt. This happens in some areas but could be an incredible opportunity for the students, the dental schools, and the legislature to work together to establish programs that offer new dentists an opportunity to learn and grow while simultaneously serving the population that so needs our help. And we should continue to work with Congress to lower the interest rates for these student loans.

MEMBERSHIP IN ORGANIZED DENTISTRY HAS STABILIZED, OR EVEN INCREASED, IN THE PAST TWO YEARS. TO WHAT DO YOU ATTRIBUTE THIS TREND? WHAT ELSE CAN THE VDA DO TO AUGMENT ITS RANKS?

I hope that membership has stabilized because we are getting better about telling our story and engaging our members. We want members and nonmembers to see

► DENTISTRY - CONTINUED ON PG. 39

Credit Card Processing
Best Card
simple | secure | trusted
877-739-3952

VDA Services
VIRGINIA DENTAL ASSOCIATION

SEND IN A RECENT STATEMENT TO SEE WHAT BEST CARD CAN SAVE YOUR PRACTICE!

FAX: 866.717.7247 EMAIL: COMPARERATES@BESTCARDTEAM.COM

You will receive a no-obligation savings analysis and a $5 Amazon Gift Card

service

Featuring
people *not*
prompts!

savings

Average dental office savings
24% or $2,768
annually over prior processor

smart

Do the Math: *fees divided by $ processed* = effective rate

Competitors' average effective rate >3%
Best Card average effective rate 2.1%

LEARN MORE AT WWW.BESTCARDTEAM.COM

- **VDA Members: own EMV "chip" equipment with 2-Year Warranty for as little as $169**
- Best Card BCPAY · PAYLINK **ONLINE system enables automatic posting of payments to Eaglesoft, Dentrix, PracticeWorks and Open Dental**
- **Take payments at your website, set up recurring billings and more. Mobile processing options available, too**

VISA DISCOVER

Best Card LLC is a registered ISO of Wells Fargo Bank, N.A., Concord, CA

the value in membership and to be excited to be a part of what we are doing!

CHINESE WARLORD SUN TZU SAID, NEARLY 2400 YEARS AGO, "CHOOSE YOUR BATTLES WISELY." SHOULD THE VDA INITIATE LEGISLATION THAT IS UNLIKELY TO BECOME LAW? HOW DO WE DEMONSTRATE TO OUR MEMBERS THAT WE ARE ADVOCATING FOR THEM?

I do feel that we as an organization should "choose our battles wisely". However, there are times when we need to be at the forefront of our profession, protecting our members. The VDA has a reputation of leading the fight for issues important to its members and we should continue to be that organization. We were one of the first states to challenge and redefine the definition of dentistry back in 1999. In 2010 we led the country in getting a non-covered services bill passed. Just last year we successfully lobbied a bill which would prevent insurance companies with which we participate from secretly selling those policies to other companies which may not reimburse at the same rate. This pioneering legislation has since been mirrored throughout the country. Now we are taking on the definition of teledentistry to ensure the protection of our patients and our members. So though we should choose our battles, our history is choosing our battles and successfully winning them!

WHAT WOULD YOU SAY TO A VDA MEMBER WHO IS PLANNING TO DROP OUT, OR AS WE LIKE TO SAY, BECOME A "NON-RENEW"?

It is always important to understand why a member chooses not to renew their membership. Each person has a reason, and each reason should be addressed. I do feel that organized dentistry is responsible for allowing dentists to practice the way they want to practice. It provides a unified voice politically to protect our profession; I am hopeful that a discussion would help the doctor who's on the edge, opt to be a part of this organization.

DO YOU HAVE MENTORS? WHO ARE THEY? WHY HAVE THEY BEEN SO IMPORTANT TO YOUR CAREER?

I think everyone has mentors and I have had many throughout my life. My father was obviously my first mentor; I grew up watching him go to work and love what he did. I also worked with dentists throughout my career who mentored me in my professional development: Wilford Cocke, Tom Eichler, Tim Kirkpatrick were my earliest influencers. In school I worked with Bob Barnes, Hugh Douglas, and Noel Root who constantly challenged and encouraged me to be the best I could be. Anne Adams invited me to the Richmond Dental Society when I moved to Richmond and encouraged and supported me. Terry Dickinson was inspirational in every way, coaching and pushing me to be more involved and exemplifying all that organized dentistry should be. I would love to, one day, be the mentor to someone else that these incredible dentists were to me.

DENTAL SERVICES ORGANIZATIONS (DSOS) NOW EMPLOY A SIGNIFICANT PORTION OF OUR WORKFORCE. HOW WILL THE DELIVERY OF DENTAL CARE CHANGE IN THE YEARS TO COME?

Large group practices are an answer to a problem. They offer a financial opportunity, especially to new dentists, to practice in an environment where they can have a work life balance and make a fair living. Certainly these organizations need to be a part of who we are as organized dentistry. They are influencers in our profession and we want to work with them. We all want to provide the best services to our patients, we just may do it differently. One of the best things about dentistry is that it, as a profession, offers an opportunity for everyone to practice the way that they want to practice. We should be focused on maintaining that: from a cottage industry practice to a large group practice, we should all work together to protect and serve our patients, our colleagues, and our independence.

WHAT WOULD YOU LIKE TO BE DOING FIVE YEARS FROM NOW? WHAT ABOUT TEN YEARS?

Hmm…Five years from now? I will be watching my older daughter graduate from high school and begin her exciting college journey. I will still be practicing dentistry, hopefully still working with the VDA and the ADA. Ten years from now? I have no idea! Let's see what the future holds for me!

YOU are what made the 2019 Virginia Meeting a great success!













Please visit us on Facebook to see more photos.

2019 VIRGINIA MEETING

Virginia Dental ASSOCIATION













JOIN US IN CHICAGO

CHICAGO DENTAL SOCIETY **MIDWINTER MEETING**

FEBRUARY 20 – 22, 2020

REGISTER NOW • ON.CDS.ORG/MWMVA20

Stay current on your CE requirements

- **Learn from the leaders in dental education.** Choose from more than 250 courses, including valuable hands-on workshops, lectures and live patient demonstrations, plus a timely symposium discussing Oral Cancer.
- **Try out the latest products** available from more than 650 companies in our Exhibit Hall.
- **Network with colleagues and the dental community** at our special events.
- **Explore our world-class city of Chicago.** Dine in our fabulous restaurants. Shop the Magnificent Mile. Take a tour of our amazing architecture or experience our many fascinating museums and cultural institutions. Chicago is our hometown and we look forward to sharing it with you.

CDS MEMBERS REGISTER FOR FREE!

Are you an ADA member? Join CDS as an Associate Member for only $125 and pay no registration fee. Join today at **www.cds.org.**

THE ETHICS OF EMPATHY

POVERTY IN AMERICA: WHAT IS OUR ROLE?

Carlos S. Smith, D.D.S, M.Div., F.A.C.D.
Assistant Professor and Director of Ethics Curriculum, VCU School of Dentistry

A story I often pass on to my students is one I heard from an ethics colleague, from another dental school, tell some years ago. The story centers around what many would describe as a "problem" patient. We have all experienced it before. The patient who is never punctual, borderline rude, not offering much in the way of conversation or interpersonal connection, not responsive to questions and one who would certainly not win any "best attitude" awards. As you can imagine, no one, student or faculty, was especially fond of seeing the patient. Finally, my colleague decided she was going to make this patient converse with her and see why her dental visits seem to be so problematic and never go well. Upon having a conversation with the patient, my faculty colleague learned more of the patient's story. The patient had neglected her dental care for years and had finally gotten over numerous hurdles (financial, anxiety, shame, etc.) to now make her oral health a priority. While she was fully committed to following through on recommended treatments, this new found commitment came at a steep price. For every dental visit, the patient had to make the difficult decision to go without lunch or have the money to pay for transportation to the dental school. Using public transportation was no easy feat. The patient would have to take four bus transfers, miss time from work, and thereby lose wages. As you can see, this is just one way in which poverty may present itself at our doors. While one may not be able to put ourselves in the shoes of each and every patient, including those of the working poor, we must practice an ethic of empathy.

I am the first to admit that my own personal narrative – a product of the comforts of a gated South Carolina suburban neighborhood – makes it difficult to identify with the need, money and time expended around the utilization of public transportation. In fact, one of my earliest memories is of the time I spent with my entrepreneur grandfather. It was our custom that on many Saturday mornings my father would drive me to his childhood home downtown that had been in our family since the early 1900s. The home happened to be across the street from both a Bojangles and a city bus stop. One Saturday when I was about 5 or 6 years old my grandfather and I walked down to that bus stop and he said, "You'll probably never have to ride a city bus and I want you to know what it's like and always remember to treat those with less options in this life with dignity and respect." Sad to say, that day was one of the few times I've ever ridden a city bus.

