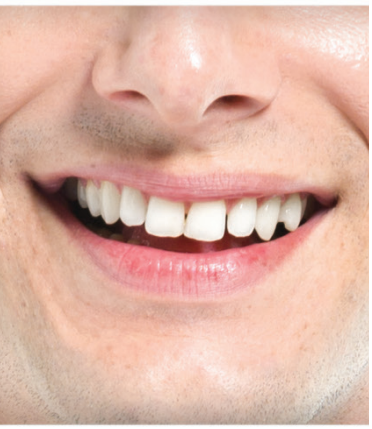
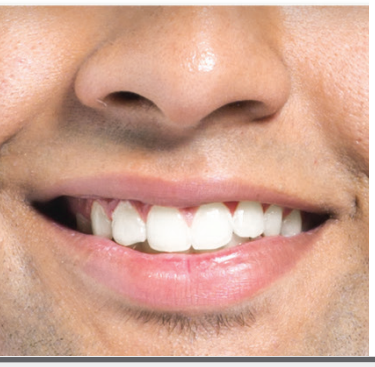
IN THIS ISSUE:

Mid Level Providers coming to Virginia?
pg. 3

Does Health Care Reform Mean More Covered Children in Your Chair?
pg. 66

VIRGINIA DENTAL
Journal
Volume 92, Number 3 •April, May & June 2015



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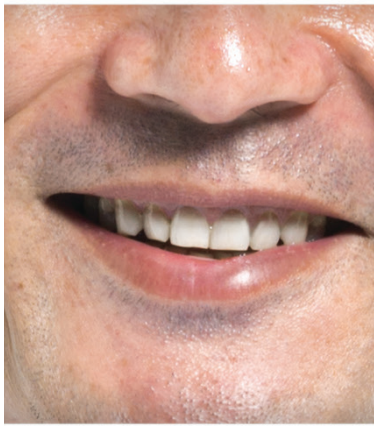
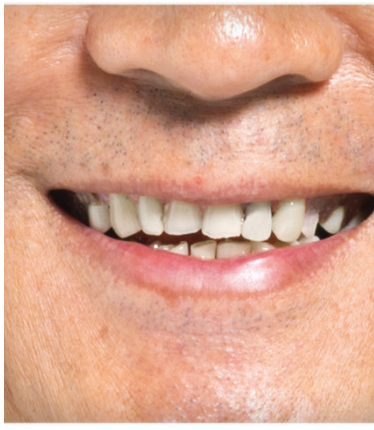
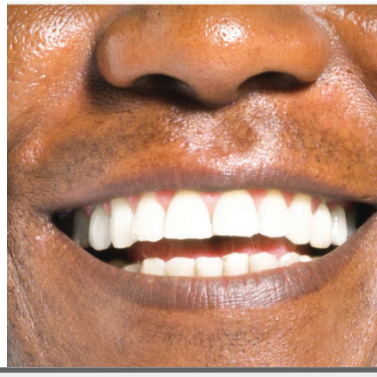

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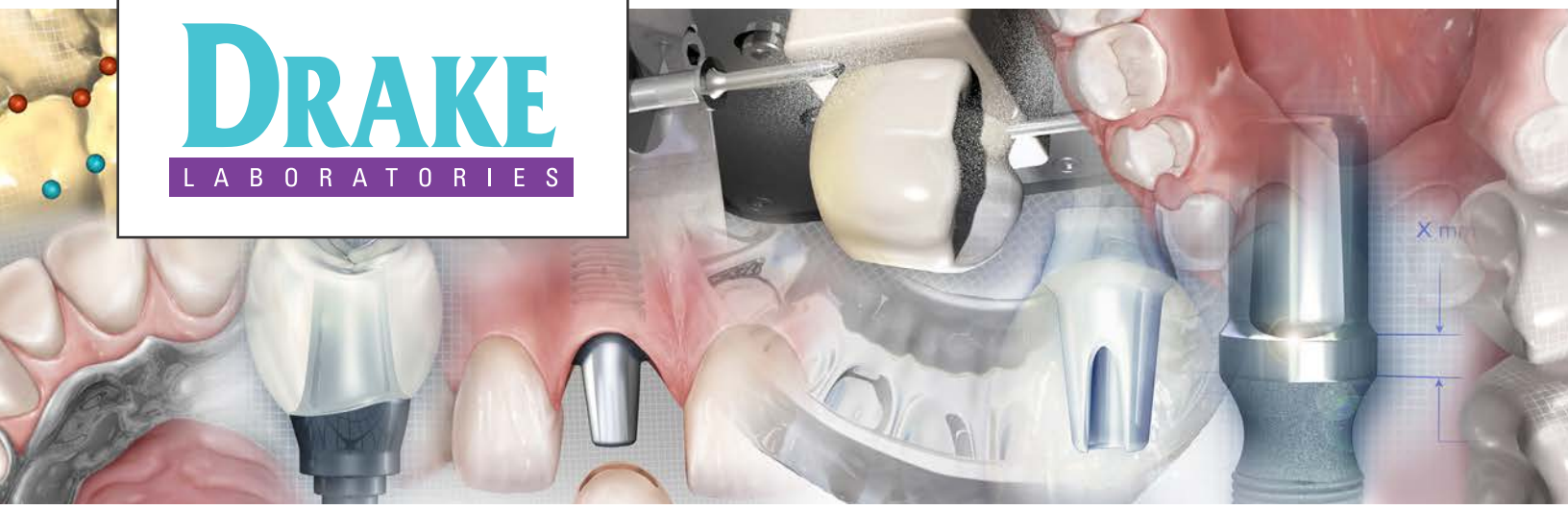

VIRGINIA DENTAL JOURNAL
APRIL - JUNE Vol. 92, NO 2

Contents

COLUMNS

3 PRESIDENT'S MESSAGE
Dr. Michael Link

5 EDITOR'S MESSAGE
Dr. Richard F. Roadcap

7 TRUSTEE'S CORNER
Dr. Julian H. "Hal" Fair, III

9 LETTER TO THE EDITOR
Dr. Marvin E. Pizer

11 LETTER TO THE EDITOR
Dr. Bob Allen

27 THE ETHICAL DILEMMA: TO REFER OR NOT TO REFER
Dr. Thomas J. DeMayo

29 ASSESSMENT: AN IMPORTANT SKILL FOR YOUR DENTAL PRACTICE
Dr. James R. Schroeder

65 I'M A NEW PRACTICE OWNER, WHAT CAN THE ADA DO FOR ME?
Dr. John C. "Cappy" Sinclair

66 DOES HEALTH CARE REFORM MEAN MORE COVERED CHILDREN IN YOUR CHAIR? THINK AGAIN.
Chris Pyle

67 TAKING THE NEXT STEP: TRANSITIONING FROM STUDENT TO DENTIST
Jeremy Jordan

68 MALPRACTICE MINUTE: INFORMED REFUSAL: A REVIEW
The Medical Protective Company

FEATURES

12 HAVE YOU SEEN ME?
Dr. Kirk Norbo

14 WHERE'S THE CHAIR?
Danny Rubin

31 WHY DENTISTS NEED TO BE MOBILE-READY
Rachel Taylor

63 PAYERS USING CREDIT/ DEBIT CARDS FOR PAYMENT

BACK COVER MEMBER SPOTLIGHT: AN INTERVIEW WITH DR. BILL HENRY
Dr. Michael R. Hanley

63 DANVILLE AREA DENTISTS PROVIDE CARE FOR ADULTS WITH DISABILITES

BEGIN 11 40 UNDER 40 ~ NEW

SCIENTIFIC (15-24)

15 ABSTRACTS - AEGD

20 VDA MEMBERSHIP TASK FORCE SUMMARY REPORT - PART II
Drs. Coe, Best, Certosimo, Coble

ADVOCACY (33-41)

33 VDA DAY ON THE HILL 2015
Laura Givens

35 VADPAC UPDATE
Laura Givens

36 COMMONWEALTH'S 2015 GENERAL ASSEMBLY SESSION REVIEW
Tripp Perrin, Chuck Duvall and Denny Gallagher

37 DENTAL BENEFITS RESOURCES
Laura Givens

39 MEDICARE OPT IN OR OPT OUT
Laura Givens

40 AN INTERVIEW WITH: DELEGATE TODD PILLION

MEMBERSHIP (43-49)

43 VDA ELECTED LEADERSHIP CANDIDATES

48 WELCOME NEW MEMBERS
Karen Clendenen

49 VDA ACTIONS IN BRIEF

UNIVERSITY CONNECTIONS (51-53)

51 2015 VCU SCHOOL OF DENTISTRY WHITE COAT CEREMONY
Dr. George Deeb

53 VCU ASDA HOSTS INAUGURAL PROFESSIONAL DEVELOPMENT SEMINAR
Kandice L. Klepper

OUTREACH (55-62)

55 VIRGINIA "GIVE KIDS A SMILE!" 2015
Jessica Park

56 DONATED DENTAL SERVICES (DDS): HIGHLIGHTING OUR VOLUNTEERS
Sherrell Bouldin

57 VDA DENTISTS AND STAFF MAKE SUFFOLK MOM A HUGE SUCCESS
Joel Rubin

58 WISE VOLUNTEER AND MISS KENTUCKY CONTESTANT?
Brittany Bentley

60 THANKS FOR MAKING US SMILE

61 MOM PROJECT CELEBRATES 15 YEARS OF SERVICE TO VIRGINIANS IN NEED
Barbara Rollins

62 DENTAL CLINIC CONTRIBUTES TO DECLINE OF EMERGENCY DENTAL VISITS

Virginia Dental Association

VIRGINIA DENTAL JOURNAL

REPRESENTING AND SERVING MEMBER DENTISTS BY FOSTERING QUALITY ORAL HEALTH CARE AND EDUCATION.

Volume 92, Number 2 • April, May & June 2015

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

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

Second class postage paid at Richmond, Virginia.

POSTMASTER Send address changes to: Virginia Dental Journal, 3460 Mayland Ct, Unit 110, Henrico, VA 23233.

MANUSCRIPT, COMMUNICATION & ADVERTISING Managing Editor, Shannon Jacobs, 3460 Mayland Ct, Unit 110, Henrico, VA 23233 or jacobs@vadental.org

PRESIDENT'S MESSAGE

MID LEVEL PROVIDERS COMING TO VIRGINIA?

Dr. Michael Link

Upon leaving the Department of Health Professions building this past January, I began to reflect on the hearing that had just taken place. The Board of the Department of Health Professions is beginning to look into utilizing alternate dental providers (mid-level dental providers) to help with access-to-care issues in Virginia. In the DHP's 50 page report, there were many references to a mid-level provider. This topic is of great concern to me because it attacks the current delivery model of dentistry that we have come to know. Think for a minute about our VCU dental students and the recent graduates who are in debt anywhere from $200,000-$300,000. How does a mid-level provider who may only go to school for a two-year program affect the future of these individuals? The Pew and Kellogg foundations assert that a mid-level provider is analogous to a nurse practitioner (NP) or a physician's assistant (PA). The fallacy with their reasoning is that neither a nurse practitioner (NP) nor a physician's assistant (PA) performs irreversible procedures like the mid-level provider would. Virginia has been an innovator in helping the underserved through its MOM projects, Donated Dental Services program, and the Give Kids a Smile program. Considering the many programs offered by our association to the underserved, why is there even a discussion about these alternative providers?

The Department of Health Professions report had many omissions. The main issues that were ignored in the DHP report were the effectiveness and shortage of hygienists and the subsequent economic cost to the Commonwealth. Any workforce changes that would further increase the demand on the supply of dental hygienists must be met with a significant expansion of that same workforce. According to the Bureau of Labor and Statistics in Virginia as of January 16, 2015, there are more jobs for hygienists than are hygienists available. Who is going to pick up the slack for private practitioners if hygienists are diverted to underserved areas? According to the ADA, the waiting period for a patient to see a dentist has been decreasing since 2008. There are many reports across the country of more and more open chair time in dental offices. That statistic supports our viewpoint of having an adequate workforce to address the current demand. Virginia, however, is not alone in the endless attacks on our practice model. North Dakota (just received the news that the mid-level provider bill failed there), New Hampshire, New Mexico, Washington, Kansas, and Maine (bill passed there for mid-level providers) all have bills before their General Assemblies that will alter their Dental Practice Acts, if passed. Proposals to get more dental services to rural areas in these states would allow dental hygienists to perform some of the same procedures as dentists under the guise of access-to-care. These mid-level providers could perform procedures such as routine checkups, cleanings, filling cavities and simple extractions. I don't know about you but when was the last time you saw a simple extraction? This topic should bring chills to every dentist in our nation. Doesn't the public desire and deserve better? Perhaps, as dentists, we have made the practice of dentistry look too easy. These Foundations are promoting mid-level providers because they believe that anyone can be trained to do these procedures in a short two years. Their assumptions simply are not true! One of our profession's goals is to protect the public at large by being self-regulating. Are we beginning to appear to be more like a trade instead of a profession? Self-regulation and adequate training should be our focus. Outside organizations are attacking our delivery model and calling it antiquated, ineffective and inadequate. In my opinion, this issue is the most serious problem facing dentistry that I have seen in my lifetime. We, as dentists, members and non-members, need to stand together as a united profession with one voice to oppose a mid-level dental provider in Virginia. We need your help on this issue if we are to remain relevant today and in tomorrow's world. The VDA is the one organization that is fighting for you on this issue. Our obligation to those that follow us is to leave our profession in a better place than when we started practicing dentistry. By getting involved in your association, it will ensure that we will have control over our profession for our generation and future generations. As I stated in my last journal article, what are you willing to do to protect the future of dentistry?

As an Association, we need to have a better answer to the Pews and Kelloggs of the world who are promoting this mid-level provider model as the answer to the access-to-care issue. But, we can't just keep saying "no" as an answer. We need to develop a better alternate plan and a true answer to the access-to-care issue. The American Dental Association and the Virginia Dental Association believe the Community Dental Health Coordinator, or CDHC for short, will be one of the answers to a more cost-effective approach to improving access to care in Virginia. A CDHC would be a newer member to the dental team who will focus on education, prevention, and patient navigation and who would help reduce oral health disparities by targeting social determinants. CDHCs live in the same communities where patients reside. There is a distinct lower training and utilization cost with the CDHC than a hygienist resulting in a lower cost for the Commonwealth of Virginia. They help people connect to dental public health resources in their communities, as well as to dentists who can provide the needed treatment. A CDHC IS NOT A MID-LEVEL PROVIDER! CDHCs will work primarily in public health, community settings, such as federally qualified health centers and free clinics, schools, churches, private practices and Head Start programs, in coordination with a variety of dental providers. The CDHC model is currently active in eight states. Under the direction of the chairman, Dr. Mark Crabtree, the Task Force has accomplished many goals, including securing an educational process for the training. I am excited and impressed by the direction and speed of this task force. I look forward to future updates.

Our "Day on the Hill" in January was a huge success! My thanks to our incredible VDA staff, members, dental students and volunteers who attended this most important day. To have a personal relationship with your legislator is one of the best grassroots effort campaigns we

have, one that enables our organization's individual members to communicate with our lawmakers. I believe that this type of effort has given us many legislative victories. We, as an association, are able to convey our concerns facing dentistry on a more personal level. This has helped us immensely in the past and will help us with future concerns, including any dealings with the mid-level provider issue. I encourage everyone to attend next year's event and to get involved in the process. This is your profession. Protect it!

The Public Relations Campaign is off and running under its new chairman, Dr. Kirk Norbo. The focus of the PR campaign has changed from broadcast and cable television to internet-based advertising. With TV commercials being very expensive, the Task Force chose to test digital advertising online. We feel this internet-based advertising will give us a greater return on our investment. In December, the Task Force noticed that the number of clicks on "Find a Dentist" button did not decrease when only digital advertising was used, but it actually increased. We are mindful of the expense to our members and are trying to get the most "bang for the buck." The question I have for each of you is how have you committed to this campaign? Have you updated your profile on the VDA website? Have you submitted a picture to the VDA?

Does the VDA have your website information? You need to take full advantage of this campaign to the get the best results. To date, only 10% of our membership has updated their profile on the VDA website. There is also a new functionality on our website which will tell you the number of times your name has appeared in a search on the "Find a Dentist" button. Simply log into the site and click on your "Search Statistics." If your profile is not up to date, then the public might bypass your website and your practice altogether. A better question from a consumer's point of view would be why would I choose your practice when your profile and website are not updated with the VDA? Our Virginia Dental Association is an effective, incredibly efficient and well run organization. No one really knows what sacrifices and commitment it takes to become a dentist, except another dentist. Certainly, our patients have no idea. Much like our patients may not understand our dental training, I would venture to say that most of our members in the VDA have no idea what it takes to run our Association. The VDA is an effective organization that is well-equipped to meet our members' need to be successful. Our staff is the most dedicated and hardworking of any I have seen. The leadership at the VDA starts at the top and permeates through the whole Association. I am very blessed to be a part of this great association. However, as with any organization, we need your help. As I stated in my last journal article, what the Association can do for me is being replaced by this motto: "What can I do for my Association?" I need your help to protect the future of dentistry. I need your help NOW! What are you willing to do to protect our future? Please consider volunteering to help us! Call or email me with your ideas and comments on how we can better serve our profession and each other. Thank you.

MESSAGE FROM THE EDITOR

Dr. Richard F. Roadcap

Most years, right before Christmas, a specialists' office in our area sends us a box of cookies. Not just any cookies mind you: individually wrapped, made in Europe, covered in Danish chocolate, with the likeness of medieval architecture on the lid. Although we refer many patients to this particular dental group, we've come to expect the second week of December two pounds of tray bakes, macaroons, and *zeppole* to tide us over until the holidays. You ask: would I still refer to these specialists if they didn't send cookies? Yes, but it seals the deal.

In Virginia, there is no sanction for dental specialists paying a fee to other dentists for each referral. Commonly known as "fee-splitting", this arrangement violates the ADA's Principles of Ethics and Code of Professional Conduct[1], as well as federal statutes, which prohibit it for any patient enrolled in a federally-insured plan. Cash, checks, or cash equivalents may change hands without violating any regulation or breaking any laws. This practice may be widespread. But I've yet to talk to another dentist who didn't think it should be outlawed. Not only payments between doctors, but also payments to patients, vendors, and persons who serve the public in other occupations fall under this banner. Even the ever-popular social coupons are viewed, by the ADA Code, as fee-splitting and thus proscribed for members of organized dentistry.

After many proposals, hearings, and discussion (both public and private), the Virginia Board of Dentistry last year moved forward with its own recommendation for legislation to prohibit fee-splitting. The proposal made its way up the chain of command, past the director of Department of Health Professions, the Secretary of Health and Human Resources, and then on to Governor Terry McAuliffe's desk, where it died an inglorious death. Sandra Reen, executive Director of the Board of Dentistry, says no reason was given for the Governor's action.

