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40 UNDER 40

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DR. AMANDA KERNS

Whether she's singing Frozen songs to make younger patients feel comfortable or educating their parents about the age-one dental visit, Dr. Amanda Kerns knows that her job as a private practice pediatric dentist in Richmond is the best job.

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PRESIDENT'S MESSAGE

Dr. Vince Dougherty

It has been a great pleasure and honor to work closely with the VDA and all its amazing members. We are very fortunate to have such an impressive roster of professionals. Thank you, Dr. Terry Dickinson and staff.

I have heard the same question multiple times throughout the year: "Why don't we do anything about insurance?" My response is always, "We do." The ADA is determined to repeal the McCarran-Ferguson Antitrust Exemption for Health Insurance Companies. The insurance companies have been able to collude against healthcare professionals for years. Repeal potentially represents a huge win for dentistry and the patient. The bill passed the US House of Representatives (416-7 vote) and I am hopeful it passes the Senate. This will level the playing field. We are at an advantage having four dentists in Congress: Drs. Paul Gosar, Drew Ferguson, Brian Babin, and Mike Simpson. I spent some time with Dr. Gosar at the North Carolina annual state meeting in Myrtle Beach. I can say he is working very hard to preserve the doctor-patient relationship, protecting the future of the dental profession and the patient's future dental care. He is strongly opposed to mid-level providers.
I urge all of us to support him as well as all the dentists in Congress.

The value corner to this edition is the ADA contract analysis. It is becoming more imperative to evaluate and understand all of your insurance contracts. These can have a major impact on your bottom line. The ADA website states: "Receiving a clear, concise explanation of the terms of a provider contract may help you decide if participating in such a plan is best for you and your patients, as well as helping you avoid unpleasant surprises under the contract in the future." It is ultimately up to the individual practice to decide with which insurance companies they want to participate, if any. The ADA, VDA, and your local component are here to answer any of your insurance questions and help guide you. I strongly encourage you to take advantage of this service.

Teresa Duncan from Odyssey Management Inc. stated: "This year more than ever I've received requests on how to leave a contract. The first step is to figure out if you are even breaking even on your procedures.
I think you'll be surprised at how close you are to just breaking even on many plans. Many offices are finding that it's actually costing them money to participate." We are hopeful that most insurance plans conform to our philosophy. If there is one that is undermining your credibility or using unethical business practices, it might be in your best interest to sever the relationship. I do not feel any of us completed four years of dental school, post-dental school training, and specialty programs, acquiring hundreds of thousands of dollars in debt, to work for free.

The ADA is a great resource to help you protect your practice. When some non-member dentists are asked why they are not members, they respond "I can't afford it." My response is: "How can you not invest in organized dentistry after devoting a large amount of time and finances in your education and practice?" Between the local component, VDA, and ADA, there are thousands of people working on your behalf. It is vital that you protect the future of the profession. If you know a non-member dentist, I urge you to ask them to join our strong, growing community of dentists. We must be vigilant in educating our patients in order to protect the doctor-patient relationship.

Congratulations to Dr. Benita Miller! She is very excited and ready to take over as your new VDA President. She has been a proactive member of the VDA Board, serves on the State Board of Health, and has served dentistry for years. Please help welcome her as your new President in September.

DR. NICOLE RIVERA-VARGAS

After Graduating from Puerto Rico, I joined All Smiles Dental of Falls church.It has been an amazing experience to work in such a diverse community.On my free time I love to go on mission work to help those in need

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TRUSTEE'S CORNER

Dr. Kirk Norbo, ADA 16th District Trustee

As we move well into 2017, two issues continue to receive much attention at the ADA and throughout our tripartite system:

1. Developing a new national licensure exam
2. Reworking the specialty recognition process

Since each of these initiatives have generated a lot of discussion both pro and con, my intention is to present as much information as I can to bring the VDA membership up to speed in these areas.

When surveyed, ADA members continually place the national licensure exam and, specifically, portability and the elimination of humans from the testing process at the top of their list of concerns. Presently there are 5 testing agencies: CITA, CDCA, CRDTS, SERTA and WREB. While some argue that most states accept the ADEX exam there is not one exam that is accepted by all 53 US states and jurisdictions at this time. It is true that only a few states don't accept the ADEX exam and in my travels I have been asked many times why the ADA doesn't step in and coerce these few remaining holdouts to accept the ADEX exam, thereby eliminating the portability issue. The ADA feels that it is developing a better exam that one day will be accepted by all of the state dental boards.

So the OSCE (Objective Structured Clinical Exam) has been selected as the format for the ADA national licensure exam. An OSCE is set up to have multiple stations that may have x-rays, models, photographs, and any other pertinent clinical information about a patient that a testing candidate will evaluate to formulate a treatment plan. In essence, the candidate will be asked to use critical thinking skills to work through a given dilemma and be evaluated on his/her dental knowledge. In its purest form an OSCE has no "hands on" component and for some groups of the dental community, this is a non-starter. I understand this concern and would expect there to be a "hands on" portion included in the final ADA licensure exam product. After hearing the complaints of some of the state dental boards as well as board examiners, it would be a strategic blunder to not include manikin procedures on the exam. The failure rate is much higher on an OSCE exam than the current regional tests. If the real reason for the licensure exams is to protect the public, this gives some credence to the OSCE exam. One tenth of one percent of candidates seeking a dental license never pass a licensure exam, so does the current system really protect the public? OSCEs on the other hand, have a failure rate of approximately 15%.

As dental therapists and midlevel providers continue to seek credibility and move into the dental workforce, the major difference between a US dental school graduate and one of these lesser trained individuals is critical thinking skills. An OSCE exam that is designed to test critical thinking would distance a dentist from a therapist. In my opinion, a dental therapist could pass a regional licensure exam because the existing tests are set up to predominantly examine hand skills not critical thinking skills. Herein lies one of the major advantages of the OSCE exam. Any midlevel could be trained to accomplish Class II and Class III cavity preps but would have no idea what to do when treatment requires decision making that moves away from an ideal situation.

The other element of our existing licensure tests that needs to be addressed is the human subject. There is haptic technology (virtual dentistry) available today that could replace human patients in the testing process. This technology is expensive at this time but would be a logical solution if a concerted effort is made to move in this direction. I continually hear the argument that we practice dentistry on humans, not manikins, so why would we want to remove humans from our tests? My answer to this group is, if there is a better alternative, why not improve the test?

The specialty recognition process is another big concern. Dr. Chuck Norman (ADA past president) is chairing a task force that is making recommendations to change the current ADA guidelines. Presently, the ADA House of Delegates has the ultimate power to give specialty recognition to groups applying for this designation. This brings a conflict-of-interest into the picture that has been identified as a flaw in our current system. The American Board of Dental Specialties (ABDS) has emerged as a competing agency for specialty recognition largely due to disgruntled groups who have come to the ADA and been denied approval. Currently, the ABDS recognizes four groups: oral medicine, dental anesthesiology, implant dentistry and orofacial pain. The ADA recognizes the nine specialty groups that have been labeled the "gold standard" for our profession.

One of the major reasons this issue has come to the forefront is litigation that has arisen in Florida, Texas and California. Practitioners in those states have sued their respective state boards challenging specialty status. Now that the ABDS exists, the courts have ruled in favor of the plaintiffs concluding that the ADA is no longer the authority when it comes to specialty recognition.

The task force on specialty recognition is proposing the formation of a commission that will be responsible for this approval process. The commission will be composed of one member from each of the nine (presently) specialty groups, general dentists that would be equal to the number of specialty members (nine) and one member from the general public appointed by the commission. As presented, the commission would number 19 and put the decision making for specialty recognition into the hands of an independent group which would remove some inherent conflicts-of-interest from the process. For groups who have already gone through the recognition process by the ADA and been denied, there may be an opportunity to appeal previous rulings. If this commission is approved by the ADA HOD, the hope is that there would be a reunification of specialty organizations under the ADA umbrella. The ADA would then be viewed as the authority for specialty recognition in our profession.

In closing, please update your ADA Find-a-Dentist page and make sure to include a photo of yourself. This will help you maximize your membership value as the ADA moves ahead with the promotional campaign. Success of this program hinges on strong Find-a- Dentist member pages so make the most of this opportunity and don't be left behind. Best wishes for a happy and healthy summer season.

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MESSAGE FROM THE EDITOR

Dr. Richard F. Roadcap

Dentists join organized dentistry for a variety of reasons. There's continuing education; discounts on goods and services; access to insurance plans, such as health and professional liability; and publications. Some doctors cite camaraderie with other dentists as one reason to join. But organized dentistry's strong suit, its franchise beyond comparison, is advocacy. Advocacy in its simplest form, is joining forces with like-minded to dentists to advocate on behalf of the profession and our patients. We want our voice heard in the halls of the legislature(s) and the conference rooms of policy makers.

A few years ago, the *Wall Street Journal*[1] commented on dentistry's success in political fundraising, intending to ascribe ulterior motives to organized dentistry's efforts. Dentistry, it was noted, raised more money than any other healthcare PAC. It was a backhanded compliment on the success of ADPAC and the state PACs around the US. In Virginia, we're fortunate to have as chair of VADPAC, Dr. Bruce Hutchison, who's also the current chair of ADPAC. Our advocacy efforts in Virginia have borne fruit in recent years, with the passage of non-covered services legislation, and other laws that protect our doctor-patient relationship. More recently, Dr. Todd Pillion, a pediatric dentist from southwest Virginia, was elected to the House of Delegates, the first dentist to serve in decades. It's a legacy of which we can be proud.

Yet, there are some disturbing trends. Market share, the percentage of practicing dentists in Virginia who are members of the VDA, continues to decline. This problem is not unique to Virginia, as nationwide, ADA market share has slipped and membership count has plateaued. Today, about six out of ten Virginia dentists are VDA members. Each year, about one third of VDA members contribute to VADPAC. Non-member contributions to VADPAC are almost non-existent. Let's do some math. One-third of 60% is barely 20%, or one-fifth. So, it's fair to say that only one out of five dentists in Virginia support what has been, until now, the most compelling reason to participate in organized dentistry.

This low level of support makes the triumphs of Dr. Hutchison and his colleagues in the PAC even more remarkable. It makes me wonder: what would happen if half of VDA members joined (contributed to) VADPAC? What unfulfilled desires would we achieve? Our legislative triumphs benefit all Virginia dentists, not just VDA members. I'm reluctant to say this, but non-members are content to let dues-paying, PAC-joining dentists carry the load, while they also reap the benefits. Yes, it's unfair, but unlikely to change.

In 2017, Virginia will elect a governor, lieutenant governor, and attorney-general, in addition to all seats in the Senate and House of Delegates. Virginia is one of only two states (New Jersey being the other) that elects a governor in odd-numbered years. This incongruence means all eyes will be on Virginia, and money will flow from out-of-state, the result of not being sought in other jurisdictions. If we are to make our voice heard our advocacy efforts must not falter.

If you're not yet a contributor to VADPAC, there's good news. There's still time to join! Yes, you can donate to VADPAC apart from membership renewal, and you will be rewarded by knowing our voices will be heard and our professional values and cherished doctor-patient relationships will be protected. Let's not wait until the "Foundations" come calling, with their proposals for mid-level providers threatening to wreak havoc on our patients and profession. When we find that a legislator has agreed to sponsor one of their many salvos in the realm of professional care, it may be too late.

Why are you a member? If advocacy is not one of your priorities, then you're failing to take advantage of a most important "member benefit". Unfortunately, in Virginia, as in many other states, organized dentistry may be a victim of its own success. There's a certain complacency that someone else will take care of advocacy, based on an unblemished record of past success. In an article written for *Dental Economics* and published online, Dr. Richard Black, Chair of the ADA Council on Government Affairs, and Thomas Spangler, Senior Director of Legislative Policy for the ADA, said "Ultimately, advocacy that adequately supports dentistry and improves the oral health of the American public requires the entire dental community to pull together."[2] If you're not yet a supporter of organized dentistry's advocacy efforts, now's the perfect time to start.

1 http://www.wsj.com/video/why-dentists-are-big-political-players/4ADDACA4-8F50-43D4-B694-D541A38FBF3A.html

2 http://www.dentaleconomics.com/articles/print/volume-105/issue-1/macroeconomics/the-american-dental-association-advocating-for-dentists-and-their-patients.html

DR. DANNY M. VO

Hello everyone! I was born and raised in South Carolina, and am fairly new to Virginia! I'm working in 2 different offices in Northern Virginia, and loving it. It's a little colder than I'm used to, though!

LETTER TO THE EDITOR

DIAGNOSIS AND TREATMENT OF MYELOGENOUS LEUKEMIAS IN DENTAL PRACTICE

Dr. Marvin E. Pizer*

I – ACUTE MYELOGENOUS LEUKEMIA (AML)

This new patient called for an emergency appointment early, because of "severe pain and bleeding all over the mouth." This patient was a 38 year-old white male, who upon observation, appeared exhausted and depressed. His clinical history was compatible with the initial observation. The medical history included bloody diarrhea, sore throat, dizzy episodes, shortness of breath, and constant fatigue. His dental history consisted of inability to open his lower jaw due to swelling in his neck, and to chew food because of painful, bleeding gums along with sore cheeks and tongue. The patient states this condition was noted about 6 months ago and progressed rapidly in recent days. The physical examination revealed enlarged cervical lymph nodes bilaterally. His vital signs were within normal limits but his oral temperature was 101°F. His lips were dry with a few petechiae on the skin near the chin. The buccal mucosa bilaterally revealed necrotic ulcers which were painful to the most gentle palpation. The entire intra-oral mucosa was pale. The gingiva throughout the dentition was hypertrophic and spongy, and when touched with a cotton swab produced bleeding and a white exudate. (Fig.1)

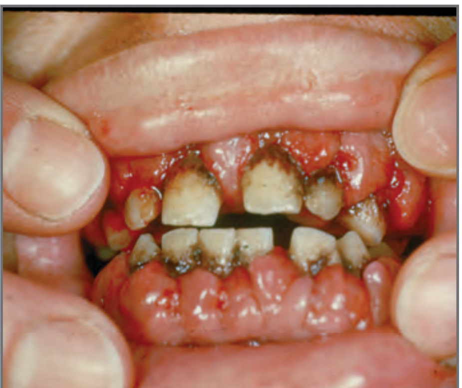

Figure 1

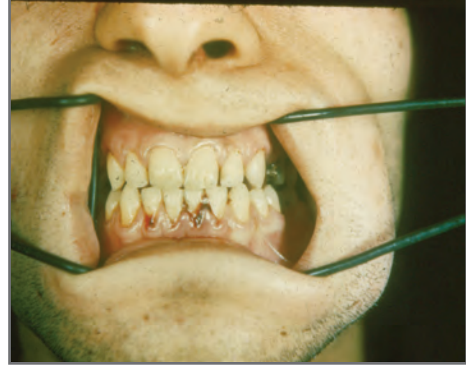

Figure 2

My immediate impression was these oral findings were the manifestation of some serious systemic disease. Some diseases which I considered were agranulocytosis, aplastic anemia, leukemia, or even infectious mononucleosis (if the duration was shorter). Not being able to make a diagnosis, the patient was referred immediately to a medical oncologist/hematologist. The patient was ill.

Two days passed when I received a phone call from the medical oncologist congratulating me! I asked "Why the congratulations?" He responded "For not touching the patient's mouth." The oncologist stated "this patient is very ill with Acute Myelogenous Leukemia (AML) and has been hospitalized." He then began to tell me "patients with AML are not candidates for any significant dentistry." Some patients with AML who have had a loose tooth extracted, have lost their life two or three days after this dental procedure. This was due to excessive bleeding and overwhelming infection.

The medical oncologist informed me that our patient was put in the hospital intensive care unit because of significant dyspnea, intestinal bleeding, with involvement of the liver and spleen. Blood chemistry followed by needle biopsy of the bone marrow revealed a marked anemia, thrombocytopenia, and granulocytopenia. (1,2,3) The white blood count (WBC) was 200,000 cells/ml blood. This bone marrow destruction was caused by the immature, abnormal (blast form) of WBC. These findings were not only in the bone marrow, but extending into the circulatory tree, which explains the spleen and liver involvements.

Our patient received IV whole blood transfusions, platelet concentrate, and a broad spectrum antibiotic to stabilize the patient, and then followed with chemotherapy. Life expectancy following diagnosis is 3-5 years (4).

Remissions occur in 50%-80% of AML patients. This is the time to treat the oral and dental pathology which may exist in your AML patient. Please check with the medical oncologist before beginning (mostly) surgical procedures. (5)

There is some encouraging news with regards to long-term disease-free AML patients. A procedure named bone marrow transplantation (BMT) (5)has been effective in about 50% of AML patients. Some medical oncologists have had the courage to call AML patients responding positively to BMT as "cured". (4)

The family dentist treating AML patients should consult with the medical oncologist, and take the time to explain, even in detail, what the dental procedures entail in time, trauma, pain, and proposed medications. This will be offering the safest and best healthcare for our patients. Most medical oncologists are not familiar with the time and trauma of dental procedures – they should be enlightened.

II – CHRONIC MYELOGENOUS LEUKEMIA (CML)

The dental patient with CML may articulate to their dentist recent symptoms of unusual weakness. Not suspecting any illness, the patient may make other comments, such as loss of weight (not intentional) and night sweats. The dentist on examination of the head and neck notes only some pallor of the skin, but some bruises on the chin. Palpation of the lymph nodes in the neck will find only nodes that look and feel normal. The vital signs are normal, but there is elevation in oral temperature – 101.5°F.

Intra-oral examination reveals pale mucosa with scattered areas of ecchymosis and petechiae on the buccal mucosa bilaterally, in the right floor of the mouth including the soft palate. (4) There is no significant gingival hyperplasia but some gingival margins were inflamed and bled easily. (Fig. 2) This is not malignant tissue.

With these findings I felt compelled to refer this patient to a medical oncologist. The report I received in about five days was a positive diagnosis of CML. The patient's spleen was enlarged and blood chemistry revealed leukocytosis with abnormal granulocytes containing low levels of alkaline phosphatase. Chromosomal studies identifying the Philadelphia chromosome proved the CML diagnosis (4). As the disease progresses thrombocytopenia and anemia result in the systemic and oral manifestations. (2)

Today there is great news regarding the prognosis of the CML patient. There is a targeted anticancer drug called Gleevec® (4) that produces an average survival of 30 years following the diagnosis of CML. This medication must be taken for a lifetime. (4)

CONTINUED ON PAGE 9

CONTINUED FROM PAGE 8

The dentist and medical oncologist must make certain the CML patient is taking this medication at all times including dental treatment.

*Formerly: The American University, Washington, DC, Professor of Research; Adjunct Professor, Medical Physiology; Director, Pre-professional Health Program; Chairman, Pre-Medical Advisory Committee.

Clinical Professor, Oral and Maxillofacial Surgery, VCU School of Dentistry, Richmond
Emeritus Staff, Alexandria Hospital, Alexandria

Figure 1. A typical intra-oral finding in AML. Note the extensive gingival hyperplasia with blood impinging on the crowns of the teeth. The malignant gingiva can invade the periodontal regions resulting in mobility and movement of the teeth. This gingival tissue is soft and spongy. With minimal palpation the gingiva will bleed freely and in some areas express a suppurative exudate. There is pallor of the oral soft tissue including tonsils.

Figure 2. This patient has CML. Note the extreme pallor of the skin and gingival. Petechiae are visible on the buccal mucosa, and the skin near the chin. There is minimal gingival hyperplasia and this bleeding is due to irritation, not leukemic infiltration.

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LETTER TO THE EDITOR

BLOOD ON INSTRUMENTS

Henry Botuck, DDS

As you know, there are two steps to decontaminating anything: first thoroughly clean it, and then sterilize or disinfect it. Without proper cleaning, neither sterilization nor disinfection can take place. Unfortunately, cleaning of instruments and surfaces are not fully appreciated and stressed. It cannot be perfunctory or haphazard, or your instruments will retain tiny amounts of debris and not come out of the autoclave sterile, and/or surfaces will not be disinfected.

One of the most difficult contaminants to clean off of instruments is dried blood. *Do not allow blood to dry on your instruments*. I cannot stress this enough. And, it is not just surgical instruments that should concern you, but also your periodontal curettes and scalers. So, before taking instruments that have contacted blood to the sterilization area, there are two things that you need to do: First, wipe them with a wet 2x2 sponge. Use water, *not* alcohol. Alcohol tends to harden any remaining blood onto the instrument and makes it even more difficult to clean. And second, CDC recommends that, while instruments are still in the operatory, that you spray them with a gel or foam enzymatic cleaner. CDC wants us to avoid liquid sprays. The resultant aerosols remain suspended in the air, and can irritate the lungs. If, when the instruments are brought to the sterilization area, they are not immediately put into the ultrasonic bath, they should be placed in an enzymatic holding solution. Don’t allow them to just sit on the counter and dry. Have a tray in the holding solution that can be lifted out, and then place the instruments into the ultrasonic. Do not put your hands blindly into the solution to pull out instruments!

For most dental offices, the preferred method of cleaning instruments before sterilization is with an enzymatic solution in an ultrasonic unit. The enzymes help to loosen proteinaceous material from the instruments.

Instruments should be placed gently into the ultrasonic bath using cassettes, or only a few at a time using forceps or heavy-duty gloves. Even if using heavy-duty gloves, do not risk getting a puncture wound by grabbing handfuls of instruments to put into the ultrasonic bath. The use of cassettes is preferred not only to keep the sets together, but also to make it easier to put multiple instruments into the solution more quickly. It is more efficient and lessens the danger of injury.

Enzymes in the ultrasonic solution are adversely affected by heat. If you will look at the directions for ultrasonic solutions with enzymes, or if you call the manufacturers as I did, they all say to use warm, not hot, water. The ambient temperature produced during cavitation is fine. But some ultrasonic units have features where you can further warm the solution. This is totally unnecessary for our purposes. Heated solutions are for such things as greasy auto parts, not for dental instruments. For our purposes, up to 125 degrees Fahrenheit is considered “warm”. CDC discourages us from scrubbing instruments, unless absolutely necessary, because it results in too many percutaneous injuries. However, if you must scrub the instruments, make sure that they are cleaned one at a time, and use a long handled brush. They should be submerged in the sink so there is no spatter. (Sterilization areas need deeper sinks than average.) Don’t forget the heavy-duty gloves, a mask, and protective eyewear.

DR. ALEXANDRA KATSANTONI

Pediatric Dentistry was “love at first sight” during my undergraduate studies in Athens and inspiration to change continent to achieve excellence! Now, I absolutely enjoy providing smiles for life and building relationships with my patients at “Hampton Roads Pediatric Dentistry”.

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A TREATMENT PLAN FOR RETIREMENT

Sandy Wiggins, CFP, AIF; ACG Worldwide (Actuarial Consulting Group)

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Dentists, like most people, spend more time planning the next vacation than they do planning for retirement.

A Charles Schwab survey of 1,000 respondents found 39% said they spent more than five hours exploring vacation possibilities, while only 11% said they had spent that amount of time evaluating 401(k) investment options. In fact, one-third of savers said they spent less than an hour a year on investment and retirement planning.