Empathy is a crucial foundation in building an effective dentist-patient relationship.[1] Empathy is defined as a cognitive attribute in which an individual is able to put himself or herself into another's position to share and understand the meaning and significance of one's behavior.[2] As noted by philosopher and physician Alfred Adler, empathy is to see with the eyes of another, to hear with the ears of another, and to feel with the heart of another.[3]

Each fall the Virginia Commonwealth University School of Dentistry welcomes 100 or so eager and bright eyed new students, brimming with enthusiasm and hopefully altruism. Since 2012, the School of Dentistry has undertaken a first year reading experience during new student orientation where dental and dental hygiene students have read, over the summer, a book grounded in ethics, ethical decision-making and reasoning, and professional responsibility. The intended message to the students is that ethics and professionalism are placed at the very forefront of their dental careers. A book with themes of ethics and professionalism is the first book they touch in the program. This year's book, *Evicted: Poverty and Profit in the American City*, by Princeton University sociology professor Matthew Desmond, examines poverty with a lens we have not seen previously. He peels back the ugly truth of gut-wrenching poverty that exists here in the United States. The book follows the lives of eight Milwaukee families as they struggle to keep a roof over their heads. Desmond sheds light on the ever-increasing national problem of evictions. Evicted reveals the impact of the nationwide eviction crisis that affects millions of families and its consequences — poverty, homelessness, educational disparities and yes, even health care. The eviction epidemic and poverty are particularly troubling in our beloved Virginia. The RVA Eviction Lab, a division of the Wilder School of Government Affairs at VCU, notes that Richmond has the second highest eviction rate in the country, 11% annually from 2000 to 2016, based on the Princeton University Eviction Lab analysis of millions of eviction case court records.[4]

1 Sherman JJ, Cramer A. Measurement of Changes in Empathy During Dental School. J Dent Educ. 2005;69(3):338–345.

2 Schattner A. Who cares for empathy? QJM 2012;105(3): 287–90.

3 Aggarwal VP, Garg R, Goyal N, et al. Exploring the missing link - Empathy among dental students: An institutional cross-sectional survey. Dent Res J (Isfahan). 2016;13(5):419–423.

4 https://cura.vcu.edu/ongoing-projects/rva-eviction-lab/

► EMPATHY - CONTINUED ON PG. 44

► EMPATHY - CONTINUED FROM PG. 43

Five of the top ten cities in the US with the highest eviction rates are located in the State of Virginia. Richmond, Roanoke, and Hampton Roads faced the highest rates of eviction.[4] High eviction rates are disproportionately found in minority communities, with more than 60% of all majority African American tracts facing eviction rates greater than 10%.[4]

At this point you may be asking yourself, what does this have to do with dentistry? As a true profession, with a contractual obligation for the betterment of society, the answer is everything. Desmond's book allows a deep look at the working poor in America (who often hold multiple jobs), debunks narratives of welfare queens, and gives voice to many of our veterans whose disability pay barely allows them to stay above water. For those in our society who have to make the impossible decisions of choosing between what gets paid, which utilities to have on at what time, rent or food for the day or week, the priority of dental care lags behind.

Access to care remains an under-addressed issue that dentistry must combat head on. While we have had successes, the larger issue still remains. Many of you have underserved patients you treat for free, many participate in Donated Dental Services, more of you volunteer faithfully with Mission of Mercy projects, and there are those of you that, even facing continually dwindling reimbursement rates, participate as Medicaid/DentaQuest providers. Your role in eliminating disparities in oral health care through these mechanisms is both laudable and noteworthy. There is no question that we should be proud of these initiatives, however we must continue to examine our models of oral health care delivery for additional alternatives and creative ways to address the issue. For example, the state of California recently embarked on a very lofty program of forgiving up to $300,000 toward dental school debt with the condition of at least a 30% Medicaid caseload for at least 5 years.[5]

5 https://www.dentistrytoday.com/news/industrynews/item/5105-california-to-pay-off-student-loans-for-medi-cal-dentists

We must partner with organizations who have been at the forefront of aiding the underserved, such as the National Dental Association (in Virginia, the Old Dominion Dental Society and its many local components such as the Peter B. Ramsey Dental Society in Richmond), the Hispanic Dental Association, the Society for American Indian Dentists and such efforts as the Virginia Health Catalyst (formerly the Virginia Oral Health Coalition). Many of these organizations, and their individual members, have been at the forefront of eliminating access to care issues for decades, and no dialogue on poverty and meeting the oral health needs of the underserved is authentic without their voices.

For many of our underserved patients, even when actual cost of delivery of care is eliminated, there still remain barriers to receiving care. This is significant for pediatric dentists where parental work schedules, transportation, new regulations regarding school attendance and missed days of school create additional obstacles beyond reimbursement for services rendered.[6]

While none of us alone will solve America's issues of poverty or eliminate all disparities in oral health care, it is incumbent upon us as dental professionals to wade into the deep water of poverty's impact in the United States. Is our goal to eradicate poverty all together, to solve both our nation's and state's eviction and housing crisis? While it would be nice, it isn't in any way practical or within our sphere of influence to solve. However, everyone has an ethical obligation to do his or her part. Whatever course of action you take, one empathetic professional at a time can make a difference. Empathy and seeing through the eyes of another, especially our fellow underserved humanity, is not only a hallmark of trust, or effective communication, or even concern for others, it is above all, a matter of ethics.

6 Kelly S.E., Binkley C.J., Neace W.P., Gale B.S. Barriers to care-seeking for children's oral health among low-income caregivers. Am. J. Public Health. 2005;95:1345–1351

Editor's Note: Dr. Smith is a general dentist and director of ethics curriculum at the VCU School of Dentistry. He is also a member of the board of directors of the American Society of Dental Ethics and the Virginia Dental Association Foundation. He serves in the Department of General Practice where he is a clinical group practice leader and maintains a private practice within the VCU Dental Care Faculty Practice.

KNOWING
REGULATIONS IS HALF THE BATTLE

DID YOU KNOW?

A SERIES FROM THE VIRGINIA BOARD OF DENTISTRY

► REMOTE SUPERVISION

Did you know that dental hygienists can only practice under the remote supervision of a dentist at a federally qualified health center; charitable safety net facility; free clinic; long-term care facility; elementary or secondary school; Head Start program; mobile dentistry program for adults with developmental disabilities operated by the Department of Behavioral Health and Developmental Services' Office of Integrated Health; or women, infants, and children (WIC) program?
§54.1-2722. E and F of the Code of Virginia.

► EMPLOYEE DENTIST – NAMES ON DISPLAY

Did you know that a dentist who is practicing under a firm name or who is practicing as an employee of another dentist is required by §54.1-2720 of the Code to conspicuously display his name at the entrance of the office? Did you also know the employing dentist, firm, or company must enable compliance by designating a space at the entrance of the office for the name to be displayed?
18VAC60-21-30.A of the Regulations Governing the Practice of Dentistry.

► LISTING OF FEES

Did you know that dentists are responsible for conducting their financial responsibilities to patients and third party payers in an ethical and honest manner by maintaining a listing of customary fees and representing all fees being charged clearly and accurately?
18VAC60-21-60.B(1) Regulations Governing the Practice of Dentistry

► TERMINATING THE DENTIST/PATIENT RELATIONSHIP

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

WHAT DENTISTS SHOULD KNOW ABOUT VAPING AND TOBACCO

Earlier this year, Virginia's General Assembly passed legislation banning the sale of tobacco and nicotine products to those under the age of 21 in response to the rising popularity of e-cigarettes among young people. A study released by the Annals of Internal Medicine found that 10.8 million American adults use e-cigarettes, and more than half of them are under age 35.

Even more startling is this statistic: according to the National Youth Tobacco Survey, in 2018, 20.8% of high school students had reported using e-cigarettes in the last 30 days, an increase of 78% compared to 2017. In 2011, that number was just 1.5%.

As the Virginia Dental Association continues to monitor for new research on the health implications of e-cigarettes, we are pushing for greater awareness about the known impacts of nicotine and tobacco products on oral health.

If you are asked about the impact of vaping and tobacco products on one's oral health by patients, a patient's parent(s) or even members of the community, here are a few talking points you can use to guide the conversation.

WHAT IMPACT CAN TOBACCO AND NICOTINE PRODUCTS HAVE ON ONE'S ORAL HEALTH?

- Extensive research has shown that tobacco and nicotine products are detrimental to one's overall and oral health.
- Smoking can lead to a variety of adverse oral effects, including gingival recession, oral cancer, mucosal lesions (e.g., oral leukoplakia, nicotine stomatitis), periodontal disease, and tooth staining.
- Smokeless tobacco is associated with increased risks of oral cancer and oral mucosal lesions and can also cause gingival keratosis, tooth discoloration, halitosis, enamel erosion, gingival recession, alveolar bone damage, periodontal disease, coronal or root-surface dental cavities due to sugars added to the product, and tooth loss.

IN REGARD TO ORAL HEALTH, IS USING E-CIGARETTES (VAPING) SAFER THAN CIGARETTES OR OTHER FORMS OF TOBACCO?

- The long-term health effects of e-cigarettes are still unknown, and I advise my patients to avoid these products.
- A study published in 2018, that was supported by the American Dental Association Foundation, found that vaping sweet e-cigarettes can increase the risk of dental cavities.
- E-cigarettes still contain nicotine, which aside from being extremely addictive, can increase a person's risk of having periodontal damage.
- The number of young people who use e-cigarettes is concerning and every effort should be made to prevent these products from getting into the hands of children. Recent adoption of legislation in Virginia banning tobacco and nicotine products to those under the age of 21 is a step in the right direction.

HOW COMMON IS ORAL CANCER?