A frequent refrain from the hesitant goes as follows: common courtesies between doctors, e.g. crullers from Panera Bread®, will be criminalized thus making enforcement impractical and unfair. The ADA Code says simply that "Dentists shall not accept or tender 'rebates' or 'split fees'." I polled my fellow dental editors, and found that states such as Nevada, Michigan[2], and Oklahoma all ban fee-splitting without severing the carefully cultivated relationships among practitioners. Ugly headlines preceded this year's attempt by the General Assembly to move forward with ethics reform for legislators. The dental profession shouldn't need publicity about unmarked envelopes, gift cards, and resort vacations for motivation. A coordinated effort by the VDA and its most able lobbying team should clear a path for appropriate legislation in the 2016 session.

As Mr. Schutte points out in the article referenced here, "Economic considerations…should not form the basis for or even be a consideration factoring into the decision of who to refer a patient."[3] Let's hope that next year will see the passage of what nearly all VDA members desire, legislation that puts an end to payments from doctor to doctor for referrals. Will this spell the end of *cantucci di prato* and coolers at Christmas? Perhaps. Organized dentistry need not wait for a public outcry to reinforce our professional standards.

1 http://www.ada.org/~/media/ADA/About%20the%20ADA/Files/code_of_ethics_2012.ashx

2,3 Schutte DJ. Illegal and unethical referral fees and fee splitting. J Mich Dent Assoc 2006; 88 (11): 16

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ADA TRUSTEE'S CORNER

DECEMBER 2014 BOARD MEETING

Dr. Julian H. "Hal" Fair, III; Trustee, 16th District

The meeting began on a Thursday, as the second-year Trustees joined the new Trustees for their orientation. The second-year Trustees were there to give perspective and insight to the first-year group. The Board is fortunate to have a great new Trustee class, very engaged and very eager to perform the duties of the Board. The new class consists of Dr. Rick Asai, Oregon; 11th District, Dr. Bob Bitter, Illinois; 8th District, Dr. Chad Gehani , New York; 2nd District and Dr. Lindsey Robinson, California; 13th District. Also included is our new 2nd Vice President, Dr. Thomas Gamba from Pennsylvania. . Participants were again asked to fill out a survey so that the orientation can continue to be improved from year to year.

Friday and Saturday were busy days during which our standing committees met to begin their work for the year. The work formed the basis for many of our later discussions on audit, financial, compensation, governance and strategic planning issues. I would like to acknowledge Dr. Bob Plage who serves on the Audit Committee as the HOD member. His contribution and insight are invaluable.

On Sunday, we joined with staff and council Chairs and Vice-Chairs for a full day session focused on the need to implement our new strategic plan. We heard some fascinating data from Kantar Research and a report of focus groups comprised of both members and non-members. From our discussions it is evident that we must act differently under our new strategic plan if we expect different results as far as membership growth is concerned.

In Summary:

- There is considerable agreement among the trustees, other volunteer leaders and staff that the ADA must adopt a more disciplined approach to deciding on what programs and services should be engaged.
- The criteria the groups reviewed were considered a good start but were in need of revision. Several groups wanted to see how criteria were rated – the staff reported that weighting will be developed later by Admin Review.
- It was agreed that the HOD and Councils also need to adopt disciplined systems for decision-making.
- It was generally accepted that "less is more" and therefore the ADA must reduce the number of programs and services it offers.

I am sure that as the councils begin to meet this year you will be hearing more about the implementation of the new Members First 2020 Strategic Plan.

Our formal meetings began with a meeting of the Board as shareholder of ADA Business Enterprises, Inc. We heard from Dr. Jim Mercer, chair of ADABEI. Dr. Mercer discussed the savings available to members through ADABEI discounts of over $14,000 per member. Among new products under development or consideration include a HIPAA Compliance kit. ADABEI also plays a key role in the Power of 3 through joint licensing agreements with state societies. I want to thank Dr. Mercer and the entire ADABEI board for their hard work.

"ADA must adopt a more disciplined approach to deciding on what programs and services should be engaged."

The Board has been working hard to take full advantage of the New Dentist Committee as an advisory committee of the Board. Drs. Michael LeBlanc and Chris Hast, chair and vice chair of the committee, addressed us at this meeting. The NDC is hard at work with the Council on Annual Sessions to make the "meeting within a meeting" of the New Dentist Conference and the Annual Meeting a success. The new dentists will have a dedicated hotel at the Washington, D.C. meeting and there will be a leadership track of CE courses available. NDC has set a goal of 400 registrants to the new dentist conference. The combined meeting will include time specifically for interaction between the Board and new dentists as this was a main concern of the committee.

The Success Program is another area of focus with the NDC and the committee is working hard to improve that program as part of our student strategy. The NDC will be working hard to enhance its relationship with ASDA. They have also been charged with considering ideas for new, innovative programs for the Association, as well as considering the value of existing programs from the perspective of new dentists.

Following the presentation, the Board discussed the need to encourage new dentists to participate in ADA leadership. The Board also approved a resolution to have an additional NDC meeting in August, in conjunction with a Board meeting. The New Dentist Committee has significant work to accomplish and can take advantage of an additional meeting. This will also allow a joint strategy session with the committee and a social event. The BOT looks forward to that opportunity.

The Board also discussed the "universal assessment criteria" that is used as part of our budget process to assess the relative value of ADA programs against a common set of criteria. The criteria were addressed by Budget and Finance and by the full group which participated in the Sunday strategy session. The Board discussed the criteria and proposed some changes to them in order to address some of our concerns. The criteria have now been approved and will be used in the upcoming budget process.

Michael Graham provided us with an update on developments in Washington. Addressing Medicaid is essential going forward. A workgroup has been appointed consisting of myself, and Drs. Dow, Shenkin and Zenk to guide our efforts on this front. Staff, too, will be working to develop possible approaches for the Workgroup and we all look forward to progress on this issue.

Former ADA president and current ADA FDI delegation chair, Dr. Greg Chadwick, presented us an overview of the ADA role within FDI. As recognized leaders on global oral health, FDI needs us to address global health issues. But we also need FDI, as our "seat at the table" on international matters. For example, FDI provided the ADA with our opportunity to prevent the UN mercury treaty from including a ban on dental amalgam. We are lucky as a delegation to have the leadership of Dr. Chadwick. **Thank you Greg**.

As part of our obligation to stay abreast of our environment, Marko Vujicic, Ph.D., presented a report on the State of the Dental Market in 2014. The data shows that the dental market is not recovering with the general economy. Demand for dental care will likely continue to stagnate, with the exception of the public sector, especially for children.

While the number of children gaining dental care continues to grow, that growth does not exist for adults. Dr. Vujicic examined why this is the case, investigating barriers to care. Financial barriers and the lack of perceived need ("my mouth is healthy") far exceed any barrier relating to the number of providers. This may not be the case for Medicaid adults, but more work is needed to fully understand the dominant barriers facing this population. Further research on Medicaid expansion was also presented. In many states, there is a rapid expansion of the dental Medicaid population, but this poses its own threats and opportunities. The threats focus on the fact that Medicaid coverage expansion does not mean funding expansion (or addressing structural barriers inherent in the system). Medicaid expansion is an opportunity because it should increase the demand for dental care.

At this meeting, we welcomed the current class of the Diversity Institute both for lunch and for our diversity discussion during our meeting. Diversity is a key topic for the future success of the Association and as part of this meeting we reviewed and approved the 2014-2019 Diversity and Inclusion Plan. The Plan recognizes the risks we face if we ignore diversity, as well as the benefits we will reap if we succeed in becoming diverse as an association. These include greater membership and a greater opportunity to shape our profession. Our **first goal** under this Plan is to increase diversity in membership. **Goal Two** is to have an inclusive organization. The **final goal** is to institutionalize stability, in other words, to sustain the plan. **If any state in our 16th District has implemented plans or has ideas on how to increase diversity within our membership please share that with me and I will pass the information along to the Diversity Committee.**

We learned at this meeting that the ADA Foundation will not be hosting a formal Give Kids A Smile! Gala, but will follow a format similar to that used in San Antonio to honor Dr. David Whiston. This provides us with an opportunity to return to a less formal event on Monday evening for delegates and the Board. Last year, some on the Board felt that we collectively needed a better opportunity to honor Dr. Chuck Norman as our outgoing president. This will provide us with such an opportunity going forward.

Also at this meeting the BOT took a hard look at the student debt problem and possible approaches to it. Specifically, we examined business strategies addressing the issue. The private student loan market is dominated by a handful of major players, with many major banks dropping out of it. Underwriting standards are stricter than they used to be. The refinancing market, however, is starting to see new refinancing products emerge. This market is not well developed and therefore may provide the ADA an opportunity. Among the options open to us are to:

- Endorse a specific lender for existing products
- Endorse an advisor who could provide information on a variety of lenders
- Enter into a marketing relationship with a lender for a new product tailored to our members
- Enter into a marketing relationship enhanced with an ADA financial commitment to the program.

Clearly, the level of complexity under the last listed option far exceeds that found under the other options. Our next steps are to develop these concepts further for discussion by the Board at our next meeting.

Bill Robinson, our new Vice President of Member and Client Services, updated us on current activities under the Membership Growth Plan. Membership growth in market share continues to lag. We are seeing some progress in some of the satisfaction indicators we use, but clearly more is needed to be done. Some of the data shared with us highlight the importance of diversity because our shares in key market segments continue to lag. Bill also briefed us on the Membership Plan for Growth, our grant program to state and local societies focusing on membership initiatives. The Council on Membership provides oversight and determines which applications are funded.

In closing, the Board is looking forward to its retreat in February. It is always a fun time and a chance for the BOT to relax and get to know each other in a more informal setting. However we will have some serious discussions. We will be have an update and strategic discussions on the Power of Three. I look forward to updating you on that and our March BOT meeting in my next report.

LETTER TO THE EDITOR

A MALIGNANT INFECTION OF DENTAL ORIGIN

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

There exist two types of Ludwig's Angina:

1. A submandibular mass which contains a suppurative component, which can be drained and cultured
2. The submandibular mass has no exudates or suppurative material to drain and culture. This type has a poor prognosis and the case reported here is an example of this type.

While seeing patients in my office, I received an urgent call from the emergency room of Alexandria Hospital. I was asked to evaluate and treat an extremely ill patient. When I arrived I see a middle-aged white male with a tracheotomy in place and antibiotics being administered intravenously. His vital signs were relatively stable and blood work revealed a moderate leukocytosis but a very elevated blood glucose of 500mg. The patient was transported to operating room.

On intraoral exam there was trismus, the floor of the mouth was elevated bilaterally with a firm mass. It appeared that there was a partially impacted left third molar with a large carious lesion and pericoronal inflammation. The inflammation appeared to be heading toward the tonsillar region. Extraorally the bilateral swellings of submandibular regions and the submental regions were indurated with no areas of fluctuance. Radiographs revealed a necrotic and partially impacted left third molar. Before proceeding I sought consultation with an otolaryngologist who after examination of the patient agreed that the left mandibular third molar be removed and that the tonsil also be removed. After this it was decided to make 4 cm incisions in the right and left submandibular regions and in the submental regions. Incising in the areas felt like cutting wood. There was no evidence of suppuration or any loose, wet soft tissue. Drains were inserted deep into the incisions hoping for some exudates. (Figure 1) The procedure was performed with sodium pentathol. The patient was put on intravenous penicillin G.

On the second postoperative day there was no improvement and we decided to get an (outstanding) infectious disease specialist on this case. He used massive dosages of antibiotics and there was still no evidence of any drainage.

On the third postoperative day, the blood sugar was more controlled, but the neck swelling appeared to be descending in the neck. Our pathologist asked that I excise some muscle tissue from the neck mass, which was done in order to find some pathogens. (Figure 2)

On the fourth day there was still no suppuration, and the neck mass was still indurated and appeared to be approaching the supraclavicular regions. (Figure 3) Additional incisions were made to no avail. At this time a thoracic surgeon was consulted for possible involvement of the mediastinum. On the fifth day there was mediastinum invasion and the patient died.

Massive dosages of antibiotics were used and administered intravenously and intramuscularly. Some of the antibiotics used were penicillin G, streptomycin, staphcillin, tetracycline, etc. This case was seen at least twenty years ago and since then many new antibiotics are available. The patient had laceration of the supratemporal region treated by the emergency room.

*Formerly: Professor of Research, Adjunct Professor, Medical Physiology, the American University; Clinical Professor of Oral and Maxillofacial Surgery, Medical College of Virginia/Virginia Commonwealth University

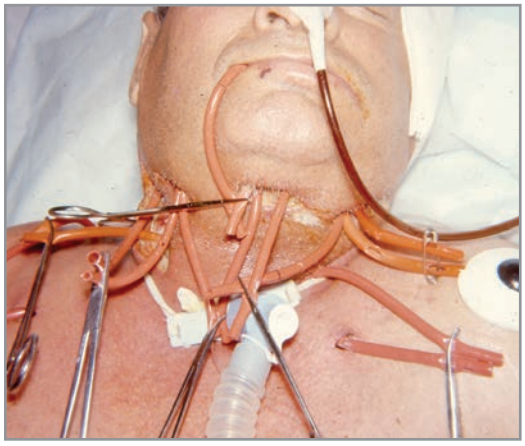

Figure 1

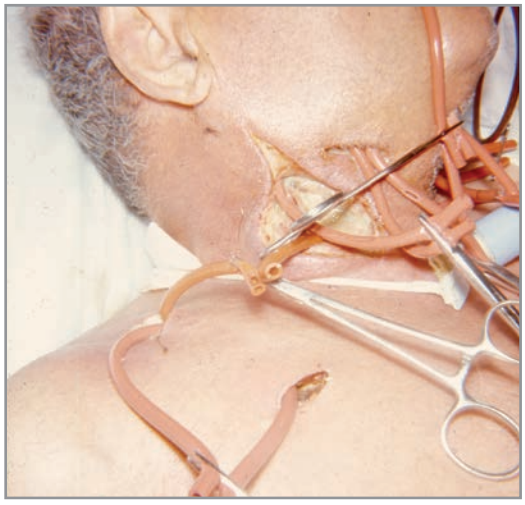

Figure 2

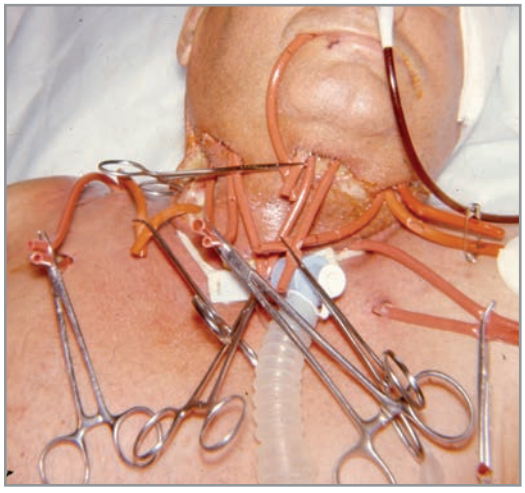

Figure 3

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courage TO LEAD

159th NC Dental Society Annual Session
May 14-17, 2015

Make Plans to Attend the 2015 NCDS Annual Session in Myrtle Beach

This year's Annual Session will be held at the Kingston Plantation Resort in Myrtle Beach, SC, May 14-17. Enjoy a strong speaker lineup, special events, and time to spend with colleagues you may not see very often. Be sure to make your reservations soon. The room block fills up quickly. Make a reservation by contacting Embassy Suites at Kingston Plantation, **800-876-0010**. Use Group Code **NCD** for discounted rates. Visit **www.ncdsannualsession.com** for more information.

Download the new 2015 NCDS Annual Session app at Google Play or the App Store.

LETTER TO THE EDITOR

MISSION ACCOMPLISHED!

Dr. Bob Allen

MOM event was held at Kings Fork Middle School in Suffolk February 28, 2015.

It was 5 a.m. when I departed home for the 45 minute drive from Hampton to Suffolk. It was still dark when I lined up behind all the cars coming into the parking lot surrounded by piles of snow. Police and volunteers were everywhere. I saw no one that I recognized, but picked up my badge at the front desk and entered for a bagel and drink before orientation.

I volunteered to do extractions.

As we broke the orientation I found my self standing beside a 27 year old young lady, a senior hygiene student from Roanoke. She had a dazed expression, and I suggested that she assist me; she was thrilled, as she has never assisted during surgery. Ruth and I made quite a team. By 7:30 a.m. we had removed our first tooth and by 10 a.m., we had accomplished so much I thought it was close to noon. Every chair appeared to have a dentist or hygienist working on a patient. So much surgery was done we had delays getting forceps and syringes from the sterilizing area that were not too hot to handle. I believe the large numbers of volunteers (students, dental students, dentists, hygienists and other) almost overwhelmed the system. But it all worked out. By 11:30 a.m. (as suggested during orientation), "Ruthie" and I decided to go early to the lunch room for the variety of good food provided and take a break. That also gave the sterilizing volunteers time to catch up with the providers.

By 3 p.m. I had begun my last extraction; was tired by the twenty five + extractions that we had done, my back was aching.

Ruth and I knew that this would be my last one for the day. She approved.

I am approaching my 82nd birthday and volunteered for this M.O.M. project to prove to my self that I could still "cut the mustard". I held my own, I found it necessary to request help on two extractions from someone younger with more stamina than I; I also jumped to help a senior dental student who could not get a root out in nearby chair. There was no reluctance from anyone who requested help or who was asked for help.

The patients were cooperative and appreciative.

I shared the following thought to dental friends: That not one of my "M.O.M." patients would not fit into any general practice that I know. Folks, with no financial resources just do not fit into our "fee for service" dental system. The alternative for these people is "no" treatment.

By 4 p.m., as I looked around many were doing the same as I; there were many empty chairs as others were finishing up also. There was still some dentistry being performed. I was tired, but probably would do it again tomorrow if asked.

My reward was meeting so many great professionals, general volunteers and the many students helping us do the work. I made a lot of new friends and saw many old friends whom I never see--except at dental society meetings, M.O.M. clinics, and homeless connect events in Norfolk. I may not be physically able to attend another M.O.M. event, but this was time well spent for an old guy who still loves dentistry.

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40 UNDER 40

NEW Feature

A new feature of the Virginia Dental Journal, 40 under 40 will introduce you to VDA members under forty years old in forty words or less.

40 UNDER 40

DR. TYLER BALL

I am a general dentist in Richmond, Virginia where I am currently employed at Jessup Family Dentistry. I love the concept of "general" dentistry and its various disciplines, and feel very fortunate to be part of such a rewarding profession.

HAVE YOU SEEN ME?

THE VDA IS WORKING FOR YOU!