Although it may not seem the most rewarding way to spend time today, developing a plan for retirement will yield years of future enjoyment.

Important questions to answer:

- How much am I spending?
- How much will I need in retirement?
- How much should I save?
- When to begin drawing social security?
- How to generate income during retirement?
- What is the appropriate investment strategy?
- What type of professional assistance will I need?

Seven steps to start planning for a successful retirement:

1. Get a handle on expenses
2. Quantify goals
3. SAVE
4. Pay as little tax as required by law
5. Develop the appropriate investment strategy
6. Stick with the plan
7. Work with a professional

GET A HANDLE ON EXPENSES

The first step in managing your money is to examine how much you're spending. Equally important is "what" you are spending it on. You won't know how much you need to save for retirement if you don't know how much you will need to maintain your lifestyle.

Examining your expenses has another benefit. Once you've determined where your money's going, you will likely identify expenditures that are not necessary. This is a perfect opportunity to evaluate what's really important to you and make sure that you are focusing on your goals and not losing future wealth to unnecessary expenses.

QUANTIFY GOALS

Visualize what your retirement will look like. One of my favorite quotes is "Dream deep as dreams precede reality". I have no doubt that you can have financial success if you quantify and work toward it.

Conventional wisdom says you need a retirement income equal to 85 to 100 percent of pre-retirement income. The logic behind this rule of thumb is to provide you with the same amount of spendable income in retirement as in pre-retirement, after backing out annual savings, and certain work-related expenses.

You will likely need to balance short-term financial goals like paying down student debt, funding an emergency fund for unexpected expenses, and saving for your kid's college expenses with your long term goal of a comfortable retirement.

What will your "retirement" look like? Partial employment, travel, service, hobbies, and enjoying time with friends and family are all considerations.

SAVE

Another helpful rule of thumb is to save 10 to 15 percent of your annual income. By saving and investing 10-15% each year, compound interest will help you build the financial nest egg to support your retirement lifestyle. Studies show that this should be enough to allow you to reach your retirement savings goals, while also enjoying your income today.

Don't worry if you can't save 15% of your income today, we all have financial obligations to manage. However, examining where your money is going, and reducing unnecessary expenses, can increase your savings.

PAY AS LITTLE TAX AS REQUIRED BY LAW

Taxes are the biggest inhibitor of wealth accumulation.

Learned Hand was a United States judge in the early 1900s. Below are two of his quotes.

> *"Anyone may arrange his affairs so that his taxes shall be as low as possible."*

> *"In America, there are two tax systems, one for the informed and one for the uninformed, both are legal."*

There are many opportunities to minimize your tax bill each year. Qualified Retirement Plans remain one of the best tax planning tools available for dentists. A tailored 401(k) plan can yield significant tax advantages today and tomorrow.

Tax harvesting in your investment portfolio can also have a meaningful benefit in your wealth accumulation over time.

DEVELOP THE APPROPRIATE INVESTMENT STRATEGY

Risk is a four letter word. If not managed, it can wreak havoc on your wealth; without it, you will not enjoy financial gain. Understanding investment risk is paramount to achieving financial success.

There is an art and science to determining the necessary amount of risk required to achieve your financial goals. The amount of risk you can afford to take today might not be appropriate later in your career. Determining how much to save each year, coupled with your desired retirement lifestyle are two factors to be considered when evaluating how much investment risk is needed to achieve your goal.

The right financial advisor can help you consider these factors and develop an investment strategy that is right for you.

STICK WITH THE PLAN

Just like regular visits to the dentist, regular ongoing reviews of your progress towards your retirement goals make sense. Your goals, your financial picture and your health are ever changing. Therefore, adjustments may be necessary in order to achieve your goal.

CONTINUED ON PAGE 12

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Focus on what you can control…saving rate, investment risk, lifestyle, how long you can or want to work, your tax bill. It is important to remember that you can't control market returns, so don't depend on high returns to meet your needs.

SEEK OUT ADVICE FROM A PROFESSIONAL

There are many things to consider, so it's important to work with someone with experience and whom you can trust. There are many types of financial and investment registrations and certifications. Not all financial advisors have the experience working with dentists. Not all financial advisors are required to put your interests first. Make sure you understand how your advisor is getting paid, whether they are acting in a fiduciary capacity and what their credentials are.

HELPFUL TOOLS IN SELECTING AN ADVISOR:

https://brokercheck.finra.org/
https://www.cfp.net/
https://www.cfainstitute.org/

Your plan should be developed with long-term success in mind. Set milestones like paying off student loans, maximizing retirement, paying off a mortgage and make a point to acknowledge and celebrate achieving each milestone along the journey towards a successful retirement.

DR. PRASHANT VERMA

After completing my endodontic residency, my co-resident and I took over an amazing practice in Centreville, VA. Our practice is composed of three board-certified specialists- Strittmatter, Verma and Nosrat. We believe that excellent endodontics is the foundation for restorative predictability!

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CAN ETHICS BE TAUGHT?

AN OVERVIEW OF ETHICS AND PROFESSIONALISM EDUCATION AT VCU SCHOOL OF DENTISTRY

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

A question asked often by many in the dental profession involves ethical decision making and professional behavior. Simply, can dental ethics be taught? Perhaps the better question is, can we teach dental students [and active licensed general dentists and specialists] to act ethically? Are ethics and morality innate or can they be learned behaviors? Can an ethics course teach one how to make good, better, or right decisions? While the answers to these questions may be debated, one thing is true: we can't expect dental students, or practicing dentists for that matter, to possess and display behavior according to a standard of which they have no knowledge.

The issue of teaching ethics is an ancient one. Almost 2500 years ago, the philosopher Socrates debated the question with his fellow Athenians. Socrates' position was clear: Ethics consists of knowing what one ought to do, and that such knowledge can indeed be taught.[1] Becoming a professional is a lifelong process of consistent behavior affirming the principles of one's beliefs.[2]

At the VCU School of Dentistry the ideal of professionalism as a commitment to a lifelong process of mastery and bettering oneself remains true. Our dental ethics program is grounded in the instruction and application of the principles of ethical decision-making, reasoning, and professional responsibility. This occurs through didactic and experiential learning exercises that are integrated across the four years of the dental curriculum. Even as part of the admissions process, candidates who are invited for an interview are presented with several questions related to professionalism, communication, and ethics, prior to, and during the interview.

Beginning in 1996, the School of Dentistry initiated the annual Dr. Cyril R. Mirmelstein Lectureship Symposium on Ethics. The symposium has included such topics as "The Emergence of Ethics and Professionalism in Dentistry", "Law and Medical Ethics", and "No Easy Answers: Ethics in the New Millennium". The invited speaker meets with the third and fourth-year dental students, fourth year dental hygiene students, and faculty. Seminar attendance is required for all students and the dental clinics are closed to allow for this. The invited speaker also provides the keynote address at the 2nd year (D2) white coat ceremony. This year's speaker was Dr. Phyllis Beemsterboer, Professor and former Associate Dean for Academic Affairs in the School of Dentistry at Oregon Health & Science University and past president of the American Society for Dental Ethics.

The school's summer reading experience grounded in ethics, ethical decision-making and reasoning, and professional responsibility is at the forefront of the first year (D1) orientation week. Prior to matriculation in early summer, each D1 student receives a letter from the dean welcoming them to the dental school and placing a keen emphasis on ethics and professionalism. A hard copy of the selected summer reading book accompanies the letter and serves as the first formal interaction the student has with the dental school curriculum. 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. Begun in 2012 with the assistance of the Levy Ethics Endowment (Dr. Mayer Levy and Mrs. Susan Levy), the books chosen have been: *The Immortal Life of Henrietta Lacks* by Rebecca Skloot, *Five Days at Memorial* by Sheri Fink, and *Better* by Dr. Atul Gawande. This year's reading is, *Dreamland: The True Tale of America's Opiate Epidemic* by Sam Quinones. During the orientation week, the D1 students have an introductory session on the book and break into small groups for in-depth discussion guided by facilitators from School of Dentistry faculty, alumni and national/state/local organized dentistry leaders.

In 2008, a formal stand-alone course in dental ethics, titled "Introduction to Professionalism, Ethics, and Ethical Decision-making" was introduced. This course evolved from a previous course titled "Introduction to Dentistry" where ethics was a significant part of the material covered. In this D2 course students are exposed to different ethical decision-making models. These models are used to aid students in evaluating ethical dilemmas, which are discussed through small group activities. The course is primarily case-based, reviewing ethical dilemma scenarios, and providing intensive practice in identifying and resolving ethical dilemmas that occur in dental practice, both in the dental school clinics and in a practice setting following graduation. The course offers students the opportunity to practice application of the principles of ethical decision-making and professional responsibility using several different frameworks (e.g., conflicting central values, conflicting duties, rights and responsibilities) to resolve several common ethical dilemmas. During this course, the students encounter and work through a series of dilemmas relating to the patient-dentist relationship (e.g., informed consent and patient confidentiality), dental insurance and reimbursement systems, professional obligations related to ethical codes, business best-practices in dentistry, the inherent conflicts between running a business and running a professional practice (e.g., conflicts of interest), professional responsibility related to the laws and regulations governing dental practice, conflicts between ethical and legal obligations and responsibilities in practice, and conflicts that arise as the result of the changing healthcare environment.

"Are ethics and morality innate or can they be learned behaviors?"

A special session of the course is devoted to examining ethical dilemmas experienced by students in the comprehensive care setting at the dental school with a panel of third (D3) and fourth (D4) and students. Students are recommended to the course director by their respective group practice leaders for having and displaying model ethical practice behav-

CONTINUED ON PAGE 14

1 Manuel Velasquez, Claire Andre, Thomas Shanks, S.J., and Michael J. Meyer, "Can Ethics Be Taught?" Santa Clara University, Markkula Center for Applied Ethics, 1987

2 Ethics Handbook for Dentists, An Introduction to Ethics, Professionalism and Ethical Decision Making, 2016

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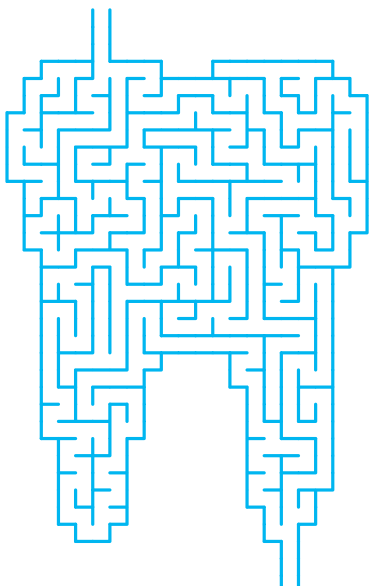

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iors. This formal ethics course offers students the opportunity to engage in and intensively practice the application of the principles of ethical decision-making and professional responsibility in the academic, practice and practice management environments. The students are given a copy of the American College of Dentists Ethics Handbook for Dentists. An overview of ethical decision-making is presented using these supporting documents: ADA's Principle of Ethics and Code of Professional Conduct, the School of Dentistry Technical Standards, the School of Dentistry Attributes of Professionalism, ASDA Code of Ethics and ASDA White Paper on Ethics & Professionalism in Dental Education (2009). Past members of the Virginia Board of Dentistry, who review ethical cases that have been brought before the board, also conduct Guest lectures. Students are also introduced to the ethical dilemma video project from the American College of Dentists and Indiana University School of Dentistry.

Many other courses in the curriculum introduce students to the application of ethical, legal and regulatory concepts to the provision and/or support of oral healthcare services, and the application of the principles of ethical reasoning, ethical prescription writing and prescribing best practices. Ethical decision-making is also integrated within the behavioral science curriculum as it relates to health disparities, motivational interviewing and patient communication, emotional intelligence and mindfulness, and best workplace practices. Specific attention is focused on one's professional role in improving access to oral healthcare and patient treatment, ethical issues related to treating special care/complex need patients and identifying and working through any possible ethical problems related to accessing care, managing patient expectations, treatment adherence and professional conduct within the clinical setting.

Courses in patient management, professional conduct and practice management also have a keen focus on ethical decision-making and ethical behavior. In the two-course series practice management, students participate in seminar-formatted courses with guest lecturers. The D3 course focuses on the student understanding the business of dentistry. Specific topics addressed (and their correlation to ethical practice) include: regulations, marketing, communication, finance, hiring staff, working with specialists and allied personnel, office equipment and supplies, planning practice location, types of practice models, economic dental trends, and other current trends in the business of dentistry. The D4 course focuses on providing students with a wide variety of "just in time" learning essential for starting practice. Specific topics addressed include practice models available in the delivery of dental care to their patients, different types of insurance required for dental practice as well as the types of dental insurance that patients can obtain for their treatment reimbursement, risk management and dental liability. Ethics and professionalism are addressed with course sessions on ethical decision-making, professional role identity, organized dentistry, professionalism and self-regulation.

Even with evolving technology and no limits to our favorite new materials and gadgets, dentistry remains the hallmark of a true profession. The dental profession is an invaluably rewarding career path where we have the privilege of insuring optimal oral health for our nation's citizens. Our social contract to do the best for our patients, always putting their needs ahead of our own, remains in tact. However, the profession must uphold and pass down the high standards for which we have historically been known. While there are many who anecdotally feel that ethically dentistry is at a crossroads, I believe there is also much to be hopeful about concerning this new generation of dental students and dental professionals. There are many who are dedicated to strong ethical standards of practice and professional life overall, both public and private. Fortunately, at the VCU School of Dentistry we have a robust ethics curriculum in tandem with our strong clinical program, preparing superbly well-rounded general dentists and specialists for the professions immediate future and beyond.

Editor's Note: Dr. Smith is a general dentist and serves in the Department of General Practice where he teaches in both clinical and pre-clinical courses, serves as a group practice leader and maintains a private practice within the VCU Dental Care Faculty Practice.

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18VAC60-21-90.C and D of the Regulations Governing the Practice of Dentistry

• RECORDED DIAGNOSIS
Did you know that for every treatment rendered to a patient you must list the diagnosis for performing that treatment, along with the options discussed with the patient including the risks and benefits of treatment or nontreatment?

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

• STANDARD OF CARE
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§54.1-2706(5) of the Code of Virginia

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EPA REINSTATES FINAL RULE ON AMALGAM SEPARATORS

Jennifer Garvin, ADA News

The Environmental Protection Agency June 9 issued a final rule governing the management of dental amalgam discharges into sewer systems.

In December 2016, the EPA issued a final rule requiring most dental offices nationwide to install amalgam separators but withdrew the rule following the White House's Jan. 20 memorandum ordering federal agencies to freeze all new or pending regulations. The rule will be effective July 14 and compliance for most dentists will be July 14, 2020.

The ADA, which worked with the EPA for several years on the final rule, commended the agency for what it considers "a fair and reasonable approach to the management of dental amalgam waste."

"The ADA shares the EPA's goal of ensuring that dental amalgam waste is captured so that it may be recycled," said ADA President Gary L. Roberts in a statement. "We believe this new rule — which is a federal standard — is preferable to a patchwork of rules and regulations across various states and localities.

The rule includes reasonable exemptions, a phase-in period for existing dental offices and considerations for dental practices that have already installed the devices. As of July 14, 2017, new dental offices which discharge dental amalgam must comply immediately with the standards in this rule.

The final rule closely follows the ADA's best management practices and incorporates three: requiring use of separators; prohibiting providers from flushing waste amalgam, such as from traps or filters, down a drain; and prohibiting the use of bleach or chlorine-containing cleaners that may lead to the dissolution of solid mercury when cleaning chair-side traps and vacuum lines. The new rule also meets the nine principles established by the ADA House of Delegates as a condition for ADA support for a national rule.

Additional highlights of the rule include:

- Dentists who practice in oral pathology, oral and maxillofacial radiology, oral and maxillofacial surgery, orthodontics, periodontics, and prosthodontics are exempt from the rule.
- Dentists who do not place amalgam and only remove amalgam in unplanned or emergency situations (estimated at less than 5 percent of removals) are also exempt.
- Mobile dental units are exempt.
- Dentists who already have separators are grandfathered for 10 years.

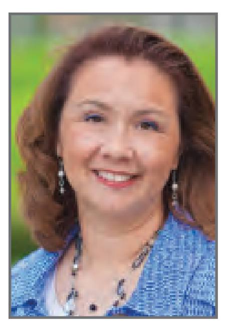
Although less than 1 percent of mercury released to the environment from man-made sources comes from dentistry, the ADA has encouraged dental offices to follow its Best Management Practices for Amalgam Waste to help reduce discharges of used amalgam into dental office wastewater. In 2009, the Association amended its best management practices to include the use of amalgam separators that comply with ANSI/ADA Standard 108 for Amalgam Separators, which takes into consideration the standards developed by the International Organization for Standardization, a worldwide federation of national standards bodies.

The ADA will develop practical resources to aid member dentists with questions they may have regarding compliance. In addition, ADA Business Resources has partnered with HealthFirst, a vendor that offers ADA member dentists special pricing on an amalgam separator device that will meet the federal regulatory requirements along with recycling services.

For more information, visit ADA.org/RecycleAmalgam.

DR. CAITLYN R. NUGER

Loving life as a pediatric dentist and excited everyday to be treating the awesome kiddos of Burke! Second year in practice after residency in Philadelphia. I look forward to building lifelong relationships with my patients and their families!



IMPLEMENTATION OF D4346 IN YOUR OFFICE

Teresa Duncan, MS, FAADOM

2017 gave us the new dental code D4346, however, confusion still exists around the usage and the coverage of this code. The code is interesting in that it was intended to fill a gap in coverage between those patients who need scaling and root planing and those who have a healthy mouth. As a reminder, the code in its entirety is:

D4346 scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation The removal of plaque, calculus and stains from supra- and sub-gingival tooth surfaces when there is generalized moderate or severe gingival inflammation in the absence of periodontitis. It is indicated for patients who have swollen, inflamed gingiva, generalized suprabony pockets, and moderate to severe bleeding on probing. Should not be reported in conjunction with prophylaxis, scaling and root planing, or debridement procedures.

The confusion stems from its practical usage in the office and then on the coverage side of the code. The implementation of the code into practice is dependent upon a clinical team (both doctor and hygienist) who are able to confidently recommend the procedure. While this sounds simple, it's often not. Many offices have differences in clinical opinions and so it's important for the doctor and the hygiene team to share the same soft tissue management philosophy. Review cases with your team of when this code is most appropriate. You may see this in the mouth:

- Bleeding upon evaluation and probing but pocket depth is not alarming
- Inflamed gingiva but no evidence of bone loss on radiograph

Relaying the information to the patient when they are expecting "just a preventive visit' can be problematic as well. It's a good idea to practice your verbiage – as a team- so that it flows smoothly when the patient is in front of you.

If the diagnosis of gingivitis is made, this code may be appropriate. The hygiene department should discuss how this code can change the flow of the patient's visit. Keep in mind that a diagnosis is needed in order to recommend this procedure and to use the code D4346. The code is not meant to replace prophylaxis, scaling and root planing or osseous surgery. Rather it is meant to more accurately describe a common periodontal condition for which a code did not exist. Until your office is used to how this code is reimbursed, remember that this will be a confusing financial conversation. Being upfront about the cost is the number one rule of insurance and financial customer service. This leads me to the next confusion point. What is the true cost to the patient? If insurance is involved then you will need to explain that no longer is this visit covered as a preventive measure. There is a real chance that not only will the patient's deductible be applied but they'll also have a copayment. Most insurance companies have been covering it but will provide benefits for a D1110 which is a lower fee. You are able to charge up to the contracted fee for D4346 but the difference between D1110 and D4346 will be borne by the patient. Sometimes this can be a significant amount if the deductible is large. Insurance coordinators will need to either call the insurance company or verify benefits online to ensure that they know how it will be processed. Add this to their many insurance-related tasks!

In order to have this conversation you'll need visual evidence and strong verbal skills. Speaking the periodontal readings is a way to involve the patient in this process. Let them know what the numbers mean but also use your intraoral images to educate the patient. The fact that the necessity for D4346 is not evident on radiographs means that the camera is your best friend. Show your patient the inflammation that you see and gently point out that more bleeding is present than you would prefer. If you are not communicating this to the patient then it becomes more difficult for the administrative team members to discuss copayment.

Administrative team members across the country have shared with me that even though benefits are being provided for prophylaxis, patients are not happy with the added out-of-pocket expense. Some teams have shared that they've stopped using the code as it's just been problematic. If this sounds familiar then regroup! Have a team discussion on how this can fit into your clinical guidelines and commit to the following items:

- Attempt to find out how D4346 is covered during regular benefit checks.
- Practice (as a team) both the clinical and financial conversations for this code use.
- The insurance coordinator will follow up on claims to ensure that they are paid at least at the prophylaxis allowance. Appeals should be filed if applicable.
- Increase efforts to document diagnosis so that claim requests for information are supported.

Implementing new codes are a team effort and should be approached as a group initiative. When everyone is on the same page then patients will benefit from consistent, effective and superior patient care.

Teresa Duncan, MS, FAADOM is an international speaker who focuses on revenue, dental insurance & management issues. Her website features more insurance information along with online insurance training and a book on Insurance Conversations. www.odysseymgmt.com

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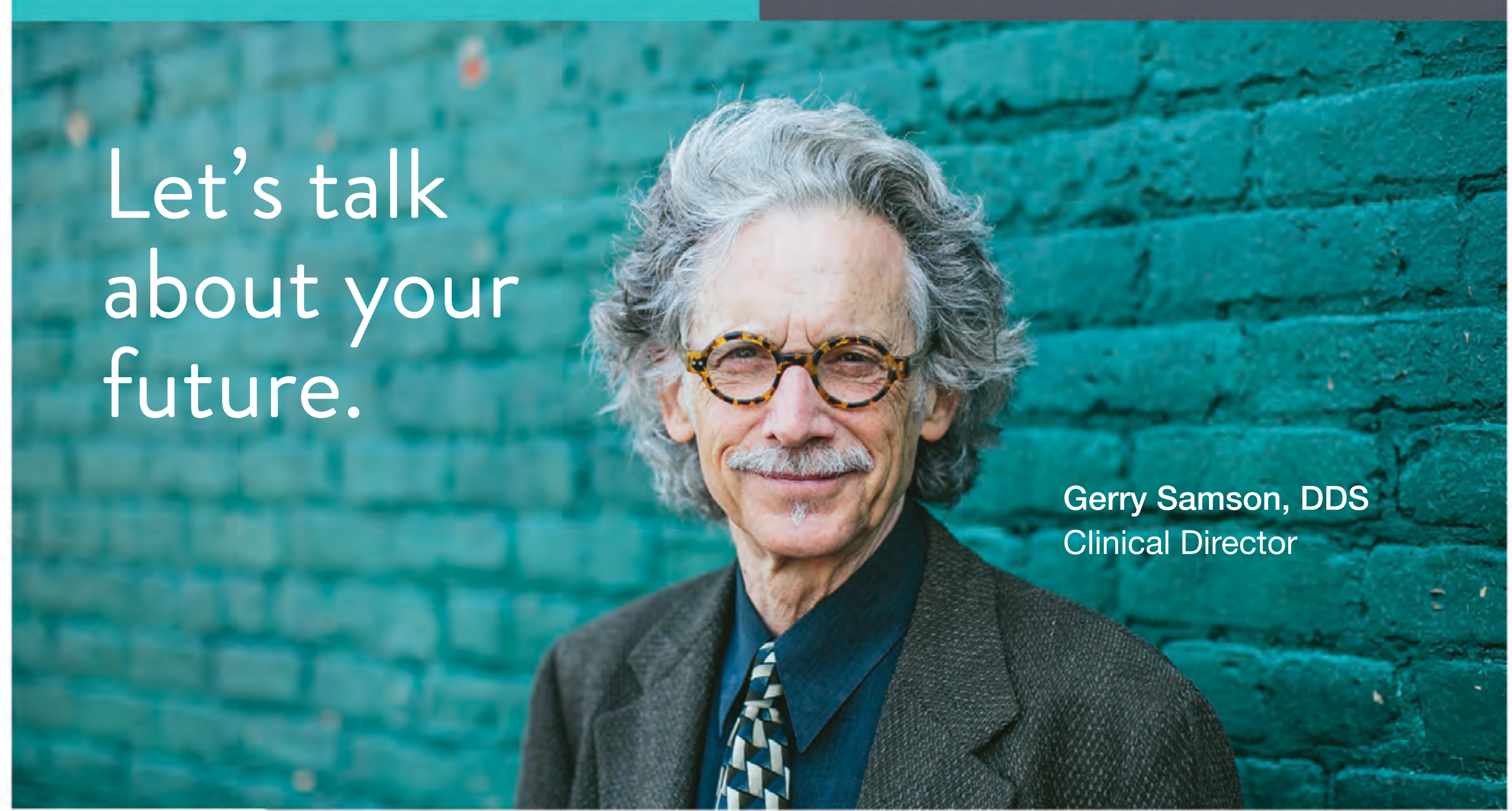

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A PRESCRIPTION FOR DENTAL PROVIDERS FACING CYBERATTACKS

Colin Hite and Emily Scott,
Hirschler Fleischer

As large hospital and healthcare systems shore up their cybersecurity programs, cyber criminals are on the hunt for new and easy prey. Frustrated hackers are increasingly turning their attention to smaller healthcare practices, many of which do not have formal cybersecurity defenses in place. Dental practices are among the cyber criminals' easiest targets.