- Oral cancer impacts an estimated 53,000 Americans per year and is the eighth most common cancer among men.
- As with many forms of cancer, early detection can improve a patient's survival rate. It is important to visit your dentist twice per year for regular cleanings and checkups. Regular check-ups allow your dentist to conduct oral cancer screenings and to monitor for any changes in your oral health.
- Just as you would make an appointment to see your physician for changes in your health, if you experience any noticeable changes in your oral health such as bleeding or swollen gums, changes in sensitivity to temperature, loose teeth, mouth ulcers or sores that don't seem to heal and toothache or mouth pain, make an appointment to visit your dentist before your regularly scheduled checkup. While these symptoms do not mean you have oral cancer, you should be examined by a dentist.

VDA Policy Statement
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.

Henry Schein Professional Practice Transitions proudly introduces Snowden Brown!

Thinking about retiring or selling your dental practice within the next 10 years?
Want to buy a dental practice?
CONTACT ME TODAY!

- 25+ years in the dental industry
- Knowledge of both the clinical and business aspects of dentistry
- Expert in practice sales, valuations and assisting buyers

SNOWDEN BROWN
703-936-1239
Snowden.Brown@HenrySchein.com

HENRY SCHEIN®
PROFESSIONAL PRACTICE TRANSITIONS

www.henryscheinppt.com

■ PRACTICE SALES ■ VALUATIONS
■ TRANSITION CONSULTING/PLANNING
■ ASSOCIATESHIPS

FIXED INTEREST RATE

3.89%

on the full term of your loan — up to 15 years[1]

Call 800.497.6076
bankofamerica.com/practicesolutions

Act now and save! Use this secured loan to

- Purchase an existing practice
- Expand, remodel, add a location or relocate[2]
- Consolidate debt[3] or purchase equipment

Apply by November 30 and close by December 31, 2019

VDA Services
VIRGINIA DENTAL ASSOCIATION

BANK OF AMERICA

[1] For the limited time beginning with applications submitted on July 1, 2019, and ending with applications submitted on or before November 30, 2019, take advantage of a 3.89% interest rate on terms no less than ten years and no greater than fifteen years on qualifying approved Practice Solutions secured term Practice Sales and Acquisitions, Debt Consolidation, Remodels, Relocation, Expansions and Additional Locations and Equipment loans closed by or booked by December 31, 2019. Loan approval amounts must total a minimum of $250,000 on eligible product types in order to qualify. Payoff prohibited in the first year of the loan, and a prepayment fee will apply for each of the following four years of the loan term. Excludes Practice Solutions startup loans, lines of credit, refinances of existing Practice Solutions loans and commercial real estate loans, and any product that contains a variable rate. To be eligible for the interest rate offer of 3.89% the borrower before loan closing must have a demand deposit account with Bank of America that is the primary business operating account of the borrower. Promotional rate is not applicable during the project phase of the loan. Subject to credit approval. Other restrictions may apply.
[2] All programs subject to credit approval and loan amounts are subject to creditworthiness. Some restrictions may apply. The term, amount, interest rate and repayment schedule for your loan, and any product features, including interest rate locks, may vary depending on your creditworthiness and on the type, amount and collateral for your loan.
[3] Bank of America Practice Solutions may prohibit use of an account to pay off or pay down another Bank of America account.
Bank of America Practice Solutions is a division of Bank of America, N.A.
Sponsorship of endorser's products and services is not an expressed opinion or approval by the Bank. All promotional and marketing materials are Bank of America Practice Solutions property, as such, cannot be changed, altered or modified, orally or in writing. All questions regarding these materials should be directed or referred to a Bank of America Practice Solutions Sales Associate.
Bank of America is a registered trademark of Bank of America Corporation.

INFORMED CONSENT PRIMER

Anthony E. Chillura, DMD, FICD

Informed consent is an educational process where a health provider must tell a patient all of the potential benefits, risks, and alternative treatments; and assess the patient's understanding. It is an educational process by which a patient is provided sufficient information to make an informed, reasoned decision regarding treatment. The definition and legal regulations of informed consent varies state to state. As a general rule, there should be open dialogue so the patient can ask questions. The treating dentist is the best person to discuss the proposed treatment plan and answer any questions. Further, the dentist should assess the patient's understanding of the procedure by having the patient recap the procedure. Additionally, consent should be given without coercion or fraud, based upon the patient understanding of what will take place. It is prudent to follow the same outline for informed consent in your practice so as to not miss a step.

PROCESS OF INFORMED CONSENT:

1. Initial diagnosis by provider
2. Recommended treatment plan
3. Alternative treatment plan options
    - Option of referring the patient to a specialist
4. Potential risks of all treatment plans
5. Potential risks of not treating
6. Opportunity for patient to ask questions
7. Documentation of #1 - #6 in patient chart

Documentation is key to the informed consent process. Written consent should include the dentist's name, procedure, alternate treatments, potential risks of not treating, questions posed by the patient, time, date and witness to signature to consent. A copy should be placed in the patient's file along with a chart entry that informed consent process took place.

CONSENT FROM INCOMPETENT INDIVIDUALS AND MINORS

Situations that involve minors and mentally disabled individuals or children require extra steps to obtain informed consent. Questions must first be answered regarding who is able to give consent for those individuals.

A mentally disabled person may have an appointed guardian authorized to make medical decisions or authorize informed consent for that individual. In most situations, parents can give informed consent for treatment for their minor children. State definitions vary regarding who is considered a minor.

NON-ENGLISH SPEAKING PATIENTS

Since the informed consent process includes clear communication of the treatment plan, it is imperative that non-English speaking patients have a full understanding as well. Some patients may come with an interpreter to their appointment; if one is not available you should provide one prior to rendering any treatment requiring informed consent. In addition, consideration should be given for non-English speaking patients that may not be able to read in their native language as well. Consider using alternative communications methods for these patients, such as visual diagrams and aids that can then be included in the informed consent document.

INFORMED REFUSAL

Patients may tell the practitioner that they do not want or need to discuss the proposed treatment plan stating that they trust the practitioner to perform the procedure. It is important to continue forward with informed consent in these situations to avoid any future cause for legal action. If the patient goes further with not wanting to discuss consent, it is important to then document informed refusal.

Any patient can refuse treatment for whatever reason. Your responsibility as the practitioner is to inform and explain the risks of refusing treatment. Document in the patient chart and have the patient sign an informed refusal form. Depending on the refusal, or number of times refused, this can be a basis for patient termination if continued recalcitrance could be considered negligence. At recall appointments, do not assume future refusal and revisit the patient refusal diplomatically.

Editor's Note: Dr. Anthony Chillura is the Director of Dental Risk Management for the Professional Protector Plan (PPP) For Dentists. To learn more about the PPP for Dentists, please visit protectorplan.com or contact Virginia state administrator, RK Tongue Co., Inc., at 800-638-6353. PPP is a proud endorsed partner of the VDSC.

AWARDS AND RECOGNITION

DR. CAITLIN BATCHELOR
Special Service Award

DR. SCOTT BERMAN
Leadership Award

DR. WILLIAM DOUGHERTY, III
Special Service Award

DR. SAM GALSTAN
President's Award/Special Service Award

DR. CHRISTY HAMLIN
Leadership Award

DR. RALPH HOWELL
Special Service Award

BARRY ISRINGHAUSEN
Presidential Citation

DR. CLAIRE KAUGARS
Special Service Award

JILL KELLY
Special Service Award

DR. MICHAEL LINK
Emanuel W. Michaels Distinguished Dentist Award

DR. BENITA MILLER
Leadership Award, Special Service Award

DR. ANTHONY PELUSO
Leadership Award

DR. ELIZABETH REYNOLDS
Special Service Award

DR. RICHARD ROADCAP
Presidential Citation

NORMA ROADCAP
Presidential Citation

DR. ANTHONY SAVAGE
2019 President
Southern Association of Orthodontists

ROBBIE SCHUREMAN
Presidential Citation

DR. TED SHERWIN
Special Service Award

AWARDS AND RECOGNITION

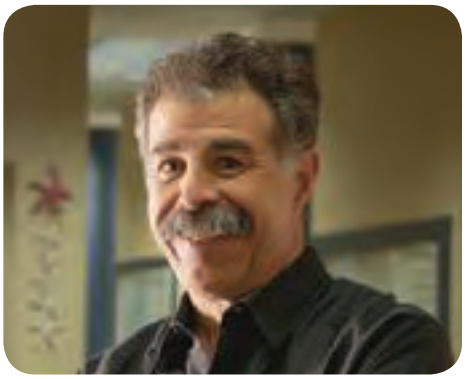
DR. CYNTHIA SOUTHERN
Special Service Award

DR. RONALD TANKERSLEY
Special Service Award

DR. STEPHANIE VLAHOS
Leadership Award

LAUREN WADE
Dental Team Member Award

DR. C. SHARONE WARD
Presidential Citation



DR. DAG ZAPATERO
Presidential Citation

DR. ANDREW "BUD" ZIMMER
Torchbearer's Award

2019 ACD FELLOWS
L-R: Drs. Sandra Catchings, Caitlin Batchelor, Dawn Hunt, William Hunt, Cheryl Billingsley, Marcel Lambrechts, Sayward Duggan, James Willis; also pictured Drs. W. Vincent Dougherty, Richard Taliaferro

2019 VDA FELLOWS
L-R: Dr. Paul Olenyn, Chair, Fellows Committee; Drs. Ashkan Ghaffari, Pamela Morgan, Justin Norbo, Duane Bickers, Brian Thompson, Michael Gorman, George Jacobs, Caitlin Batchelor, Brooke Goodwin, Luiza Kreuzer