If you've searched the internet lately, chances are you've run across an ad from the VDA. Beginning in December the VDA increased its digital display advertising as a way to get the message out about our "What a Healthy Mouth" campaign. We will be able to capture the public's attention while they are reading their morning news, searching for dinner ideas or even updating their Facebook status. This is just one of the ways the VDA is working for you. We encourage you to follow the five simple steps below to be sure you're making the most of the campaign. Learn more about some of our other campaign strategies on the following page.

ARE YOU MAKING THE MOST OF THE VDA'S ADVERTISING & PR CAMPAIGN?

Kirk M. Norbo, DMD

In the last edition of the *Virginia Dental Journal*, I was pleased to see the 2 pieces on pages 8 and 9 regarding the advertising and public relations campaign. The efforts are part of a three year campaign aimed at making VDA Members more visible to the public. The PR Task Force (of which I am the Chair) is working with experts in the field to have an integrated campaign that leverages search engine optimization, digital display advertising and public relations efforts to highlight the members of the VDA and enhance the reputation of your association.

My question for members is this – are you making the most out of this campaign and getting the greatest impact for your investment? With a little time and effort you could maximize the results you see from this campaign (See the easy steps below). The VDA is working hard to drive the public to search for a dentist on the VDA website but it is up to each member to make the most out of their profile and what potential patients see when they search for you. Since the campaign launched in May of 2013 there have been over **109,000** hits on the Find a Dentist page – that averages out to 174 per day! What are patients seeing when they search for you on the VDA website? Take time to find out and make changes where needed – the small investment of time could provide big returns for you and your practice.

FOLLOW THESE STEPS!

MAKE THE MOST OF THE VDA'S ADVERTISING & PUBLIC RELATIONS CAMPAIGN

STEP ONE:

Update your Find A Dentist Profile.
If you do nothing else...do this! If patients search for a dentist and your contact information is wrong, they won't be able to find you. Simply login to www.vadental.org/pro and double check to be sure we have your contact information correct, add a photo of yourself, and add your website address.

STEP TWO:

Download the VDA Member logo.
While you're logged in to the VDA website visit https://vadental.org/pro/member-resources/download-logo and download the VDA member logo.

You can use this on your business cards, letterhead, appointment reminders, website and marketing materials. Some of our members even added it to their scrubs.

STEP THREE:

Send us a photo of your practice
(landscape orientation, please)
We use these photos in two ways. First, we periodically post them on Facebook and also include them on our "Meet Our Members" web page. https://vadental.org/about-the-vda/meet-our-vda-members

STEP FOUR:

Connect with our social media efforts.
Each week we post a Tooth Tip on Facebook. Take a moment and share this Tooth Tip on your Facebook page. While you're at it don't forget to "Like" the VDA Facebook page.

STEP FIVE:

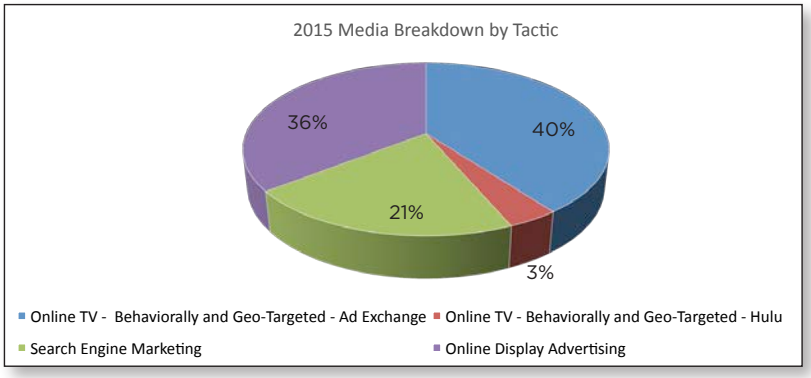
Survey your patients.
It's hard to know if the campaign is working for you if you don't ask your new patients how they heard about you. You can also take a look at how many people have viewed you VDA Find A Dentist profile when you login to the VDA website and check the "search statistics" tab. I bet you'll be surprised at how much traffic your profile has had.

NEED HELP WITH ANY OF THESE STEPS? Contact Shannon Jacobs at jacobs@vadental.org or 804-523-2186.

2015 Advertising Campaign Highlights

The Year At A Glance

Building on the success of the optimized digital campaign for the fourth quarter of 2014, the 2015 campaign will include video pre-roll, digital display banner ads and search engine optimization components. This integrated media plan is designed to continue the goal of connecting prospective patients to the VDA member dentists and positioning the VDA as a trusted healthcare resource.

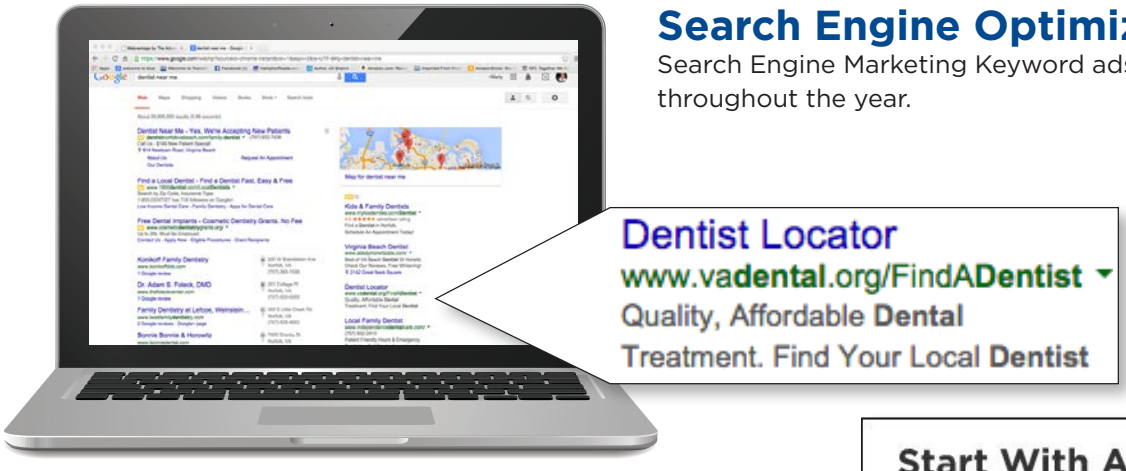


Video Pre-Roll

Features a series of video spots that educate Virginians about the value of common dental procedures as well as when they are necessary, all under the "Open Wise" brand. The clear message will be that to find a dentist and information you can trust, go to the VDA website.

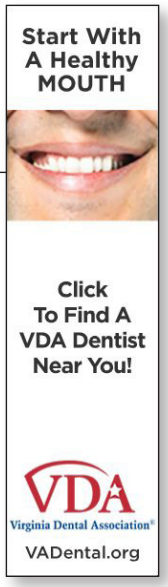
Search Engine Optimization (SEM)

Search Engine Marketing Keyword ads will run continuously throughout the year.



Digital Display

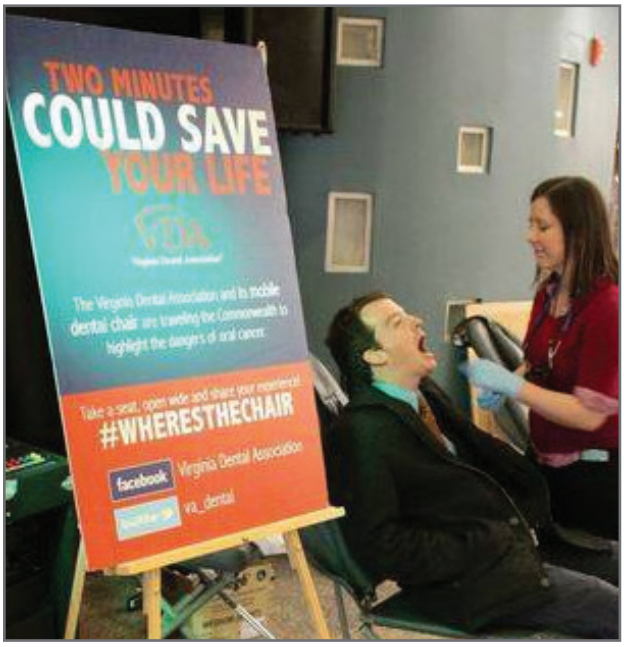
The digital display campaign will also run continuously throughout the year with a mix of digital display banner ad units.



WHERE'S THE CHAIR?

THE VDA MAKES HEADLINES IN ROANOKE

Danny Rubin, Rubin Communications Group



The VDA made headlines in Roanoke the week of February 23 with our fun and educational "Where's the Chair?" initiative. We brought a portable dental chair to 16 West Marketplace, a popular lunchtime destination in downtown Roanoke, and surprised people with impromptu oral cancer screenings.

Dr. David Black, one of our members, oversaw the oral cancer screening event, which went from 11:00am to 1:00pm.

The media also loved the "Where's the Chair?" concept as local TV stations and the The Roanoke Times covered the event. We hope to bring "Where's the Chair?" to more cities across the Commonwealth. So far the chair has appeared in Roanoke and Virginia Beach.

Where will the chair go next? Charlottesville?Richmond? Northern Virginia? You'll have to wait and see!

Until then, we have but one question:

WHERE'S THE CHAIR?

A BIG THANK YOU TO DRS. DAVID BLACK, GREG HARVEY AND ANNE NEWMAN FOR VOLUNTEERING THEIR TIME TO DO SCREENINGS AT THIS EVENT!

40 UNDER 40

DR. HOUMAN CHEGINI

I was undecided in between an additional year of residency versus hitting the real world. After hearing some different advice, I decided to start with a practice in Virginia Beach. It has been a great fit and very happy today.

AEGD ABSTRACTS:

EL-KHOLEY KE. EFFICACY OF TWO ANTIBIOTIC REGIMENS IN THE REDUCTION OF EARLY DENTAL IMPLANT FAILURE: A PILOT STUDY. INT J ORAL MAXILLOFAC SURG. 2014; 43(4): 487-490.

Problem: While dental implants have a high success rate, there are still cases in which implants fail. Infection is thought to play a crucial role in early implant failure. While antibiotics play an important role in medicine and dentistry, it is widely agreed upon by health professionals that the overall use of unnecessary antibiotics needs to be reduced. At this point, there is still no standard antibiotic protocol being used by dentists during implant therapy.

Purpose: The purpose of this study was to show if a preoperative single-dose antibiotic would be as effective as a postoperative three-day antibiotic course in reducing early implant failure.

Methods and Materials: The study included eighty patients that required dental implants between September 2010 and December 2012. Of the patients included there were 50 females and 30 males. All of the patients reported no medical issues and their ages ranged from 20 to 45 years (mean age was 31.1 years). Patients were excluded from the study if they had health conditions that would require antibiotic prophylaxis, had taken antibiotics in the past month, were pregnant, needed extensive bone grafting, or had any medical condition that may affect healing or predispose that patient to infection. The groups were randomly assigned using computer-generation and antibiotics were administered by a nurse who was unaware of the protocol. In the first group, a single dose of 1 gram oral amoxicillin was given 1 hour preoperatively and no antibiotics were given postoperatively- 47 implants were placed in this group. The second group was given 1 gram oral amoxicillin 1 hour preoperatively in addition to 500mg amoxicillin every 8 hours for 3 days following implant placement- 43 implants were placed in this group. All implants were placed according to manufacturer's protocol and were left submerged to heal for 3 months. Postoperative radiographs were evaluated at 3 days, 7 days, and 12 weeks. Postoperative wound infection was defined as presence of swelling, pain, erythema, tenderness or pus. For diagnosis of peri-implantitis apical radiolucency needed to be present around the implant in addition to signs and symptoms. At the 12 week visit, the second stage surgery was performed and healing caps were attached and torqued to 25 N cm. Any implant with good stability and absence of any clinical or radiographic signs was considered successfully osseointegrated and referred for placement of final prosthesis.

Results:

- In the first group of patients who received only preoperative antibiotics
    - Two patients showed wound dehiscence at two implant sites and the remaining patients healed without complications
    - One patient suffered pain and tenderness at the implant site after 2 weeks and was diagnosed with apical peri-implantitis. This patient was given a second course of antibiotics (500mg amoxicillin three times per day for five days)
    - At second stage surgery, all 47 implants placed were found to be normally osseointegrated and patients were referred to start the final restoration.
- In the second group that received both preoperative and postoperative antibiotics
    - One patient developed wound dehiscence with no inflammation or purulence
    - None of the patients were diagnosed with a postoperative infection, no implants showed any signs of failure, and no patients needed to receive any further antibiotics.
    - At second stage surgery, all 43 implants were found to be normally osseointegrated and were restored successfully.

Conclusions: From a statistical point of view, it can be concluded that giving one single preoperative dose of antibiotics is as effective as giving postoperative antibiotics when placing implants in a healthy individual not requiring antibiotics for another reason. Therefore, the use of antibiotics should be reserved for those instances when a high risk of postoperative infection has been demonstrated. This will reduce the likelihood of bacterial resistance and other complications that can arise from the overuse of antibiotics. The study is limited to a small sample size, but it can be reasoned that until larger, more conclusive study proves otherwise, it is advisable that a single preoperative dose of antibiotics may be sufficient for implant placement.

DR. JESSICA VELLUCCI;
Resident, Advanced Education in General Dentistry, Virginia Commonwealth University

ABSTRACT:

PRADIES G, ZARAUZ C, VALVERDE A, ET AL: CLINICAL EVALUATION COMPARING THE FIT OF ALL-CERAMIC CROWNS OBTAINED FROM SILICONE AND DIGITAL INTRAORAL IMPRESSIONS BASED ON WAVEFRONT SAMPLING TECHNOLOGY. J DENT. 2015; 43(2): 201-208.

Problem: Today computer aided design (CAD)/ computer aided manufacturing (CAM) techniques are seen as a standard workflow in general industry to obtain high quality products in terms of accuracy and cost production efficiency. One significant advance in the field of dentistry is the production of high resistance all ceramic restorations that until today can only be produced by CAD/CAM systems. The use of materials like zirconia has grown dramatically in the last decade due to their esthetic, mechanical and biocompatibility properties. Recently there have been developments in various optical impression systems that enable the practitioner to utilize intraoral scanners to obtain direct impressions in the oral cavity. However the number of studies that evaluate the fit of the restorations manufactured with an intraoral scanner is still limited.

Purpose: The authors conducted this in vivo prospective study in order to evaluate the accuracy of a digital intraoral impression workflow and compare it with conventional silicone impressions workflow by measuring the marginal and internal misfits of the zirconia-ceramic crowns generated with both systems.

Methods and Materials: The authors enrolled thirty participants into this study between the ages of 16 and 65 years of age that needed a single crown restoration in a posterior tooth. A total of 16 molars and 18 premolars were treated, 15 in the maxilla and 19 in the mandible. For each of the 34 teeth, three crowns were made- two crowns for the study, one made by each impression method (intra oral digital impression-IDI and conventional two step silicone impression –CI) and one crown to be cemented as the final restoration. The crown preparations had a chamfer finish line not exceeding a subgingival depth of 1mm. Consistent reduction guidelines were used for all preparations.

A double cord technique was used to allow for correct display of the finish line for the definitive impression in both groups. For the conventional impression a polyvinyl siloxane PVS material was used in a two-step impression technique in rim-lock metal trays. The digital oral impressions were made using an intraoral digital scanner based on wavefront sampling technology according to the manufacturer's scanning protocol- The digitized data from the conventional and digital impressions were transmitted to a CAD software program in which the copings were designed. The copings were milled from pre sintered zirconia blocks and then copings and SLA casts were sent to the lab where feldspathic porcelain was veneered on the copings of their corresponding casts. Before definitive insertion silicone replicas were produced for all 60 crowns that were made in order to register the space between the inner surface of the copings and the abutments. This thin silicone film representing the cement space was embedded in an acrylic resin for stabilization. Image analysis software was used to measure film thickness at the sites margin, axial, crest and occlusal fossa. 10 measurements at each site were taken resulting in 40 measurements around each specimen. The overall misfit discrepancy was calculated to compare the two impression methods. The sample sized was calculated for 80% power. Statistical analysis was performed by software.

Results and Conclusions: Statistical analysis showed that the IDI restorations had a significantly better fit than the CI group at every site analyzed with the exception of crest gap. The global comparison also showed significant better fit for the IDI group. The null hypothesis that there was no difference in marginal and internal misfit between crowns obtained from digital and silicone impressions was rejected. The authors found that the mean marginal gap size was 76.33 µm for the digital impression and 91.46 µm for the PVS impression. This study found that the zirconia based ceramic crowns fabricated using digital impression obtained better marginal and internal fit than the crowns fabricated from the conventional impression. While the mean marginal discrepancy in both groups was within the limits of clinical acceptability, this study indicates that that with further evidence digital impressions have the potential to eventually become the gold standard for impression making in fixed prosthodontics.

DR. JENNA MARCINCZYK;
Resident, Advanced Education in General Dentistry, Virginia Commonwealth University

40 UNDER 40

DR. FRANCISCO T. CARLOS
Born in Texas, raised in Puerto Rico, college and dental school in New England, residency in Virginia, Air Force active duty, and landed in a periodontal practice in Falls Church, VA. Worth it to find the place I call home.

ABSTRACT:

PEPLA E, BESHERAT LK, PALAIA G, ET AL. NANO-HYDROXYAPATITE AND ITS APPLICATIONS IN PREVENTATIVE, RESTORATIVE, AND REGENERATIVE DENTISTRY: A REVIEW OF LITERATURE. ANNALI DI STOMATOLOGIA 2014; 5(3): 108-114.

Purpose: Nano-hydroxyapatite has been studied extensively in the medical field due to its ability to bond to bone without creating an inflammatory reaction and stimulate osteoblast activity and therefore bone growth. Its biocompatibility and impressive characteristics make it a key area of interest for preventative, restorative, and regenerative dentistry. The authors aimed to review current literature for its use and success in dentistry.