Consider these recent examples:

- A dentist in Houston, Texas arrived at the office one morning and found himself unable to access any of his computerized records. He received a message indicating his data had been encrypted and demanding a ransom for its release.
- In Alpharetta, Georgia, a dental assistant opened an innocuous-looking email and released a virus that infected the practice's computer system. A pop-up message appeared requesting payment to un-encrypt the files.
- A California dentist fell victim to ransomware while on vacation. Without access to her files, no one in the office knew which patients had upcoming appointments or how to contact them.

As dental providers modernize their operations—convert paper files to electronic health records, establish patient portals, store data in the Cloud, and communicate with patients and colleagues via text and email—the opportunities for breach increase significantly. What can dental providers do to protect themselves from potential attacks?

Recognize the Danger

Personal Health Information (PHI) is the gold standard of data for hackers. Unlike a credit card number or social security number, PHI allows someone to assume the cyber victim's identity. Hackers target healthcare providers because of the wealth of information available on their networks. In addition to stealing the personal identifiers and financial data of individual patients, hackers mine systems for provider data to create fraudulent Medicaid/Medicare billing numbers and to gain proprietary information about new drugs and devices. This valuable information is often maintained on aging networks which lack sufficient firewalls and up-to-date security patches, making them easier to infiltrate.

In many cases, practice employees inadvertently allow malware to infect the system. Employee negligence accounts for approximately 35 percent of breaches. Patient portals, free wi-fi, doctors' tablets and cell phones, and outsourced Cloud-based data storage systems also provide opportunity for hackers to penetrate a provider's network.

Cyber attackers target small, independent practice groups, multi-office practices—and everyone in between. Importantly, the size of the dental provider does not always dictate the size of the breach. For example, a smaller practice in a wealthier area may yield more valuable PHI than a larger practice in a low-income community.

Hackers have gained access to healthcare providers' systems through phishing emails, SMiShing texts, medical devices that connect to the provider's computer network, credit card readers and ransomware. Ransomware is a program that "kidnaps" and encrypts all of a provider's electronic data, prohibiting access until the provider pays the hacker a "ransom" to obtain a decryption key. In the recently reported case of Hollywood Presbyterian Medical Center, hospital officials ultimately paid a substantial bitcoin ransom in order to regain access to their own data and systems.

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Strengthen Your Defenses Now
The threat of a breach event is ever present—so what can dental providers do to minimize the danger? To start, providers must include cyber-security in their risk management programs and conduct regular risk assessments. There is no substitution for a comprehensive data-risk assessment. Give attention to the simpler fixes first: encrypting mobile devices, maintaining regular offline data backups, separating confidential from non-confidential electronic information, and educating employees about the risks.

Additionally, dental practices should:

- Utilize cybersecurity experts (technical and legal), and consider adding a Chief Information Security Officer to your executive team for larger operations, which can be outsourced to a vendor if necessary. An enterprise approach is critical to a successful cybersecurity program.
- Implement a Written Information Security Program—your cybersecurity policy. Train employees to recognize criminal cyber schemes and accept data privacy security procedures—they are an important first line of defense!
- Develop an Incident Response Plan to address an attack and conduct tabletop exercises to test it. Your cybersecurity vendors can help.
- Advise medical device vendors of your cybersecurity efforts. Make sure vendors encrypt stored information and provide regular security updates.
- Use techniques in your vendor contracts to spread the risk of a privacy breach in your agreements. You are responsible for your data stored in the Cloud.
- Purchase cyber insurance—traditional insurance policies may not cover your actual damages or your efforts to remediate. Work with your broker and coverage attorney to procure the best insurance.

Consider Data Privacy Insurance
Insurance is typically the backstop for policyholders who have a breach incident. The market for data privacy insurance continues to evolve as insurers use vastly different forms to write the coverage. Because of the disparity in the policies, where the devil is truly in the details, it is imperative for the healthcare industry to be more proactive in purchasing cyber insurance.

Here are some important tips for placing data privacy coverage:

- Use a team approach in purchasing cyber insurance - insured, broker, coverage counsel.
- Understand your risk profile.
- Review existing coverages to know what is already available in your current program.
- Put into place other data privacy coverage as needed.
- Understand that data coverage is broader than just "cyber."
- Ensure there is coverage for using Cloud services.
- Negotiate for a retroactive date of at least one year.
- Know what legal counsel and vendors will be supplied by insurers.
- Carefully review the insurance application and fill it out honestly.

A robust cyber insurance policy is the necessary backstop to address expenses associated with a breach. In many instances a dental practice may not be likely to absorb the costs on its own – since a cyber event can be a "bet the business" issue. Cybersecurity plans must be flexible and adaptable in order to address new risks. A vertically integrated, multipronged approach is the best defense against cyber threats. Regardless, dental practices of all sizes must be aware of the duties, be proactive in protecting data, and involve all employees in the process. Become cyber savvy in 2017.

Collin Hite is the practice leader of Hirschler Fleischer's Data Privacy & Security Group. He may be reached at 804-771-9595 or chite@hf-law.com. Emily Scott is a member of the firm's Healthcare Group. She may be contacted at 804-771-1593 or escott@hf-law.com.

DR. ASHLEY A. HARMAN

I'm a pediatric dentist with Children's Dentistry of Virginia in Richmond. I find my job incredibly fulfilling teaching my little patients how to take care of their smiles and helping to create a positive experience at the dental office!

LEARN

BE AWARE OF ANTITRUST LAWS:

KNOW THE FACTS AND STAY OUT OF TROUBLE

Daniel J. Schulte, JD

Reprinted, with permission, from the Journal of the Michigan Dental Association, March 2017 issue.

Antitrust laws cannot be ignored by dentists on the basis that they are not fair, are too complicated, or make no sense. A basic understanding of the antitrust laws is therefore essential for all dental association members. Here's what you need to know . . .

REQUIREMENTS FOR VIOLATION

Section one of the Sherman Antitrust Act declares contracts, combinations or conspiracies in restraint of trade to be unlawful. For a violation of this act to occur, two things must occur: Two or more independent dentists or entities must engage in joint activity, and the joint activity must restrain competition.

Joint action. The law does not apply to actions taken individually by one dentist. There must be an agreement or understanding, and it takes more than one person or entity to have an agreement. Such joint action does not exist in a completely integrated dental group practice. In such a group practice, the separate practices of individual dentists are "merged" or "integrated" into the group. The dentists share profits and losses, and do not have independent competing practices. Because there is only one practice, the joint action element required for a violation is absent.

Any agreement by two or more independently practicing dentists, or group practices, which restrains competition, may constitute "joint action." An example of such joint action would be two or more independent dentists who together decide not to sign a managed care participating contract or who decide to terminate such a contract. Another example would be two or more dentists with independent practices who agree on minimum or maximum fees or capitation amounts. Business managers of two independent dental practices who agree that the practices will not compete against each other in a certain geographic area would be another example.

The "agreement" need not be formal or written to be illegal. A tacit understanding is enough. Dentists do not need to know the agreement is illegal in order to violate the law. The key is to avoid even the appearance of an illegal agreement. For example, informal conversations with other dentists at a dental society meeting about problems incurred with a managed care plan, which result in some dentists terminating their contracts with the plan, may be construed as an illegal agreement. A letter to another dentist that merely discusses fees may evidence and agreement to fix prices.

RESTRAINT ON COMPETITION

In order for joint action or an agreement to constitute an antitrust violation, it must unreasonably restrain trade. This occurs when the effect or purpose of the agreement is to decrease competition. To determine whether the agreement is unreasonable, the courts use two different standards, depending on the type of agreement:

- Illegal Per Se --If the agreement involves price-fixing, group boycotts or the allocation of practice territories or patients, the courts apply the per se rule. Under the per se rule, the court presumes that an unreasonable restraint of trade occurred. The plaintiff only has to prove the existence of the agreement, not that the agreement decreased competition. Under the per se analysis, it does not matter that the dentists did not intend to violate the antitrust laws, or that the agreement operates to lower consumer prices.
- Rule of Reason -- If the per se rule does not apply, a court applies the rule of reason. Under this analysis, the court balances the pro-competitive purposes and effects of the agreement against the anti-competitive purposes and effects. If, on balance, the agreement is considered to be anti-competitive, then the agreement is illegal.

"The U.S. Justice Department and the Federal Trade Commission are particularly intereted in prosecuting physicians and dentists for antitrust violations."

ILLEGAL PER SE JOINT ACTION

Price-fixing and group boycotts constitute the greatest risks of joint activities conducted by dentists that may lead to antitrust violations.

1. Price-fixing. Price-fixing is an agreement or understanding among competitors to fix, stabilize, raise, or lower prices (or any element of price) and is per se illegal. The following types of activity generally constitute price-fixing, if conducted by independent dentists:
   - an understanding to submit a certain fee to an insurance company or managed care entity;
   - an understanding not to discount fees beyond a certain percentage; and
   - a letter to an insurer stating that if fee schedules are not raised, specified dentists will terminate their contracts.

Oral or written communications between independent dentists regarding price should be avoided.

2. Group boycotts. An agreement by two or more dentists not to deal with a third party may constitute an illegal group boycott. The following types of activity may be considered group boycotts if conducted by independent dentists:
   - a tacit understanding to refuse to participate in an insurance or managed care plan;
   - an understanding among general practitioners not to refer to a specialist who participates in an unpopular managed care plan; or
   - an agreement to terminate participating contracts with a plan for any reason.

ANTITRUST ENFORCEMENT

Federal antitrust laws are enforced by the Justice Department, the Federal Trade Commission, and suits brought by private parties. The Justice Department may bring either criminal or civil action against dentists who are in violation of the antitrust laws. Criminal actions are felonies punishable by imprisonment and fines. Private parties can sue dentists for antitrust violations and, if successful, recover treble damages.

Daniel J. Schulte is legal counsel for the Michigan Dental Association.

SCIENTIFIC

PATHOLOGY PUZZLER

Dr. John Svirsky

A 54-year-old African American female with past medical history significant for hypertension, coronary artery disease, and diabetes presents to clinic with chief complaint "I think my lower jaw is infected". Patient reports that the swelling started to increase over the past several days and that her friend forced her to come to clinic to have it examined. On physical exam patient has hypoesthesia over the left distribution of the mandibular branch of the trigeminal nerve. Patient also has bony expansion that is most notable over the left lateral portion of the mandible (Figure 1) that is palpable extraorally (Figure 2). Root tips #28, 29 and 32 are noted. All branches of facial nerve are intact. Patient has normal maximum vertical opening, and is edentulous on the maxilla. Lower anterior dentition has class II mobility. Left mandibular vestibule is almost non-existent due to lateral bony expansion of the mandible with soft tissue erosion in area of teeth #21-22. The lesion is radiolucent and goes from the mesial of tooth #17 to the distal of root tip #29. It measured approximately 20 cm by 6 cm (Figure 3)

Which of the following would you include in your differential diagnosis?

1. Ameloblastoma
2. Central giant cell granuloma
3. Lymphoma
4. Multiple myeloma
5. Neurilemmoma/schwannoma
6. Odontogenic keratocyst
7. Odontogenic myxoma.
8. Residual cyst
9. Squamous cell carcinoma

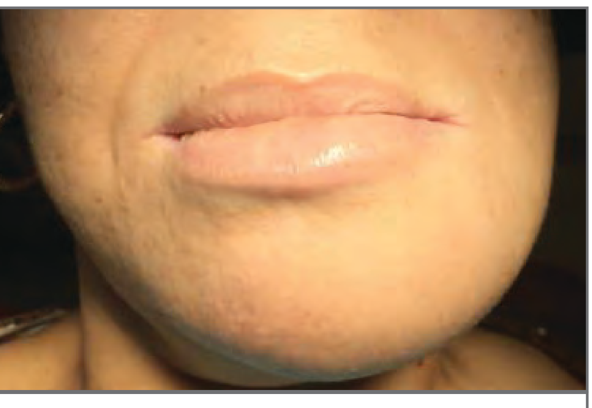

FIGURE 1

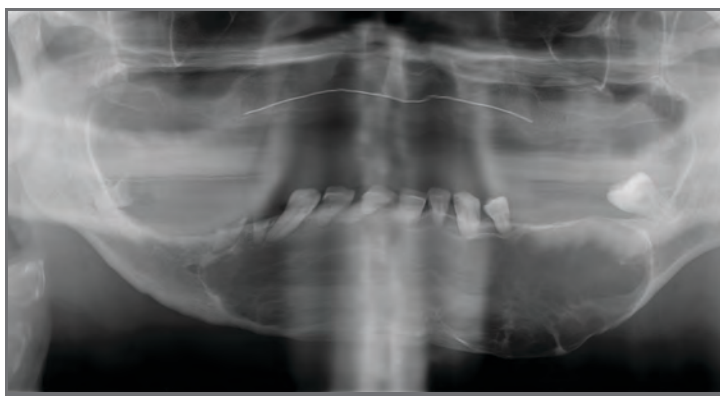

FIGURE 3

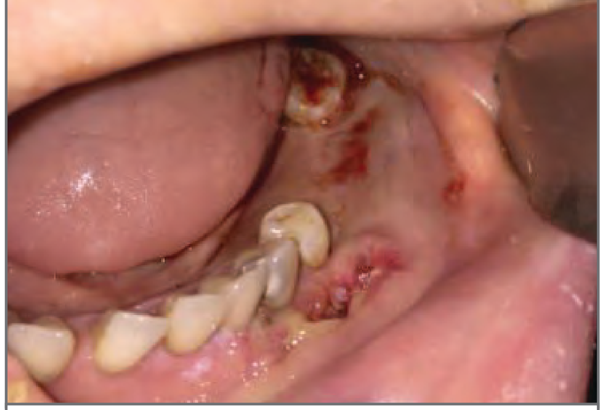

FIGURE 2

CONTINUED ON PAGE 24

PERIODONTAL ABSTRACT:

BARONE A, ALFONSI F, DERCHI G, TONELLI P, TOTI, P, MARCHIONNIS, COVANI U. THE EFFECT OF INSERTION TORQUE ON THE CLINICAL OUTCOME OF SINGLE IMPLANTS: A RANDOMIZED CLINICAL TRIAL. CLIN IMPLANT DENT RELATED RES. 2016; 18(3): 588–600.

Purpose: To evaluate and compare the clinical outcomes of implants placed with a high insertion torque (IT) and a regular insertion torque, specifically marginal bone levels and gingival recession.

Methods: Parallel-arm randomized controlled clinical trial including 116 partially edentulous patients who were treatment planned for dental implants. Patients were randomly placed into 2 separate groups 1. high-IT group receiving a CT implant with a self-tapping design and high insertion torque, or 2. Regular-IT group receiving a Blossom® CT implant with a modified cutting flute design and lower insertion torque than self-tapping models. Surgical guides were fabricated and osteotomies were made according to manufacturer's recommendations with a countersink being used to prepare the 2 mm coronal portion of the ridge. All implants were placed with the surgical unit at a maximum torque of 40 Ncm and 30 rpm and a digital torque gauge was used to calculate the mean insertion torque. Measurements of peri-implant marginal bone level (from fixture-platform to the most apical point of marginal bone), and facial soft tissue levels (based on the level of the adjacent soft tissue margins) were taken at baseline, 3, 6, and 12 months. Implant failure was defined as implant mobility, or removal of implant due to progressive bone loss or infection. Residual bone thickness was also measured on the buccal aspect of the osteotomy at the mid-facial level. Groups were identified as having less than 1 mm of bone thickness or 1 mm or greater of thickness.

Results: Of the 116 implants, 3 of them were reported as failures (2.6%). Four implants in the high-IT group showed more than 1.5 mm of marginal bone loss, and one in the regular-IT group. There were 58 implants in each of the two groups. In the regular-IT group: 27 in the maxilla with a mean IT of 29.1 Ncm, and 31 in the mandible with an IT of 30.4 Ncm. In the high-IT group: 28 were placed in the maxilla with a mean IT of 70.6 Ncm, and 30 were placed in the mandible with a mean IT of 68.3 Ncm. The 12 month evaluation of the implants revealed 0.68 mm vs. 1.01 mm bone loss between high-IT and regular-IT groups.

Conclusions: Implants inserted with high-IT showed more peri-implant bone remodeling and buccal soft tissue recession than implants in the regular-IT group. Also, sites with a thick buccal bone wall (greater than 1 mm) after implant osteotomy preparation seemed to be less prone to soft tissue recession.

Amy Reichert, DDS
Resident in Periodontics, Virginia Commonwealth University

PERIODONTAL ABSTRACT:

PIERALLI S, KOHAL RJ, JUNG RE, VACH K, SPIES BC. CLINICAL OUTCOMES OF ZIRCONIA DENTAL IMPLANTS: A SYSTEMATIC REVIEW. J DENT RES. 2016; 96(1): 38-46.

Purpose: The goal of this review is to evaluate randomized clinical trials (RCTs) and prospective clinical studies currently available on zirconia implants and analyze their behavior in relation to survival and marginal bone loss (MBL). Additionally, evaluate implant design (1 or 2 piece), temporization mode (immediate/delayed), loading mode (immediate/delayed), bulk material and influence of minor augmentation procedures.

Methods: RCTs and prospective, minimize bias and maintain high quality assessment. Nine articles matched the inclusion criteria.

Results: Implant survival outcome, analyzed with meta-analysis, found that one-year survival rate was 95.6%. Most common implant failures occurred in the early period after placement. Two studies had survival rates of 85% and 88.9%. Marginal bone loss outcome was also evaluated by meta-analysis. These results indicated that after one year, the average marginal bone loss was 0.79mm with a range between 0.44mm to 1.95mm. Results show 66% and 62% of the implants could be assigned to success grade I (≤2 mm of MBL) and 86% and 87% to success grade II (≤3 mm of MBL). There was no statistical significance when single units (SC) or fixed partial dentures (FPD) were placed, or between 1 or 2 piece units. There was no statistical significance between various implant temporizations or various implant loading concepts. However, one study reported that all immediately loaded implants placed in extraction sites were lost. There was also no statistical significance between sites with augmentation procedures and no augmentation procedures

Conclusions: Zirconia implants are thought to have improved mechanical properties with increased fracture strength, biological positive response to osteoblasts and excellent degree of osseointegration. An increasing interest for zirconia and its composites as dental implant materials has been shown in the last few years, as testified by numerous clinical studies published on this topic. Based on the present systematic review, the survival rate and MBL of zirconia dental implants supporting SCs and FPDs after one year are promising and, furthermore, comparable to available data of 2-piece titanium implants. However, more high evidence–level clinical studies are needed to confirm the long term predictability of these implants. For restoring single-tooth gaps and replacing up to 3 adjacent missing teeth, zirconia implants can be considered a treatment option with an outcome comparable to titanium implants.

Kian Azarnoush, DMD
Resident in Periodontics, Virginia Commonwealth University.

SCIENTIFIC

CONTINUED FROM PAGE 23

PATHOLOGY PUZZLER

Dr. John Svirsky

My differential diagnosis would have included an ameloblastoma, central giant cell granuloma and odontogenic myxoma. Based on the location and size the lesion is suggestive of odontogenic myxoma.These are lesions that would cause expansion. Residual cysts and odontogenic keratocysts do not cause expansion and not at this level. Cysts of this size would show cortication and typically grow through the medullary bone. Lymphomas of the jaws would not typically present as an expansile jaw lesion of this size without soft tissue involvement and a moth eaten appearance. Multiple myeloma/plasmacytoma(localized plasma cell tumor) would be more punched out, smaller and also not as regular. A squamous cell carcinoma would be far more destructive, have floating teeth and have a moth-eaten appearance.
My first choice is an ameloblastoma.

Central giant cell granulomas can also cause expansion, but typically present in the early twenties. Both of these lesions are reasonably common. An odontogenic myxoma of this size is unlikely.

An incisional biopsy was done and of course the patient never returned for follow up. About a month later she was found to have a myocardial infarction and was placed on ARTIC protocol (Advanced Resuscitation Cooling Therapeutics and Intensive Care protocol). She has not been heard from since.

The biopsy results showed a tumor consisting of both Antoni A and Antoni B tissue which makes this a neurilemmoma. This would not have been a choice in my differential diagnosis. The Schwann cells of the Antoni A tissue form a palisaded arrangement around acellular zones known as Verocay bodies. Antoni B tissue is haphazard and not organized. The majority of the tumor is Antoni A tissue with the pink acellular areas abundantly present (figures 4 & 5).

This case was submitted by Dr. Dan Tran, a second year oral and maxillofacial surgery resident at Virginia Commonwealth University.