2019 ICD FELLOWS
L-R: Drs. Cassidy Turner, Barrett Peters, Robert Morrison, Cheryl Billingsley, William Munn, Marcel Lambrechts, Caitlin Batchelor

WELCOME NEW MEMBERS

THROUGH SEPTEMBER 1, 2019

Tidewater DENTAL ASSOCIATION

Dr. Ashley Anderson – Suffolk – Virginia Commonwealth University School of Dentistry 2017

Dr. Mellanda Colson-Scott – Norfolk – Howard University College of Dentistry 1998

Dr. Leigh Fortney – Virginia Beach – Georgia Regents University School of Dentistry 2019

Dr. Rodion Kryzhanovskiy – Norfolk – LECOM College of Dental Medicine 2019

Dr. David Macdonald – Portsmouth – Virginia Commonwealth University School of Dentistry 2019

Dr. Carter Mavromatis – Virginia Beach – Medical University of South Carolina James B. Edwards College of Dental Medicine 2019

Dr. Megan Mazzarella – Virginia Beach – East Carolina University School of Dental Medicine 2015

Dr. Harry Squire – Virginia Beach – Virginia Commonwealth University School of Dentistry 2019

Peninsula DENTAL SOCIETY

Dr. David Abeyounis – Newport News – Virginia Commonwealth University School of Dentistry 2019

Dr. Karim ElKenawy – Williamsburg – University of Maryland School of Dentistry 2018

Dr. Jennifer Howard – Williamsburg – University of North Carolina School of Dental Medicine 2007

Dr. Jairo Montoya – Newport News – Rutgers School of Dental Medicine 2019

Southside DENTAL SOCIETY

Dr. Francis Babaran – Farmville – University of Colorado Denver School of Dental Medicine 2019

Dr. William Grizzard – South Prince George – Virginia Commonwealth University School of Dentistry 2019

Dr. Rebecca Karp – Chesterfield – Virginia Commonwealth University School of Dentistry 2019

Dr. Lisa Krebs – Chester – Marquette University School of Dentistry 1994

Dr. Randall Krebs – Chester – Marquette University School of Dentistry 1994

Dr. Joseph Pfab – Chesterfield – Virginia Commonwealth University School of Dentistry 2019

Richmond DENTAL SOCIETY

Dr. Mason Bates – Richmond – University of Texas School of Dentistry in Houston 2019

Dr. John Bninski – Richmond - Virginia Commonwealth University School of Dentistry 2019

Dr. Courtney Brashier – Richmond – Louisiana State University School of Dentistry 2019

Dr. Benjamin Brown – Richmond – University of Nevada Las Vegas School of Dental Medicine 2014

Dr. Pria Chang – Richmond – Virginia Commonwealth University School of Dentistry 2019

Dr. Rebekah Collins – Richmond – Arizona School of Dentistry and Oral Health 2019

Dr. Jonathan Luke Current – Richmond – East Carolina University School of Dental Medicine 2019

Dr. John Cusumano – Richmond – Virginia Commonwealth University School of Dentistry 2019

Dr. Rahma Elkamhawy – Glen Allen – Meharry Medical College School of Dentistry 2019

Dr. Philippe Franco – Henrico – Virginia Commonwealth University School of Dentistry 2019

Dr. Julia Giardina – Richmond – Virginia Commonwealth University School of Dentistry 2019

Dr. Jackson Griffeth – Richmond – Augusta University Dental College of Georgia 2019

Dr. Michael Ha – Richmond – Oregon Health and Science University School of Dentistry 2019

Dr. Daniel Hall – Richmond – University of Kentucky College of Dentistry 2019

Dr. Jeremy Hargrove – Richmond – Midwestern University College of Dental Medicine – Arizona 2018

Dr. Anne Harper – Richmond – Medical University of South Carolina James B. Edwards College of Dental Medicine 2019

Dr. Elizabeth Hering – Richmond – Virginia Commonwealth University School of Dentistry 2019

Dr. Tyler Hill – Richmond – University of North Carolina Chapel Hill School of Dentistry 2019

Dr. Christopher King – Mechanicsville – Virginia Commonwealth University School of Dentistry 2019

Dr. Shweta Kokate – Richmond – Virginia Commonwealth University School of Dentistry 2019

Dr. Chang Hun Lee – Richmond - Virginia Commonwealth University School of Dentistry 2019

Dr. Cornelius Martin – Richmond – East Carolina University School of Dental Medicine 2019

Dr. Chriska Mustafa – Henrico – Howard University College of Dentistry 2019

Dr. Priyanka Patel – Richmond – University of Pennsylvania School of Dental Medicine 2019

Dr. Skylar Penberthy – Richmond – Oregon Health and Science University School of Dentistry 2019

Dr. Nitya Reddy – Richmond – Virginia Commonwealth University School of Dentistry 2019

Dr. Inderpal Sappal – Richmond – University of the Pacific, Arthur A. Dugoni School of Dentistry 2018

Dr. Jahanzabe Siddiqui – Richmond – University of Maryland Dental School, Baltimore College of Dental Surgery 2019

Dr. Kathryn Skarda – Richmond – Virginia Commonwealth University School of Dentistry 2018

Dr. Parisa Tashakkori – Richmond – East Carolina University School of Dental Medicine 2017

Dr. Taylor Tate – Henrico – Medical University of South Carolina 2019

Dr. Jennifer Van Hook – Richmond – Medical University of South Carolina Dr. James B. Edwards College of Dental Medicine 2019

Dr. Taylor Varner – Midlothian – Virginia Commonwealth University School of Dentistry 2013

Dr. William Wang – Richmond – Virginia Commonwealth University School of Dentistry 2019

Dr. Robert Warren – Richmond – University of North Carolina Chapel Hill School of Dentistry 2019

Dr. Jennifer Waters – Richmond – University of Florida College of Dentistry 2014

Dr. Tyler Wood – Henrico – Virginia Commonwealth University School of Dentistry 2019

Dr. Elaine Wu – Richmond – Boston University Goldman School of Dental Medicine 2019

Piedmont DENTAL SOCIETY

Dr. Tahsin Anwar – Roanoke – Roseman University College of Dental Medicine 2019

Dr. Michael Board – Roanoke – Virginia Commonwealth University School of Dentistry 2019

Dr. Nader Burpee – Roanoke – University of New England College of Dental Medicine 2019

Dr. Carlton Leiner – Roanoke - Virginia Commonwealth University School of Dentistry 2019

Dr. Austin Moon – Danville - Virginia Commonwealth University School of Dentistry 2019

Dr. Lindsay Thorn – Roanoke – University of Alabama School of Dentistry at UAB 2019

Southwest Virginia DENTAL SOCIETY

Dr. Negar Massah – Abingdon – Virginia Commonwealth University School of Dentistry 2016

Dr. Benjamin Matthews – Blacksburg – University of Colorado Denver School of Dental Medicine 2018

Dr. Arti Patel – Christiansburg – Virginia Commonwealth University School of Dentistry 2019

Dr. Joni Watson – Jonesville – Virginia Commonwealth University School of Dentistry 2019

Dr. Haiwen Zhang – Blacksburg – Medical University of South Carolina James B. Edwards College of Dental Medicine 2019

Shenandoah Valley DENTAL ASSOCIATION

Dr. Anna Dinh – Albemarle – Roseman University College of Dental Medicine 2019

Dr. Shvan Kareem – Harrisonburg - Virginia Commonwealth University School of Dentistry 2019

Dr. Jeremy Lovelace – Lexington – Roseman University College of Dental Medicine 2019

Dr. Hannah Mabe – Augusta – Virginia Commonwealth University School of Dentistry 2018

Dr. Colin McCain – Charlottesville – Virginia Commonwealth University School of Dentistry 2019

Dr. Swati Pandey – Crozet – Virginia Commonwealth University School of Dentistry 2019

Northern Virginia DENTAL SOCIETY

Dr. Kopal Agarwal – Ashburn – Tufts University School of Dental Medicine 2019

Dr. Adnan Al-Karagholi – Chantilly – Virginia Commonwealth University School of Dentistry 2019

Dr. Yusur Al-Tekreeti – Prince William – Virginia Commonwealth University School of Dentistry 2019

Dr. Ashima Ahuja – Herndon – University of Maryland School of Dentistry 2018

Dr. Gina Askander – Fairfax – University of Pennsylvania School of Dental Medicine 2019

Dr. Yeu Jin Baik – Fredericksburg – Virginia Commonwealth University School of Dentistry 2019

Dr. Pamela Bui – Annandale – University of California at San Francisco School of Dentistry 2014

Dr. Synthia Chowdhury – Fredericksburg – Virginia Commonwealth University School of Dentistry 2019

Dr. Claudia Cruz – Leesburg – Columbia University Dental Medicine New York 2018

Dr. Elham Dehyar – Aldie – Temple University The Maurice H. Kornberg School of Dentistry 2019

Dr. Richard Duong – Chantilly – University of New England College of Dental Medicine 2019

Dr. Tamara Garrett – Arlington – Howard University College of Dentistry 2000

Dr. Abby Halpern – Arlington – Georgia Regents University School of Dentistry 2018

Dr. Christian Hart – Arlington – University of North Carolina Chapel Hill 2019

Dr. James Houseworth, IV – Woodbridge – University of Tennessee HSC College of Dentistry 1979