Key Points:

- Materials: The first toothpaste containing synthetic nano-hydroxyapatite (nano-HA) was marketed in Europe in 2006. Rather than changing the existing layer of enamel to increase hardness as fluoride does, it formed a new layer of synthetic enamel around the tooth. Moshaverina, et al. found that adding nano-hydroxyapatite or fluorapatite to Fuji II GC resulted in improved compressive, diametral tensile, and biaxial flexural forces and improved bonding strength to dentin after 1 and 7 days. Fluorapatite containing Fuji II continued to have high mechanical properties and binding after 7 and 30 days.
- Remineralization: T. Schoppe, et al noted improved remineralization of enamel and dentin lesions after using a nano-hydroxyapatite toothpaste as compared to those containing fluoride. Huang, et al. tested microhardness of lesions to evaluate remineralization by nano-HA under cyclical changes in pH, finding that nano-HA had the highest remineralizing capacity at pH < 7.0, thought to be due to it being an excellent source of free calcium as was measured in the solution. Min, et al studied the addition of nano-HA to sports drinks, and showed that surface microhardness was increased by nano-HA with the best results found at 0.25% nano-HA. Hangoo, et al discovered similar results using beer as the solution.
- Hypersensitivity: Orseni et al. compared desensitizing dentrifices containing 1.) 8% arginine, 1,450 ppm Na2PFO3, 2.) 8% Strontium acetate, 1,040 pm NaF, 3.) 30% microaggregation of zinc carbonate HA; all proved effective as desensitizers. Browing et al found that using a HA paste significantly reduced the number of days with sensitivity during active H2O2 bleaching; however, sensitivity was not completely eliminated.
- Surgical: Masahiro et al. analyzed nano-polymorphic crystalline HA applied to microrough surfaces of dental implants and showed these implants had increased bone volume within 50 μm of the implant; however, past this point, the bone volume was low. Singh et al. compared application of nano-crystalline HA bone graft material to open flap debridement alone for treating bony defects. The grafted sites showed statistically significant reduction in probing depth, CAL gain, and percentage of bone filling. Qu et al. found that membranes formed by a composite of nano-HA and polyamide 66 had a higher initial proliferation of bone marrow stromal cells. Other research has looked to using a nano-HA paste as a bone graft substitute and to stimulate PDL cells.

Conclusions: The authors raise great awareness about the current and future applications of nano-HA in not only implant dentistry, but also restorative and preventative arenas. The cited studies are promising, however more research and sources appear necessary to support these findings and make them routine additions to the practice of dentistry.

DR. SUZIE SHEFFIELD;
Resident, Advanced Education in General Dentistry, Virginia Commonwealth University

40 UNDER 40

DR. LINDSEY E. HOSEK

Dr. Lindsey Hosek graduated from University of Maryland Baltimore Dental School in 2013. She currently works in private practice with her father located in Virginia Beach. They pride themselves on being very technologically advanced and offer same day crowns.

ABSTRACT:

FUENTEALBA R, JOFRE J. ESTHETIC FAILURE IN IMPLANT DENTISTRY. DENT CLIN NORTH AMERICA. 2015; 59 (1): 227-246.

Problem: Implants have historically been categorized into success or failure based on osseointegration, but esthetic success is becoming a more important benchmark now that implants are a routine component in the dental armamentarium.

Purpose: To divide esthetic implant failures into two categories – white-tissue failures and pink-tissue failures and discuss how esthetic failures can be avoided and treated.

Key Points: Osseointegration has remained the main determinant in implant success, which has currently is defined as minimal bone loss and the absence of both clinical mobility and radiographic radiolucency. Failure in implant dentistry should be redefined to not only include loss of osseointegration, but also lack of esthetic outcome.

- Objective Value of Esthetic Failure: PES/WES score (Pink Esthetic Score/ White Esthetic Score) from Cosyn and colleagues, which used Belser's WES score and modified Furhauser's PES score setting esthetic boundaries to success vs. failure.
  - Seven parameters of pink esthetics were assessed on a 2 (best)-1-0 (poorest) score, including mesial and distal papillae, soft tissue level, contour, texture, color and alveolar process deficiency.
  - Five parameters of white esthetics were assessed on the same scale, including tooth form, crown outline/ volume, color, surface texture and translucency/characterization.
  - Esthetic failure is characterized as <8 PES and <6 WES.

- Pink tissue failure includes: facial recession, gingival asymmetry, papillary deficiency and gingival graying. This can be avoided by considering:
  - Implant position – Three dimensional implant placement considerations should create an ideal emergence profile by planning angulation of the implant through the palatal portion of the incisal edge of the final restoration. The implant platform should be 3mm apical to the gingival crest of planned restoration and the center of the implant should be 3mm palatal to the facial margin of the final restoration.
    - For proper bony and gingival architecture with side by side implants, inter-implant space should be no less than 3mm and the distance from the base of the proximal contact to the crest of bone should not be greater than 5mm. To correct a black triangle, proximal contacts should be extended apically when soft tissue and bony augmentation have failed.
    - For anterior edentulous spaces of three or more teeth, the bone has a flat profile, so higher esthetic results are achieved with FPDs with ovate pontics to mimic normal gingival architecture. Most esthetic is as follows:
      - Missing centrals and laterals: 1 FPD from lateral to lateral
      - Missing canine to canine: 2 FPDs from canine to central
  - Risk of esthetic failure is higher when implants are placed without surgical guides. Surgical guides created from a restorative wax-up are non-ideal, as they do not consider bony architecture, but using virtual planning can merge both bony and restorative considerations with higher accuracy for guide fabrication.
  - Timing – immediate provisionalization can be considered in cases with primary stability, a thick biotype and at least 1mm of facial bone thickness. Otherwise, delayed provisionalization should be considered.
    - If delayed, provisionals should have increasing width to slowly shape the soft tissue until desired esthetic results are achieved. The final restoration should have the same emergence profile, using a custom impression coping to replicate the provisional emergence profile.
  - Surgery should be minimally invasive for best esthetic results, maintaining at least 3mm of peri-implant gingival thickness.
  If a facial bone defect exists, grafting is necessary to avoid recession.
  - Implant diameter <4mm preserves facial bone and allows for better esthetics.
  - Implant abutment should be narrower than the platform to decrease bone loss.

- Patients with a thin gingival biotype:
  - For patients with a thin gingival biotype, the body and shoulder of the implant may need to be placed more palatally to avoid gray coloration.
  - Connective tissue grafts should be considered for gingival esthetics in patients with a thin biotype.
  - Final restoration should be zirconia abutment with all ceramic crowns for thin biotype patients for a more natural appearance. The neck of the implant abutment can also be stained with pink porcelain if needed for gingival color.
  - Patients with a thin biotype may benefit from undercontoured facial aspects of the abutment and crown to allow for maximum depth of facial gingiva.

White tissue failures can always be corrected, and should be managed with an experienced lab and laboratory technician as a team approach.

Clinical Usefulness: This article helps to establish the most important aspects of implant esthetics result from proper planning and implant placement for proper bony and gingival architecture and help in specific considerations for patients with a thin biotype. If practitioners keep these factors in mind, implant esthetics should have a more predictable success rate.

DR. COLLEEN CHAMBERS; Resident, Advanced Education in General Dentistry, Virginia Commonwealth University

ABSTRACT:

NEEL E, CHRZANOWSKI W, SALIH VM, KIM H, KNOWLES J. TISSUE ENGINEERING IN DENTISTRY. J DENT 2014; 42(8): 915-928.

Problem: When craniofacial tissue is lost due to congenital abnormalities, trauma, or infection, patients are left with physical defects that can cause significant psychological turmoil. While improvements have been made over the decades, successfully restoring lost tissues in the head and neck region continues to challenge researchers and clinicians.

Purpose: The authors of this review intended to educate readers with the greatest achievements to date as well as possible future endeavors for the field of craniofacial tissue engineering.

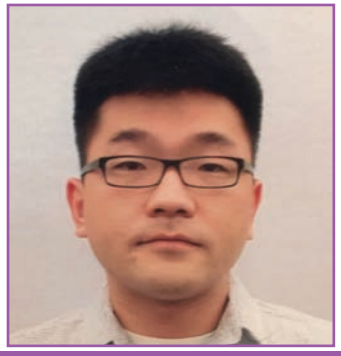
Materials and Methods: The "PUBMED" database was utilized to find applicable journal abstracts and full text articles. The following search terms were used, individually and in combination: "dental stem cells", "guided tissue regeneration", "approaches", "tissue engineering", "dentistry", "strategies", "dentino-pulp complex", "TMJ", "whole tooth", "oral mucosa", "salivary glands", and "condyle". Emphasis was placed on topics related to the causes of craniofacial tissue loss, strategies and techniques used in tissue engineering as a means to craniofacial reconstruction, achievements in the field of tissue engineering in dentistry, what materials are currently used, future prospects, and present challenges.

Conclusions: Advancements in cell injection and cell induction therapies have led researchers to the cell-matrix engineering strategy, where a cell population (generally mesenchymal stem cells) is isolated from a patient biopsy, allowed to differentiate on a scaffold designed to reconstruct the missing tissues, and then implanted onto the defect site. Success has been seen regenerating the dentine-pulp complex using this strategy. Replacing periodontal tissues has also seen success using biodegradable scaffold materials along with tissue growth factors to induce cell growth (as seen in guided tissue regeneration and endogenous regenerative technology), although results are still unpredictable due to the complexity of the tissues being replaced. Whole tooth regeneration has been attempted in rats using a scaffold in the shape of a tooth seeded with cells from porcine third molar tooth buds with some success, however the size of the tooth did not follow the scaffold. Engineering the appropriate size, color, type of tooth, and surrounding structures is still in developmental stages. Other research is being conducted to regenerate oral mucosa, facial muscles, salivary glands, bone, and TMJ. Significant progress has been made, but overall is still in experimental phases as the timing of cell differentiation and signaling necessary growth factors and cytokines of several different tissues becomes very complex.

Significant changes have already begun to take place in the field of dentistry due to advancements in tissue engineering, but much work is left to be done before large scale bioengineered reconstructions can be produced clinically. Challenges include considering the safety of patients, since even the successful results are often unpredictable and unable to be reproduced even in animal trials. Future research is aimed at placing cell based implants instead of metal-based ones, along with regenerating all tissues associated with the root of the tooth. The field of tissue engineering in dentistry has much potential for progress in the future, and clinical dentistry will continue to see permanent changes as a result.

DR. CHRISTINA COWLEY; Resident, Advanced Education in General Dentistry, Virginia Commonwealth University

40 UNDER 40



DR. DONG HONG

"Don't be a carpenter. Be a doctor." Finishing an extensive dental education through GPR and prosthodontics, boosted confidence to treat patients to return their smile. I'm blessed to work as an associate at offices in Northern Virginia and DC.

VDA MEMBERSHIP TASK FORCE SUMMARY REPORT:

AN ASSESSMENT OF FACTORS RELATED TO NON-RENEWAL OF VDA MEMBERSHIP: PART II

Drs. Julie M. Coe, Al M. Best, Alfred Certosimo, Kyle Coble
Virginia Commonwealth University

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Background
Membership renewals/retention is a critical issue to VDA's sustainability as the membership renewal rate as well as VDA market share has been decreasing recently. The authors' previous analysis of 2010 VDA membership data revealed that younger and newer members in a large component were more likely not to renew their membership. The purpose of this study was to identify reasons for non-renewals and what member benefits influenced the membership renewals.

Methods
A paired case-control design was adopted for this study. There were 337 cases who did not renew their ADA/VDA membership in CY 2009, 2010, or 2011 and 337 controls randomly selected from 2873 current members. Cases and controls were matched based on the predicted probability of renewal using significant predictor variables from our previous study. Data were collected between November 2012 and May 2013. A total of 142 responses were obtained: 46 cases and 96 controls.

Results
Over sixty percent of cases mentioned that they decided not to renew because dues were too expensive. Over thirty percent mentioned that membership in other professional organization was more valuable. For both cases and controls, the following member benefits influenced the membership renewal the most: *participation in legislative effort, subscription to journals and publications,* and *discount to CE*. The respondents desired **flexible options in the membership**, more transparency on where the dues were used, and flexible billing process.

Conclusions
Consumerism and competition among professional organizations are apparent. The membership retention may be best approached as if retaining customers. Listen to diverse demands of the customers, carefully position ADA/VDA in the market place, and communicate the membership benefits more effectively. Also the study identified the most influential member benefits that the VDA can focus their resources more strategically.

VDA Membership Task Force Summary Report: Part I identified significant factors to ADA/VDA membership renewals.[1] Factors such as age, specialty, local component, ADA years, VDA years, and dues payment percentage were strongly related to renewal while gender, race, and practice type were *not* related to membership renewal. Non-renewals occurred predominantly among those with ADA membership years <5 years (81% renewal) compared to those with 6-10 years (94% renewal) and 11-15 years renewing (98% renewal) (P = 0.0004). Sixty-nine percent of all attrition occurred before 15 years of ADA membership.[1] This is similar to Gruen et al.'s study where the authors validated that the percentage of new members and the membership's core service performance are the two most critical factors to membership retention in a professional membership organization.[2]

This study's focus was to identify reasons for membership non-renewals and the ADA/VDA membership core service (member benefits) performance related to the membership renewals. The specific aims were to:

- Obtain information about past members who did not renew and reasons for non-renewals
- Compare members who did not renew with members who did renew on perceptions of the membership core services.

Methods
This study was approved by the VCU Institutional Review Board. VDA's membership 2009-2011 membership rosters were used to identify cases: members who did not renew their membership and potential controls: those renewing their membership. The 2009 dataset had 3406 members listed, of whom 162 did not renew. The 2010 dataset had 3394 members listed, of whom 114 did not renew. The 2011 dataset had 3489 members listed, of whom 128 did not renew. These three files were merged together by unique ADA member number, yielding 3783 individual members. There were 377 cases (non-renewals) with a valid email and 2873 potential controls.

Selection of matched controls
Controls and cases were matched using factors significant to membership renewals: ADA total years, VDA total years, age, specialty group, and pay percentage. Specialty group was collapsed to: GP, no specialty, or a non-GP specialty. Pay percentage was grouped to have three values: always zero percentage (2009, 2010, and 2011), always full payment, any other combination of payment percentages.

In November 2012, invitations to the survey were sent out via email through the REDCap survey system.[3] Two email reminders and one reminder in regular mail were sent to non-responders.

Questionnaire
The survey was designed based on the extensive literature review on previous

VDA MEMBERSHIP TASK FORCE SUMMARY REPORT *Continued*

Table 1. Description of survey respondents and comparison to those invitees

	Cases		Controls		Invited
Characteristic	N	%	N	%	%
Matched characteristics					
Paygroup					
0%	3	7	8	8	10
reduced	9	20	15	16	41
100%	34	74	73	76	48
Specialty					
GP	38	83	76	79	82
Specialty	7	15	19	20	14
Other	1	2	1	1	4

	Cases		Controls		
	Mean	SD	Mean	SD	Mean
Age (years)	43.42	12.62	47.06	11.23	45.38
ADA years	9.70	9.75	13.93	11.66	11.58
VDA years	8.29	9.22	11.49	10.26	8.51

	Cases		Controls		Invited
Demographics	N	%	N	%	%
Sex					
F	18	39	39	41	39
M	28	61	56	58	61
Race					
American Indian	0	0	1	1	0
Asian	8	17	15	16	16
African American/Black	5	11	5	5	13
Hispanic	0	0	3	3	4
White	31	67	67	70	67
other	3	7	8	8	0
Component					
H-Northern Virginia	23	50	41	43	49
B-Peninsula	1	2	5	5	5
E-Piedmont	3	7	4	4	6
D-Richmond	7	15	20	21	14
G-Shenandoah Valley	3	7	10	10	7
C-Southside	1	2	3	3	3
F-Southwest Virginia	0	0	4	4	3
A-Tidewater	3	7	9	9	13

(N = number of subjects)

ADA and VDA reports related to membership and published papers and books related to professional association management. It was pre-tested and VDA's feedback was also incorporated.

Statistical Analysis

Comparisons between groups were performed using a chi-square analysis or a t-test. Multivariate comparisons were made using repeated-measures mixed-model analyses using SAS software (SAS version 9.3 and JMP pro version 10, SAS Institute, Inc., Cary NC). Statistical significance was identified at alpha=<0.05.

Results Comparison between invitees and respondents: non-response bias

Forty six out of 337 cases responded to the survey and 96 out of 337 controls responded. To test for a non-response bias, we compared the characteristics of the responding cases and controls. There was no significant difference between those invited and those responding by specialty, age, gender, race, ADA years, VDA years, and component.

Characteristics of Cases and Controls

Table 1 describes characteristics of the 142 respondents. For the questions asking about ADA/VDA membership years, the question to a current member was worded as "… years you have been a … member" while the question to a non-member was worded as the number of years "when you discontinued your membership." This resulted in the years for the cases were lower than those for the controls. Twenty-four percent of the current member respondents had reinstated their VDA membership (23 out of 96) and nine respondents indicated financial considerations as a reason.

Questions to Cases/non-members

The most common non-renewal reason (63%) was that the dues are too expensive (Figure 2). However, more than half checked multiple reasons. Of the 29 people who found dues too expensive, nine also checked that "ADA/VDA did not meet my expectation" or that "I can get ADA/VDA member benefits elsewhere without paying my dues." Nine percent of the respondents to the survey are also members of the Academy of General Dentistry.

To the question of what changes would get them to renew, over half of those responding indicated that they wished to be able to join only selected levels of the tripartite (Figure 3).

Core service performance: most influencing membership benefits

For both members and non-members, the following items have higher mean influence scores than the other items: journal subscriptions, discounts for CE, and legislative efforts (indicated with asterisk, Figure 4). No difference in the core service performance between

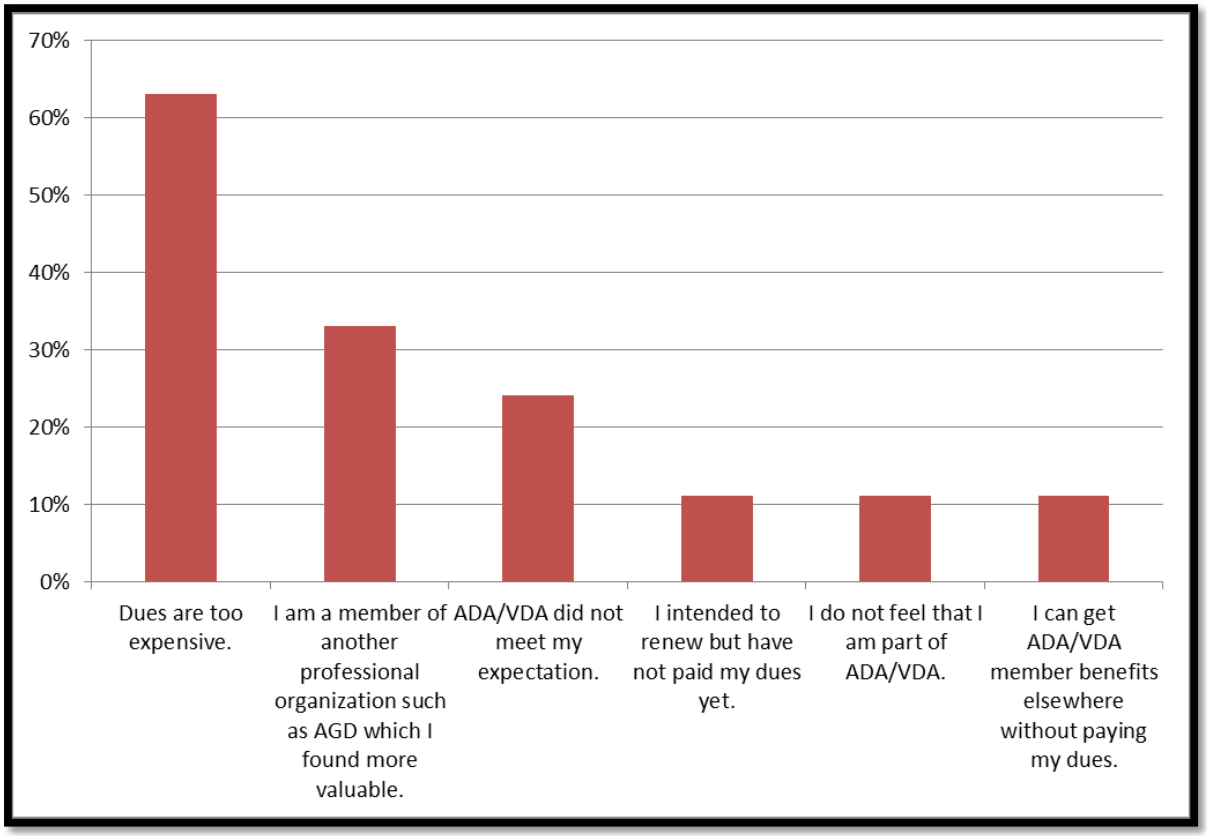
Continued on page 22

Table 2. I agree with ADA/VDAs views on political issues such as midlevel providers and dealing with insurance companies.