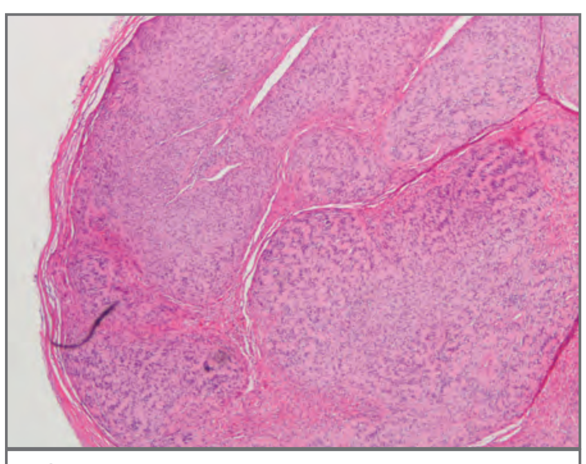

FIGURE 4

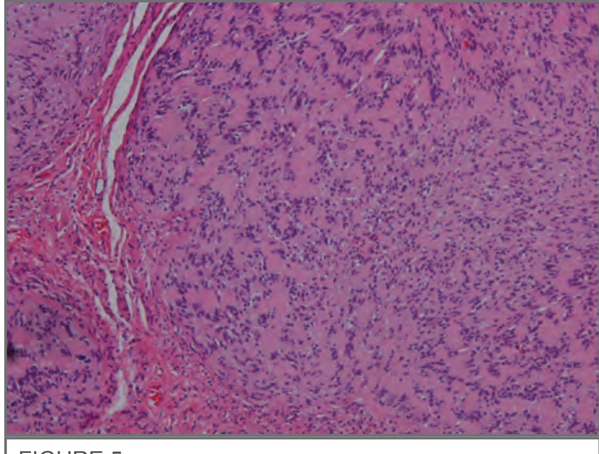

FIGURE 5

DR. JULIA L. JACKSON

I completed six years of Oral and Maxillofacial surgical training in NYC and Washington DC. I attended Temple University Dental School in my hometown of Philadelphia. Currently, for three years I have been warmly welcomed by the Northern Virginia Community.

PERIODONTAL ABSTRACT:

KRAATZ J, HOANG H, IVANOVSKI S, CROCOMBE L . NON-CLINICAL FACTORS ASSOCIATED WITH REFERRALS TO PERIODONTAL SPECIALISTS: A SYSTEMATIC REVIEW. J PERIODONTOL. 2017; 88(1): 89-99

Purpose: This systematic review aims to identify non-clinical factors reported in the literature associated with referrals to periodontists by general dentists.

Methods: An electronic PubMed® search was conducted. Ten articles met the inclusion criteria. Inclusion criteria involved: 1) participants who were general dentists 2) studies reporting on whether non-clinical factors (NCFs) affected referral of patients to periodontists 3) observational research studies 4) empirical studies using correlational surveys. Studies that met inclusion criteria were divided into 4 categories: practice, patient, General dentist (GD), and periodontist related factors. Results: The majority of these studies used surveys for data collection from a variety of populations (non US). Sample sizes ranged from 10 to 1202 participants. Seven studies reported on practice related factors which include: practice size, percentage of patients with high/low socioeconomic status, percentage of patients with insurance, number of hygienists used, and geographic location of the referring periodontist. Of these factors, practices with a small number of patients with insurance had fewer referrals than those that had more patients with insurance. GDs with two or more hygienists were more likely to refer. While GD practices greater than 5 miles from the nearest periodontist were nearly two and half times more likely to refer patients than those who were closer. GD related factors included: age, sex, previous periodontal therapy (PT) outcomes, workload and business model, continuing education attendance, and relationship with periodontists. An association was found between female practitioners and more frequent referrals amongst them, and that GD were more likely to refer when there was a perceived medico-legal issue, or those practitioners who put high priority on OHI. GPs who disliked periodontal procedures were more likely to refer, and those who performed them and had success were less likely to refer. In regards to patient related factors: age, sex, compliance, previous PT therapy, concerns and medical conditions. Patients were more likely to be referred if they were compliant and or uncooperative and had a more complex medical history. In regards to periodontist-related factors, there were five factors that GDs ranked as important: 1) clinical experience 2) positive previous referral outcomes 3) quality of communication 4) likelihood of good patient experience 5) periodontal rapport.

Conclusions: Limited research is available on NCFs associated with referrals; however NCFs play a role in the referral process and can be broken down into practice factors, general dentist factors, patient factors, and periodontist factors. All of which vary greatly across the different GP populations.

Kane W. Ramsey, DMD;
Resident in Periodontics, Virginia Commonwealth University

PERIODONTAL ABSTRACT:

GARG S, PRADEEP AR. 1.2% ROSUVASTATIN AND 1.2% ATORVASTATIN GEL LOCAL DRUG DELIVERY AND REDELIVERY IN THE TREATMENT OF CLASS II FURCATION DEFECTS: A RANDOMIZED CONTROLLED CLINICAL TRIAL. J PERIODONTOL. 2017; 88(3):259-265.

Purpose: Investigate clinical and radiographic effects of 1.2% Rosuvastatin (RSV) and 1.2% Atorvastatin (ATV) Gel delivered locally as adjunct to non-surgical treatment in patients with Chronic periodontitis with Class II furcation defects.

Methods: In this nine-month triple masked study, 105 patients with chronic periodontitis with mandibular Class II furcation defects were examined for this study. Patients were included in the study if they were systemically healthy with class 2 furcation probing depth>5mm and horizontal probing depth >3mm on endodontically vital mandibular molars. Ninety patients selected randomly assigned to one of three treatment groups. Group 1 patients were treated with scaling and root planing followed by placebo gel local drug delivery (LDD), group 2 with SRP followed by 1.2% RSV gel LDD, and group 3 with SRP followed by 1.2% ATV gel LDD. Clinical parameters measured at baseline included: 1) modified sulcus bleeding index (mSBI); 2) full mouth plaque index (PI) score; 3) probing depth (PD); 4) relative vertical clinical attachment loss (RVCAL); and 5) relative horizontal CAL (RHCAL). Radiographically, defect depth reduction (DDR) for each defect was estimated at baseline and at 6 and 9 months using an image analyzer. Bone defect depth (BDD) was measured as the distance from the furcation fornix to the base of the defect. Measurements taken at initial and 6,9 months. Drugs were redelivered at the 6-month time period

Results: All groups had a decrease in modified sulcus bleeding index with treatment; however RSV had a statistically significant greater reduction at both 6 and 9 months when compared to ATV and placebo. A statistically significant difference in the decrease in PD, RHCAL, and RVCAL was observed in groups 2 and 3 compared with group 1 from baseline to 6 and 9 months. Bone Defect Depth decreased in RSV: 1.31mm, 30.8%; ATV: 1.06mm, 25.5%; and placebo: 0.196mm, 4.6% at 6 months. At nine months Bone Defect Depth decreased for RSV: 1.77mm, 42%; ATV: 1.42mm, 32%; placebo: 0.213mm, 4.9%.

Conclusion: 1.2% RSV gel was significantly better than with 1.2% ATV gel as adjunct to SRP in patients with mandibular Class II defects regarding clinical and radiographic parameters.

Charles Stoianovici, DMD
Resident in Periodontics, Virginia Commonwealth University

PERIODONTAL ABSTRACT:

PANIZ G, NART J, GOBBATO L ET AL. CLINICAL PERIODONTAL RESPONSE TO ANTERIOR ALL-CERAMIC CROWNS WITH EITHER CHAMFER OR FEATHER-EDGE SUBGINGIVAL TOOTH PREPARATIONS: SIX-MONTH RESULTS AND PATIENT PERCEPTION. INT J PERIO REST DENT. 2017; 37(1):61-68

Aim: The purpose of this prospective randomized clinical study was to evaluate the influence of a deep chamfer intrasulcular margin design on the periodontal soft tissue parameters when compared with a feather-edge subgingival tooth preparation and intrasulcular margin. The secondary purpose was to determine whether the patient perceives any difference between the two types of finishing lines in terms of esthetics and functional comfort.

Methods: Fifty-eight patients were included in the study. The teeth planned for full coverage restoration were randomly assigned to the treatment groups: group 1 (deep chamfer) or group 2 (feather-edge) with the facial restorative margin prepared 0.5 mm below the gingival margin then provisionalized. Rounded shoulder and feather-edge burs were used for patients of group 1 and 2, respectively. Final restorations were done 12 weeks later with zirconia ceramic (Lava, 3M ESPE) layered for all the teeth. Periodontal probing depth (PPD) at three different facial sites (mesial, midpoint, distal), plaque index (PI), gingival bleeding on probing (BoP) were compared at baseline and 6 months follow-up, with a visual analog scale (VAS) and satisfaction questionnaire also given at 6 months.

Results: All participants completed the 6-month follow-up. Of these restorations, 2 were lost prior to the 6-month follow-up, 1 due to abutment root fracture and 1 due to porcelain fracture. These 2 sites were not included in the statistical analysis. Statistically significant differences were present for bleeding on probing, gingival recession, and patient satisfaction. Featheredge preparation was associated with increased bleeding on probing (48.4%) compared with group 1 (30.5%). Deep chamfer was associated with increased recession, with higher frequency of restorations with equa- or supragingival margin position compared with featheredge group (7.6% and 1.1%, respectively). Improved patient comfort was registered with chamfer margin design.

Conclusion: Subgingival margins are technique sensitive, especially when feather-edge design is selected. This margin design may facilitate soft tissue stability but can expose the patient to an increased risk of gingival inflammation. More BoP is present around featheredge margins and significantly more gingival recession is present around deep chamfer margins.

Danielle McCormack, DDS

Third year Resident in Periodontics, Virginia Commonwealth University

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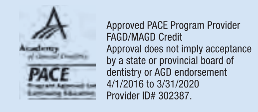

PERIODONTAL ABSTRACT:

STEFANINI M, FELICE P, MAZZOTTI C, MARZADORI M, GHERLONE EF, ZUCCHELLI G. TRANSMUCOSAL IMPLANT PLACEMENT WITH SUBMARGINAL CONNECTIVE TISSUE GRAFT IN AREA OF SHALLOW BUCCAL BONE DEHISCENCE: A THREE-YEAR FOLLOW-UP CASE SERIES. INT J PERIO REST DENT. 2016; 36(5):621-30.

Purpose: To evaluate the short and long-term (3 years) soft tissue stability after a surgical technique combining transmucosal implant placement with submarginal connective tissue graft (CTG) in area of shallow buccal bone dehiscence.

Methods: Twenty patients were selected at the dental clinic of Bologna University. All patients were periodontally and systemically healthy. All patients presented with an intercalated edentulous area (only missing 1 tooth) distal to the canine in the maxilla or mandible, at least 4mm of bone width, and 10mm of bone height as measured by CBCT with healthy tissue upon probing and a minimum of 2mm keratinized tissue (KT). All patients received one Straumann Standard Plus transmucosal implant of 10mm length and a diameter of 3.3mm for replacing premolars and 4.1mm for replacing molars. All received a session of prophylaxis and oral hygiene instruction. The following measurements were made at baseline, 6months, 1 and 3 years: vertical soft tissue level (VSTL) as distance from most apical extension of edentulous area to the reference point of the stent (SRP). The following clinical measurements were also taken: soft tissue thickness (STT), KT height (KTH), bone dehiscence (BD) as measured from apical extension of the implant collar to apical extension of buccal bone crest, graft thickness (GT). The following clinical measurements were made as time of final restoration: VSTL, periodontal probing depth, clinical attachment level (CAL), KTH, and presence of peri-implantitis or mucositis, and STT measured 2mm apical of gingival margin. Standard intraoral radiographs were taken at each time point. Surgical technique consisted of crestal incision with two short mesial and distal incisions to preserve adjacent interdental tissue. A full thickness buccal flap beyond mucogingival junction was utilized. Palatal/lingual flap minimally raised to provide access to the implant site. Implant placed with collar 2mm above bone and 2mm high healing caps were placed. A free gingival graft was taken from palate and de-epithelialized to make a CTG and then sutured to buccal flap 1mm apical to the flap KT margin (submarginal CTG). The mesio-distal length of graft 6mm greater than implant diameter and apicocoronal dimension was chosen to cover the transmucosal portion of the implant, the implant exposure, and 2mm of bone apical to the buccal BD. Buccal flap was then coronally advanced and the KT adapted to healing cap with sling suture. Restorations were placed at 6 months.

Results: There was a clinically significant increase in VSTL, STT, and KTH. Statistically significant increases in buccal soft tissue thickness and improvement of vertical soft tissue level were achieved at the follow-ups. A significant increase in keratinized tissue height was also found. No significant marginal bone loss was recorded. The results were achieved with no buccal recession or peri-implant disease.

Conclusions: Results showed that combining transmucosal implant placement with submarginal CTG covering shallow buccal bone dehiscences provides successful long-term results in terms of marginal soft tissue stability (vertical and horizontal soft tissue increases) and peri-implant health, with no signs of peri-implant disease at 1 and 3 years.

John White, DDS
Resident in Periodontics, Virginia Commonwealth University

PERIODONTAL ABSTRACT:

HUWAIS S, MEYER E. A NOVEL OSSEOUS DENSIFICATION APPROACH IN IMPLANT OSTEOTOMY PREPARATION TO INCREASE BIOMECHANICAL PRIMARY STABILITY, BONE MINERAL DENSITY, AND BONE-TO-IMPLANT CONTACT. INT J ORAL MAXILLOFAC IMPLANTS. 2017; 32(1):27-36.

Purpose: To evaluate the hypothesis that a new osseodensification technique in preparation of implant osteotomies in cancellous bone increases primary stability, density, and bone to implant contact compared with a standard drilling technique.

Methods: Three techniques were used to create 72 implant osteotomies in the cancellous bone of 12 porcine tibias: standard drilling technique, osseous extraction with a tapered, multi-fluted bur, and osseodensification technique using the same tapered bur used in a counter-clockwise direction. 5 steps were used to enlarge each osteotomy. Drill speed and torque were controlled. Heat generation was measured during drilling. Primary stability was compared between groups by measuring insertion and removal torques with the load cell and implant stability quotient (ISQ). 4.1mm implants were inserted, then removed, then the osteotomy was enlarged to 6.0, and stability was re-measured. Densified crust thickness was measured in 8 separate sites, and morphology and density was measured using micro computed tomography.

Results: Significant increases in both insertion and removal torques were found using the osseodensification technique, compared to the other two drilling methods. No significant differences in implant stability or temperature during drilling were detected between the groups. Imaging of the osseodensified sites revealed increased peripheral bone density, and bone to implant contact was three times greater with the osseodensification drilling procedure.

Conclusions: A novel osseodensification drilling procedure demonstrated higher insertion torques, increased peripheral bone density, and greater bone at the implant surface as compared to standard drilling techniques. This new technique could improve implant surgery success, especially in areas of decreased bone density.

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SCIENTIFIC

PERIODONTAL ABSTRACT:

PAJNIGARA NG, KOLTE AP, KOLTE RA, PAJNIGARA NG. VOLUMETRIC ASSESSMENT OF REGENERATIVE EFFICACY OF DEMINERALIZED FREEZE-DRIED BONE ALLOGRAFT WITH OR WITHOUT AMNION MEMBRANE IN GRADE II FURCATION DEFECTS: A CONE BEAM COMPUTED TOMOGRAPHY STUDY. INT J PERIO REST DENT. 2017; 37(2):255-262

Purpose: The present study was planned for volumetric assessment of the regenerative efficacy of demineralized freezed dried bone (DFDBA) with or without an amniotic membrane(AM) in Grade II furcation defects both clinically and radiographicaly by CBCT.

Method: A total of 20 with chronic periodontitis were assessed in this split-mouth study. The inclusion criteria included moderate to severe periodontitis with assessed probing depth and clinical attachment loss >5 mm, and at least one pair of bilateral Grade II furcation defects on contralateral sides, in either maxillary or mandibular arch, this was determined by clinical evaluation and confirmed by radiographic evaluation. The exclusion criteria included patients who had any systemic diseases, allergy, drug use or had periodontal therapy in last 6 month. Patient's were divided into two groups with Group 1 as the control group with DFDBA alone to regenerate the sites and Group 2 as the test group that used both DFDBA and AM to regenerate the sites. Human amniotic membrane (AM) is a novel tissue engineered biomaterial that has recently been tried in the field of dentistry to regenerate lost tissues and accelerate repair with wound healing and antibacterial properties.
Oral health status, plaque index (PI), gingival index (GI) probing depth (PD) , horizontal probing depth , clinical attachment loss (CAL), and recession were measured at baseline, 3 months and 6 months. A CBCT analysis was also done and included the measurement of bone defect height, depth, and width at baseline and at 6 months.

Result: GI and PI improved significantly .PD, and horizontal probing depth at 6 months showed a drastic reduction with a larger reduction of Group 2. It illustrated a measurement of 1.1 mm for both PD and horizontal probing depth compared to a baseline value of 5.25 mm and 4.05mm respectively. CAL also improved from baseline of 5.75 mm to a result of 1.85mm for the test group and showed better results from that of the control group, which showed a result of 3.6mm. Radiographic parameters measured on the CBCT of the defect height, defect width, defect depth and volume also show a significant reduction in defect size for the test group. However, recession did not improve for both groups. Group 1 showed gingival recession to be 1.2 mm while Group2 showed results to be 0.75mm. The initial baseline value: 0.5mm

Conclusion: DFDBA with AM showed a greater reduction in clinical parameters and in bone defect volume when compared to DFDBA alone. This difference was statistically significant, indicating better results for combination therapy over monotherapy in treatment of Furcation II defects

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PERIODONTAL ABSTRACT:

CASTAÑO A, SHAH SS, CICERO G, EL CHAAR E. PRIMARY ORAL MELANOMA – A NON-SURGICAL APPROACH TO TREATMENT VIA IMMUNOTHERAPY. CLIN ADV IN PERIO. 2017; 7(1):9-17

Purpose: This article presents a case of oral melanoma and how it was treated with immunotherapy versus surgical intervention.

Methods: In this report, patient was a 49 year old nonsmoking Mexican male with no significant medical history. A growing mass that became larger and darker about 3 months after receiving scaling and root planning (SRP) was noticed. Patient reported having mild pigmentation in the anterior maxillary gingiva for about 10 years but the pigmentation got significantly darker over the past three months.

Upon intraoral clinical examination, a purple and black pedunculated mass of 2-3 cm in size was evident in the attached gingiva and alveolar mucosa associated with the posterior left maxillary alveolus. Lesion did not affect tooth mobility or vitality. Incision biopsies were performed on both the anterior maxilla and the exophytic mass of the left posterior maxilla. The biopsy of the anterior maxilla showed hyperplastic epithelium with an atypical proliferation of melanocytes in the basal and parabasal cell layers and diagnosis was "atypical melanocytic proliferation". Posterior maxilla was diagnosed with "oral melanoma". Patient had three positive left neck lymph nodes and required aggressive intervention but tumors were too extensive for immediate surgical excision so the oncologist and oral surgeon decided to treat with ipilimumab and pembrolizumab in order to decrease the tumor size prior to surgical treatment.

Results: After many rounds of immunotherapy there was a single persistent node that was 5mm in size and considered resolved and the left posterior buccal gingiva mass had completely resolved.

Conclusions: Traditionally, radical surgical therapy had been the main treatment option for melanoma patients. Chemotherapy and radiotherapy had been used as adjuncts. In his case, surgery would have resulted in loss of half of the maxilla with radical neck dissection. These therapies may result in more surgically conservative treatments, which may in turn offer greater quality of life in patients whose prognosis is poor.

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VIRGINIA BOARD OF DENTISTRY EMERGENCY REGULATIONS: WHY, WHAT AND WHERE?

WHY DO WE NEED REGULATIONS? WHAT ARE THE NEW REGULATIONS? WHERE DO WE GO FROM HERE?

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The recently implemented regulations by Virginia Board of Dentistry and the need to comply with such regulations may seem to impose a burden on clinicians during the course of providing direct care to their patients on a daily basis. However, it is hoped that the awareness that these efforts will bring will benefit patients and will make these requirements worthwhile. Because no provider can ignore the current national trends in opioid use and misuse, all health care providers, including dentists, have important roles to play in properly prescribing and monitoring the use of controlled substances, with the ultimate goal of curbing this epidemic. In this article we will discuss why these regulations are needed, what are the new regulations, and where we do go from here now the regulations are in effect.

WHY DO WE NEED REGULATIONS?

According to Center for Behavioral Health Statistics and Quality 2016 report, in 2015 20.5 million Americans 12 years or older had a substance use disorder. Of these, 2 million had a substance use disorder involving prescription pain relievers and 591,000 had a substance use disorder involving heroin. Other estimates show that the number of heroin users in the United States jumped from about 404,000 in 2002 to 914,000 in 2014, and the number of those with heroin “dependence or abuse” more than doubled from 2002 to 2014, increasing from about 214,000 to 586,000. The human cost of opioid use and abuse as measured in loss of life over the past 15 years is staggering. More than 520,000 people are hospitalized in the US for opioid abuse and over 78 people die each day in the country from opioid overdose. By 2015, drug overdose had become the leading cause of accidental death in the US, reaching 52,404 lethal drug overdoses. Of these deaths, opioid addiction is driving the epidemic, with 20,101 overdose deaths related to prescription pain relievers, and 12,990 overdose deaths related to heroin in 2015. This increase in fatalities was preceded by a similar steady increase in overdose death rates between 1999 and 2008, which was paralleled by an increase in the sales of prescription opioids and increase of substance use disorder treatment admissions related to prescription pain relievers during the same period.

In addition to the aforementioned human cost, the recent epidemic has similar enormous financial costs to the society. Recent estimates of economic burden in the US estimated the societal cost of prescription opioid abuse in the United States for 2007 to be $55.7 billion with 830,625 years of potential life lost before the age of 65. These costs included medical costs, loss of productivity, and criminal justices costs.

This recent peak of the opioid epidemic and its human and financial costs clearly corresponded to an association between the increased in number of prescriptions sold in the US and increased availability of heroin in the US market. In one study, the increased drug availability as expressed by opioid prescriptions dispensed by US pharmacies and the production of heroin in Mexico is associated with increased use and overdose and opioid-related deaths in the US. Furthermore, four in five new heroin users started out misusing prescription painkillers and 94% of respondents to a survey of people in treatment for opioid addiction indicated that they switch to using heroin from prescription opioids because the latter is “far more expensive and harder to obtain” than heroin. It has also been shown that prescription opioid abuse precedes heroin use within an average of two years.

Frequent prescription opioid use and abuse is associated with a 40-fold increased risk of dependence on or abuse of heroin. Another association between abuse of prescription opioids and heroin use is shown by incidence of heroin initiation to be 19 times higher among those who reported prior nonmedical pain reliever use than among those who did not. Furthermore, 86% of young, urban, injection drug users had used opioid pain relievers nonmedically prior to using heroin. Sharing of unused pain relievers contributed to the dangers of nonmedical opioid use in these adolescent age groups. The source of opioids in this population, in initiation and nonmedical use of pain relievers, is mostly from medications supplied free from family members or friends, or from personal prescriptions. All of this data points to undisputable link between prescription analgesics and the peak in the opioid epidemic in the US over the last decade.