Dr. Stephanie Hoyos – Arlington – State University of New York at Buffalo School of Dental Medicine 2017

Dr. Kasra Khamooshi – Fairfax – Nova Southeastern University College of Dental Medicine 2019

Dr. April Kwan – Fairfax – University of Texas School of Dentistry at Houston 2019

Dr. Nicholas Leon-Guerrero – Arlington - University of the Pacific, Arthur A. Dugoni School of Dentistry 2014

Dr. Richard Liu – Springfield – Boston University Goldman School of Dental Medicine 2014

Dr. Hue Ly – Springfield – Boston University Goldman School of Dental Medicine 2012

Dr. Mahdi Majarrad – McLean – Temple University The Maurice H. Kornberg School of Dentistry 2019

Dr. Ahmad Naimee – Fairfax – University of Maryland, Baltimore College of Dental Surgery 2019

Dr. Van Nguyen – Fairfax – Case Western Reserve University School of Dental Medicine 2016

Dr. Maria Obregon Merlo – Woodbridge – Tufts University School of Dental Medicine 2019

Dr. Minuja Ojha – Herndon – Tufts University School of Dental Medicine 2019

Dr. Esther Park – Vienna – University of North Carolina Chapel Hill 2019

Dr. Kamran Raja – Chantilly – Boston University Goldman School of Dental Medicine 2003

Dr. Renuka Rao – Annandale – Roseman University of Health Sciences College of Dental Medicine 2019

Dr. Pooyan Refahi – Alexandria – Tufts University School of Dental Medicine 2015

Dr. Kevin Salinas – Woodbridge – Virginia Commonwealth University School of Dentistry 2019

Dr. William Santo Domingo – Arlington – University of Puerto Rico School of Dental Medicine 2002

Dr. Patrick Shine – Alexandria – LECOM College of Dental Medicine 2017

Dr. Lauren Snyder – Fredericksburg – Virginia Commonwealth University School of Dentistry 2018

Dr. Sahil Trehan – Fairfax – Virginia Commonwealth University School of Dentistry 2019

Dr. Thinh Trinh – Alexandria – New York University College of Dentistry 2019

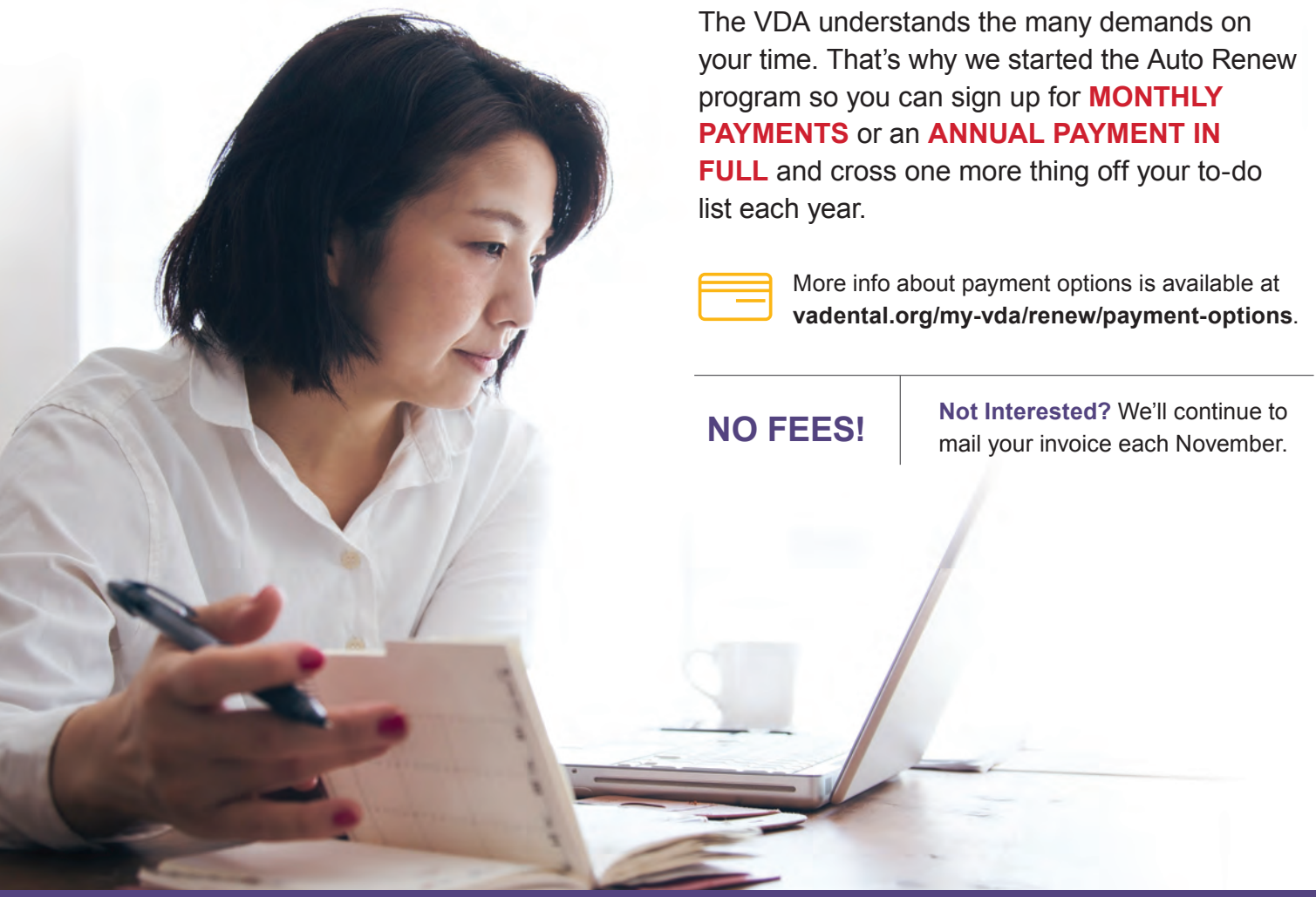
IN MEMORY OF:

Name	City	Date	Age
Dr. Herbert D. Davidson	Boca Raton, FL	November 9, 2018	91
Dr. Anthony C. Viscomi	Fairfax, VA	July 25, 2019	71
Dr. James R. Wampler	Salem, VA	November 23, 2018	84

Virginia Dental ASSOCIATION

Put time back in your practice with

Membership Auto Renew!



The VDA understands the many demands on your time. That's why we started the Auto Renew program so you can sign up for **MONTHLY PAYMENTS** or an **ANNUAL PAYMENT IN FULL** and cross one more thing off your to-do list each year.

More info about payment options is available at **vadental.org/my-vda/renew/payment-options**.

NO FEES!

Not Interested? We'll continue to mail your invoice each November.

Call **804.288.5750** and ask to sign up for auto renew or select "auto renew" when you renew your membership at **vadental.org/my-vda/renew.**

VDA Foundation
VIRGINIA DENTAL ASSOCIATION

2018-19 Core Sponsors and Supporters...

Thank You for Your Generosity!

The generosity of our Sponsors and Supporters helps ensure that we not only improve the oral health of thousands of Virginia each year, but it also helps make the VDAF a stronger and more sustainable organization.

We **TRULY APPRECIATE** the companies, foundations, and individuals who fully embrace our mission to provide access to dental care for underserved Virginians.

VDH Virginia Department of Health — Protecting You and Your Environment

Jenkins Foundation

RMHF Richmond Memorial Health Foundation — The foundation for better health

Cranemasters Inc.

Queen Virginia Skill & Entertainment — Charitable Giving

DentaQuest Partnership for Oral Health Advancement

DentaQuest

VDA Virginia Dental Association

Dominion Energy Charitable Foundation

Henry Schein Dental

John Randolph Foundation — Healthy communities. Bright futures.

The Cameron Foundation

VDA Richmond Dental Society

Oral Health Foundation — Pierre Fauchard Academy

Delta Dental

United Concordia Dental — Protecting More Than Just Your Smile

Dental Lifeline Network — More than Dentistry. Life.

Buchanan County Youth, Inc.

Herndon Foundation

VirginiaPremier — Powered by VCU Health

The Emily S. and Coleman A. Hunter Charitable Trust

The Walter W. Regirer & Maria Teresa Regirer Foundation

ADDRESSING A REAL NEED IN SPECIAL NEEDS

Andrew Jockers*, Veronica Palumbo*, and Matthew R. Cooke, DMD**

The special needs patient population is sometimes considered the most underserved patient population in the US. “Special Needs” is a catch-all term for patients diagnosed with everything from Autism Spectrum Disorder to Cerebral Palsy to Traumatic Brain Injuries. This wide range of patients is defined by the Special Care Dental Association (SCDA) to be “people with physical, medical, developmental, or cognitive conditions which limit their ability to receive routine dental care[1].” Studies show that these types of patients suffer not only from their base condition, but also from a large disparity in terms of access to dental care[2].

To evaluate this assertion, we note that the special needs community is not a small population. Some studies estimate the percentage of patients with some intellectual or developmental disability (IDD) requiring specialized care to be around 12%[3][4]. Furthermore, studies have shown that both caries and periodontal disease are highly prevalent amongst this particular population[2][6]. In the case of some of the more common IDD conditions (unspecified intellectual disability, autism spectrum disorder, and cerebral palsy[5]), we have evidence showing high prevalence of both caries and periodontitis in these patients[6].