	Cases (non-members)		Controls (members)	
Response	N	%	N	%
Yes	17	37	64	67
No	7	15	6	6
I am not very aware of ADA/VDAs view on legislative and regulatory issues.	22	48	25	26
Total	46		95	

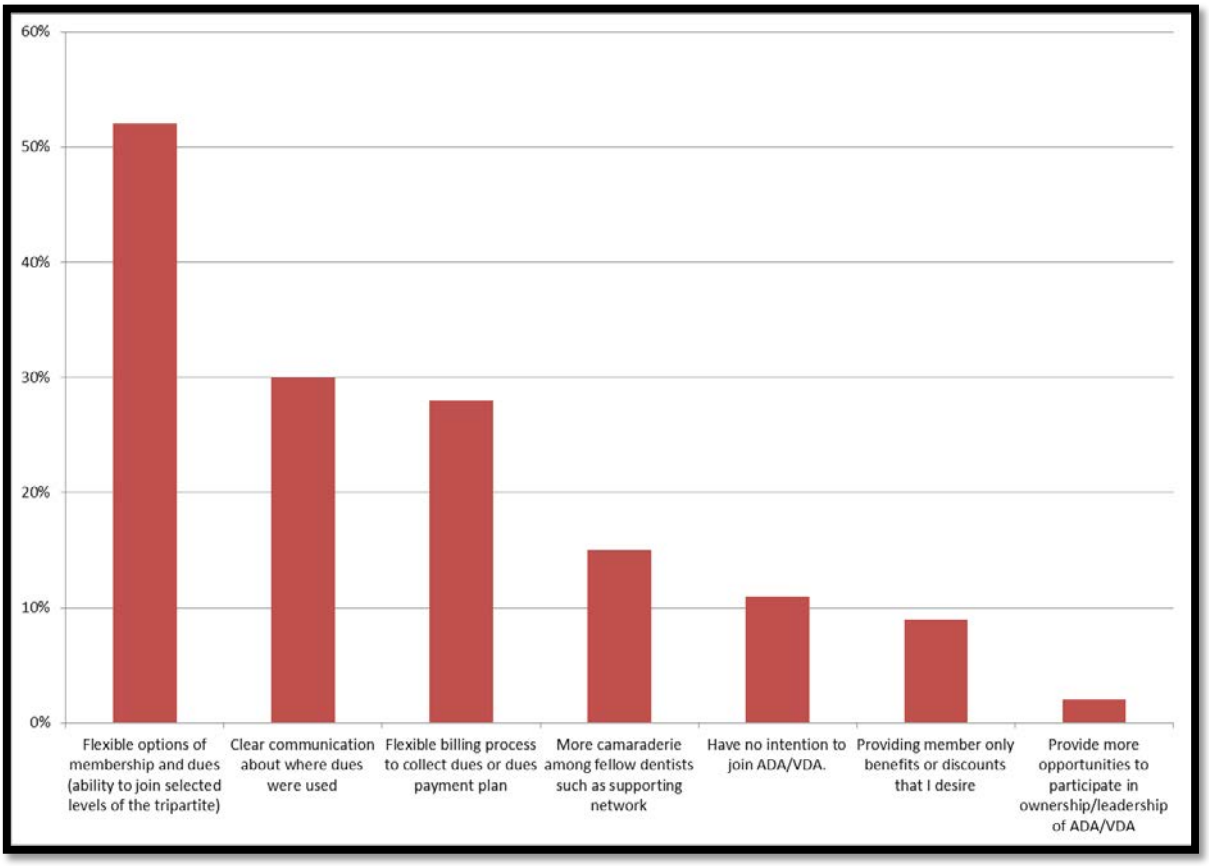
(Note: chi-square p-value = 0.0026)

Figure 1. Questions to non-renews: What made you decide not to renew your ADA/VDA membership?



VDA MEMBERSHIP TASK FORCE SUMMARY REPORT *Continued*

Figure 2. Questions to non-renews: What change would make you renew?



members and non-members was found (P = 0.0476). The items influenced membership renewals independent of each other (P < .0001).

Opinions regarding membership dues and organized dentistry

Current members indicate "yes" 59% (95%CI = 48.9 to 68.3%) of the time whereas only 16% (95% CI = 7.7 to 28.8%) of non-members respond this way (P < .0001). Both members and non-members were then asked about a reasonable dues level and these responses are summarized in Figure 5. The final section asked questions about organized dentistry. Members are twice as likely to agree with the political views of VDA/ADA (Table 2).

Discussion/Conclusions

Both members (Controls) and non-members (Cases) perceived dues to be expensive. They may perceive the dues "expensive" compared to other organizations or compared to benefits received in exchange for the dues. Competition with other professional organizations may have affected the non-renewal. ADA/VDA need to determine how to position it from other competitors and communicate the member benefits' values compared to those of the competitors to justify the dues.

To improve member retention, ADA/VDA need to focus on the most influential member benefits such as *journal subscriptions, discounts for CE*, and *legislative efforts*. Flexible options in membership would likely empower the members if the current tripartite bylaws allow it. Clear communication about where the dues were used to the members will help justify the dues and increase transparency.

Conclusions

To better retain their members and market share, ADA/VDA need to realize the increase in consumerism and competition in the professional organization membership market and approach the membership retention by listening to the *customers'* (member dentists) diverse demands, carefully repositioning ADA/VDA among the competitors, and effectively communicating the member benefits in exchange for the membership dues. Also this study identified the most influential member benefits so that the ADA/VDA can focus their resources more strategically.

Acknowledgment

Sincere gratitude is expressed to the Virginia Dental Association, especially to Ms. Leslie Pinkston. The REDCap survey software is funded by the Center for Clinical and Translational Research and VCU Technology Services grant support (CTSA Award Number UL1TR000058).

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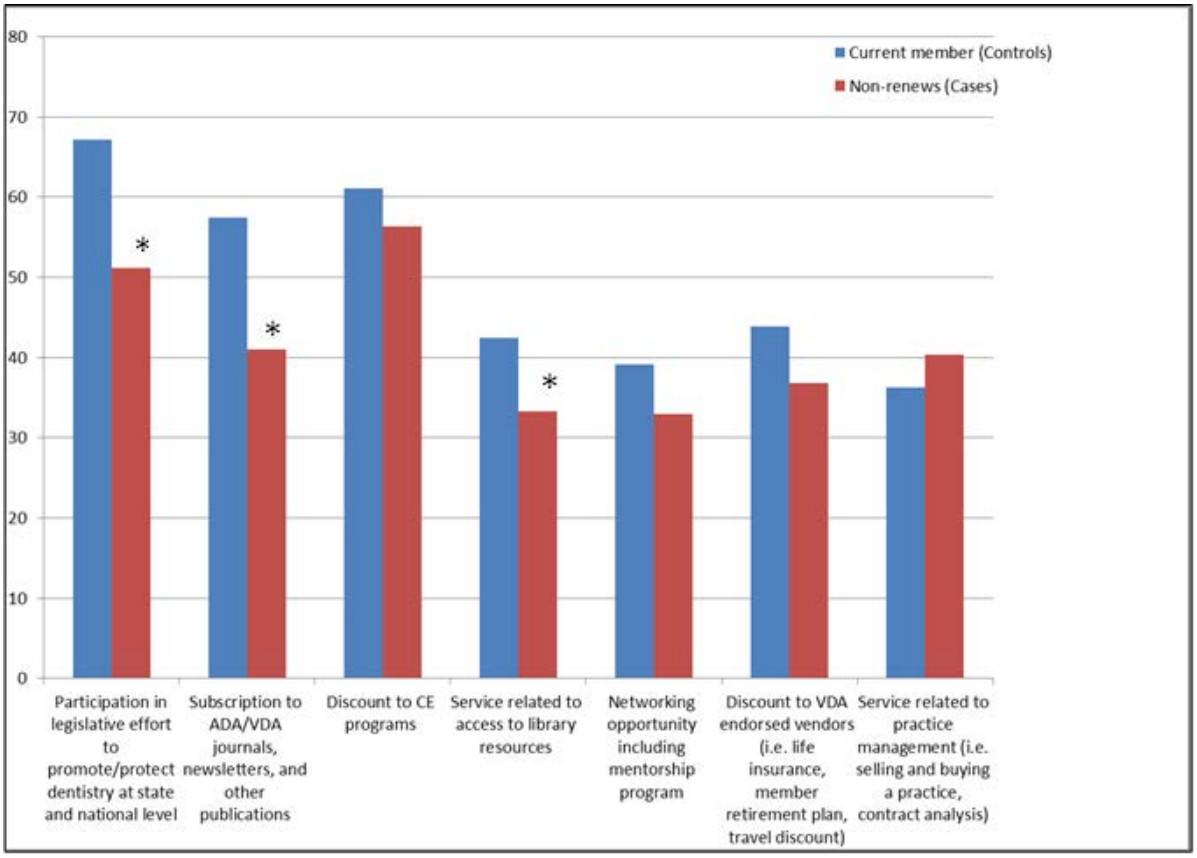
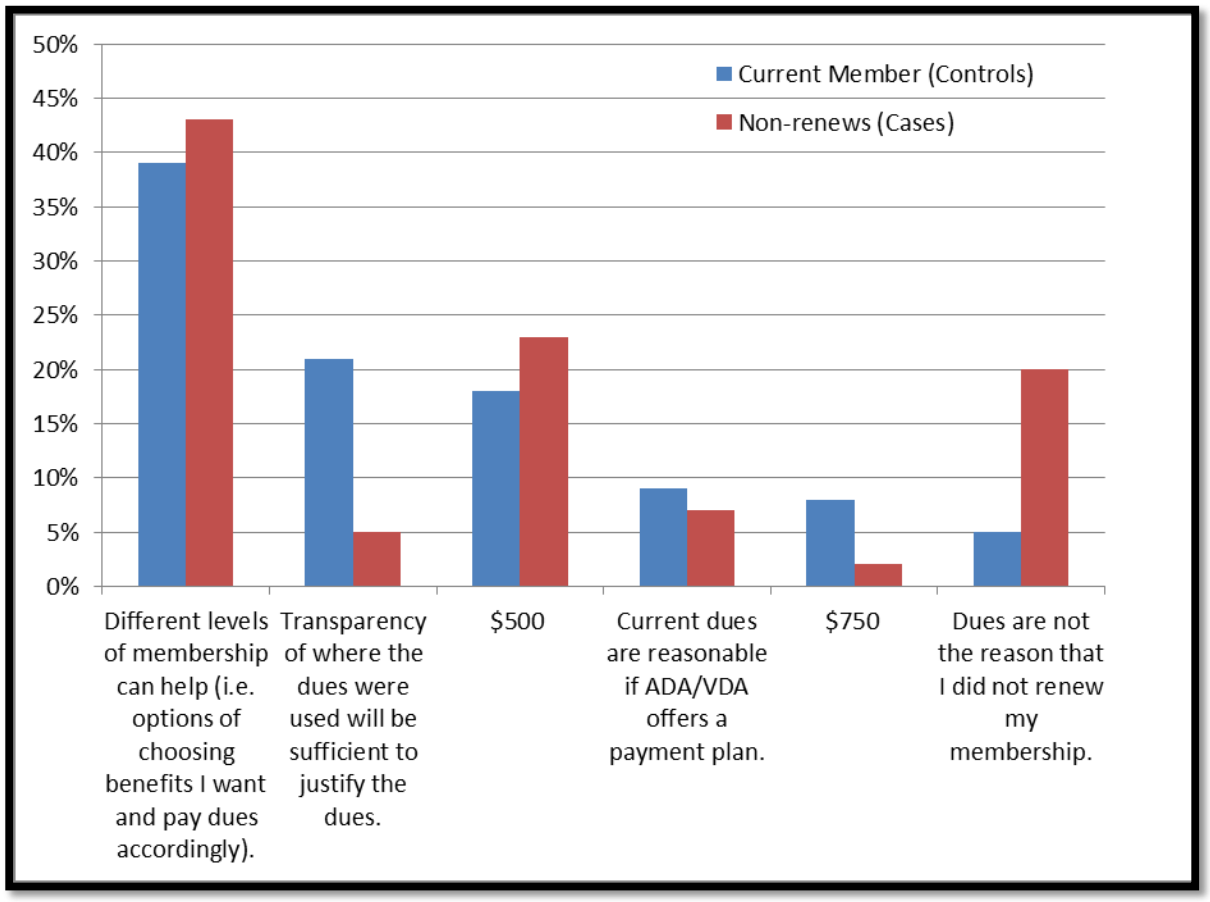
Figure 3. Core Service Performance
How much did each benefit influence you to decide wheather or not to renew ADA/VDA membership? (VAS: 1-100)



(Items with * indicates that there is a significant difference between control means and cases means.)

Figure 4. Opinions about membership dues
If the current tripartite dues prohibit you from renewing your membership with ADA/VDA, what would be the reasonable dues to maintain your membership?



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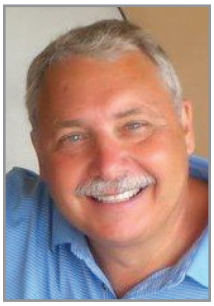

THE ETHICAL DILEMMA:

TO REFER OR NOT TO REFER

Dr. Thomas J. DeMayo; VDA Ethics & Judicial Affairs Committee

Prium Non Nocere ("above all, do no harm") is the principle precept of Medical Ethics and is also found within the ADA's Principles of Ethics and Code of Professional Conduct under "Nonmaleficence". The Principle of Nonmaleficence in brief states that the dentist has the obligation to provide the patient with proper diagnosis and treatment and to refer when necessary.

Today's patients have a higher "dental IQ" than ever before and also have higher expectations regarding the treatment that they receive. There are many reasons which govern whether a procedure is performed by a general practitioner or if that procedure is referred to a specialty practice, but one's personal economics should never enter into the equation. Likewise the patient's trust in the general practitioner and fear of being referred to an unknown provider should not sway a dentist to perform a procedure that he or she otherwise would refer. The practitioner has an ethical and legal obligation to self-assess and decide if he or she has the expertise needed to manage a particular dental malady in a timely and predictable fashion. Every dental specialty association offers guidelines to the dental community concerning when it is prudent to treat or to refer a patient. And any local specialist would be happy to provide their general practitioners with lectures that review their specific specialty's guidelines.

In general, reasons for a referral should be based on the level of difficulty associated with the treatment procedure for that specific case, the dentist's personal level of expertise and confidence, the patient's medical history, and/or the patient's level of anxiety. Conditions specific to a patient such as a heightened gag reflex or limited opening, could make procedures, that otherwise would appear to be routine, very complicated. Proper diagnosis is paramount because only then can proper treatment follow. If the diagnosis was wrong, any treatment rendered, no matter how clinically excellent, is in reality a failure. This could lead to a patient's loss of confidence in the dentist, the procedure, and in the dental profession. State of the art technology, instruments and the utilization of novel materials are no replacement for clinical skill and experience but are rather adjuncts that a practitioner can employ to reach a desired goal. It is imperative that a careful sequence of case selection and treatment planning be carried out based on the clinical presentation and the dentist's own knowledge of his or her abilities and limitations[1]. The bottom line, as mandated by the ADA and VDA, is that the practicing dentist must be able to provide the patient with a level of care or competence that is consistent with the specialists who provide that same care in that same geographic area (this is The Standard of Practice). If a case exceeds one's training or comfort zone or the general practitioner simply feels that it exceeds a personal level of competence, the patient should be referred. For a reasonable patient, who respects his or her dentist's judgment and diagnostic skill, when time is taken to explain why a referral is necessary, the patient should be appreciative of the referral. The proper referral will actually allow the dentist more time for other procedures and will enhance the patient's satisfaction and ultimately the doctor -patient relationship. The patient and the practice of dentistry will ultimately benefit from the ideal and proper treatment that is afforded to our patients.

In order for a referral to be a positive experience for the patient, general dentists need to have a good working relationship with each specialist to whom they refer. Most specialists will go the extra mile to treat an emergency patient in a timely manner. It should be understood however, that providers who regularly refer difficult cases will receive a scheduling priority and providers who only refer cases that had inadequate diagnosis or treatment, and want the specialist to "bail them out of trouble" generally will not receive top priority. A referring dentist should keep the specialist informed (verbally or in writing) of the suspected diagnosis, patient-specific nuances, treatment plan, what you anticipate as a treatment outcome, as well as what you have already discussed with the patient. Following any specialty treatment the general dentist should schedule a follow-up appointment with their patient. Of course the specialist should always provide a report following any treatment that includes appropriate information (as necessary) i.e. pre-op and post op images, histological diagnosis or the potential need for future procedures.

Advances made in dentistry have allowed our patients to maintain a functioning dentition for a lifetime, and any treatment alternatives that we offer our patients must have their wellbeing and health as our primary goal. We must always honestly assess our own level of expertise with regard to every patient's unique treatment needs, and determine when to treat and when to refer.

1 Law A.S., Withrow J.C., ENDODONTICS Colleagues for Excellence Spring/Summer 2005

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ASSESSMENT:

AN IMPORTANT SKILL FOR YOUR DENTAL PRACTICE

Dr. James R. Schroeder

In my previous chapter of life I spent 14 years on the school board and for the past 37 years have served as an adjunct faculty member at Virginia Commonwealth University School of Dentistry.