This expanding epidemic was highlighted when the drug problem was classified as an epidemic by the Centers for Disease Control and Prevention in 2012 and later the US Surgeon General on November 26, 2016, declaring (for the first time) substance abuse a public health crisis. The Commonwealth of Virginia was not spared from this epidemic, as manifested in change in death rate from opioids over the past 9 years. The total deaths from all opioids rose from 491 in 2007 to an estimated 916 in 2016, nearly doubling in less than 10 years. The numbers exceeded, for the first time in 2015, the number of deaths

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from motor vehicle accidents. Similarly, in a press release November 21, 2016, Governor Terry McAuliffe advised that State Health Commissioner Marissa J. Levine, MD, MPH, FAAFP declare Virginia's opioid addiction crisis a "state of public health emergency." Such declaration at both the federal and state levels across the country allowed for the passage of several local and nationwide regulatory changes to combat the crisis. In response to this, the Virginia Board of Dentistry formed an Advisory Panel on Opioids to discuss developing possible regulations to help curb the epidemic in Virginia. In January, the Panel met and drafted regulations pertaining to opioid prescribing. The Board of Dentistry reviewed the drafted regulations on March 10th and they were approved. The effective date for these regulations was April 24, 2017 and they will expire on October 20, 2018. Until the time of expiration, the Board of Dentistry will work on developing permanent regulations. Comments may be submitted by members of the public from May 15- June 14, 2017.

WHAT ARE THE NEW VBOD EMERGENCY REGULATIONS?

The new regulations can be categorized into seven key elements. These elements are:

- Definition of acute and chronic pain
- General analgesic prescribing regulations
- Regulations regarding the specific documentation for patients receiving opioid treatment
- Guidelines for prescribing for acute pain
- Guidelines for prescribing for chronic pain
- New Continuing education requirements for opioid prescribers
- Requiring use of Morphine Milligram Equivalent (MME) for calculation of opioid treatment and use of Virginia Prescription Monitoring program (VPMP) to monitor prescribing

DEFINITIONS IN THE REGULATIONS

Since the duration of opioid analgesics prescribed for the management of pain differs based on the type of pain, the regulations were set to distinguish between the two most common types of pain treated by dental practitioners. The major categories of pain are:

- Acute pain: for which controlled substances may be prescribed for no more than three months.
- Chronic pain: nonmalignant pain for a period greater than three months.
- Other definitions including Morphine Milligram Equivalent (MME) for calculation of opioid treatment and use of Virginia Prescription Monitoring program (VPMP) to monitor prescribing which we will discuss later in this artile.

GENERAL ANALGESICS PRESCRIBING REGULATIONS

- Prescribers should consider non-pharmacologic and non-opioid treatment for pain prior to using opioids, and
- If and when an opioid is considered it should be a short-acting opioid in the lowest effective dose for the fewest possible days.

DOCUMENTATION REQUIREMENTS

The new regulations require that before dentists prescribe a controlled substance for management of pain, the dentist must:

A. **perform** a history and physical examination appropriate to the complaint,

B. **conduct** an assessment of the patient's history and risk of substance abuse, and

C. **query** the PMP if the opioid prescription is for more than 7 days or before refill.

The results of history and physical examination should be documented in the patient records. Such records should include: a description of the pain, a presumptive diagnosis for the origin of the pain, an examination appropriate to the complaint, a treatment plan, the medication and quantity prescribed, and the date, type, dosage, of opioid prescribed.

GUIDELINES FOR PRESCRIBING OPIOID FOR ACUTE PAIN

Based on the definition provided in the regulations (as described earlier), prescribing for management of the pain differs depending on whether the pain is acute or chronic. For management of acute pain the regulations require that:

- Initiation of opioid for acute pain shall be with short-acting opioids and is limited to a quantity that **does not exceed a seven-day supply**, unless extenuating circumstances are clearly documented in the patient record. If a prescription is to exceed 50 MME/day, the dentist must carefully document the reasons in the patient's record.
- Before exceeding 120 MME/day, the dentist must document the justification for such doses and **shall refer to or consult** with a pain management specialist
- Naloxone must be prescribed for any patient with any of the following risk factors: 1. Prior overdose, 2. substance abuse, 3. Doses in excess of 120 MME/day, 4. or if the patient is taking benzodiazepine concomitantly.

GUIDELINES FOR PRESCRIBING OPIOID FOR CHRONIC PAIN

If a dentist treats a patient with opioid prescription for chronic pain, he (she) shall either: a. refer the patient to a medical doctor who is a pain management specialist; or b. comply with regulations of the Board of Medicine guidelines if he or she chooses to manage the chronic pain with an opioid prescription.

SPECIFIC NEW CE REQUIREMENT

Any dentist who prescribes any Schedule II through IV controlled substances shall obtain two hours of continuing education (CE) on pain management for purposes of the next renewal cycle (starting 3-31- 2018). This may be part of the 15 hours required for renewal of licensure. Effective June 9, 2017, dentists may obtain the CE credits prior to March 31, 2018.

USE OF MORPHINE MILLIGRAM EQUIVALENT (MME) AND PRESCRIPTION MONITORING PROGRAM (PMP)

Both MME and PMP are tools that are previously not as commonly used, or not used at all prior to the development of these regulations. Accordingly, they are worthy of further elaboration in this article.

MORPHINE MILLIGRAM EQUIVALENT (MME)

Morphine Milligram Equivalent is a value assigned to opioids to represent their relative potencies. MME is determined by using an equivalency factor to calculate a dose of morphine that is equivalent to the ordered opioid. MME is a method to compare the "relative corresponding quantity" of the various opioid molecules that are used in the treatment of pain.

The importance of need to calculate the total daily usage of opioids is based on a study of a national sample of patients with chronic pain from 2004 -2009. In this study, patients who died of opioid overdose were prescribed an average of 98MME/day when compared to other patients who were prescribed an average of 48MME/ day. Calculating the daily dose helps identify patients who may be at risk for an overdose and may benefit from close monitoring, dose reduction, prescribing naloxone or other measures of risk reduction from overdose

In calculating MME the following factors are considered: strength of the drug (ex. 5mg, 7.5mg..etc.), quantity of the drug (number of tablets), intended duration of treatment (the number of days is the prescription is intended for) and the potency of the drug. Potency of the drug is a numerical factor assigned to the various opioids. As per the CDC such number for some of the opioids is as below in table 1 **Calculation of MME can be accomplished from any of several online opioid dose calculators. It can also be manually calculated using the following formula:**

MME (Morphine Milligram Equivalents /Day (MME/D) = $\frac{\textit{Strength x Multiplier x Quantity}}{\textit{Days}}$

OPIOID	CONVERSION FACTOR
Codeine	0.15
Fentanyl transdermal (in mcg/hr)	2.4
Hydrocodone	1
Hydromorphone	4
Morphine	1
Oxycodone	1.5
Oxymorphone	3

Table 1

Example of calculated 50 MME/day equivalence:

- 50 mg of hydrocodone (10 tablets of hydrocodone/ acetaminophen 5/300)
- 33 mg of oxycodone (~2 tablets of oxycodone sustained-release 15 mg) •
- 12 mg of methadone

EXAMPLE OF CALCULATED 90 MME/DAY EQUIVALENCE:

- 90 mg of hydrocodone (9 tablets of hydrocodone/ acetaminophen 10/325)
- 60 mg of oxycodone (~2 tablets of oxycodone sustained-release 30 mg)
- 20 mg of methadone (4 tablets of methadone 5 mg)

USE OF PRESCRIPTION MONITORING PROGRAM (PMP)

PMP is a state program that provides prescription-related information for patients whose doctors are providing or considering initiating treatment that include prescriptions in scheduled II-IV. This information is available in a central database that is very useful tool a prescriber can use in making prescribing decisions for prescriptions of such drugs. Information obtained from PDMPs can be used to guide providers in prescribing opioids based on such findings. Some of the considerations that should be made when using the information from the PMP include:

- Prescribe as planned when the PDMP reveals no issues for concern.
- Contact the pharmacy when there is a question about information on the report
- Contact a previous prescriber when there is a question about a previous prescription
- Discuss concerns with the patient to resolve or clarify questions about the report.
- Change the treatment plan so the planned opioid prescription need not be written
- Refer the patient to a pain management specialist or other substance use specialist if the patient agrees to a need for treatment.
- Discharge from the practice as a last option, but be mindful of laws regarding patient abandonment

CONCLUSIONS: WHERE DO WE GO FROM HERE?

As Sam Quinones, author of *Dream Land: The True Tale of America's Opiate Epidemic* puts it, "…this is the first epidemic that really began not with drug dealers on the street and mafias or drug gangs, but with doctors. That's why it's nationwide." Accordingly, curbing this epidemic has to start with doctors.

Dr. Thomas Frieden, director of the Centers for Disease Control and Prevention (CDC), noted ***"The prescription overdose epidemic is doctor-driven. It can be reversed in part by doctors' actions. Prescription opioid overdose deaths can be prevented by improving prescribing practices. We can protect people from becoming addicted to opioids and clinicians are key to helping to reverse the epidemic"***.

For providers to change their role from part of the initiation of opioid epidemic in the US to the role of curtailing and preventing the progression of the epidemic, there is a need for a paradigm shift in the way dentists and other opioid prescribers understand dental pain and use evidence-based strategy to manage this type of pain. While there is no precise "prescription" for appropriate prescribing of opioid for management of acute dental pain, using the new regulations and guidelines can be very helpful for many to be aware of their prescribing pattern, and prevent patients from, misusing and abusing opioid prescriptions. Such regulations, however, are by no means a substitute for adequate understanding of the biology of dental pain, and adequate communication with patients as a part of the multistep strategy in managing pain.

Editor's Note: This article serves as information only, for the benefit of VDA members. All licensees are advicse to read and comprehend the entire Emergency Regulation and Notice of Intended Regulatory Action.

EDIC RISK MANAGEMENT | WITHIN YOUR CONTROL

Growing Misuse of Prescription Drugs — One Thing You Can Do To Help

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In September 2014, Dr. Nora Volkow, the director of the National Institute on Drug Abuse, reported that opioid prescriptions had increased threefold over the past two decades. "More deaths now occur as a result of overdosing on prescription opioids than from all other drug overdoses combined, including heroin and cocaine," Volkow said.

Today, the media (print, television, and internet) is awash in stories about the growing incidence of the misuse — and overdoses — of prescription pain relievers. Researchers now recognize that narcotic pain relievers (e.g., Vicodin, oxycodone, etc.) are pathway drugs leading to heroin use. That disturbing pattern makes the number of prescriptions written even more important. The occurrence of substance abuse and overdoses, particularly heroin, is also on the rise.

Why does this matter to you? Dentists frequently prescribe narcotic pain relievers. A recent conversation with a total stranger at a train station illustrated the problem. When my conversation partner learned I worked for a professional liability company insuring dentists, she immediately asked why dentists prescribed so many pain pills for a simple procedure. After such a procedure, her dentist gave her a prescription for narcotic pain relievers — 60 pills. She said her pain lasted two days and she took three pills. She now has 57 left.

How are extra pain pills relevant? It can begin simply enough: A teenager, looking for a kick, raids the family medicine cabinet. Enjoying the "high" from the medication she finds, she takes more. The situation can reach the point where she no longer takes the pills for a high, but rather, to prevent the withdrawal from them. She is addicted.

Addicts, having used up the medications at home, start buying pills to feed their addiction. But they are pricey. That's where heroin comes in. Heroin, the chemical cousin of prescription opiate pills, is cheaper than the pills. According to a recent *Washington Post* article ("Cheap Fix: Heroin's Resurgence,"- July 26, 2015), single pills bought on the street can cost as much as $50 or $60. A single dose bag of heroin can be had for as little as $10.

The point of this information is not to lay the addiction problem at the feet of dentists. Dentists do not prescribe opiates on a whim: They prescribe them to treat the pain associated with procedures they perform. In days past, the issue of under-treating pain was at the fore, and health care providers are sensitive to the proper treatment of pain. They prescribe opiates appropriately in the vast majority of cases.

Given the growing misuse of prescription drugs, it makes sense to reconsider prescribing practices. Long standing prescribing patterns that were learned in school, or have been used for convenience, should be examined. Simply prescribing a larger number of pills to prevent patients from calling in the evening or on weekends for more is no longer reasonable.

Most patients have some amount of pain that subsides shortly after a procedure and they only need a small number of pain relievers. Some patients will have more pain, and it is not always possible to tell which patient will require more than a small amount of pain relief. Yes, it is inconvenient for patients to have to come in to the office to get a prescription for more pain medications. But given current trends, prescribing a larger number of pills to cover that small number of patient's pales in comparison to the potential for addiction.

The discussion of opiate use should also include patients who seek these medications. Efforts are being made to stem the tide of patients trying to obtain prescriptions from multiple doctors for the same medication. The efforts have been led by the Food and Drug administration (FDA) reclassifying hydrocodone to a Schedule II controlled substance. Though the government has tried to enact legislation to mandate continuing education requirements for prescribers of Schedule II medications, none of the legislative bills have been enacted. However, several states have enacted such legislation.

Given that dentists prescribe a good number of opioids, it might be the time to take a hard look at prescribing practices. You can reduce the number of medications that could lead to misuse, and possibly addiction. You have the power to help curb this problem — it's in your prescription pad. ■

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WHAT YOU MUST KNOW!

Dr. James R. Schroeder

A graduating dentist came into my office last month to discuss life after graduation. He had been presented with a contract from a corporate dental provider, commonly known as a dental service organization (DSO) and wanted to discuss the opportunity with me. As a side note, this recent dental school graduate was encouraged to pursue a master's degree before applying to dental school. Now, six years later, he's married with two children and financially burdened with over $350,000 in educational loans. During his interview process with several private practices, he was not viewed as a strong candidate due to his heavy debt load and his limited clinical experience. His clinical experience consisted of 4 crown preps, 3 anterior endodontic procedures and very limited exposure to pediatrics, a skill set often desired by practices when seeking recent graduates.

Before I tell you the rest of this story, let me share with you the other side of this equation. After working with a number of private practitioners firsthand, I've gained insights into the very real and common challenges private practice dentists face when looking to bring on an associate. First and foremost, many dental practices today are now experiencing 25%-35% in insurance write-offs from their gross production leaving less revenue on the table to pay for an associate salary. The increasing number of negotiations between insurance companies and employers is taking place and the dentist is not at the negotiation table - yet he's the "featured item" on the menu.

Dentistry has become one the last arms of healthcare to avoid the tremendous power of leverage. Traditionally, we've operated as solo doctors or group practices. Medicine and pharmacy have long experienced the demise of mom and pop operations. Today, the solo doc and pharmacist are becoming part of our history.

The mindset as "clinician owners" is evolving to the mindset of "providers". This mentality shift is probably the most notable in recent graduates. For example, many young graduates are not only signing up for higher salaries made available by the DSOs, but they're also signing up for multiple insurance programs not realizing the poor reimbursement fees many are providing. Many practices I consult with are finding that their insurance write-offs are as high as 42%. This leaves 58% on the dollar to pay for staff, fixed costs and doctor salaries. This situation is further complicated by the many students who carry $200,000-$300,000 of educational debt, most of which is paid for by after-tax dollars. The financial status of practices today is literally being shaped by insurance companies who are bidding on employer contracts.

As these external forces occur, it's imperative that we understand the implications they have on each stage of the dental practice. Remember, venture capitalists are evaluating our industry from a business standpoint and they see amazing opportunities for increasing the bottom line.

DSOS RECOGNIZE THAT THEY CAN PROVIDE THE FOLLOWING:

1. Centralize and create business efficiencies that far exceed anything currently being utilized.
2. Leverage marketing dollars and using tested methodologies to bring in new patients into the dental practice.
3. Expand access to dental care by increasing operational hours and days that the facility will be open for business.
4. Reduce operational costs of supplies due to economies of scale.
5. Enhance the ability to provide benefits to employees, thus impacting the caliber of staff.
6. Provide strict adherence to budget line items.
7. Allow the dentist to focus on delivering patient care and the rapid changes taking place in technology, materials and throughout the industry.

SO WHERE DOES THAT LEAVE THE FUTURE OF SOLO PRACTITIONERS OR GROUP PRACTICES?

There is little doubt that the traditionally structured dental practices will continue to see increasing competition with DSO-"owned" practices for the foreseeable future. However, there are lessons to be learned from DSOs and opportunities to excel where DSOs are weak. Developing strong leadership skills, relationship building skills and word-of-mouth marketing enhanced by social media will be more critical than ever for the private practice. Likewise, hiring and retaining quality associates, hygienists, assistants, and support staff can help differentiate the private practice from DSOs. This is the Achilles' heel of many corporate practices as they cut staff salaries to increase profit. Spend time assessing the quality of the workplace culture you provide employees, and set aside your ego in inviting constructive criticism and ideas to grow. Ideas often come from the employees and may help owners more quickly figure out what works for the practice, patients, and specific location. It's important to recognize that in addition to the dentist's acumen, some may have an affinity toward leadership and staff development, while others may have an affinity towards marketing and business management. Very few dentists will have the unique ability to have or seek to excel in all three areas. As a result, I find many who are isolated within their four walls and wake up one day with a disturbing realization that they don't know what they don't know. The landscape surrounding suddenly looks foreign and is a far cry from the day he hung his dental license on the wall.

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SO HOW DID THE STORY END FOR THE YOUNG DENTIST CONSIDERING THE CORPORATE POSITION?

The young dentist ended up accepting the corporate dental position with a salary of $120k and benefits. The $10k/month is before taxes and his note payment for school loans is $3500/month. Along with the $120k annual salary comes an expectation for this young dentist to see between 40-45 patients a day. My recent follow-up with this gentleman revealed that his greatest challenge that he personally faces is his ability to deliver the quality of care he deeply desires to embrace.

WHERE DO WE GO AS AN INDUSTRY FROM HERE?

There are several areas for examination and strategic development using a collaborative approach.

1. Bring a balance of productivity and profit with assurance in quality patient care. The external forces of insurance companies and corporate entities must be included.
2. Address and examine the declining clinical experience in a 4-year doctoral curriculum with increasing debt; this must be acknowledged by multiple stakeholders.
3. Be open to growing your skill sets. Success in today's challenging world will require not only outstanding dental acumen but a keen understanding of business, marketing and leadership to navigate a successful and satisfying journey; these skills will also allow dentists to become leaders within their industry rather than be subjugated to large corporations who have a limited understanding of the complex world of patient care.

There are many lessons we can learn from corporate dentistry in today's world. In Virginia, in the last five years, two new corporate structures have been developed. There unique model has the dentist as the owner and decision maker within the corporate structure. Please take the time to visit their websites to learn about the exciting changes taking place in the delivery of private practice dentistry: Atlantic Dental Care (Virginia Beach) and Central Virginia Dental Care (Midlothian). These new models provide economies of scale often enjoyed by larger corporate structures. As professionals, we must stand strong and avoid passively watching our profession be shaped by outside forces. This is a unique opportunity for individuals and organized dentistry to be proactive in shaping our future.

What's important to understand today is that no matter where you are within your career journey as a dentist, there are and will continue to be, external forces actively changing the dental landscape. Yet, if you are an owner-dentist, you still have the greatest advantage of all: to proactively influence the change taking place in your environment.

Take time to examine the many new developments taking place and to be part of the solution as we move forward.

Editor's Note: Dr. James R. Schroeder practiced dentistry in Richmond and is the founder of Leadership by Design. If you have any questions or would like help implementing a change in your office, contact Dr. Jim Schroeder at 804-897-5900 jim@drjimschroeder.com

The American Dental Association has a wealth of information that can be helpful to understand the changes taking place. American Dental Association www.ada.org

DR. ASHLEY WHITE

My name is Ashley White. I am a recent graduate of LSU School of Dentistry in New Orleans, LA, the land of Mardi Gras and WhoDat Nation. I am currently practicing with Drs. Kirk and Justin Norbo in Purcellville, VA.

GIVE NEW GRADUATES AN AWESOME GIFT, A BRIGHT FUTURE

Dr. Bruce Hutchison; Chair, ADPAC; Chair, VADPAC

Returning home from speaking at the University of Washington's dental school graduation, I was reminded of the proverbial circle of life. The graduation ceremony brought back many wonderful memories of my own graduation, just as if it was yesterday. Then, when talking with the newly graduated doctors, I realized that I was able to answer many questions about their futures and was able to pass on some very important words of wisdom. I told each one how proud I was of them because I knew what it took to be able to finally walk across that stage. I also reminded them that as they close the door on this chapter of their life, a new chapter opens. It will not be easier or harder, but will just be different.

They are so eager to know their own future but, at the same time, so unsure of where the path will take them. Reflection brings so many unanswered questions. At the same time, I realized my own personal responsibility. My responsibility as a mature practitioner is to help them find their way, to be a mentor, to help pave the path for their successful future- just as others paved that path for me. It reminded me how important it is to be involved in the process of making certain that those who follow us will be successful in delivering the very best dental care to their patients. We understand the realities of government regulation, insurance company interferences and the consequences of unethical behavior. In other words, we must be involved and stay involved so that they will continue the greatness of this profession that has brought so much to each of us.

Not all this comes without a 'cost'. You must be involved in the political process. Legislators make decisions every day, both on the state and federal levels, that directly and indirectly affect how you and I, and our future colleagues, will practice dentistry. What is the price? A contribution to the VDA's political action committee (VADPAC) is the simplest way to make a difference. Simply writing a check helps guarantee our future. Think of it as a graduation gift to the newly graduating dentists. It will help give them hope for a future filled with success and not a future filled with more insurance regulations, mid-level providers and those outside our profession making decisions about us, professing they know best for us. Be part of the answer! Make a difference for the future of these young colleagues.

SEND YOUR GRADUATION GIFT FOR A FUTURE FILLED WITH HOPE TO:

Laura Givens
c/o VDA, 3460 Mayland Court #110
Richmond, VA 23233

Or

Go to http://www.vadental.org/advocacy/vadpac and download our contribution form.

DR. RUSS VILLIER

When not wrangling his kids down a mountain, Dr. V loves practicing in the Roanoke Valley. A Kentucky native, this Louisville grad is proud to be in Southwest Virginia serving his patients at two health clinics and in private practice.

VADPAC UPDATE

Laura Givens, Director of Legilative and Public Policy

VADPAC is $64,000 away from reaching the 2017 goal of $375,000! We MUST hit our goal- If VADPAC does not get the contribution support it needs from you and your component colleagues, the insurance companies could very well be emboldened to try to turn around our non-covered services and assignment of benefits laws that we worked very hard to pass years ago. Our charge to you is to not give our political foes the motivation or an ounce of reason to believe that the 2018 session will be the year to try an end-around on us in Richmond.

This is an important election year and we urge all members to contribute to VADPAC – don't ride the coattails of others who give year after year – step up and stand shoulder to shoulder with them. Please review the chart below to see how close your component is to reaching its goal. We applaud Southside Dental Society for already surpassing their goal by quite a lot and encourage our other components to follow their example!

Have you made your 2017 contribution to VADAPAC? If not, please contact Laura Givens at givens@vadental.org or 804-523-2185 to make your contribution today. Let's make 2017 a stronger year than ever for VADPAC!

WHEN YOU GIVE TO VADPAC, YOU ARE RAISING THE VOICE OF DENTISTRY.