Further, unique craniofacial morphology in patients with developmental disabilities can increase their risk of having comorbidities such as traumatic occlusion, TMJ problems, and bruxism. These harmful conditions, in addition to many others, not only increases their risk for disease, but also complicates their care[7].

Rounding out the importance of this issue is the strong correlation between oral health and systemic disease. The integration of oral health care with systemic disease reveals a strong need for preventive measures to achieve overall well-being[8]. This association necessitates comprehensive care for this higher risk population.

Despite this notable prevalence of disease and necessity of preventive care, the needs of the IDD population tend to go on unmet[2][9]. Broad categories such as psychological, financial, and educational barriers have been established as the primary causes for the healthcare disparity[9]. However, these reasons go beyond that. This issue is multifactorial and complex and is beyond the scope of this particular paper to address the causalities on an individual basis.

It should be noted that, despite these issues, there are many efforts around the country to provide for the special needs population. We have even seen some intriguing recent case studies addressing novel methods for increasing access for these patients[10]. Unfortunately, these flickers of hope are dampened by the sheer volume of patients alongside the limited number of providers attempting to serve them[10].

In 1997, Special Olympics Healthy Athletes began to combat this access-to-care disparity. This program was created to offer free healthcare screenings and information to Special Olympics athletes during competitions. Its efforts directly target low access by providing care at facilities where a large number of special needs individuals are expected to attend, regardless of offering healthcare.

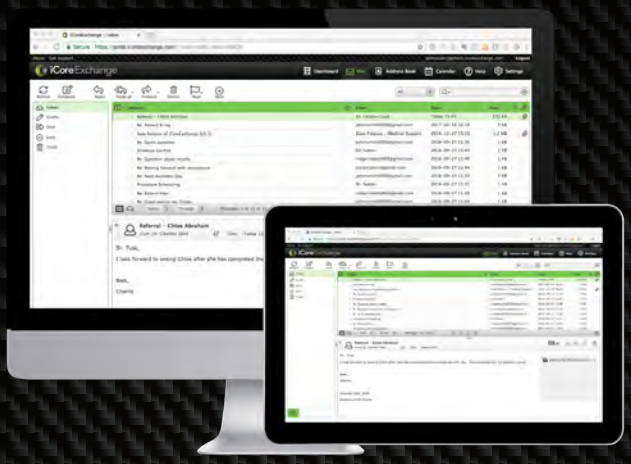
The Special Olympics Healthy Athletes: Special Smiles and the Mission of Mercy project have been teaming up to provide dental care in a dual purpose event where Special Olympics athletes (as well as non-participating persons with disabilities) are treated at a mobile dental clinic provided by the Mission of Mercy project.

This year, on a soggy Saturday in June, dental students from Virginia Commonwealth University joined forces with students from the University of Pittsburgh School of Dental Medicine to provide free surgical, restorative, and

► NEEDS - CONTINUED ON PG. 61

It's easy to comply with HIPAA law when emailing PHI.

iCore Exchange



No Size Restrictions on Attachments

No Phishing, Spam or Ransomware

No Hidden Fees

HIPAA Audit Trail for Every Message

VDA Services
VIRGINIA DENTAL ASSOCIATION

DPR TOP 50 PRODUCTS 2017 · TOP 10 ENCRYPTION ENTERPRISE SECURITY · TOP 10 DENTAL SOLUTION Healthcare Tech OUTLOOK · STARTUP +HEALTH

Limited Time Offer

Subscribe now for 1 month FREE

Offer ends 11/30/19

888.810.7706 iCoreConnect.com/VDA

► NEEDS - CONTINUED FROM PG. 59

prophylactic services to these patients. The efforts were largely student-led with oversight from faculty of both institutions, as well as local dentists, hygienists, and assistants from the area. In the auxiliary gymnasium on the campus of St. Christopher's School in Richmond, more than 130 patients were seen over the course of a day. There were 65 restorations, 46 extractions and more than 80 prophies completed. A collection of services worth nearly $35,000 were provided absolutely free to the young and old athletes and friends who have such a desperate need.

The efforts of these events are both impressive and admirable. However, the care of an entire patient population cannot be borne on the backs of free clinics and volunteer services. At these events we find continuously a profoundly unmet need in a population who endure oral and dental disease often as an unfortunate aspect of their condition. The access to care for this population must improve in the interest of creating a better quality of life in patients whose disease processes and oral comorbidities are no fault of their own. The duty now falls to the dental professionals of the world to begin seeing their problem as our problem. It will be neither easy nor lucrative, but there may be no patient population more deserving of our skills, our efforts, and our time.

*Class of 2020, University of Pittsburgh School of Dental Medicine

**Assistant Professor, University of Pittsburgh School of Dental Medicine

References

1. SCDA Definitions. (n.d.). Retrieved July 24, 2019, from: https://www.scdaonline.org/page/SCDADefinitions
2. Ummer-Christian, R., Iacono, T., Grills, N., Pradhan, A., Hughes, N., & Gussy, M. (2018). Access to dental services for children with intellectual and developmental disabilities – A scoping review. Research in Developmental Disabilities,74, 1-13. doi:10.1016/j.ridd.2017.12.022
3. Lawton, L. (2002). Providing dental care for special patients: Tips for the general dentist. Journal of the American Dental Association,133(12), 1666-1670. doi:10.14219/jada.archive.2002.0118
4. Bethell, C.D., Read, D., Blumberg, S.J. et al. (2008). What is the Prevalence of Children with Special Health Care Needs? Toward an Understanding of Variations in Findings and Methods Across Three National Surveys. Maternal Child Health Journal. 12: 1. https://doi.org/10.1007/s10995-007-0220-5
5. Suzanne McDermott, Julie Royer, Tara Cope, Scott Lindgren, Elizabeth Momany, Jae Chul Lee, Mary Joan McDuffie, Emily Lauer, Stephen Kurtz, and Brian S. Armour (2018) Using Medicaid Data to Characterize Persons With Intellectual and Developmental Disabilities in Five U.S. States. American Journal on Intellectual and Developmental Disabilities: July 2018, Vol. 123, No. 4, pp. 371-381
6. Silvana Nunes da Silva Thais Gimenez Rafael Celestino Souza Anna Carolina Volpi Mello-Moura Daniela Prócida Raggio Susana Morimoto Juan Sebastian Lara Giovana Correia Soares Tamara Kerber Tedesco. (2016). Oral health status of children and young adults with autism spectrum disorders: systematic review and meta-analysis. International Journal of Paediatric Dentistry 2017; 27: 388– 398. doi: 10.1111/ipd.12274
7. Kratunova E., da Fonseca M.A. (2019) Common Oral Conditions in Children with Special Needs. In: Nelson T., Webb J. (eds) Dental Care for Children with Special Needs. Springer, Cham. doi: 10.1007/978-3-030-10483-2_8.
8. Anders, P. L. and Davis, E. L. (2010), Oral health of patients with intellectual disabilities: A systematic review. Special Care in Dentistry, 30: 110-117. doi:10.1111/j.1754-4505.2010.00136.x
9. Davis, M. J. (2009). Issues in Access to Oral Health Care for Special Care Patients. Dental Clinics of North America,53(2), 169-181.
10. Atchison, K. A., Weintraub, J. A., & Rozier, G. (2018). Bridging the dental-medical divide: Case studies integrating oral health care and primary health care. Journal of the American Dental Association,149(10), 850-858.

VISIT vdaf.org **TO LEARN ABOUT UPCOMING VOLUNTEER OPPORTUNITIES.**

Photographs by Scott Blankenship

ADDICTED TO...MOM?

A DISEASE WE CAN AFFORD TO SPREAD!

Dr. Tiffany N. Nightengale

Mission work is something that has always been an integral part of my life, though I didn't always refer to it in that language. Growing up, my parents encouraged my brother and I to participate in activities that made a difference in our community. We were a "scout" family, both reaching the zenith in our teenage years (Eagle Scout and Girl Scout Gold Award, respectively) and participated in a host of perennial church activities that filled our weekends with service to the less fortunate.

My college years were busy, juggling the demands of pre-dental coursework and forming bonds with new people that would become lifelong friends. I was able to do a touch of volunteer work here and there, but nothing as perennial as in my younger years. When I got to dental school, my eyes were opened to a new world-dental missions. Participating in four mission trips to the Dominican Republic while a student at the University of Louisville helped to shape my view of my chosen profession. Having the ability to make a profound, immediate difference in someone else's life by relieving pain or boosting self confidence? I knew this was something I wanted to participate in for the rest of my budding dental career. The only question that remained was, "How"?

Fast forward to the beginning of practice in 2006. The first few years were a transitional period, learning the art of clinical dentistry and a new juggling emerged; professional life versus personal life. I felt so busy, unsure if balance would ever come. Mission work was still in my heart, but where would I find the time and money? With overwhelm in my line of vision, I filed mission work into the category of "one of these days".

My "one of these days" occurred in 2013. I was familiar with the annual Wise MOM Project from my VDA communications, and decided now was the time. Participating in this weekend event would not break the bank and required just a few hours of driving instead of tireless planning and preparation to travel abroad. My only apprehension was making the trek from Hampton Roads to an unknown part of the state; so I approached my parents to see if they would be interested in joining me in this adventure (hey, I could use a shotgun driver or two!). They both gave a firm YES without hesitation, so I knew there was no turning back-Wise County, here I come!