Assessment is a popular mantra in the field of education at all levels. The Standards of Learning (SOLs) were introduced in the '90s, established and measured to provide objective evidence that students were learning and tax payer dollars were being used effectively. Dental students are required to complete numerous assessments to assure high standards, which include very specific metrics, to evaluate their performance. It is important for the student to learn self-assessment technical skills in preparing a tooth for a crown, or when instrumenting and obturating a tooth for an endodontic procedure. The vast majority of dental education is occupied in teaching and acquiring technical skills. Along with the intense technical training, there is the delivery of a wide field of knowledge to develop critical thinking and judgment coupled with technical skills.

Development of self-assessment skills in the application of this newly acquired knowledge and technical skills is essential, as no one will be looking over their shoulder as they deliver care to their patients after graduation. An ever changing knowledge base after graduation requires all health care professionals to regularly apply a method of self-assessment and ask the difficult question, "Am I current with state of the art knowledge and techniques in my profession?"

As I currently work in the field of practice transitions and development I have realized that upon graduation we enter the world of private practice and often don't transfer those technical self-assessment skills learned in dental school to all phases of our practice and business. Government, insurance and corporate forces are all having an impact on our profession and how we function and continue to be successful as professionals and business entities. I am experiencing a wide range practice models throughout Virginia that have stimulated me to raise the flag for an objective assessment process to evaluate the health of your practice BEFORE you enter into any action plan for change, development or growth.

Often assessment is based upon a "feeling" or "I think" instead of well-defined standards, factual data or criteria. The reality of any business is it has three components: cost, quality, and service. As owners of dental practices we would do well to build a template that allows for an objective assessment of these three areas. This can be a major undertaking and may require outside resources where your knowledge and skill level may not allow you to complete a comprehensive office assessment. One of the greatest limitations of practices reaching their full potential is the failure to block out time throughout the year to plan, assess and develop strategies around finances, service and quality.

Understanding the financial aspects of your practice beyond "Do I have enough to cover the operations in my checking account?" may require the expertise of setting up your books that allows you to track your revenue and expense streams to monitor your trends.

An accurate set of trends can guide you in making intelligent strategies and following the outcomes to see if your implemented strategy was effective instead of concluding "I feel it was a good idea" or "I am comfortable" which are not always good metrics! A prime example is the participation in multiple insurance contracts, without a clear understanding of the trend taking place in decreasing reimbursement for procedures performed. The benefit of being a provider needs to be carefully analyzed with objective facts, not feelings.

Expanding the concept of assessment can be applied in the area of service that patients receive and can further the ability of a practice/business in reaching its full potential. Having a written series of standards and training on how the phone is answered that creates the highest percentage of bringing people into the office is a major source of growth. Exit surveys of patients and staff leaving your practice can provide an enlightening perspective to the service people experience from your team.

As owner and leader your ability to develop your team is often overlooked. Pursuing self-assessment of your own leadership skills which will have a major impact on your professional career is largely ignored in medical and dental education. There are many opportunities to pursue personal growth as we wear the two hats of professional and business entity. This can be a good starting point which can equip you to develop an assessment of the multiple areas of your practice and a process to move forward.

Properly executed this can put you, the business owner and professional, in the driver's seat. Today I emphasized the importance of objective assessments to determine where you stand today. With that tool in your hand you are able to plan where you want to be next year at this time.

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.

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WHY DENTISTS NEED TO BE MOBILE-READY

Rachel Taylor, Senior Marketing Manager, Demandforce

Dentistry is a cornerstone of the medical industry—everyone needs a good dentist in their lives. Oftentimes, the bond you form with patients lasts your entire career. But in today's digital age, the way that people recommend medical professionals to each other has changed drastically. Word-of-mouth still carries weight, but it's how those words travel that has evolved.

According to Search Engine Watch, in early 2014, the landscape in which any business operates changed forever when internet usage on mobile devices exceeded PC usage for the first time. Tablets and mobile devices are taking over the market, and that makes for an exciting piece of internet history that many recognize but few are really cashing in on; recent stats from Mobify help illustrate this shift:

- Over 1.2 billion people access the web from their mobile devices. Global mobile traffic now accounts for 15% of all internet traffic.
- As of 2012, 116 million Americans owned smartphones, a figure that accounts for 58% of all U.S. consumers.
- Mobile-based searches make up one quarter of all internet searches.
- 25.85% of all emails are opened on mobile phones, and 10.16% are opened on tablets.

Why Dentists Should "Go Mobile"

Pew Internet conducted a study on how the internet is changing people's approach to healthcare. In March 2011, their Internet and American Life Project and the California Healthcare Foundation found that more than 80% of U.S. internet users search online for health-related information. One of the study's most interesting findings was that 44% of internet users are actually looking for doctors and other healthcare providers when they search for health information online. This means you need to not only be easy to find online, but when patients and potential patients find your website, it needs to be mobile-friendly. First, ensure you are easy to find without requiring someone to scroll multiple smartphone screen-lengths to find your practice. This includes claiming your Google+ Page, Yelp Page, Citysearch page and more. Once you have claimed your pages, be sure to keep recent reviews and content on all of them. Solutions like Demandforce can automate this process by collecting reviews and syndicating them across the web.

In terms of your website, sites such as DeviceAnywhere and Perfecto Mobile let you test and preview your website on different screens for free. These previews can help you visualize your mobile issues on different devices and guide your decisions for making changes. Go mobile to enhance your patients' and potential patients' experience with your practice online today.

Demandforce integrates seamlessly with your existing practice management software to automate your online communications and marketing. Demandforce has tools to help you better communicate with your existing patients through mobile-ready communications and helps to build your online reputation to attract new patients. For more information, or to request your personal product demonstration, please visit: demandforce.com/vda *or call 800-210-0355. Be sure to mention you are a VDA member for exclusive pricing.*

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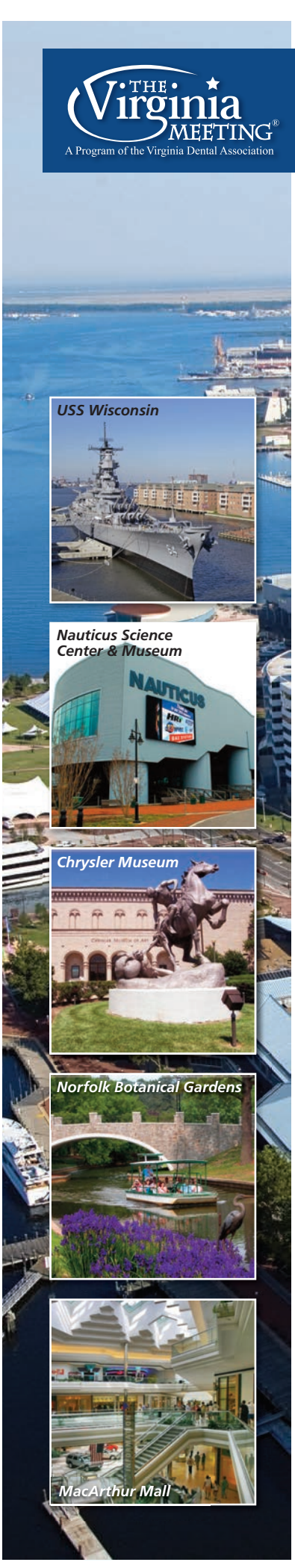


USS Wisconsin

Nauticus Science Center & Museum

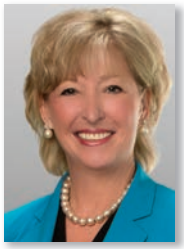
Chrysler Museum

Norfolk Botanical Gardens

MacArthur Mall

Thursday, September 17

Hal Crossley, DDS, MS, Ph.D	*Avoid Liability: Know Your Patients' Medications and Their Impact on Dental Treatment*
John Cranham, DDS	*Treatment Planning the Worn Dentition*
Laney Kay, JD, MPH	*Blood, Spit, and Fears: A Painless OSHA and HIPAA Update*
David Canfield, DDS, FADSA	*Sedation Recertification - Enteral Sedation Re-Permit Update*
Stephen Alouf, DDS & Scott Miller, DDS	*The Benchmark Denture: The Single-Visit Alternative Denture Built on Classic Principles*
Shannon Pace Brinker, CDA, CDD	*From Our Side of the Chair*
David Canfield, DDS, FADSA	*Emergency Management and Procedures Update*
William Prescott, EMBA, JD	*Joining and Leaving the Dental Practice*
Shannon Pace Brinker, CDA, CDD	*Become a Whitening Specialist*
Rhonda Savage, DDS	*It's a Jungle Out There! Don't be eaten alive - grow with team-building at its best.*
Tidewater Center for Life Support	*Heartsaver CPR*



Keynote Session by Dr. Rhonda Savage

Friday, September 18

John Cranham, DDS	*Occlusion for the Esthetic Restorative Practice*
Hal Crossley, DDS, MS, Ph.D	*Top 50 Most Prescribed Medications & Their Impact on Dental Treatment*
Steve Kelley	*Art Irritates Life: Syndicated Editorial Cartoonist Steve Kelley on Politics and Stuff People Actually Care About*
Roger Levin, DDS	*Set Your Practice on Fire! New Strategies for Increasing Production*
Rhonda Savage, DDS	*Dentistry Dedicated to Excellence: Take a Stand Against Periodontal Disease*
Hamid Shafie, DDS, CAGS	*Current Trends in Implant Placement and Loading for Fully Endentulous Patients*
Dave Weber	*The Winner In You: Raising the Bar on Patient Care and Customer Service*
Dave Weber	*Some Days You're The Pigeon, Some Days The Statue*
David Landwehr, DDS, MS	*Efficient and Effective Endodontics*
Tidewater Center for Life Support	*Healthcare Provider CPR*
Stephen Trutter & Josh Contrucci	*How Practice Ownership Can Launch You Over Your Financial Hurdles*

Saturday, September 19

Steve Kelley	*Art Irritates Life: Syndicated Editorial Cartoonist Steve Kelley on Politics and Stuff People Actually Care About*
Rhonda Savage, DDS	*Covering Your A$$ets: Embezzlement Prevention*
Hamid Shafie, DDS, CAGS	*Principles of Attachment Selection for Implant Supported Overdentures and Their Impact on the Outcome of Treatment*
Shannon Pace Brinker, CDA, CDD	*The Exquisite Art of Anterior, Posterior, Single, & Multiple Unit Provisionals*
Michael McMunn, DDS and a team of dental sleep experts	*Dental Sleep Medicine From A-Z*
Roger Levin, DDS	*Build Your Ideal Practice and Dream Team*
William Prescott, EMBA, JD	*Entering Practice - Make the Right Choice First!*
Laney Kay, JD, MPH	*Blood, Spit, and Fears: A Painless OSHA and HIPAA Update*
David Landwehr, DDS, MS	*Efficient and Effective Endodontics*
Tidewater Center for Life Support	*CPR Refresher Course*

Visit www.vadental.org/pro/events/virginia-meeting or call (804) 288-5750 for more information.

Information will be updated throughout the year.

VDA DAY ON THE HILL 2015

MEMBERS AND STUDENTS SHARE THEIR STORIES WITH LEGISLATORS

Laura Givens, VDA Director of Legislative & Public Policy

Over 120 dentists and VCU dental students gathered at Richmond's downtown Omni Hotel for breakfast on January 16. While enjoying a hot meal on a chilly January morning, the enthusiastic group of advocates were briefed by VDA lobbyists and then heard from VDA member and freshman Delegate Dr. Todd Pillion (R-Abingdon).

As a pediatric dentist with practices in Southwest Virginia, Dr. Pillion knows better than most the importance of health care policies in Virginia, particularly those affecting the profession of dentistry and dental patients. Now, as a Delegate serving Virginia, he will be in position to address issues affecting the profession and educate other lawmakers on some of our key issues.

For the first time in recent memory, the VDA was fortunate to not have mission critical issues to work on during the 2015 legislative session, although our lobbying team managed to stay busy working on dental-related matters (view the session update for details). A lack of advocating for specific legislation was of course not a reason to avoid visiting with our supportive legislators as having a presence in the halls of the General Assembly is always important. Building relationships is important and spending time with policymakers and talking more broadly about the profession and our work is invaluable

More than anything else, participants this year were able to share information on the many things that VDA members have been involved in over the past year and discuss the truly proactive and solutions-oriented approach our membership takes with so many issues. These conversations centered on several successful Missions of Mercy (MOM) projects throughout the state, the Give Kids A Smile program in February 2014 and, of course the ongoing volunteerism of hundreds of dentists and staff members caring for patients through the Donated Dental Services program. In addition to these VDA Foundation programs, it is always important to acknowledge the Dental Medicaid Smiles for Children program and the large increase in participation of dentists and eligible children since its inception in 2005.

The VDA thanks all member dentists, VCU dental students and other members of the dental community for their participation at this year's Day on the Hill. We had wonderful representation of members and dental students attend and we hope to have an even larger group next year. The success that the VDA had during this past General Assembly session and many before it certainly gives proof to the incredible importance of the Day on the Hill activities.

Please mark your calendars to attend the 2016 VDA Day on the Hill: **January 22, 2016.**

Should you have any questions regarding legislative affairs that have an impact on your patients and your profession, please contact Laura Givens at givens@vadental.org or 804-523-2185.

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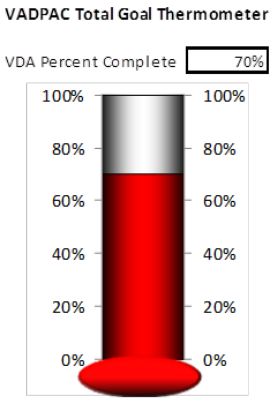
VIRGINIA DENTAL POLITICAL ACTION COMMITTEE UPDATE

Laura Givens, VDA Director of Legislative & Public Policy

Component	% of 2015 Members Contributing to Date	2015 VADPAC Goal	Amount Contributed to Date	Per Capita Contribution	% of Goal Achieved
1 (Tidewater)	29%	$45,500	$24,625	$239	54%
2 (Peninsula)	33%	$27,500	$21,935	$327	80%
3 (Southside)	35%	$14,000	$8,240	$250	59%
4 (Richmond)	29%	$67,750	$48,230	$298	71%
5 (Piedmont)	32%	$30,000	$22,590	$263	75%
6 (Southwest VA)	43%	$25,250	$23,830	$372	94%
7 (Shenandoah Valley)	35%	$30,000	$23,295	$288	78%
8 (Northern VA)	29%	$135,000	$89,102	$290	66%
Other Contributions					
TOTAL	**31%**	**$375,000**	**$261,847**	**$290**	**70%**



Total Contributions: $261,837

Must Raise $113,153 to Reach Goal

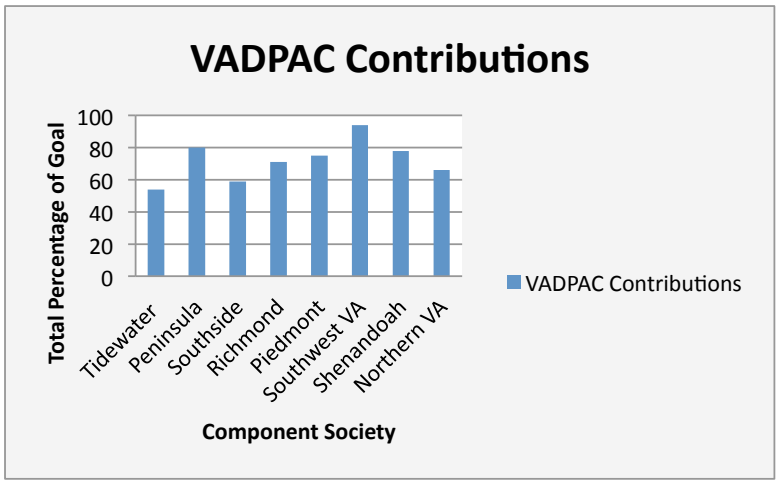
2015 Goal: $375,000

FREQUENTLY ASKED QUESTIONS ABOUT VADPAC

Why does VADPAC support Democrats AND Republicans?
VADPAC is not affiliated with a particular political party and supports legislators regardless of their political affiliations.

Why is this year especially important to make a contribution to VADPAC?
All seats in the House Delegates and Senate are up for grabs in November, which makes our participation in the form of people and money critical in 2015 and beyond. Your participation will ensure we sustain the very positive reputation our members have in the halls of the Capitol.

Your generosity has played a large part in advocating for the dental profession and our patients. The depressing state of the economy continues to affect our profession, along with burdensome red-tape of insurance companies and many other things that impact our ability to serve the most vulnerable patients. **It is for that reason that we must remain more vigilant than ever in protecting patients and our profession. We need your generous support today!**



How do I make a contribution to VADPAC?
If you have not already contributed to VADPAC or, if you would like to increase your contribution, you may make a contribution on our website at https://vadental.org/pro/vadpac, mail a check made out to the VDA and mail to the VDA office or call Laura Givens at 804-523-2185 to make a contribution over the phone.

I'm not sure if I've made a contribution this year. Where can I find that information?
If you would like to confirm whether or not you have made a contribution for the 2015 year and/or would like to confirm the amount total, please contact Laura Givens at givens@vadental.org or 804-523-2185.

COMMONWEALTH'S 2015 GENERAL ASSEMBLY SESSION REVIEW

VDA Lobbyists Tripp Perrin, Chuck Duvall and Denny Gallagher

The 2015 General Assembly has come and gone and no doubt it will go down as one of the most amiable in recent memory; even adjourning early and passing several important pieces of legislation and significant budget amendments with relatively minimal public bickering. No doubt the credit for the 45 days of minimal partisan posturing goes to the leaders of both parties but, make no mistake, the fact that all 100 members of the House and 40 in the Senate are facing reelection in November contributed to the member's predisposition to quickly get in and out of town with minimal controversy.