Component	% of 2017 Members Contributing	2017 VADPAC Goal	Amount Contributed to Date	Per Capita Contribution	% of Goal Achieved
1 (Tidewater)	32%	$45,500	$29,870	$322	66%
2 (Peninsula)	40%	$27,500	$25,695	$360	93%
3 (Southside)	41%	$14,000	$19,470	$337	139%
4 (Richmond)	33%	$67,750	$66,195	$345	98%
5 (Piedmont)	36%	$30,000	$23,580	$290	79%
6 (Southwest VA)	55%	$25,250	$22,830	$331	90%
7 (Shenandoah Valley)	40%	$30,000	$28,517	$314	95%
8 (Northern VA)	32%	$135,000	$94,815	$333	70%
TOTAL	**40%**	**$375,000**	**$310,972**	**$329**	**83%**

TOTAL CONTRIBUTIONS: $310,972 • 2017 GOAL: $375,000 • MUST RAISE $64,028 TO REACH GOAL

VADPAC FUNDRAISERS

GEARING UP FOR THE 2017 ELECTIONS

Laura Givens, Director of Legilative and Public Policy

Three events for members of the Virginia General Assembly were held this spring and others are being planned for later this summer prior to the 2017 elections on Tuesday, November 7th. Members are encouraged to contribute and attend VADPAC challenge fundraisers as they are a wonderful opportunity to gather socially with your friends and colleagues while getting better acquainted with legislators in an intimate setting. VADPAC appreciates VDA member involvement in steering committees to make these fundraising events successful. Below are the fundraisers that we held this spring.

DELEGATE JOHN O'BANNON IN RICHMOND

Drs. Anne Adams and Charlie Cuttino hosted a VDA fundraiser for Delegate John O'Bannon at their home in Richmond on May 15th. Delegate O'Bannon represents House District 73, which includes parts of both Henrico County and the City of Richmond. A practicing physician, Delegate O'Bannon is one of only a handful of health care providers serving in the General Assembly. Dr. O'Bannon is a budget conferee and the Vice Chair of the House Health, Welfare and Institutions Committee. He is always an incredibly accessible and hard-working member of the Virginia General Assembly and has provided a consistently high level of leadership during his legislative tenure. Dentists from his district and surrounding areas were happy to attend this event to support Delegate O'Bannon and to have the opportunity to thank him for his hard work in the General Assembly.

HUGE TURNOUT FOR ADA'S FIRST DENTIST AND STUDENT LOBBY DAY

Laura Givens, Director of Legislative and Public Policy

The ADA combined its annual advocacy conference with the American Student Dental Association this year: the ADA Dentist and Student Lobby Day (formerly the ADA Washington Leadership Conference). Nearly 1,000 dentists, dental students, state association staff and other dental leaders attended the conference in DC on March 26-28. The Virginia Dental Association had strong representation with the following members in attendance: Dr. Dave Anderson, Dr. Alonzo Bell, Dr. Mark Crabtree, Dr. Terry Dickinson, Dr. Sam Galstan, Dr. Ralph Howell, Dr. Bruce Hutchison, Dr. Rod Klima, Dr. Michael Miller, Dr. Justin Norbo, and Dr. Kirk Norbo. Students from Virginia in attendance were Mr. Connor McCall, Mr. Craig McKenzie, Mr. Elham Dehyar, Mrs. Swathi Devaki, Mr. Johnny Kim, Mr. David Voth and Mr. Nicholas Yesbeck. These member dentists and students devoted much of their time away from patients and school to attend this important event and the VDA is very grateful for their participation.

The issues and bills addressed this year included The Competitive Health Insurance Reform Act of 2017 (H.R. 372), Student Loan Programs under the Higher Education Act and Health Care Reform: Support Oral Health. For more information on these issues and the status of these bills, you may visit the ADA's website or contact ADPAC staff at 201-898-2424.

SPEAKER-DESIGNEE KIRK COX FUNDRAISER IN COLONIAL HEIGHTS

Thanks to the leadership of Dr. Sam Galstan and Southside Dental Society members, the VDA hosted a wonderfully successful fundraiser for Delegate Kirk Cox on April 26th at the Swift Creek Mill Theatre in Colonial Heights. Over 40 VDA members, friends and guests were in attendance. Delegate Cox represents the 66th district, which includes part of Chesterfield County and the city of Colonial Heights. He has a profound understanding of how legislation and the budget impacts all health care providers and their patients and has provided a consistently high level of leadership during his legislative tenure. In February, the General Assembly House Republican Caucus unanimously elected him as the Speaker-Designee. Delegate Cox will be sworn in as the 55th Speaker of the Virginia House of Delegates next January and we look forward to that exciting day.

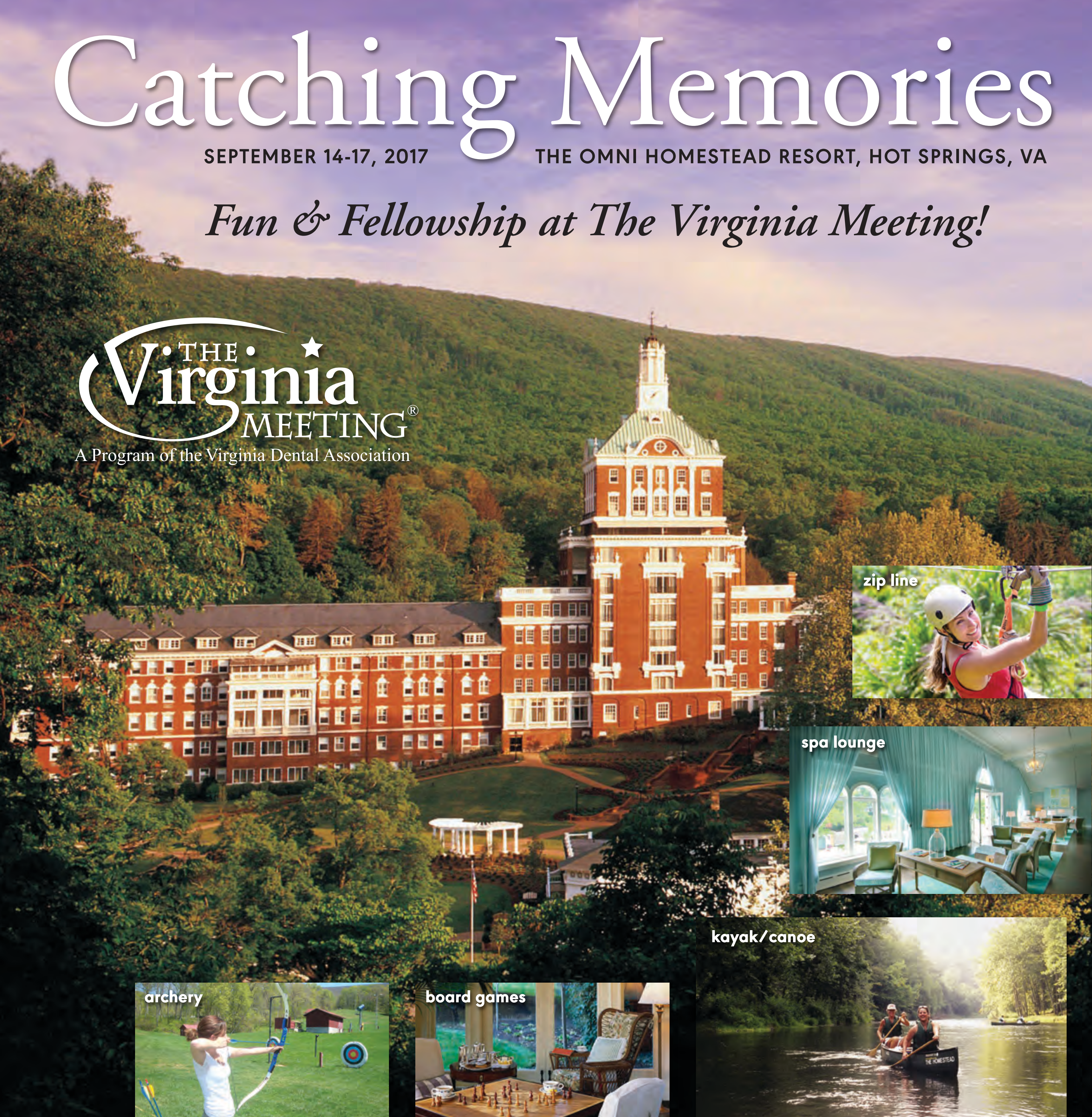
DELEGATE BOBBY ORROCK IN FREDERICKSBURG

On May 9th, the VDA hosted a fundraiser for Delegate Orrock at the Courtyard Marriott in historic Fredericksburg. Drs. Stan Dameron, David Huddle, Lloyd F. Moss, Jr. and Lloyd F. Moss, III helped make the event a success. Delegate Orrock represents the 54th district in the House of Delegates, which encompasses parts of the Counties of Caroline and Spotsylvania. As a senior member of the House, Delegate Orrock chairs the House Health, Welfare and Institutions Committee, which is the focal point for all health care policy matters coming before the House of Delegates. VDA members and guests in attendance were happy to be part of the event to help thank Delegate Orrock for his hard work as a member of the Virginia General Assembly.

Catching Memories

SEPTEMBER 14-17, 2017 THE OMNI HOMESTEAD RESORT, HOT SPRINGS, VA

Fun & Fellowship at The Virginia Meeting!



Believe it or not, The Virginia Meeting is more than just exceptional clinical and practice building CE – there's fun stuff, too! If you haven't already, register today and get ready for:

- A 15% discount for the spa!
- Golf, fishing, tennis and much, much, more!
- Three great sessions to help you leverage your practice for more down time
- Two spectacular signature events: The President's Party – Catching Memories & the VDAF Roaring Twenties Speakeasy

No matter what you choose, we hope you have a great time and we look forward to seeing you in September!

Registration Form (PAGE 1 OF 2)

SEPTEMBER 14-17, 2017

✓	Registration Type*	May 27 - August 25	On Site Sept. 13-17
	VDA Member Dentist	$325	$375
	VDA Member Dentist (1-3 years out of dental school)	$70	$85
	VDA Member Dentist (4-6 years out of dental school)	$160	$185
	VDA Member Dentist (7-9 years out of dental school)	$245	$285
	ADA Dentist (Non-VDA)	$470	$530
	NON-Member Dentists	$705	$745
	Active Military Dentists (Non-VDA)	$300	$350
	ODDS Member Dentist (Non-VDA)	$325	$375
	Retired Life VDA Member	$0	$25
	Assistant	$80	$85
	Office Staff	$80	$85
	Lab Technician	$80	$85
	Hygienist	$80	$85
	Spouse/Guest of Registrant	$45	$50
	Guest (ages 12 and under)	$20	$25
	Student (Dental, Hygiene, Assisting)	$0	$0
	Exhibitor	$0	$0

Please use this page and the next to register for the **2017 Virginia Meeting**. Please note that each registrant will require a separate form. Feel free to make copies of this form as needed.

**membership verification required*

Registration Sponsored by

Virginia Meeting App

☐ Again this year, a Virginia Meeting App will be available, which will include all content normally in the onsite brochure. If you plan to continue utilizing the paper brochure, please check this box and we will print one for you. If you do not check the box, you are indicating that you would prefer to use the app instead.

Virginia Meeting Mailing List

☐ I would like to **OPT OUT** of the Virginia Meeting mailing list. Leave blank if you would like to be included in meeting communications.

Annual VDA Golf Tournament

Code **S47** - *Additional Information*

Handicap: ______________________

I would like to be grouped with the following players:

____

____

____

Prefix: Mr. Mrs. Ms. Dr.

**Required*

*First Name: ______________________

*Last Name: ______________________

Company Name: ______________________

Specialty: ______________________

Component: ______________________

*Phone: ______________________

*Mailing Address: ______________________

____

Membership #: ______________________

*Email: ______________________

Total Cost $

❑ VISA ❑ MC ❑ AMEX

Expires: ______________________

Card#: ______________________ 3 or 4 digit code: ______

Name on Card: ______________________

Address on Credit Account: ______________________

____

Signature: ______________________

Print Name: ______________________

*Emergency Contact Name: ______________________

*Emergency Contact Phone: ______________________

In case of refund, check should be made payable to: ______________________

If paying by check, make payable to VDA • **Mail:** The Virginia Meeting c/o Custom Registration, 2001 E. Randol Mill Road, Suite 135, Arlington, TX 76011 • **Phone:** (817) 277-7187 • **Fax:** (817) 277-7616 • **Online:** www.vadental.org

Refund and Cancellation Policy: All refunds must be submitted in writing by August 25, 2017. Conference badges and materials must accompany request. All refunds are subject to a 20% charge per total registration fee that will be processed within 15 business days to the primary registrant. The 20% fee will be calculated based on the original registration total. Refunds will be processed via check to the original payee within 10 business days for receipt of request.

No refund requests will be accepted after August 25, 2017.

Registration Form (PAGE 2 OF 2)

Please register for any course, activity, or event you would like to attend to be granted access.
(✓ check corresponding box)

THURSDAY, SEPTEMBER 14, 2017

✓	Code	Course Title/Topic	Speaker/Event Host	Time	Cost	Credits
	T1	Pierre Fauchard Breakfast	Pierre Fauchard Members	6:30am-7:30am	$45	–
	T2	Solving Ten Major Challenges in Dentistry – 2017 (includes a boxed lunch) **Circle Type: Chesapeake Classic Vegetarian Italian Deli**	Dr. Gordon Christensen	7:30am-3:00pm	$45	7
	T3	Endodontic Diagnostics and Treatment Planning: Anesthesia, Access, Isolation	Dr. John Olmsted	12:30pm-3:30pm	$0	3
	T4	Exhibit Hall Opening Reception	VDA	3:00pm-5:00pm	$0	–
	T39	Addiction and Opioid Epidemic: Current Concepts and the Role of the Dentists	Dr. Omar Abubaker	3:30pm-5:30pm	$0	2
	T5	Fourth Annual VDA Ping Pong Tournament	VDA	4:30pm-8:30pm	$20	–
	FRIDAY, SEPTEMBER 15, 2017					
	F11	AGD Breakfast	Academy of General Dentistry	7:00am-8:00am	$0	–
	F12	Use Online Rating Sites to Promote Your Practice	Mrs. Emily Shane	9:00am-11:00am	$0	2
	F13	Stay Out of Jail: Avoid Coding Errors and Excel in Insurance Administration	Dr. Charles Blair	9:00am-12:00pm	$0	3
	F14	Update on Biochemical Irrigation, Rotary/Reciprocation Instrument...	Dr. John Olmsted	9:00am-12:00pm	$0	3
	F15	From Risk to Results: Periodontal Instrumentation for the Advanced Practitioner	Mrs. Theresa Johnson	8:00am-11:00am	$0	3
	F16	Online Marketing 101: Selecting Strategies, Building a Plan & Measuring Success	Mrs. Cheryl Pederzoli	8:00am-11:00am	$0	3
	F17	Come in and Catch it, the Review that Sticks	Dr. John Svirsky	9:00am-12:00pm	$0	3
	F18	Boxed Lunch Pick-Up **Circle Type: Chesapeake Classic Vegetarian Italian Deli**	VDA	11:30am-1:30pm	$37	–
	F19	VDA Fellows Lunch	VDA Fellows	12:00pm-2:00pm	$35	–
	F20	Cutting Edge Endodontics Highlighting Negative Apical Pressure Irrigation...	Dr. John Olmsted	1:00pm-4:00pm	$75	3
	F21	Financing Multiple Dental Offices	Mr. Josh Contrucci & Mr. Mohamed Abdullah	1:00pm-4:00pm	$0	3
	F22	Unveiling the Mystery of Caries Management: What's the Secret?	Mrs. Theresa Johnson	1:00pm-4:00pm	$0	3
	F23	The HPV Vaccine and Other New Approaches for Fighting Oral Cancers	Dr. Iain Morgan	1:00pm-4:00pm	$0	3
	F24	Luxurious Travel Demystified-How to Turn Your Practice into Free Travel	Dr. Bruce DeGinder & Mr. Lucian Sarega	1:00pm-4:00pm	$0	3
	F25	Use Online Rating Sites to Promote Your Practice	Mrs. Emily Shane	1:00pm-3:00pm	$0	2
	F26	Exhibit Hall Closing Reception	VDA	3:00pm-5:00pm	$0	–
	F27	VDA New Dentist and Dental Student Reception	New Dentist Committee	5:00pm-6:00pm	$0	–
	F28/F28A	VDA President's Party – Catching Memories	VDA	7:00pm-10:00pm	$65/$30	–
	SATURDAY, SEPTEMBER 16, 2017					
	S33	ICD Breakfast	ICD	7:30am-8:30am	$25	–
	S34	Tips and Tricks (and Warnings) for Online Marketing Success	Mrs. Cheryl Pederzoli	8:00am-11:00am	$0	3
	S35	Use Online Rating Sites to Promote Your Practice	Mrs. Emily Shane	9:00am-11:00am	$0	2
	S36	The Future of Dentistry	Dr. Charles Blair	9:00am-12:00pm	$0	3
	S37	Restoration of the Endodontically Treated Tooth, and Postoperative Care...	Dr. John Olmsted	9:00am-12:00pm	$0	3
	S38	Can I Upgrade with My Miles? Understanding the World of Travel Loyalty Programs	Dr. Bruce DeGinder/Mr. Lucian Sarega	9:00am-12:00pm	$0	3
	S40	Conquering Adhesion Dentistry & the Direct Posterior Composite Esthetic Restoration	Dr. Alan Atlas	9:00am-12:00pm	$0	3
	S41	It's More than Physical and Other Love Stories	Dr. John Svirsky	9:00am-12:00pm	$0	3
	S42	OSHA – What's New and What Do I Have To Do?	Ms. Leslie Canham	9:00am-12:00pm	$0	3
	S43	Boxed Lunch Pick-Up **Circle Type: Chesapeake Classic Vegetarian Italian Deli**	VDA	11:30am-1:30pm	$37	–
	S44	Travel "Secrets" Unleashed for Hassle Free Travel	Dr. Bruce DeGinder/Mr. Lucian Sarega	1:00pm-4:00pm	$0	3
	S45	Enhancing the Esthetics & Function of High Strength All-Ceramic & CAD/CAM Restorations	Dr. Alan Atlas	1:00pm-4:00pm	$0	3
	S46	HIPAA – What's New and What Do I Have To Do?	Ms. Leslie Canham	1:00pm-4:00pm	$0	3
	S47	Annual VDA Golf Tournament	VDA	1:00pm start time	$175	–
	S48	VDAF Roaring Twenties Speakeasy	VDAF	7:00pm-10:00pm	$75	–
	SUNDAY, SEPTEMBER 17, 2017					
	Sun42	Past Presidents' Breakfast	VDA	7:00am-8:00am	$0	–

Your Name: ______________________________ **Total Cost** $

REGISTER ONLINE: WWW.VADENTAL.ORG/EVENTS/VIRGINIA-MEETING

A GOLFER'S DREAM

Dr. Marcel Lambrechts

When I think of golf at the Homestead it always puts a smile on my face. The breath-taking vistas, beauty of the surrounding foothills and the play-ability of the courses that are always rated as some of the best in the country make it a must for my wife and I to enjoy during our stays. They have two amazing courses. I have played both the Old Course and the Cascades course and love both of them for different reasons.

The website describes the Old Course like this…"The Omni Homestead Resort's Old Course was completed in 1892 and is distinguished as home of the nation's oldest first tee in continuous use. As the game has evolved over time, so too has the Old Course – updates by William S. Flynn and Rees Jones have kept pace with the times. Abundant fairway contouring gives most shots a side hill, uphill, or downhill lie to smallish greens, making approach shots interesting".

What they don't tell you is that the old course has five par 5s and five par 3s which make this 6055 yard par 72 a really fun course. Many of the par fives are reachable with two good shots and you may have more than one eagle putt in the same round! One thing for sure is that you will have more birdie chances on this course than many you will ever play. The fairways are nice and lush and the rough is playable making it even more enjoyable. By the way…don't miss the secret overlook behind the 14th tee! My wife and I have also seen a family of bears parading across the 10h fairway so keep your eyes peeled for nature at every turn!

The Cascades course is one of the nicest places you will ever play golf. This is the fabled course where Sam Snead became the legend of the region. This course is so amazing that every blade of grass has been seemingly hand trimmed and the fairways have the "baseball outfield" mower trim treatment all around the course. The greens are like soft felt carpets and the bunkers are immaculate. Having said that, the course at Par 70 is more challenging than the Old Course. The rough is more penalizing and the added length (6600 yards) makes for demanding second shots. It is a tour quality course that will be one of your all-time favorites as you become more familiar with it. With the Par set at 70, even if you have a "bogey-a-hole round" you will still break 90! They do have nice complementary shuttles to take to the course and back and they will transfer your clubs for you as well.

The practice facility is simply beyond compare. It is a short walk or cart ride up the hill to the grass tees where the complementary balls await. There are chipping greens at the top of the hill with dramatic views of the resort. Likely, you and your wedges will be alone at the top of the hill with nary a worry as you perfect your short game. They do offer lessons and rent clubs. If you are just learning the game this is definitely a great place to take in some quality golf instruction.

On Saturday of this year's Virginia Meeting (September 16), we are going to hold a **FUN** VDA golf tournament. It has a 1:00 p.m. shotgun start and we are playing the illustrious Old Course. It will be a Captains Choice and we will have lunch and prizes for all of the players and winners. *For the less savvy golfers and folks with a killer putter, be on the lookout for a putting tournament with complementary beverages during the meeting as well.*

I look forward to seeing you "on the course" after you have been "in the course". Make sure you enjoy all the amenities the Resort has to offer!

Editor's Note: Dr. Lambrechts is a member of the VDA Council on Sessions, and practices in Sandston.

OPEN BITE

HOMESTEAD'S MATT THOMAS HELPS ANGLERS MAKE CONTACT WITH FISH

Dr. Roy L. Wolfe

"Take a few steps back." I'd hooked a large rainbow trout and my guide, Matt Thomas, hoped to get closer with the net. Following instructions, I backpedaled and landed in six inches of water. Despite the comic relief the fish remained hooked, and I returned to a standing position. Moments later, Matt slid the net under a rainbow nearly 18 inches long. The moral: always follow your guide's instructions.

Matt Thomas, an Orvis endorsed guide, has spent the last seven years teaching fly fishing and guiding anglers on The Homestead Resort's Cascades stream. This woodland gem is stocked with two species of trout, rainbow and brown, and there's a healthy population of wild, naturally reproducing fish. There's plenty of opportunity to hook and land fish, even for first-time anglers.

Matt says almost half of his clients have never fly fished before, so some instruction is needed. I asked what was the biggest challenge for first-time students. It's not fly casting, that arcane series of motions that defies the laws of physics. He said it was a combination of setting the hook, and learning to play (or land) the fish. Both require a certain degree of finesse, a trait that's also essential to clinical dentistry. Matt said he could teach basic fly casting to a novice in about 30 minutes, and allow experience to teach them the details.

The Cascades is a small "freestone" stream (meaning it flows over rocks and hard strata) and wading, although necessary, is minimized to avoid scaring the fish. All fishing there is catch-and-release: a quick photo of a fish held by wet hands, followed by the return of the fish unharmed. This policy ensures opportunity for others who follow.