The Road to Wise brings two words to mind...scenic and LONG. I forget the length of the Commonwealth and number of counties contained (95-WOW!). I walked into the experience with no expectations, yet came to be in awe of the behemoth before me on the fairgrounds. I was truly impressed by the level of organization amongst such a large number of healthcare professionals. The services being offered that weekend were comprehensive and delivered in such an efficient manner. I found my niche with the triage crew and was welcomed with open arms by vets who had been present since the first project. The level of camaraderie and patient interaction was so memorable, I knew I was hooked.

I may have lost Mom and Dad in the midst of networking with such a large group of like minded individuals, but they found their way, making friends with new faces from across the state. We spent our evenings in Wise County exhausted yet satisfied, bonding on a new level.

I am proud to say Summer 2013 was the first of many Mission of Mercy Projects I have been honored to participate in. I continued to bond with the parentals as we completed five MOMs in two years! Of course, by 2016 a little thing called life happened again and there was slight hiatus in our expeditions. However, in January of this year I said enough was enough and put July 2019 on the books.

I'll tell you what-we couldn't have picked a better year to return to Wise. Every MOM Project is special, but there's something about Wise that is hard to put you finger on- it's a little more memorable. Maybe because it was my first, or possibly because this year marked the 20th year, it's hard to clarify-all I know is that returning to find a new home on the campus of UVA Wise was awesome! Just like my favorite sweater or most comfortable pair of shoes, my old pals from triage remembered my face and saved me a chair. The weekend was yet another beautiful labor of love. I wish I could tell you my favorite part, but that would be impossible. The spirit of giving is infectious and the dynamic energy assure me I'll always come back.

Smile.

THERE'S A BETTER WAY TO BUY DENTAL SUPPLIES.

Join together with independent dentists and get big savings on dental supplies for practices of every shape and size.

TDSC is proud to be affiliated with **VDA Services** to help save **Virginia Dental Association** members more on supplies than they pay in dues.

ENDORSED BY:

VDA Services
VIRGINIA DENTAL ASSOCIATION

SHOP ONLINE AND START SAVING TODAY

tdsc.com The Dentists Supply Company

Classifieds

VIRGINIA DENTAL ASSOCIATION

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

JOBS Dentists

6447 - AMAZING DENTIST!
MIDLOTHIAN, VA
In search of an AMAZING dentist who loves to grow, loves to learn, loves to teach, and strives for excellence! We are a general and sedation focused FFS practice in Midlothian that aims for excellence in all aspects of inter-office and patient encounter/treatment. If you can add to this environment, contact us with: 1) resume 2) Where you see yourself in 1, 3, 5 years 3) favorite stress relief!
Contact: Ashley | 804-379-4483
midlodentist1@gmail.com

6454 - GENERAL DENTIST
CHESTER, VA
Looking for an associate dentist for a state-of-the art dental office. We are detail oriented, locally owned and operated. We have three very established offices in and around Richmond. We see a large number of new patients and exciting patients. Great pay and compensation, partnership opportunities are open for the appropriate candidates.
Contact: Dr. Varkey | 804-874-2333
richmonddentist@gmail.com

6457 - PART-TIME DENTIST
RICHMOND, VA
Daily Planet Health Services (DPHS) is seeking a part-time dentist. DPHS is a federally qualified health center in Richmond. Job Requirements: DDS or DMD, a license to practice dentistry in Virginia and a DEA license. Minimum of 2 years of general dentistry experience required. Bilingual (English/Spanish) is a plus. Experience working with homeless and/or under-served populations preferred. Must demonstrate a willingness to serve as a member of a team and exude excellent professional demeanor.
Contact: Dr. Jernice Giles | 804-934-1837
sarterj@dailyplanetva.org

6458 - ASSOCIATE DENTIST NEEDED
VIRGINIA BEACH
An Associate Dentist is needed in our growing practice. Lots of opportunities for general and advanced restorative dentistry. Office is paperless and equipped with computer in each room. We have wonderful staff that make the transition into our practice easy. Great salary! Please send your resume to Buban2@yahoo.com

6469 - GENERAL OR PEDIATRIC
DENTIST - CHARLOTTESVILLE, VA
We have an opening for a Pediatric or General Dentist at a busy dental practice. The practice is a multidisciplinary practice, however, patients are primarily children. Our practice also has in-house general anesthesia and an in-house orthodontist. The practice has a culture of mission-minded dentistry with a focus on increasing access to care to the communities of Central Virginia. Our team will fill your schedule for you. This position is full-time or part-time (your choice). The compensation is offered as a % of production. The production calculation includes all procedures, including prophy and fluoride. Our benefits package is very competitive: Sign-on bonus; 100% Health Insurance coverage; 401(k) Matching; License/DEA Cost Reimbursement; Malpractice Coverage; CE stipend; Professional Organization Membership dues reimbursement; Lab Fees Paid by Practice. Contact: jharv003@gmail.com

6473 - DENTAL ASSOCIATE
VIRGINIA BEACH
Full or Part time Dentist Associate position available in a multiple office practice! Applicants proficient in endo and routine O.S. a plus. Experience preferred but not required. Please forward resume or recent C.V. Contact: Sheri | 757-417-7300
Sheri@DrHooper.com

6485 - ASSOCIATE DENTIST
RADFORD, VA
Seeking a talented, motivated associate dentist in beautiful southwestern Virginia. Our privately-owned, family practice is well established and has been around for 40+ years. Patient base for new hire would be transferred from another dentist so there is no need to advertise. We consider ourselves a laid back, high production office with an opportunity for growth in a low pressure environment. The position is a great opportunity for a recent graduate looking for mentorship within a group practice or an experienced doctor ready to produce. Our office is located in beautiful southwestern Virginia near a bend in the New River. The area offers plenty of recreation including hiking, biking, running, boating and much more. The area is very family friendly with plenty of southern charm to go around. Contact: Tyler Burningham | 540-250-2765
tylerandann@yahoo.com

6487 - ASSOCIATE DENTIST
WILLIAMSBURG, VA
James A. Burden, D.D.S. & Associates has an immediate opening for an energetic, goal driven Associate Dentist to join our well established Williamsburg office. We are seeking someone who wants to be part of a fast-paced cohesive team that likes to work hard and have fun. You will be providing comprehensive treatment to a steady flow of patients, including hygiene exams. We offer: Highly Competitive Salary, Partnership/Buy-In Potential, Benefits Package (including medical, 401k, vacation, sick time, CE assistance & more) Relocation Assistance Requirements: D.D.S. or D.M.D. from an American Dental Association accredited dental school. Current active unrestricted license to practice dentistry in Virginia (or the ability to obtain) Comfortable explaining treatment to the patient
Contact: Amy Eveland | 757-229-1224
amy.eveland@smilesofwilliamsburg.com

JOBS Dentists

6490 - DENTIST - WILLIAMSBURG, VA
James A. Burden, D.D.S. & Associates has an immediate opening for an energetic, goal driven Dentist to join our Williamsburg team to provide comprehensive treatment to a steady flow of patients. We offer: Highly Competitive Salary, Partnership/ Buy-In Potential, Benefits, and Relocation Assistance. Contact: Sharon Steward | 757-229-1224 sharon.steward@smilesofwilliamsburg.com

6493 - DENTIST NEEDED - UP TO $25,000 SIGN-ON BONUS ROANOKE, VA
Smile Virginia is seeking a caring dentist to join our in school-dental program to provide comprehensive dental care to kids in need. Full and part-time positions available with competitive compensation and a sign-on bonus. Work a school schedule, no weekends and summers off. Contact: Silvana Ayar | 586-823-0037 sayar@mobiledentists.com

6500 – ASSOCIATE DENTIST MYRTLE BEACH, SC 29577
Want to move to Myrtle Beach? Full or Part-Time Associate Dentist needed for a state of the art, well established facility located near one of our most beautiful beaches in South Carolina. We are a family practice that provides almost all types of dental services, including: IV/ Oral sedation, dental implants, restorative, endo, crown/bridge, and surgical extractions. Fee for service practice, no PPOs or HMOs. Digital and paperless! Fully trained and highly experienced team. Income potential is excellent. Sedation credentials a plus but not mandatory. Contact: Lisa | 843-293-670 lisa@marketcommondentistry.com

6501 - ASSOCIATE TO PRIVATE PRACTICE OWNERSHIP - 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 117 dentists have a shared vision of delivering quality care in the Hampton Roads communities (Williamsburg to Virginia Beach) we serve through our 74 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. Whether you're tired of working for someone else, a recent graduate, or student, ADC is designed to provide you with the clinical and business mentoring to ensure your success. Meet us at https://youtu.be/D1LBEvGgIu8 and http://www.atlanticdentalcare.net/. Forward resume/inquiry to receive opportunities listing. Confidentiality Assured. Contact: Marina | 757-455-5554 atlanticdentalcare@cox.net

6512 - DENTAL ASSOCIATE VIRGINIA BEACH
Busy General Dental practice in Virginia Beach seeking full time associate. Established practice with 30+ year reputation for honest and quality treatment. Modern office has 10 OPs with the latest technologies including cone beam imaging, CEREC Omnicam w/MCXL milling unit, laser, digital radiography, Intraoral cameras, etc.. Excellent new patient flow. Located in one of the highest growth areas of Virginia Beach. A candidate with a strong interest in implant placement/surgery is preferable. Collecting 2M+ on 4 days. Exceptional staff with outstanding team work and support. Benefits include 401K, health, disability and more. Email CV to associate@princessannecenterfordentalarts.com for additional practice information. Contact: Tracy Oliver, DDS | 757-641-0316

6524 - DENTIST - HAMPTON, VA
Busy general dentistry practice actively looking for dental associate. This candidate must be a friendly, outgoing and a motivated dentist with at least 2 years of experience, a team player and ready to work! Great earning potential! Must have an active Virginia License. Please forward your resume to familydentistry11@yahoo.com or call 202-909-3675 ASAP! 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. Diagnose and provide appropriate dental treatment to patients -Educate patients and parents of patients on maintaining proper oral health -Communicate with dental staff on our team regarding patient treatment plans -Supervise the work of professional, technical and administrative staff.