With that backdrop, it was not surprising to have a relatively quiet 2015 for the VDA. A less combative year like this is important every now and again as it gives the Association membership and its legislative allies time to breathe and determine what the key strategic priorities for the profession and patients you serve should be moving forward. You can rest assured we will have more than our fair share of battles in the years ahead. No matter, there were still several topics of importance on which the VDA was involved during the GA session:

- **Mandating Certain CE Requirements.** HB 2358 (Rasoul) was introduced late in the process. The legislation would have made it mandatory for the Virginia Board of Dentistry to establish regulations to include a mandatory requirement for continuing education on the topics of substance abuse, addiction, and related pain management for all dentists. Such mandatory requirements are not typically part of the Code. We worked with the patron, the Medical Society of Virginia and others to ensure this bill died in committee, which it did in early February. The issue will be reviewed by the Governor's Prescription Drug Task Force on which the VDA's Executive Director, Dr. Terry Dickinson, serves.
- **Putting Pressure on the Department of Medical Assistance Services (DMAS) to Implement the Medicaid Deferred Compensation Legislation.** As you may recall, the VDA requested a bill to be introduced that passed unanimously during the 2014 General Assembly Session that would allow dentists to put some compensation earned from the *Smiles for Children* dental Medicaid program into a tax-deferred Virginia Retirement System account. We spent a great deal of time researching and lobbying this legislation and, as noted, at the time of passage there was no objection to bill. Since that time, DMAS and DentaQuest have raised concerns about the cost implications of implementing the program – originally estimated at $50,000, for some reason, that number has increased tenfold to over $500,000. There is language in the just passed budget that requires DMAS to report to the money committees on their implementation progress by no later than July 1, 2015. We don't anticipate much in the way of positive movement.
- **Medicaid Benefits for Pregnant Women.** Introduced in the Governor's budget, Medicaid coverage for pregnant women was approved by the General Assembly. The program took effect March 1, 2015 for pregnant women who are 21 and over and enrolled in a Medicaid and FAMIS. Additional information can be found here: http://goo.gl/Kkrrxq
- **Another Dental Study by the Joint Commission.** A study resolution was introduced – SJ 240 (Favola) – that would have mandated the Joint Commission on Health Care (JCHC) to review dental care for older Virginians and recommend ways to improve access for this group. We met with the patron several times on this topic and, while we applauded the goal, we explained that a) we had just completed a nearly 3 year JCHC study centered on the topic of access; b) were already working on a nursing home pilot project; c) the issue in this case often comes down to who pays the freight and there were no budget dollars for it; and d) the VDA was very willing to work with some of the groups advocating for this study to develop solutions outside of a formal, political and time consuming effort. The legislation never made it out of the Senate Rules committee and the JCHC has told us that they have no plans to take it up in the year ahead.
- **Non-Covered Services.** The optometrists introduced legislation (HB 1444) similar to the 2010 VDA non-covered services bill. In fact, they used the same patron as we did to carry their water, Delegate Lee Ware (R). They followed a similar playbook to ours and we made sure the insurance companies saw us watching at every turn. We need to review the final product with the Council on Government Affairs at the VDA as there may be some extra bells and whistles on their legislation that we may need to pursue. Stay tuned.

The US Chamber of Commerce (#1) spends on average, $266,000/day on its lobbying efforts in Washington DC while hospitals (#3) spend only $92,600/day.

A really good reason to give to ADPAC!

DENTAL BENEFIT RESOURCES

Laura Givens, VDA Director of Legislative & Public Policy

Issues with dental insurance companies (which are actually dental benefit companies) are a hot topic when it comes to inquiries from VDA members. Most of the questions that we receive from members have to do with reimbursement rates, covered versus non-covered services, down-coding, and some specific plan questions.

FREQUENTLY ASKED QUESTIONS

Where can I go to get clarification on an issue with an insurance company?

- Begin by contacting the particular company to discuss the issue and ask questions about the plan coverage for the specific patient.
- The **Virginia Bureau of Insurance** is an incredibly helpful resource for VDA members. Their toll-free phone number is 877-310-6560.

How do I go about filing a complaint against an insurance company?

- If you have a complaint and would like the VDA Dental Benefits committee to review the issue before going to the Virginia Bureau of Insurance, please fill out our Claim Resolution Form, which you can find at https://vadental.org/files/public/content/file/3830/upload/3091.pdf, and submit to Laura Givens at givens@vadental.org or call 804-523-2185 to discuss before submitting. Please also attach any specific details that would help in their review. Remember to be sure that no patient information is apparent on any documents that you share. The nature of your complaint can include UCR fee disputes, assignment of benefits, unauthorized ADA code change, coordination of benefits, explanation of benefits, denial of claim, etc. The VDA wants to know what members are experiencing as participating providers with specific dental benefit companies.
- You may file complaints with the Virginia Bureau of Insurance. Again, their number is 877-310-6560 and their website is https://www.scc.virginia.gov/boi/.

I am trying to decide whether or not to participate with a plan. Can the VDA help?

VDA members who are trying to make a decision whether or not to participate with a particular plan and would like to have a contract reviewed can submit the contract to the VDA and we will then submit it to the **ADA Contract Analysis Department**. The dentist can only submit contracts that have not yet been signed. Once the department reviews the contract and returns it to the VDA, the analysis will be provided to the dentist. Contact Laura Givens at 804-523-2185 or givens@vadental.org if you have a contract that you would like to be analyzed before signing.

What actions has the VDA taken to advocate for dentists and their patients in regards to dental benefits?

- **Assignment of Benefits**
  - In 1999, after a heated contest with a number of dental benefit companies, the General Assembly agreed with dentists and granted dentists and oral and maxillofacial surgeons the right to have their patients assign their benefits to the treating dentist and balance bill the patient.
- **Non-Covered Services**
  - In 2010, the General Assembly agreed almost unanimously with VDA legislation restricting insurance companies from mandating fees for procedures for which they were NOT paying benefits.
  - It has now been five years since the Virginia General Assembly passed legislation to prohibit dental benefit plans from mandating fees on non-covered services. Since the law passed, insurance companies have found loopholes that go against the spirit of this law, for instance, "covering" formally non-covered services as low as 5%. This issue and other issues surrounding the law have been on the VDA's Council on Government Affairs and Dental Benefits Committee agendas and a task force has been tasked to research this issue.

Why do some plans not have to abide by state laws?

These plans are called self-funded or ERISA plans. Keep in mind that the Virginia state laws above only apply to dental benefit contracts that are registered in the state of Virginia. Many of your patients may have a self-funded plan. With a self-funded plan, an employer essentially pays claims with its own funds (out-of-pocket) from collected premiums rather than using predetermined premiums to compensate an insurance provider for assuming financial risk. Employers generally have more flexibility with these types of plans as they can determine what dental expenses will and will not be covered and they also have responsibility for plan decisions. These are also called ERISA plans. ERISA stands for the Employee Retirement Income Security Act of 1974. The reason these plans are exempt from many state insurance laws is because they are governed by the US Department of Labor. If you question the legality of an action taken by a dental benefits plan, the first question you should ask is if the patient's plan is self-funded. If so, Virginia state laws, such as the non-covered services law, would not pertain to that particular plan. In other words, the Federal law 'trumps' the state law.

Is any action being taken at the Federal Level?

Yes, the ADA is advocating a bill that would end the free ride that the health insurance industry has enjoyed for nearly 65 years, making health care insurers accountable to the principles of fair competition. **H.R. 494, the Competitive Health Insurance Reform Act,** would eliminate the McCarran-Ferguson antitrust exemption granted to the health insurance industry nearly 65 years ago. Repealing this exemption would empower federal agencies like the U.S. Department of Justice to

DENTAL BENEFITS RESOURCES - *Continued*

investigate and challenge collective action by insurance companies, and enable parties victimized by illegal and anticompetitive conduct to pursue remedies against those insurers. These victims may include dentists, their patients, and the public at large, all of whom would benefit from the repeal of McCarran-Ferguson. When insurance companies are permitted to act in disregard of antitrust principles, consumers are less likely to see as much innovation and variety in the marketplace as they would in an atmosphere of robust competition for their business. The ADA and VDA encourage members to write to their Representatives and ask them to support H.R. 494, the Competitive Health Insurance Reform Act.

Are there any alternative plans that I can implement in my practice for patients without insurance?

- Some dentists have found solutions to treating patients without dealing with dental insurance companies. Information on alternative programs can be found at the following links:
  - Dr. Gregory Yen's Wellness Program: http://yendentistry.com/services
  - Atlantic Dental Care, PLC: http://www.atlanticdentalcare.net/
- The VDA is researching alternatives to help members find solutions. In addition to the above, the VDA is reviewing the Arkansas' Dental Health Network: http://arkansasdentistry.org/index.php/2013/12/3068/.

Where can I find current helpful information regarding dental benefits issues? The VDA, in collaboration with the ADA, strives to continue to provide value to its individual members through assisting with dental benefits issues. VDA members can find a dental benefits resource page on the VDA website by https://vadental.org/pro/resource-center?field_resource_list_tid=196

Questions? Please contact Laura Givens at givens@vadental.org or 804-523-2185.

MEDICARE OPT IN OR OPT OUT...

WHAT YOU NEED TO KNOW

Laura Givens, VDA Director of Legislative & Public Policy

A final rule was published by the Centers for Medicaid and Medicare Services (CMS) in 2014 that requires practitioners who prescribe Part D covered drugs to be enrolled in Medicare or opt out for those prescriptions to be covered under Part D. This means that neither the practitioner, nor **the beneficiary submits the bill to Medicare for services rendered. Instead, the beneficiary pays the physician out-of-pocket and neither party is reimbursed by Medicare. A private contract is signed between the dentist and the beneficiary that states that neither one can receive payment from Medicare for the services that were performed.** The practitioner must submit an affidavit to Medicare expressing his/her decision to opt out of the program. Dentists are included with physicians and other practitioners who are permitted by statute to opt out of the Medicare program.

Medicare is administered by Palmetto GBA in Virginia and the opt-out affidavit can be found on their website: http://goo.gl/DqU0ya If you do not wish to participate with Medicare but prescribe Medicare Part D prescriptions and would like for them to be covered for Medicare-eligible patients, this affidavit form must be completed and submitted to Palmetto GBA. **By submitting a completed affidavit to opt out of the Medicare Program, prescriptions written by opted out providers will be covered by Medicare. Any testing, such as pathology, will be paid to the laboratory providing the test.** A contract is only necessary when a dentist who has opted out of Medicare wants to provide a Medicare service to the patient and forego filing a Medicare claim (by signing the contract, the patient is agreeing to the dentist's fee). These contracts are not necessary for the patient to have Medicare Part D prescription coverage (patients will be covered as long as the dentist has opted out or enrolled with Medicare). The opt out period is valid for two years at which time the provider must choose to either renew the opt out or enroll. Providers cannot choose to enroll during the opt out period.

"The ADA actively opposes this provision and is seeking an exemption for the dental profession."

The enrollment deadline indicated in the rule is June 1, 2015, however; CMS recently delayed the enforcement date to December 1, 2015. The ADA actively opposes this provision and is seeking an exemption for the dental profession. Although the ADA immediately expressed their disagreement and concerns with the rule when it was first announced in May 2014, CMS moved forward with the enrollment or opt-out requirement. A few weeks ago on January 13, VDA Executive Director, Dr. Terry Dickinson and ADA Executive Director, Dr. Kathleen O'Loughlin, met with CMS Administrator, Ms. Marilyn Tavenner and this issue was at the top of their agenda for discussion. To read about their meeting, you may visit the following web link: https://vadental.org/pro/news/3622. Further discussion between the ADA and CMS will occur and the VDA will be sure to keep members informed of the outcome.

Additional Information on the Medicare Opt Out Program:

- **CMS Opt Out Process and Requirements Information:** http://goo.gl/veKwlW
- ADA Resources for Opting Out of Medicare: http://goo.gl/K6JnAk
- Medicare Decision Tree (Flow Chart): http://goo.gl/mDF0s4
- Sample Medicare Opt Out Private Contract: http://goo.gl/X8uGPC (note: the only reason for having a signed contract with a patient is if the dentist has opted out of Medicare and the dentist wants to provide a Medicare covered dental service to the patient and forego filing a Medicare claim (meaning the dentist can charge his/her full fee).
- Palmetto GBA's headquarters phone number: (803) 735-1034

Watch for updates on this topic by email.

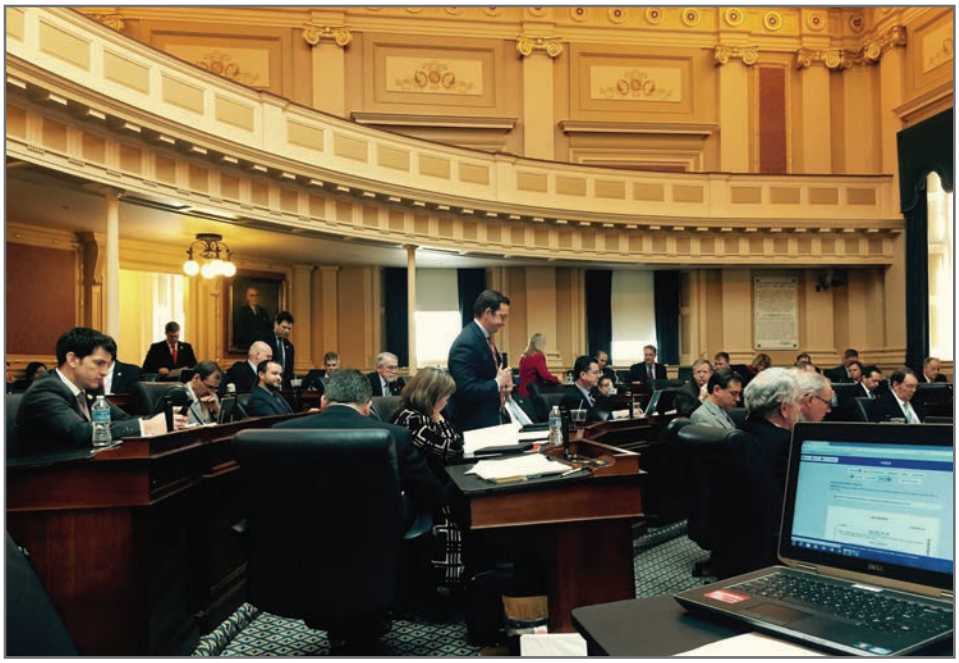
40 UNDER 40

DR. KEVIN BIBONA

Kevin Bibona worked on Wall Street before training at VCU. He now practices orthodontics in Richmond with Drs. Curt Wiltshire and Bryan Brassington. Kevin is married to his wife Jeane and they have two chocolate labs, Smoot and Gifford.

AN INTERVIEW WITH:

DELEGATE TODD PILLION



Dr. Todd Pillion speaks at the General Assembly.

VIRGINIA DENTAL JOURNAL: Dr. Pillion, you're the first dentist elected to the General Assembly in recent memory. What led you to seek election to the Virginia House of Delegates?

DR. TODD PILLION: Yes, according legislative records at the Library of Virginia, I am the sixth dentist to serve in the General Assembly and I'm only one serving now. Dentists serve people and solve problems. Serving as a Delegate requires the same skill set. I truly enjoy serving the public in leadership roles which I did in college, in dental school, in the Virginia National Guard, and in my years in private practice. Also, I've always been involved in politics to some degree, but not at the state level before. It's very competitive. Of course we both know that you have to be competitive just to get into dental school.

VDJ: What has surprised you most during your first term? Tell us why.

DR. PILLION: The quote that all freshmen legislators hear is that it's "like drinking from a fire hose". That description could not be more accurate. The volume and diversity of legislation to be considered during session is incredible. I'm assigned to the Transportation Committee, the Counties, Cities, and Towns Committee, and the Science and Technology Committee. In regards to transportation, I'm an owner in a car dealership, so I have a limited knowledge of the auto industry. I served on the planning commission in my hometown, Abingdon, which gave me limited experience with local government issues. My scientific background as a practicing dentist has gone a long way to help me with the work of the technology committee. Fortunately, I'm surrounded by colleagues in the House who bring their knowledge from their "day jobs", too.

VDJ: Tell us about the learning curve for a freshman Delegate. Do you have mentors in the General Assembly you can call upon?

DR. PILLION: Each delegate is assigned a mentor. (Delegate) Israel O'Quinn is from a neighboring district. He's my assigned mentor. Of course I've known (Delegate) Terry Kilgore for years. I worked on his campaign when I was in high school. Long rides back to Southwest Virginia have provided time to ask questions and get advice on everything. Speaker Howell is a true leader who shepherds all the Delegates. He's a true Virginia gentleman – he leads by example, he's approachable, kind and fair. (Delegate) Kirk Cox is also a great leader – level, steady.

VDJ: How do legislators view the dental profession? How can we improve our image?

DR. PILLION: Our profession is highly regarded. We're viewed as one of the most ethical professions. We're also known as business leaders, self-starters who can lead. We're held in high esteem. My advice: keep on doing what we're doing.

VDJ: You represent a district that includes much of southwest Virginia. What should be done to improve access to dental care in that area? Or, the rest of the state?

DR. PILLION: I represent the 4th Legislative District which stretches from the Tennessee border to the Kentucky border in Southwest Virginia. Improving access to dental care for the residents of my district will require more than additional free clinics. I was a (dental) student in 2001 when the first MOM Project was held in Wise County. As a proud Southwest Virginian, I told the organizers that a free clinic would never work. I was amazed, and proven very wrong, when I arrived that first morning to a line of people that seemed to go on forever. This is an economic issue. What the people of the 4th District need are jobs that provide a paycheck and insurance. I currently serve on the Virginia Tobacco Indemnification Commission which provides vital investment monies for economic development in Southwest

and Southside Virginia. The Commission invests in infrastructure, workforce training and development, business recruitment, and education projects to bootstrap our economy to better times. My priority as delegate is to utilize all of the economic tools available to the Commonwealth to create new jobs in Southwest Virginia for its residents. Residents who could then afford to pay for preventive dental care in an office setting, instead of having their teeth removed at the county fairgrounds. And as residents gain the ability to choose to purchase dental care, we will need to ensure that an adequate number of dentists are available to serve the region. An interim approach to dealing with potential shortages of dentists in Southwest and Southside Virginia is to recruit students from those areas because history shows those individuals, like myself, are more likely to return to those regions to practice.

VDJ: Some parties have promoted "mid-level" providers as a means of solving access-to-care problems. What's the best way to counter this argument?

DR. PILLION: While hygiene is important, it's a screening mechanism. Mid-level providers burden the system with duplicated cost. What is required are well-trained, qualified dentists. We're trained to work efficiently. It is not possible to learn what you need to learn in the short time (mid-levels) are trained. Any time we need to push back against this idea I think we should. There are various reasons why dentists don't accept Medicaid, but the main reason is the low reimbursement levels. Why not use that money to get more providers and increase incentives, and really solve the problem?

VDJ: What would you say to dentists who are considering a campaign for public office? What are the rewards, the pitfalls?

DR. PILLION: Go for it! We need more dentists in every aspect of public life. We're highly regarded business leaders and a valuable asset to our communities. I get to work with some of Virginia's finest men and women who are here in Jefferson's house trying to make a difference in our state. The pitfalls? It doesn't come without sacrifice. I will be away from my wife and children and my practice 45 days this year and 60 days next year. Thank goodness for the tremendous support system I have in place. Then there's the financial loss; the $17,000 salary of a delegate doesn't begin to compensate me for my time, but no one does this for the money. What has been very awakening to me is that every vote has benefits and consequences. Every vote has two sides. I can't make everyone happy. I listen to my constituents and do what in my judgment is best for the Commonwealth.

VDJ: What direction will Medicaid dental services take over the next five years? Will the benefit for pregnant patients continue to be funded?

DR. PILLION: I see Medicaid as something Virginia has to have, that is children's dental Medicaid. I hope to increase funding for providing care and accepting more patients. I would like to see an increase in providers that are actively participating. I would like to think that patients are seeking care, not just signing up. As for pregnant patients, I'd like to see us provide preventive care for all patients, and not just single out one group.