I also asked Matt a philosophical question: What's the greatest reward of fly-fishing? He reminded me it's not all about the fish. He said fishing for many was a form of meditation, a discipline much like zen, where total concentration is required and distractions are shut out. With its spectacular scenery, fifteen foot waterfalls, and stair-step plunge pools, the Cascades Gorge doesn't give visitors much chance to think about the world outside. As an added bonus, there's no wireless service in the gorge, voiding the temptation to check emails or text messages.

For many, fly fishing is intimidating. The gear, the terminology, the nuances can seem overwhelming. Yes, much like a bonded resin restoration on the interproximal surface of a maxillary second molar, it's technique sensitive. But a good instructor like Matt Thomas can introduce you to a sport that draws upon dentists' many skill sets. Call (540) 839-7760 to schedule, or e-mail mattthomas101010@gmail.com. Take a step back and learn one of the world's oldest, but most rewarding sports.

Editor's Note: Dr. Wolfe practices general dentistry in central Virginia.

SHOOTING SPORTS AT THE OMNI HOMESTEAD RESORT

Dr. Mark A. Crabtree

Our family first visited the Homestead Resort when we accompanied our church's youth group on a ski trip. Rebecca and I immediately fell in love with Bath County and America's First Resort. Since then we have made the The Homestead one of our family's vacation "homes".

The unique character of this fantastic resort is reflected in its name The "Home"stead. It is certainly a home away from home and a wonderful environment for families including small children. Beyond the fantastic accommodations and glorious dining, there are first class outdoor activities for every member of your family. Golf, tennis, hiking, biking, snow skiing, ice skating, zip lining, equestrian activities, swimming, taking in the hot springs and a world class spa are some of the leisure interests that can be enjoyed.

My favorite activity is sporting clays. Here I received my first formal training in the sport from David Judah, the Director of The Homestead Shooting Club. This historic gun club hosted the first-ever U.S. Open Sporting Clays Championship in 1992 but its history goes back to 1933. The Homestead's wooded courses simulate many types of game birds and rabbits. I like to describe the sport as golfing with a shotgun. The numerous stands present different targets to challenge each person's skill. A great service is that Certified N.S.C.A shooting instructors are available here to help you improve your game regardless of your level of expertise.

One of my favorite memories is taking my daughters to the Shooting Club for their first shooting lesson. They had long expressed an interest in learning how to shoot and asked for a pink shotgun. I couldn't find an appropriate sporting clays shotgun in pink so they had to settle for a pink camo case with a nice 28 gauge. David Judah took my daughters, Sarah and Virginia, and Dr. Edward "Chopper" Snyder's daughter Katie out on the skeet range and properly introduced them to a great sport to safely enjoy for the rest of their lives. I'll never forget the excitement they had busting their first clays and I love the pictures from that day. This year while attending the Virginia Meeting plan to set aside some time to enjoy a fantastic sporting clays course or take a lesson and learn a fun and exciting new sport. Offerings at the Shooting Club include: four skeet fields, two sporting clays courses (weather permitting), trap and five-stand courses. Guns, ammo, vests, and eye and ear protection and Group and private lessons are available with advance reservations. Call (540) 839-7787 to schedule a time to enjoy this great sport.

Editor's Note: Dr. Crabtree, a VDA Past-President, practices in Martinsville

DR. MCKENZIE WOODARD

Previously an associate and now a Partner at Commonwealth Dentistry, a group practice with offices throughout the Greater Richmond Region. We focus on comprehensive care and enjoy working with our patients to connect overall wellness with dental health.

FALCONRY - ONE FOR THE BUCKET LIST...

Dr. Cassidy Turner

Have you always wanted to try what is thought to be the oldest sport in the world? Did you ever find yourself sitting in that high school English class wondering what William Shakespeare was talking about when he would repeatedly mention a female character was a haggard hawk? Were you fascinated when you found out that the fastest animal in the world, a peregrine falcon, could go over 200 mph? Or are you one of those individuals that thought holding a bird wearing an eccentric little leather hat with tassels was a bucket list worthy experience? If any of these thoughts have ever crossed your mind then perhaps you were destined to be a falconer. The Homestead Resort, which is the location for the 2017 and 2018 VDA Annual Meeting, offers you the opportunity to channel your inner bird whisperer and try your hand at falconry.

So what can you expect when you sign up for this unique experience? The morning of my falconry class I quickly learned that the birds that were living in the mews (a luxury housing complex for the birds of prey) were similar to me in a number of ways. The birds were sitting in their house squawking loudly, letting our group know that they were hungry, perhaps even hangry, and it was feeding time. A Harris's Hawk was selected because apparently this bird species is considered cooperative by raptor standards and are therefore used for the beginner falconer. The falconer got the bird dressed in her hunting outfit which consisted of the highly anticipated eccentric little leather hat, disappointingly only known as a hood, as well as a leather anklet and strap.The birds are highly food motivated and somewhat lazy so they follow the falconer to get their food. Who among us doesn't like a free delicious effortless meal? As it turns out these birds and I also have a similar palate, we both enjoy chicken. I prefer my chicken grilled while the hawk seemed to be impatient and preferred her chicken raw, fed to her out of a leather gloved hand. As long as the bird we were working with was hungry she was cooperative and would follow the falconer or whoever was wearing the leather feeding glove. We were able to interact with the hawk and she flew effortlessly back and forth between the participants following the gloved hand containing her meal. The falconer leading this course knew her bird well and was monitoring the hawk's food intake while educating us about the history and techniques of falconry. Nearing the end of the class the hawk started to become less cooperative. This was the signal to the falconer that she was full and it was time to put her hood back on and return to the mews. All of the group members had the opportunity to take photographs with the bird and ask the falconer any questions that could be thought of during the class. I enjoyed my beginner falconry class so much that I immediately signed up for the intermediate falconry class the following day. So if you are looking to take a journey 4000+ years back in time, engage in the sport of kings, have the most unique Facebook profile picture, or cross off that bucket list item then drop what you are doing and sign up for the falconry class at the Homestead and you will not be disappointed.

Editor's Note: Dr. Turner is a member of the VDA Council on Sessions and practices in Richmond.

DR. HALEY HAUSSER

Graduated Magna Cum Laude from the University of Maryland and then completed a 1 year GPR program at the DC VAMC. Since, I've been happily practicing comprehensive dentistry in private practice at Mt. Vernon Center for Dentistry in Alexandria.

Outreach

VDAF BUILDING COMMUNITY SUPPORT

Tara Quinn, VDA Foundation Executive Director

This year, the VDAF has made great strides toward strengthening its community support and increasing awareness of its impact on serving Virginia's most vulnerable populations. Going into its first year independent of VDA and VDSC financial support, a broadening base of corporate, foundation, and individual donors is now taking form.

Finally, the VDAF was just awarded a grant from the Richmond Memorial Health Foundation to develop a strategic communications plan in order to ensure the long-term success and sustainability of the organization. The grant supports engagement of a communications consultant to assist with this initiative in order to enhance awareness of the VDAF's mission, programs, and impact.
This year, the VDAF also celebrates the 20th anniversary of the Virginia Donated Dental Services (DDS) program. Since its inception in 1997, DDS has provided vital dental treatment to over 3,900 low-income seniors and disabled Virginians with a total value of care of over $12 Million. To recognize these achievements and strengthen the program for the future, we are working to raise $20,000 this year. Caring for this vulnerable population's complex dental needs requires retaining the sensitive and competent staff who shepherd these cases through our nearly 600 dedicated volunteer dental offices every day. Help us to continue facilitating this life-changing care by donating to the "$20,000 for 20 Years" Campaign today. Contact Tara Quinn at 804-523-2181 for more information or visit http://www.vdaf.org/how-to-donate-to-vdaf.html to donate now.

2017 GRANTS AWARDED

- Richard & Caroline T. Gwathmey Memorial Trust for Missions of Mercy (MOM)
- Sentara Healthcare & Optima Health for the Yorktown MOM project
- United Concordia Dental for MOM
- Richmond International Raceway/RIR Cares for MOM
- The Smiles for Life Foundation
- The Jenkins Foundation for Richmond Donated Dental Services (DDS)
- Virginia Department of Health for MOM
- Henry Schein Care Global Production Donation Program for MOM

YORK HIGH SCHOOL SITE FOR MARCH MOM PROJECT

York High School in Yorktown was the site for the first Peninsula Mission of Mercy project held on March 24-25th. Some 543 patients received dental care valued at nearly $500,000. Free dental services provided included 77 cleanings, 549 fillings, 995 extractions, 18 root canals, 15 crowns and 20 full sets of dentures. Over 400 volunteers gave of their time and talents and made Peninsula MOM possible.

We thank Dr. Bryan Geary for his leadership and the Peninsula MOM Planning Team for making the project a success!

RICHMOND AREA PARTNERSHIPS

Julie Ericksen, Program Manager, Donated Dental Services

One of the wonderful things about the Donated Dental Services program is that we are uniquely positioned to leverage dental care for the needy in the Richmond area. Through our kinship with the VDA, we have long-established contacts and relationships. For example, Dr. Terry Dickinson, Executive Director of the VDA, has a project at the Virginia Home to provide dental care for patients there, along with a couple of colleagues and VCU senior dental students as part of their community service rotation. This of course also serves as a unique and challenging training field for the students.

The Virginia Home provides loving, lifelong residential care to adults with permanent physical disabilities. Many of the residents there are profoundly disabled and all qualify for our Donated Dental Services program. When the needs of the patient move beyond the capacity of Dr. Dickinson's team to care for them within the Virginia Home, we manage the connection of the patients to local dental practitioners and labs outside of the Virginia Home.

M&M (her nickname) is one particular resident living at The Virginia Home that we supported through Donated Dental Services. M&M has no arms and no legs. We connected her with Dr. Karen McAndrew's office in the Richmond area for her general dentistry needs, Dr. Thomas Eschenroeder of Commonwealth Oral and Facial Surgery for her oral surgery needs, and Colonial Dental Laboratory for her lab work. Dr. McAndrew's office was delighted with the patient and M&M was able to take advantage of the unique skills of a talented prosthodontist, oral surgeon and lab.

Here is a note I have from their office: "The visit with Ms. ----- went very well. She is such a pleasant person. We will eventually need a lab and an oral surgeon for her to extract her maxillary teeth. Dr. McAndrew is looking into making a separate appliance with a wand just for her to use as an appendage."

That is another wonderful thing about our program – we work with dentists who are donating their care pro bono. A dentist who is willing to provide pro bono care to our patients is generally a very kind and enthusiastic dentist and is likely doing well enough financially to feel comfortable giving away care. Therefore, they are top-notch dentists and garner rave reviews from our patients. Our patients have the benefit of treatment in the finest dental offices in the Richmond area.

We make it easy for these dentists by brokering the outside work of labs and specialists needed for the patient. They simply have the joy of exercising their craft in their offices for patients who are deeply needy and they don't have to worry about asking for favors of others to complete the care they have started – we do all of that for them! We eliminate the hassle, we confirm the patients they treat are truly needy, and if the patient is non-compliant, we make those difficult phone calls.

Because of our relationship with the VDA, we are also an integral part of the Virginia Meeting, which happens once per year hosting member dentists across Virginia. At this large meeting, we have the opportunity to meet, interact, and thank our volunteer dentists directly as well as to recruit new dentists. We use the opportunity of the meeting to provide a gala fundraising event, which is fun and helps us build the strong partnerships with dentists that make our program so successful.

Other partners with which we successfully team in the Richmond area to make their and our work more effective, is Lucy Corr Village and the VCU School of Dentistry. We have used creativity and partnerships to enhance the offerings of any one of these organizations to be more effective for the Dental Safety Net and the truly needy in Virginia.

COMMUNITY UNITES FOR 11TH NOVA MOM

James Willis, DDS

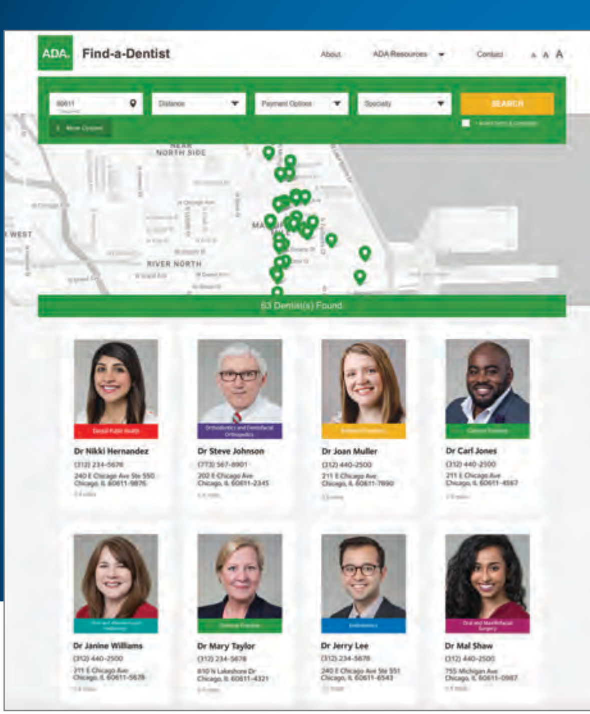
Dentistry is a unique profession in that dentists like to help each other and enjoy helping community members who simply do not have routine dental care. It's a privilege to be in a position to help people in need.

The Northern Virginia Dental Society (NVDS) hosted on the 10th and 11th of March 2017 our 14th Mission of Mercy (MOM). The event was held at the Northern Virginia Community College (NVCC) medical education campus in Springfield. We had strong support from our member dentists as well as hygienists and dental assistants. We were also joined by a couple hundred community volunteers who were excited to contribute in whatever way they could, from helping patients with registration, to escorting patients through the clinical areas, to translating into a slew of languages, and providing food and drinks to volunteers. With such wonderful volunteerism, and with such a strong team of leaders, chairing the committee is a joy and we were able to provide much-needed dental care to a wonderful portion of our community.

Senator Dave Marsden, Representative Eileen Filler-Corn of the 41st District, and Chairwoman of the Fairfax County Board of Supervisors, Sharon Bulova, all showed their support of MOM by visiting during the event. We also received media coverage from CBS, NBC, the Fairfax Times, and other local reporters.

We are very grateful to have been able to take advantage of the exceptional facilities of the Medical Education Campus of the Northern Virginia Community College. It is genuinely heart-warming to participate and witness such a large community coming together to provide services to those in need.

We are particularly thankful that we were able to use MOM to provide our community members information regarding our two Northern Virginia Dental Clinics that are available for their use in Fairfax and Sterling.

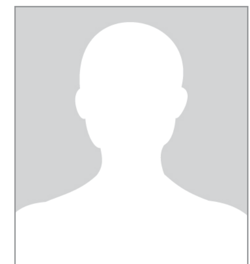


5 Minutes Today, More Patients Tomorrow with the NEW **ADA Find-a-Dentist®**

Exciting news! The ADA is launching a new consumer advertising campaign to bring more patients to you. Over the next 3 years, the ADA is investing $18 million on paid search and digital ads that drive prospective patients to the **NEW ADA Find-a-Dentist®** tool. Don't miss out on new patients — update your profile today at **ADA.org/findadentist**. It only takes 5 minutes.

The best way to stand out in search results is to make sure your profile has the information patients look for most:

- Photo
- Business address
- Office hours
- Practice email
- Payment options
- Insurance types
- Languages spoken



Which dentist would you choose?

Profiles with photos show up near the top of the search results and get **11 times more clicks** than those without. Don't be photo shy — upload a photo today!

Visit **ADA.org/findadentist** to update your profile and access resources to help promote your practice.

ADA American Dental Association®

VIRGINIA BOARD OF DENTISTRY UPDATE

Karen S. McAndrew, DMD, MS

Another productive meeting with the Board of Dentistry (BOD) reveals further insight into the many purposes of this organization. A working collaboration with patient safety and excellence in all aspects of dentistry is at the heart of its purpose. The BOD met on Friday, June 9 for their quarterly meeting. High on the priority list was the Opioid Crisis in Virginia and the regulations imposed on dentists when prescribing medication with a high propensity for addiction. Often addiction surfaces after abuse of prescription drugs.

Dr. David Brown, Director of the Department of Health Professions, commended the BOD on their great work putting together the opioid prescribing emergency regulations. A workgroup creating a curriculum for pain management courses will soon convene and the opioid e-prescribing requirement is set to take effect in 2020. Dr. John Alexander discussed the opioid prescribing emergency regulations that dentists should familiarize themselves with. There has also been recent attention on the addiction problem facing the elderly. The BOD approved the requirement for dentists to complete 2 hours CE by March 31, 2019 regarding the opioid crisis management. This regulation will go into effect when the Governor signs the new emergency regulation.

The dental hygiene remote supervision law becomes effective on July 1, 2017. A Guidance Document must be developed to indicate and provide consistency in the educational course content for those dental hygienists wanting to be part of this program. No one can practice under this statue until the course content is clearly defined and course requirements are met. These Guidance Documents will be forthcoming. Dr. Wyman pointed out that the current DAII certification will continue to be evaluated by the Regulatory-Legislative committee. The goal is to encourage people to pursue the designation of DAII while simultaneously protecting the public.

Virginia is cited as being very progressive at encouraging licensure and transportability among the states. The BOD discussed adding a PGYI (Post-Graduate Year One) Pathway for Licensure and decided to require the program in Virginia to be 12 months (June-June). Licensure will continue to be a hot topic within the ADA. Similarly, on the education topic, Dr. Rizkalla presented the ADA's Development of a National OSCE (Objective Structured Clinical Examination). He did not agree with the ADA's push for the development of OSCE since it does not include patient based clinical examinations. The BOD determined that more research is needed into the most appropriate language for Virginia's "clinical examination" requirements. They will continue to keep the community updated.

There were other noteworthy discussions that members of the dental community are encouraged to be familiar with. The BOD noted that certain issues continue to require more extensive examination and discussion. These include The Dental Water Quality Report and the amount of biofilm in dental units. Federal regulations also need to be addressed involving care credit and how to protect the public. The Attorney General of Virginia clarified expert witness designation regarding cases brought to the BOD. Ongoing investigation will continue regarding tracking of CE and the community will continue to be updated on the progress of monitoring the necessary annual CE requirements.

The quarterly meetings by the BOD are an informative session open to the public, which compiles all of the works/meetings/recommendations and actions performed. I encourage all members of the dental community to come to a BOD meeting to witness, first hand, the many hours of work and deliberation that go into regulating dentistry to encourage its positive progression as new laws/regulations/techniques and situations arise. It is a group dedicated to the progression of dentistry while overseeing the safety and well-being of the public. I look forward to seeing you at the next BOD meeting as we gain an appreciation for the hard work and dedication that goes into managing clinical practice with oversight. I will save your seat!

Editor's Note: Information contained herein is for the benefit of our readers, and is deemed reliable but not guaranteed. All VDA members are advised to read and comprehend Virginia Board of Dentistry policies and regulations.

DR. MILAN SIMANEK

My Fairfax City family practice offers general dentistry, oral surgery, implants and braces. I provide excellent care with new 3-D CBCT technology. I've achieved Tier Advancement in the AOS and IAO and I lecture to doctors throughout the U.S.

MEET THE CANDIDATES

VOTE ONLINE AT **WWW.VADENTAL.ORG**

CANDIDATE FOR OFFICE OF PRESIDENT ELECT

DR. SAMUEL GALSTAN

CANDIDATE FOR OFFICE OF SECERETARY/TREASURER

DR. TED SHERWIN

CANDIDATE FOR OFFICE OF ADA DELEGATE

DR. BRUCE HUTCHISON

DR. FRANK IUORNO

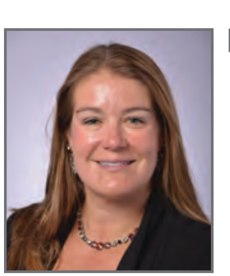
DR. RODNEY KLIMA

DR. RICK TALIAFERRO

CANDIDATE FOR OFFICE OF ADA ALTERNATE DELEGATE

DR. PAUL OLENYN

DR. DANIELLE RYAN



DR. CYNTHIA SOUTHERN

DR. STEPHANIE VLAHOS

WELCOME NEW MEMBERS

Karen Clendenen, VDA Membership and Meeting Coordinator

TIDEWATER DENTAL ASSOCIATION

Katherine Carson – Suffolk – West Virginia University School of Dentistry 1996

Sarah Groy – Virginia Beach – Temple University The Maurice H. Kornberg School of Dentistry 2011

Ronald Kondoff – Virginia Beach – University of Kentucky College of Dentistry 1985

Peter Kuenzli – Virginia Beach – Virginia Commonwealth University School of Dentistry 1988

Marco Lopez – Norfolk – Case Western Reserve University School of Dental Medicine 2016

Allen White – Virginia Beach – Virginia Commonwealth University School of Dentistry 1998

PENINSULA DENTAL ASSOCIATION

Shanail Allen – Toano – Howard University College of Dentistry 2006

Aaron Iverson – Williamsburg – University of Minnesota School of Dentistry 2014

Yujin Jung – Newport News – Loma Linda University School of Dentistry 2014

Preston Loving – Newport News – Virginia Commonwealth University School of Dentistry 1983

Sara Luke – Williamsburg – University of Iowa College of Dentistry 2016

Anthony Martin – Yorktown – Virginia Commonwealth University School of Dentistry 1996

SOUTHSIDE DENTAL SOCIETY

Lori Ha – Richmond – Virginia Commonwealth University School of Dentistry 2013

RICHMOND DENTAL SOCIETY

Surya Dhakar – Glen Allen – Virginia Commonwealth University School of Dentistry 1999

Lavanya Tortiker – Glen Allen - Boston University Goldman School of Dental Medicine 2016

PIEDMONT DENTAL SOCIETY

James Burton – Lynchburg – University of Louisville School of Dentistry 2014

Allison Moala – Roanoke – University of Pennsylvania School of Dental Medicine 2015

Kristina Staples – Farmville – Virginia Commonwealth University School of Dentistry2009

SHENANDOAH VALLEY DENTAL ASSOCIATION

Blaine Bohrer – Strasburg – West Virginia University School of Dentistry 2002

Jennifer Chalker – Timberville – Loma Linda University School of Dentistry 2004

Erika Santos – Charlottesville – New York University School of Dental Medicine 2015

Sarah Summers – Charlottesville – University of Louisville School of Dentistry 2017

NORTHERN VA DENTAL SOCIETY

Azita Abbasi-Hafshejani – Sterling – University of TX Health Science Ctr.-San Antonio Dental School 2008

Henry Dean – Loudoun – New York University School of Dental Medicine 2003

Laura Ki – Fairfax – Virginia Commonwealth University School of Dentistry 1993

Minh-Tam Le – Falls Church – Howard University College of Dentistry 2015

Michael Paesani – Falls Church – University of Pittsburgh School of Dental Medicine 2007

Amar Patel – Herndon – University of Pennsylvania School of Dental Medicine 2006

Angela Pohuja – Arlington – University of Connecticut School of Dental Medicine 2015

Afsaneh Shahidi – Fairfax – Howard University College of Dentistry 2015

Louis Traci – McLean – Virginia Commonwealth University School of Dentistry 2004

Vernon Williams, Jr. – Fredericksburg – Howard University College of Dentistry 2005

DR. ADAM WILLIAMS

I was fortunate to have the opportunity to join a group practice in Roanoke, Virginia after graduating from dental school. It has allowed me to grow as a practitioner while serving patients in the community.