JOBS Staff

6505 - FRONT DESK/ OFFICE MANAGER - ARLINGTON, VA
We are in search of a superstar to help serve our patients with the highest level of care and service. If you are dedicated to your profession, passionate about serving people through dentistry and are looking for a nice place to fine tune your skills, then we could be the one. It's F/T job and we need someone to work Saturdays. Position is available immediately About You: -Passionate, Friendly, Motivated and Energetic. -Ability to perform and meet goals in time. -PREVIOUS dental Assisting Experience is a MUST -PREVIOUS front desk and insurance experience is a MUST -Familiar with all dental procedures and protocols. -Must be able to work some Saturdays -One last important thing, candidate takes pride in her/his APPEARANCE and SMILE Again, previous experience is a must. Position is available immediately Please send your resume. Job Type: Full-time
Contact: Ahmed | 619-278-9239
a.alsalim1981@gmail.com

6518 - FRONT OFFICE OPPORTUNITY FOR VA DENTAL ASSISTANT ARLINGTON, VA
Our amazing general dentistry practice is looking for a wonderful dental assistant to concentrate on front office duties. We are located in Arlington, Virginia across the street from the metro. It's a small, personalized office that is digital and paperless with a stellar dentist and fabulous patients. The candidate we seek is a team player, great with technology, personable, punctual, and who can work at a faster paced environment. Previous front office experience is a plus. Please email or call us today to schedule an interview. Thank you in advance.
Contact: Tina | 571-455-6219
doctortamaragarrett@yahoo.com

6506 - DENTAL OFFICE MANAGER CHESTER, VA
Our office is seeking an individual who will be friendly, welcoming, and hard working who is highly organized to take over all management duties for our practice. Those duties will include managing front desk staff and clinical staff. They should also be able to multi task in our fast paced office. Duties would include preparing daily reports, deposits, monthly reports, posting EOBS, accounts payable, assisting the front desk staff in keeping schedule full, collections and presenting treatment plans, ordering front desk supplies. Must be comfortable with talking with patients regarding financial arrangements. Must have a clear knowledge of dental procedures, dental codes and dental insurances. Must also have clear and professional communication skills, verbal and written. We are dedicated as a team to establish and build great relationships with our patients and each other. We would like someone with at least 3-5 years experience.
Contact: Milan Bhagat
Dentistoffice03@gmail.com

6523 - HYGIENIST - PART TIME HAMPTON, VA
PART TIME HYGIENIST needed ASAP to join our fabulous and growing team. DENTAL EXPERIENCE REQUIRED. Must have an active Virginia License. Full time and Part time hours available. Compensation depends on experience. If you're interested please email your resumes to: familydentistry11@yahoo.com OR call 202-909-3675 ASAP! Applicants must possess the ability to work in a progressive environment. Busy Hampton, VA office is actively looking for a full-time or part-time HYGIENIST. This candidate must be friendly, outgoing and motivated.

6525 - DENTAL INSURANCE COORDINATOR HAMPTON, VA
DENTAL COORDINATOR needed ASAP to join our fabulous and growing team. DENTAL EXPERIENCE REQUIRED. Duties include: answering phones, scheduling appointments, computer experience, attention to detail, multi-tasking, insurance coordination and customer service. Full time and Part time hours available. Compensation depends on experience. If you're interested please email your resumes to: familydentistry11@yahoo.com OR call 202-909-3675 ASAP! Applicants must possess the ability to work in a progressive environment. Busy Hampton, VA office is actively looking for a full-time or part-time DENTAL COORDINATOR. This candidate must be friendly, outgoing and motivated.

Products & Services

6445 - SIRONA CEREC AC OMNICAM SCANNER - BURGESS, VA
Used excellent condition With Software 4.6 Comes fully functional from a working office, Selling only because of upgrade In constant use since purchased new in 2013 Includes a camera calibration unit Includes STL export license Under 7 year warranty with Patterson $22,500 or best offer Shipping costs assumed by buyer. Estimates are between $150 and $850. Collaborative research will be done to minimize cost.
Contact: Les | 804-453-3101
FinaFamilyDental@gmail.com

6470 - FOR SALE: WHIPMIX VAC U SPAT - RICHMOND, VA
1 Whipmix Vac u Spat mixing machine with 1 medium and 1 large mixing containers. Various other dental lab items.
Contact: Bill Betzhold | 804-358-8301
wcbetzho@gmail.com

6483 - ITERO ELEMENT 2 FOR SALE CHARLOTTESVILLE, VA
I would like to sell a new, uncrated Itero Element 2 scanner. Great price reduction. We just do not need two scanners.
Contact: Jeffrey E Hodges | 434-293-8944
jhodges2250@gmail.com

Office Space Sale/Lease

6453 - DENTAL OFFICE FOR LEASE OR SHARE - VIENNA, VA
2,400 sq.ft. 2 operatories, 2 open bay chairs, and 3 more chairs to add already plumbed.Digital x rays, pano and ceph,sterilization and lab areas,eaglesoft, surveillance cameras,etc.Ideal for a specialist or a dentist with existing patients.
Contact: Ana | 703-938-1415
brightsmilevienna@gmail.com

6491 - NEW OFFICE FOR SALE ARTLINGTON, VA
A new dental office is for sale. Located in Ballston, heart of Arlington. 3 ops fully equipped, and it's plumbed to have four. 1180 sq. ft. It's really TURNKEY. If interested please reach out by email.
Contact: a.alsalim1981@gmail.com

6513 - DENTAL CONDOMINIUM FOR RENT OR PURCHASE - GLOUCESTER POINT, VA
Bright, fresh and fully equipped, this turn key dental office is available immediately. Three operatories, fourth plumbed. 1500 sq. ft. Nitrous oxide, digital x ray, Eaglesoft practice management. Perfect for a satellite or startup. Previous owner was a prosthodontist and laboratory is highly equipped, but no patients convey. Very reasonably priced.
Contact: Angela Render | 757-927-3879
angelarender@hotmail.com

Practice Transitions

6449 - PRACTICE FOR SALE ROANOKE, VA
General Practice For Sale Established General Practice 100% Fee For Service with annual revenue in the high 500k EBIDTA 15% Owner retiring with flexibility for a transition period. Stand alone real estate available for sale or lease. Proforma with cash flow analysis available after NDA in place. Contact: William
virginiadentist2019@gmail.com

6471 - BUSY PRACTICE FOR SALE PENNINGTON GAP
Busy rural family practice 35 years. Four Operatories, Digital, Xrays, Pan Vertical Bitewings, Cone beam, operative Microscope Sale Lease Building Retiring.
Contact: James Roberson | 276-220-6462, cell 276-220-6462
skjmroberson@hotmail.com

6486 - DENTAL PRACTICE FOR SALE GREAT NECK - VIRGINIA BEACH, VA
Well established practice in Great Neck area of Virginia Beach in an office space of 1500sq ft. Work week to fill 2 days of patients.
Contact: Dean Kent | 757-373-6486
drdkent@partnersindentalhealth.com

6502 - SATELLITE PRACTICE FOR SALE - RICHMOND-CHESTERFIELD 23234
This well established, efficient, satellite practice is ready to grow. Working only ONE DAY a week, we are collecting $150K, so there is great potential at a great price of $127,500. We are getting 25 new patients a month with this limited schedule. Adding a second day will double the income immediately. Recently updated interior with 3 ops, and another plumbed, nice lab, digital x-rays and digital charting. I will work with a buyer for a "warm transfer" if requested.
Contact: Dr. Ken Stoner | 804-402-8096
kstoner775@aol.com

6503 - PRIVATE PRACTICE ASSOCIATE MENTORSHIP OR 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 117 dentists have a shared vision of delivering quality care in the Hampton Roads communities (Williamsburg to Virginia Beach) we serve through 74 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/D1LBEvGgIu8 and http://www.atlanticdentalcare.net/. Forward inquiries/resume for opportunities. Confidentiality Assured.
Contact: Marina | 757-455-5554 |
atlanticdentalcare@cox.net

What is the goal for your practice?

- Practice sales and acquisitions
- Exit strategy consulting
- Appraisals and analysis
- Practice protection plan
- DSO transitions
- Associate placement

Contact us at (877) 365-6786
choicetransitions.com

CHOICE℠
Dental practice transitions
An NPT Company

Virginia Dental
ASSOCIATION

Virginia Dental Association
3460 Mayland Ct, Ste. 110
Richmond, VA 23233

AFTCO
TRANSITION CONSULTANTS
Since 1968

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**