VDA - BOARD OF DIRECTORS

ACTIONS IN BRIEF - APRIL 21, 2017

1. Approved: A resolution asking the Council on Sessions to provide more detail pertaining to the selection of the 2019 Virginia Meeting site (i.e. rooms, space needed, meeting costs, etc.) and present at the Board meeting in June.

2. Approved: A resolution that the VDA Board of Directors will lead a guided discussion and exploration on the topic of VDA branding (including all eight component societies) in an effort for all entities to become more unified, consistent and recognizable. Budget impact: $4,000.00

3. Approved: The Council on Finance recommendation to hire the firm of Keiter CPA as the VDA auditor.

4. Approved: A resolution to publish the Hyatt Regency Coconut Point Hotel vacation package, via text, to members with website links to hotel reservations on VDA or NOVA sites. Report on metrics at the June Board meeting.

5. Approved: A resolution that the Board of Directors approve a New Dentist Advisory Board and after approval of a Bylaws change by the VDA House of Delegates, a member of that Board will serve as a voting member of the VDA Board of Directors for a one-year term.

   Background: The Strategic Plan Goal Group focusing on younger members suggested the above as a way to get new dentists (members out of dental school for ten years or less) more involved in the leadership of the VDA.

VDA - BOARD OF DIRECTORS

ACTIONS IN BRIEF - JUNE 9, 2017

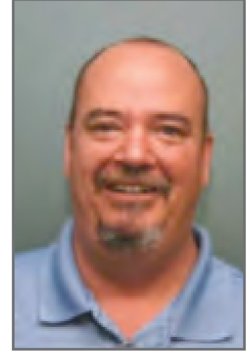
1. Approved: The 2018 Budget as presented.

2. Approved: A resolution that the VDA will promote study clubs that require VDA/ADA membership.

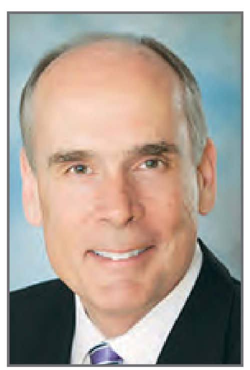
3. Approved: A resolution that the 2019 Virginia Meeting will be held in Richmond and the 2020 meeting at The Main hotel in Norfolk.

AWARDS AND RECOGNITION

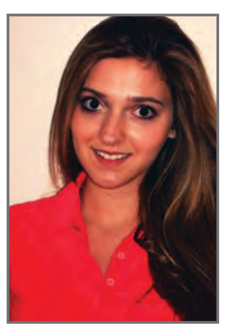
Dr. Steven G. Forte
Spirit of Service Award
American Association of Endodontists



Robbie Schureman
Help Somebody Hall of Fame
Connect Virginia



Pat Finnerty
Honorary Membership
American Dental Association



THE TRANSITION TO CLINIC:
A STUDENT'S PERSPECTIVE

Amanda Toulme, Associate Editor; Class of 2019, VCU School of Dentistry

A couple weeks ago, my classmates and I crossed the threshold from pre-clinical studies to full-time patient care. "We made it!" we exclaimed to each other as we high-fived during our D3 orientation. After countless long days spent in our mannequin lab, it was time to treat some real patients. Being a health care provider for the first time presents great privilege and great responsibility, and each day of clinic has brought unexpected experiences.

After two years spent with dummies, treating a human has its own set of challenges. There is blood. There is saliva. There is a tongue that seems to have a life of its own. Our patients feel pain, and they expect their dentist to relieve their pain and to do so efficiently. We're not just cutting a prep or passing a practical anymore. As a faculty member told me, we have to think about how to treat the whole patient – not just one tooth, and not just the mouth. Each patient has differing anatomy, different financial constraints, and different goals and desires. We're beyond the world of the "ideal prep" from our preclinical courses, but the principles that we gained from these classes are still the basis for our treatments.

With this new position comes fears and insecurities. "Will I be as good as the D4 that treated this patient last year?" "What if I pulp a tooth?" "I can't get the signature pad to work, or the mouse pad, or the entire computer, or the Cavitron" (that last quote actually did happen to me during a recent recall appointment). Luckily, at VCU we are surrounded by caring classmates and supportive faculty who know that we are still learning. We are split into eight general practice groups, which allows us to establish working relationships with the same faculty and peers. I already feel bonded to my practice group, and I know that any of them would help me in a heartbeat.

One of the most common struggles as a new student dentist is knowing when to ask for help. However, we are still students, and we should be continuously asking questions and soaking up as much knowledge as we can. Even though it might feel like we've hit the big time, we are only halfway through our dental education. So far, clinic has proven to be an amazing learning environment. Whether I am the provider or the assistant, I've learned so much in just a couple of weeks through hands-on experience.

Even when the days are draining, feeling a patient's thankfulness makes any appointment rewarding. In dental school, we have the opportunity to work with patient populations that we might not otherwise have the chance to treat. Many of our patients come from underprivileged backgrounds, and some have struggled with health issues such as HIV+ status. As student dentists, we need to remember that even though an aspect of oral hygiene or a specific fact about teeth may seem obvious to us, others have not been so lucky as to have the education and opportunities that we have. Our job is to treat our patients to the best of our abilities. We should educate them, but never judge them, because ultimately we are the ones who have the privilege to treat these individuals and to base our education around them. Without our patients, we would have no school and no job.

Recently, I had a very stressful appointment. This patient required consults from three different departments of the dental school. In both of the appointments I've had with her, I was running around all over the building. In the end, I was scared that I would let her down. Her English language skills were limited, and I knew that she was in pain—I just hoped that I had covered everything I could concerning her condition.

But at the end of the appointment, she patted me and said "You took care of me good," and hearing that made all of the stress completely worth it.

DR. SCOTT ENGLE

Scott is a 2014 graduate of the University of Maryland Dental School. He has been practicing in Coastal Virginia area since graduation. Recently, he has joined a practice that integrates modern technology with classic personal touch.

JOBS - DENTIST

5535 – Mobile Practice Dentist
Premier Mobile Dentistry of Va, LLC is seeking a Virginia-licensed DDS or DMD to travel with a Premier mobile dental clinic and provide routine dental care to non-ambulatory residents of long-term care facilities. The mobile clinic will be based out of Christiansburg, but the successful candidate must be willing to travel throughout the Southwest part of Virginia as required. Premier is looking to staff a mobile clinic 5-days per week and will consider full- or part-time applicants. The successful candidate will have a current Virginia license, valid malpractice insurance, and a dedication to ensuring the highest quality of care to patients. EOE. To apply, contact Amie Rabel: amiefalcon@gmail.com or 225-324-5945.

5558 - Shenandoah Valley Dentist
We are looking for talented dentists to join our team full time or part time. We are a dentist owned multi office group practice in need of a seasoned dentist or a recent GPR/AEGD graduate. We offer comprehensive modern dentistry for the entire family. The candidate must have integrity and possess good interpersonal skills. You'll work with state-of-the-art technology and have valuable opportunities for continued education, training and mentorship. Visit: MyDentalHealthAssociates.com Send cover letter and CV to: drlagrua@MyDHA.net

5559 - Dentist & Pediatric Dentist
Come join a community health center with over 40 years of experience and a strong Senior Leadership Team! Eastern Shore Rural Health is located in a rural area close to Virginia Beach and Washington, D.C. We are Patient Centered Medical Home certified and have been recognized as a "best-practice" by the Bureau of Primary Health Care. ESRHS offers a competitive benefits package, new up-to-date facilities and electronic dental records. Must enjoy seeing pediatric patients as well as adults. For more information visit our website www.esrh.org. Jeannette Edwards, Chief Human Resources Officer 757-414-0400 ext. 112

5582 – FT/PT DENTIST
Looking for a full time dentist or several part-time dentists to work Monday-Friday in Richmond area. Beautiful office setting, good compensation and low stress! Experience a must. Must enjoy working primarily with Seniors! This could be ideal for someone who is retired but still has passion in providing dental care to those in need! Katherine Reynolds, 757-927-2238, Smiles-2u@cox.net

5588 – PT Dentist Yorktown
General dentists needed to join our team. PT position -Looking for military experience and/or additional training a plus. Patient-centered practice offers modern equipment, digital records/radiographs, friendly staff, and convenient location.
Contact: Melissa 757-898-0845 victorydental@verizon.net

5597 - FT/PT General Associate Dentist
We are a successful and growing office located in Virginia Beach, VA. Currently one doctor working full time and one hygienist. Five fully equipped operatories, 100% digital office.We are looking for a motivated associate to join our team Monday through Friday and every other Saturday. He/She must be able to perform molar root canals, crown/ bridge, restorations, partials/dentures, and extractions. New graduates are welcome to apply. Must have a current and valid Virginia dental license, CDS, DEA, and CPR. Compensation depends on experience. MUST BE ABLE TO START IMMEDIATELY! Please forward CV to e-mail provided.
Contact: Susan 757-962-7000 idealsmilesfamilydentistry@gmail.com

5605 - Endodontist opportunity
Central Virginia Endodontic private practice is looking for associate endodontist to cover at least 3 days a week and possibly more. Can start in July / August 2017. All new equipment including Zeiss Microscopes, ASI carts. No quotas or set corporate dental treatment plans. We value quality treatment guided by your training and expertise.
Contact: Mark 434-260-7025 mvagnetti@piedmontendova.com

5606 - Associate Dentist Needed
Immediate Job Opening, Lynchburg, VA. Take over 750k Gross Practice; Vacation, Health Insurance Provided; 401k, Profit Sharing, Long Term Disability and Other Benefits
Contact: Dr. Frank C. Crist, Jr. 434-239-2651 drfcc@bradycrist.com

5611 - General Dentist/Dental Services Manager
Busy dental safety net clinic in central Virginia seeks experienced general dentist with specialty skills and commercial dental practice experience. The position requires the candidate to have clinical organization expertise and an understanding of productive scheduling. Leadership experience will be essential to the coordinator for the clinic. Must have succeeded working a multi-column schedule and be willing to support/direct other providers including specialists. Position offers base salary plus generous incentive bonus plus medical, vacation and holiday pay. Location is in a dental professional shortage area and eligible for student loan forgiveness. Veterans encouraged to apply. Clinic is an Equal Opportunity Employer. Please send resumes to hrcoordinator.lbd@gmail.com

5617 – FT/PT Pediatric Dentist
Our growing Orthodontic & Pediatric Dental practice in Richmond VA is looking for an energetic, personable, and highly skilled Pediatric Dentist to join our clinical team on a full or part time basis as a long-term associate. • We are a growing, well-established practice with a long history of providing excellent, comprehensive dental care for children, teens and adults. • We have a beautiful office setting, a relaxed atmosphere and a highly trained and supportive staff. • Our goal is outstanding treatment results delivered with the best customer service available. We strive to offer the best dental experience for our patients and their families. • We are equipped with state of the art technology, highly motivated technicians and employees who truly love what they do. • Excellent earnings potential. • Because of our continued growth, we are excited for the opportunity to add a new, great Pediatric Dentist to our practice and clinical team. In addition, there are many opportunities for community outreach and providing treatment to the under-served of our community. Candidates must be warm and caring as well as possess superior clinical skills and the ability to effectively communicate to staff, patients and families. Requirements: DMD or DDS with Pediatric Dental Certification. If this sounds like you, then we can't wait to meet you. Please give us a call or email at your convenience.
Contact: Reid 804-330-0508 ext. 208 reid@drbyrddds.com

5621 - P/T Associate Dentist Opportunity
Bowman Family Dentistry is seeking an associate dentist to join our well-established Dental office, which has served our patients for 50 years in the beautiful Shenandoah Valley, Waynesboro, Virginia. Must be a positive, highly motivated, compassionate team-oriented candidate with excellent chair-side manners who provides high quality dental care with high ethical and moral standards. As a team we perform a wide range of services, for families with members of all ages, which include Preventive, Restorative, Prosthodontics (Fixed & Removable), Extractions, & Endodontics. Initial hiring terms will be part time (2 days per week) with potential to build into a full time position in the future. Excellent earning and growth potential. Current Virginia Dental License, DEA, & CPR required. Please email your Resume/CV and Cover Letter to info@bowmanfamilydentistry.com or fax to Rebecca Shin, DMD at 540-221-4297

5630 – Full time Dentist - Fredericksburg
Busy, family oriented, non-corporate general dentistry practice seeking full-time dentist with no weekends or evenings. We are well established and have been serving the Fredericksburg area for over 20 years. Competitive compensation based on production with full benefit package available. Experience is a plus but new grads will be considered.
Fredericksburg Dental Associates, 540-373-0602,
galatrodds@fdadental.com

5633 – General Dentist
General Dentist needed to work at the Fauquier Free clinic in Warrenton, Virginia. 3 days with potential to add more days in the future. $510/day, CE and malpractice insurance provided. Beautiful brand new facility: 4 chairs, scan-x & sensors, rotary endo, Nitrous, Excellent staff and office manager.
Contact Dr. Jason S Woodside 540-219-6791
Woodsidedds@yahoo.com

5635 - Experienced Dentist -Reston, VA
Fusion Dental is a doctor owned multispecialty group practice with 7 locations in Maryland and Virginia. Our doctors use a comprehensive mouth-body approach including Oral Cancer screenings and annual exams to help identify overall health risks, while providing education and treatment to patients. Each Fusion Dental location is dedicated to providing quality patient care, with safety standards that meet and often exceed government regulations. New patients are often surprised at the individual attention that is given during each visit. Their satisfaction is measured by annual surveys and doctor reviews, and we are constantly monitoring the patient experience. We have a unique opportunity for a doctor to step into a thriving practice. The ideal candidate will practice full scope dentistry with strong experience in advanced cosmetic dentistry. Pankey and Dawson trained candidates are given preference.
Contact: Kate Anderson, 781-213-3312, kateanderson@amdpi.com

5641 - Part Time Associate Needed
Part time associate needed at our rural, but very busy general dentistry practice in Hot Springs, VA. Fully staffed private practice has a schedule full of new patients! 6 ops scheduled 4 days per week. Part time days are flexible. Guaranteed daily rate based on experience. Malpractice provided, 401(k) available. Take advantage of this opportunity to join a family oriented community! Contact Zac at zrhinesmith@benevis.com or 770-710-3042.

5642 – General Dentist
Stensland Dental Studio is single-dentist practice launched by Dr. Steve Stensland in April of 2010. The practice has grown beyond the capacity for Dr. Stensland to fully accomodate new patients, so we are looking for an associate who can work 3-4 days a week. We are searching for a doctor who is interested in a long-term position in a fast-paced environment. We pride ourselves on excellent customer service and are highly respected in the Williamsburg community, as evidenced by our over 230 5-star google reviews. Therefore, we are taking our time to find the right fit for our office - someone with excellent customer service skills, superior dental knowledge & technique, and genuine compassion for patients. Our practice is a combination of fee-for-service and participation with some major insurance plans. Our digital office uses state-of-the art equipment, including a CEREC and a cone beam. We have 7 functional operatories with the potential for 9 and 3 full-time hygienists (hoping to add another one soon). Qualifications: Must hold a DDS or DMD degree with a license to practice in Virginia. Experience preferred. Compensation and benefits: Base salary with production based bonus Malpractice insurance covered CE reimbursement.
Contact: Lynann Stensland, 757-897-7745,
lynannstensland@gmail.com

5645 - Associate for Group Practice Wanted
Great opportunity for energetic General Dentist to join a large, comprehensive family practice. You will have unlimited opportunity to build your clientele within the practice and develop skill sets to match your interests. The right candidate will work with the practice owners to learn sedation, implants, orthodontics and sleep dentistry from seasoned practitioners who have built the practice by putting patients first. We have a dedicated staff of experienced dentists, assistants and hygienists to support your role in our growth. Our unique production payout structure relieves you of traditional owner/operator expenses while giving you the freedom to become an integral part of our team. This is a once in a lifetime opportunity for the right candidate who wants to position themselves for long term growth. Please forward your CV, credentials, resume and cover letter to: Lee Austin, Operations Manager Email:laustin@dentistrichmond.com

5648 - Full Time Pediatric Dentist
We are seeking a full time Pediatric Dentist to join our multi-specialty practice. We are located in Hampton, VA, and are centrally located to all of the major cities in Hampton Roads. $175,000.00 annual. Entitled to monthly bonus equal to 30% of monthly net collections in excess of $ 55,000.00.
Contact: Michelle Bunch 757-896-5050 mbunch@caring4kids.com

JOBS - DENTAL STAFF

5583 - Dental Assistant - Dynamic & Energetic!
Our established and growing family dental practice in CHARLOTTESVILLE, VA seeking a dynamic, energetic and experienced Dental Assistant to join our team. As our ideal candidate you will have strong skills with chairside assisting, and partner with the doctors in the discovery and presentation of dental treatment. Patient satisfaction and relationship building are a high priority with our team. High energy, the ability to multi task with a pleasant and helpful style as well as the ability to manage your time effectively is a plus. We offer a great compensation package with benefits. You should also have a strong desire for success in yourself and others. Requirements you will need to meet: • Bring at least 3 years of hands-on, chairside experience • Current Dental x-ray license • Current CPR Certification We will offer you: • Medical & Dental Benefits • Paid Holidays after 90 days • Retirement & Paid Time Off & more! • Friendly, Team-Focused Work Environment Thank you for considering our Dental Assistant opportunity! Please forward your resume and 5 reasons you're our next team member to RobynR@bentericksen.com or fax to (440) 848-8833.

5589 - Dental assistant and Receptionist
Apple Tree Dentistry (http://www.appletreedent.com) has two open positions available. We are ooking for a part-time patient scheduling & insurance coordinator who will primarily work at a reception desk. We cross-train our staffs. Must be able to work on Saturdays. Please email with your resume if you are interested. Thank you! Contact: Dr. Sehmi Lee 804-897-3345 appletreedent@gmail.com

5631 – Hygienist
Northern Virginia - Chantilly dental office seeking hygienist. Flexible working hours Monday - Thursday.
Contact: Christine 703-378-1010

PRACTICE TRANSITIONS

5591 - GREAT GROWTH OPPORTUNITY! RICHMOND PRACTICE FOR SALE
Description: Expand your business with this small but growing practice that is currently experiencing an influx of new patients from neighboring retired dentist. Enjoy working alongside an experienced, committed dental team ready to assist you in the transition. Three treatment rooms in an office located on busy street with outstanding visibility; condo rental available for purchase. Ideal for a starter practice or additional satellite location to broaden your service offering in Richmond market! Contact immediately for additional details.
Contact LBD Transitions | Jim Schroeder | (804) 897-5900 | drjimschroeder@gmail.com

5592 - PRACTICE FOR SALE - WLLIAMSBURG AREA
Longstanding, very well-established dental practice that services patients from Williamsburg, Newport News, Yorktown and Peninsula areas. This is an ideal acquisition for dentists seeking a satellite office with over 2100 patient charts. Three treatment rooms, 1200 square feet. Call for details.
Contact: Jim Schroeder 804-897-5900 drjimschroeder@gmail.com

5628 - Turn Key Dental Practice – Alexandria
Turn Key practice in Alexandria. 3 Ops with room to expand to 6 ops. Fully equipped and furnished. New facility. Some patients. Ideal for a dentist looking to expand or start own practice. Priced for a quick sale at $195,000. Serious inquiries to alexandriadentaloffice@gmail.com

5639 - Lexington VA- Practice Transition
Full service family & cosmetic dental practice with growth opportunity and an outstanding dental team. Patient Centered, Fee-for-Service, seeking full-time dentist for exceptional opportunity in lovely, small college town. Please reply in confidence with your objectives and CV to pam@lifetransitions.com

5622 - Dental Practice for Sale including Real Estate for $370,000 on Eastern Shore!
Price Reduced! Great Opportunity for Younger Dentist! Includes Real Estate! Sales price is $370,000 and includes the real estate, which is assessed at roughly $200,000. Practice revenues are $375,000 annually. Light & Raphael is pleased to offer for sale a general dental practice near the eastern shore in Virginia. This is a tremendous opportunity for a younger dentist. The current dentist is not accepting new clients as retirement approaches. The practice is closed on Wednesday and Fridays and there are certainly enough existing clients and potential clients to expand the hours and revenues of the practice. It is anticipated that the staff will remain with the business after closing. Financing possible for a qualified buyer.
Contact Gavin Raphael at Light & Raphael.
Email: Gavin@lightandraphael.com or 804-355-2458

5627 - General Practice #VA-1377: Chesapeake
5 Operatories. Average collections $536,762. Well Established PPO practice with additional room for growth! Free standing building. 4 ops with the opportunity for a 5th plumbed. Great net profit and option to own real estate as well! For details contact Amanda Christy, NPT (National Practice Transitions, LLC) 877-365-6786 x230, a.christy@NPTdental.com or register for FREE on our website (www.NPTdental.com) as a member for immediate updates.

5643 - General Practice #VA-1284: Petersburg
3 Operatories. Average collections $557,458. Average net profit $290,162 (52%)! Very profitable. Well-established practice. Southside of VA, 2 hrs from DC. For details contact Amanda Christy, NPT (National Practice Transitions, LLC) 877-365-6786 x230, a.christy@NPTdental.com or register for FREE on our website (www.NPTdental.com) as a member for immediate updates.

5644 - General Practice #VA-1289: Lancaster County.
5 Operatories. Average collections $553,045. Average net profit $239,631 (43%)! Highly sought after location near the water. Stand alone building that offers a spacious, updated, modern & paperless environment. 40 plus new patients every month & outstanding net profit! For details contact Amanda Christy, NPT (National Practice Transitions, LLC) 877-365-6786 x230, a.christy@NPTdental.com or register for FREE on our website (www.NPTdental.com) as a member for immediate updates.

OFFICE SPACE FOR SALE/LEASE

5560 - Great Built-Out Location to Lease in Bustling City of Fairfax
This unique and newer (2004) ground level 2300 sqft dental suite sits in a high visibility location with signage and ample parking in the bustling City of Fairfax. Appropriate for general or specialist practice. Easy access from Route 66 via Route 50 or Route 123. Situated amongst retail and restaurants. Bright and welcoming space. Patients won't need to ride an elevator to a darkened hallway to reach you. Set up for 6 operatories with room to add a 7th. Handicap accessible with 2 ADA bathrooms. Previously occupied by busy pediatric practice that grew so much they had to move for even more space. Ample free parking. Move-in ready. Landlord financing of buildout updates to needs/taste negotiable. Photos available on request. Contact Donna at 703-855-3393 or drye@weichert.com.

5599 – A NOVA dental office space for lease
Prime dental office located in the very desirable burke professional center. This nice corner unit with four operatories is ready for move-in. Previously occupied by an endodontic practice. Perfect for specialist or general dentist. Rent: $2,530 + utilities. If interested please send email brushforhealth@yahoo.com for more information.

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DR. LAUREN SIMON

After graduating from VCU, Lauren served on active duty in the military, and then briefly in public health before purchasing her private practice. She enjoys being a family general dentist and loves being a part of the Nokesville community.

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