VDJ: How do you see the overall healthcare system evolving over the next five years? The dental care system five years from now?

DR. PILLION: That's a tough one. All of us want to see Virginians taken care of. A Federal handout is not what we need – there are too many strings attached. What happens when the Federal subsidy expires? I think there are other ways we can take care of this rather than relying on government. I'm for less government, not more. As a dental Medicaid provider, we have to take care of children. None of us want patients to go untreated. What we need is for the economy to take care of that. I have patients who signed up for Obamacare, realized the deductible was astronomical, then dropped Obamacare and have no insurance. What good is that? Patients aren't looking for high deductibles and less benefits. They're looking for better coverage. Obamacare plans haven't provided that.

VDJ: What are the greatest challenges faced by the dental profession?

DR. PILLION: Loss of autonomy is the profession's greatest challenge. Insurance companies dictating what dentists should do, instead of what's best for the patient. Federal and state governments over regulating the practice of dentistry. And Wall Street corporate dentistry displacing Main Street dentists. The practice of dentistry should be a private business; the dentist should own the business. We need to do all we can to keep it that way.

VDJ: Is the dental profession over-regulated? If so, give examples.

DR. PILLION: We're very good at self-regulation, as long as we remain an ethical group of professionals. Of course there are regulations that need to be changed. The separator mandate being proposed by EPA is one example. When regulations are considered, we have to be very careful not to make decisions based on a knee-jerk reaction.

Dr. Todd Pillion (R) with visitors during "Day on the Hill"

VDA ELECTED LEADERSHIP CANDIDATES

VOTE AND VIEW CVs BEGINNING JULY 1st AT www.vadental.org/pro

DR. VINCE DOUGHERTY

CANDIDATE FOR THE OFFICE OF: PRESIDENT ELECT

Dentistry has always been a part of my life. I watched my father practice without all of today's technological advancements. So much change has occurred over the last forty plus years. I want to continue to help direct the change in a way that benefits the practice of dentistry and our patients.

I have the will, the confidence, and the passion for the position. I promise to represent you in the best way possible. Serving as ADA Alternate Delegate and as a past president of the Northern Virginia Dental Society, I have acquired leadership and decision making skills to act confidently on your behalf. I have also recently served as the Northern Virginia Dental Society's representative to the Virginia Dental Association Board of Directors.

One of today's critically important issues is access to care. As a past chair of the VDA Task Force on Access to Care and Work Force Issues, I feel I have the knowledge to make informed decisions. I will base any decision I make upon the following question: "*Does this strengthen the doctor/patient relationship?*"

Today, there are potential threats to historically common principles in dentistry. One of those principles is being able to make decisions about how to practice dentistry. Dentists and dental students are always aspiring to practice in a way that most benefits the patient. This principle may not be a constant in the future.

I have had the pleasure of working with great mentors, including past presidents of the Virginia Dental Association, who have offered invaluable guidance and are true professionals. I have been able to incorporate their guidance to best develop my leadership skills.

There is great value in Virginia Dental Association membership. The past presidents have done an excellent job in both communicating and building upon this value. I would like to continue the positive momentum of our association. In doing so, I strive to assure every member understands and capitalizes on the value of a Virginia Dental Association membership available to them.

There are always opportunities for guidance. I am excited to discover these opportunities and apply them in such a way to propel the Virginia Dental Association toward greater success. That momentum drives the progression of dentistry.

I respectfully ask for your vote. I understand that in fulfilling the position, it will be an ongoing responsibility to our profession. I hope to serve you in this capacity and look forward to representing our great state.

DR. TED SHERWIN

CANDIDATE FOR THE OFFICE OF: SECRETARY/TREASURER

I am excited to place myself for your consideration for VDA Secretary/Treasurer and thank those individuals who have encouraged me to do so.

I know that those who attended last year's VDA House of Delegates heard the discussion surrounding the financial challenges that lie ahead. While we are currently strong financially we can see the writing on the wall, we like all membership organizations face a rocky road ahead. If you decide to elect me as Secretary/Treasurer, I cannot promise you easy solutions, but instead, a steady hand, and a long term goal of building the financial capacity that allows the VDA to successfully carry out its Strategic Plan.

I believe my experience as past Secretary/Treasurer and President of the VDA along with 5 years of service on the ADAs Budget and Finance Committee will be helpful in working with the House and VDA leadership as we determine our best way to move forward.

I ask for your support for VDA Secretary/Treasurer,

VDA ELECTED LEADERSHIP CANDIDATES - Continued

DR. DAVE ANDERSON
CANDIDATE FOR THE OFFICE OF: ADA DELEGATE

Anyone who has served on the delegation realizes what an honor and privilege it is. It is the extra benefit and great joy it generates to have a voice in how our profession is portrayed, administered and advanced. Taking your concerns to the House is a pleasure.

We are now at a crossroads. Student debt is at an all time high. For profit schools are producing more dentists than ever. Fewer and fewer graduates can practice as they desire. These are just a few of the challenges we face. Problems require someone who has been there working for our profession. This is why I ask for your continuing support and vote.

DR. VINCE DOUGHERTY
CANDIDATE FOR THE OFFICE OF: ADA DELEGATE

Dentistry has always been a part of my life. I watched my father practice without all of today's technological advancements. So much change has occurred over the last forty plus years. I want to continue to help direct the change in a way that benefits the practice of dentistry and our patients.

I have the will, the confidence, and the passion for the position. I promise to represent you in the best way possible. Serving as ADA Alternate Delegate and as past president of Northern Virginia Dental Society, I have acquired leadership and decision making skills to act confidently on your behalf. I am currently serving as the Northern Virginia Dental Society's representative to the Virginia Dental Association Board of Directors.

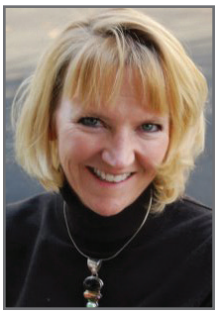
One of today's critically important issues is access to care. As past chair of the VDA Task Force on Access to Care and Work Force Issues, I feel I have the knowledge to make informed decisions. I will cast any vote based upon the following question: "Does this strengthen the doctor/patient relationship?"

I respectfully ask for your vote. I understand that in fulfilling the position, it will be an ongoing responsibility to our profession. I hope to continue to serve you in this capacity and look forward to representing our great state on a national level.

DR. SAM GALSTAN
CANDIDATE FOR THE OFFICE OF: ADA DELEGATE

I have had the honor and privilege of serving and representing the VDA as an alternate delegate to the ADA, and would like to continue this by now serving as a delegate. I bring passion, enthusiasm, dedication and hard work to organized dentistry, and a skill set that has grown and evolved over the years. Dentistry has been a wonderful profession to be included in, and it has brought us all many blessings, but as the Bible tells us, "to whom much is given, much is expected". I have worked extensively with access to care issues and even earned a Master in Public Health degree to help better lead and understand these complex issues, and I will continue to learn and grow to better serve. We need to make sure that we are inclusive, and that we look at issues from many different points of view. I have been most fortunate to be married to my practice and life partner, Dr. Sharone Ward, who is able to analyze complex issues and come up with clear and logical solutions. We all need to seek out colleagues like this to get their wise counsel and opinions and ideas so that we are certain that we are making the best possible decisions for all parties involved. Many great leaders from the VDA have represented us well in the ADA, and these people have put us in a good position, and I am most appreciative of this, however dentistry is changing rapidly, and we need to not rest on our past laurels.
I respectfully request your vote as ADA delegate. Thank you.

VDA ELECTED LEADERSHIP CANDIDATES - Continued



DR. ELIZABETH REYNOLDS
CANDIDATE FOR THE OFFICE OF: ADA DELEGATE

It has been such an honor to serve you and our profession for the past three years as your ADA Delegate and I would like to sincerely thank you for this opportunity and for the trust you have placed in me.

Our profession is certainly facing significant challenges during this very difficult period. The ADA must remain a dynamic and dedicated representative of our profession and I would like to be a part of that. During my three years as Delegate I have had incredible experiences in organized dentistry including the privilege of serving on the Council of Ethics, Bylaws, and Judicial Affairs, where I encountered amazing people with unparalleled dedication to the ethics of our profession and our association. These opportunities have allowed me to develop relationships with delegates across the country which have proven instrumental in aiding the 16th District in building the coalitions that help get your voices heard. I know our profession can continue to be the amazing profession we have enjoyed and I would love to be a part of maintaining it. I know that my energy, enthusiasm, and dedication can make a difference! I hope that you will support me with your vote for ADA Delegate this year!

DR. PAUL OLENYN
CANDIDATE FOR THE OFFICE OF: ADA ALTERNATE DELEGATE

Having served the Virginia Dental Association as an alternate delegate to the American Dental Association, I feel a great sense of accomplishment and pride. The honor of having represented this association at a national level is something I would like to continue with in the future. In the past, I have been an active member of the Virginia Dental Association, including holding the title of President of the Northern Virginia Dental Society, Chairman of the Patient Relations Committee, and delegate to the Virginia Dental Association. I have been honored to have had a chance to serve our community in these positions and have felt a great sense of responsibility while serving in these offices.

Our dental profession is entering a new frontier with the Affordable Care Act and corporate dentistry. The coming changes could greatly affect not only the way in which we deliver the quality of care, but also the manner in which we run our practice. I would like to continue to express your concerns to the American Dental Association. Your vote would allow me to continue in this endeavor .

DR. DANIELLE RYAN
CANDIDATE FOR THE OFFICE OF: ADA ALTERNATE DELEGATE

As a young dentist, I realize that it is crucial to look out for the future of our beloved profession. My hope is that my generation of dentists is able to enjoy a long and thriving career, like so many before us. With the numerous challenges that lie ahead, I understand that the only way to protect what we, as a profession have worked so hard to establish, is to stay involved with organized dentistry and proactively address these challenges.

Having served in VDA leadership roles such as Component President and Delegate as well as Delegate on a national level for the Academy of General Dentistry and having had experience as an ADA Alternated Delegate, I feel that I am a qualified candidate for the position of ADA Alternate Delegate. I will do my very best to be a good representative of the younger dentists in the organization and bring a fresh perspective to the position. Thank you for your support!

VDA ELECTED LEADERSHIP CANDIDATES - Continued

DR. CYNTHIA SOUTHERN
CANDIDATE FOR THE OFFICE OF: ADA ALTERNATE DELEGATE

I would like to serve as an ADA alternate delegate. I served as alternate delegate by appointment last year. I grew up watching my father serve our component and the VDA. After graduating dental school, I began practicing with my father in Pulaski. I have learned through my father and my experience with the association that hard work pays off. I have been involved with my component and state association since 2000. I am very committed to our profession and would like the opportunity to continue to serve at the next level. My work at the VDA level has provided the experience that is needed to serve as an ADA delegate. It is with great pleasure that I am seeking the position of Alternate Delegate to the ADA.

DR. GUS VLAHOS
CANDIDATE FOR THE OFFICE OF: ADA ALTERNATE DELEGATE

It is with great pleasure to announce my candidacy for ADA Alternate Delegate. Dentistry is at a major crossroads and it is being challenged on many issues by Foundations that are trying to develop Mid-level providers. The FTC challenged the authority of State Boards to set guidelines for the dental profession. My experience on the ADA's Council of Government Affairs has given me the knowledge to help the ADA fight the battles concerning these challenges. The VDA's Delegation welcomed six new members and as Chair of the Virginia Delegation it was a great pleasure to work with them this past year. With you help and support to elect me as an Alternate Delegate, I will help mentor the new delegates for the future of dentistry. I leave you with some words from Benjamin Franklin, "By failing to prepare, you are preparing to fail". I ask for your support for this position to help the ADA prepare and be successful in its future challenges we face in dentistry.

DR. STEPHANIE VLAHOS
CANDIDATE FOR THE OFFICE OF: ADA ALTERNATE DELEGATE

The ADA House of Delegates is the governing body of the Association and as a former ASDA Delegate to the ADA, I understand firsthand the power of the House of Delegates. The ability to serve as an alternate delegate and influence policy of the association is a privilege which I take seriously. Dentistry has enjoyed much success but it will also face many challenges as we move forward. We, as an Association, must work together to overcome these. As a new dentist who also serves on the VDA New Dentist committee, I hope to bring a fresh perspective to the VDA delegation. I also hope to use my past leadership experiences within ASDA to form relationships with the ASDA delegation in order to understand the needs of dental students. By working together we can improve upon the future of dentistry.

With my past leadership experiences and knowledge of organized dentistry, I am up to the task of serving as ADA alternate delegate. I respectfully ask for your support and I look forward to representing the VDA to the best of my ability.

The VDA Bylaws authorizes the VDA Board of Directors to appoint the Dean of the VCU School of Dentistry to serve as an ADA Alternate Delegate. The Board has appointed Dr. David Sarrett, Dean, VCU School of Dentistry, to serve a third term as ADA Alternate Delegate. This appointment fills the sixth alternate delegate position that is available for election in 2015.

WELCOME NEW MEMBERS

Karen Clendenen, VDA Membership and Meeting Coordinator

TIDEWATER DENTAL ASSOCIATION

Sarah Esparza – Norfolk – University of Maryland 1999/Scott AFB, IL 2000

Bernarda Frias – Virginia Beach – Stonybrook University 1997/NY St. Barnabas Hospital 1998

Michael E. Reimer – Virginia Beach – VCU 2012/2013

Christine J. Sankowski – Virginia Beach – University of Pennsylvania 2010/Mt Sinai Hospital NY 2014

Michael Sims – Virginia Beach – University of Louisville 1985

PENINSULA DENTAL ASSOCIATION

Francisco Limon – Hampton – University of Texas 2013

Gary Riggs, Jr. – Hampton – University of Kentucky 1986/NY Montefiore Med. Ctr. 1989

Michael Whyte – Williamsburg – VCU 2013

SOUTHSIDE DENTAL SOCIETY

Melanie Resendes – Midlothian – VCU 2006

RICHMOND DENTAL SOCIETY

David M. Clark – Richmond – VCU 2006

Anh-Thu Do – Richmond – VCU 1992

Jessica Dombroski – Richmond – VCU 2012

Keith Wallace Eldridge – Richmond – VCU 2014

Enrique O. Esplugues – Richmond – University of Washington 2012/Master of Science 2014

Sanath Kommineni – Henrico – University of Southern California 2010

Garry Myers – Midlothian – University of TX Health Science Center 1985/VA-1st MDSS/SGSLM/Langley AFB 1991

Brandon Newcomb – Dillwyn – VCU 2014

Clara M. Spatafore – Richmond – WV University 1984/1989

Andrew Vorona – Richmond – Temple University 2013

John Wisniewski – Glen Allen – Fairleigh Dickinson University 1980

Andrew Zima – Chesterfield – VCU 2008/2010

PIEDMONT DENTAL SOCIETY

Brad Lentz – Lynchburg – University of Pittsburgh 2011/VA Med. Ctr. Pittsburgh 2012

Adam Williams – Roanoke – VCU 2014

SOUTHWEST VA DENTAL SOCIETY

Jeri Bullock – Abingdon – Loma Linda University 2011

Chris Davenport – Bristol – VCU 2013

Alistair Kok – Pearisburg – Ohio State University 2003

SHENANDOAH VALLEY DENTAL ASSOCIATION

Melissa Fries – Winchester – NYU 2003/ VCU 2009

NORTHERN VA DENTAL SOCIETY

Mina Abdolahi – Sterling – VCU 2011/University of Iowa 2013

Folake Akinbi – Fairfax – VCU 2005

Joanna Claustro – Reston – Tufts University 2011

Charlston Choi – Fairfax – University of Maryland 2003/2006

Anil Dwivedi – Vienna – University of Pennsylvania 1991/1992

Mauricio Garcia – Leesburg – El Bosque University (Columbia) 1992/Lutheran Med. Ctr. 2012

Brian Gottlieb – Arlington – University of Southern California 2011

Phyllis Greer – Dumfries – University of the Pacific 2006

Jolanta Griffiths – Haymarket – University of Connecticut 2010/FL-VA Medical Ctr. Miami 2011

Hanna Hanania – Dale City – University of Maryland 2001

John Houser – Gainesville – University of Pittsburgh 1997/GA-Us Army Dental Activity 1998

Malini Iyer – Vienna – University of Pennsylvania 2003/University of Texas 2009

Maryam Jamali – Vienna – Howard University 2014

Shawn Kumra – Arlington – University of Maryland 2005

Gloria Lee – Sterling – University of California-Los Angeles 1997

Fernanda Levine – Arlington – Pontificia Universidade Catolica Mina Gerais (Brazil) 2007/St. Mary's Hospital, Waterbury CT 2013

Javier Sanz Moliner – Alexandria – Spain:Universitat Internacional de Catalunya 2003/SUNY at Buffalo 2009

Yvonelle Moreau – Alexandria – New York University 2014

Fadwa Nassar – Falls Church – NY University 1999/VCU 2001

Continued on page 49

VDA ACTIONS IN BRIEF

Board of Directiors - January 15-17, 2015

The following actions are reported as information only:

1. Approved - A resolution to rescind the previous resolution to give support for Delta Dental's legislative bill that would allow for the offering of standalone dental plans (and, in return, they would support a bill submitted by the VDA that would require all insurance plans offering dental plans in the Commonwealth of Virginia to have a de minimis clause of at least 50%).

   Background: It was felt that the VDA would be giving up a lot to not only Delta, but to all dental benefit providers and getting little in return. If wanted, the VDA can pursue the de minimis clause addition without the help of Delta or others.

2. Approved - A resolution that the VDA will take a position of 'neutral' in regard to Delta Dental's legislative bill that would allow for the offering of standalone dental plans (and, in return, they would support a bill submitted by the VDA that would require all insurance plans offering dental plans in the Commonwealth of Virginia to have a de minimis clause of at least 50%).

3. Approved - A resolution to reappoint Dr. David C. Sarrett, Dean of the VCU School of Dentistry, to serve another term (2016-2017) as an ADA Alternate Delegate.

   Background: Article V, Section 1 (line 550) of the Bylaws states that the Dean of the VCU School of Dentistry shall serve a two year term as Alternate Delegate upon the approval of the Board of Directors.

4. Approved - A resolution to approve the VDAF Board of Directors.

Patrick W. Finnerty, President; Robbie Schureman, Vice President; Edward J. Weisberg, DDS, Treasurer; Graham Gardner, DDS; Secretary; Robert H. Walker, Jr.; Anne C. Adams, DDS; Ralph L. Howell, Jr., DDS; Norma Roadcap; David L. Jones, DDS; Meera Gokli, DDS; William R. Harland; Barry Isringhausen; Audra Y. Jones, DDS; David C. Jones, DDS; Juan A. Rojas, DDS; D. Omar Watson, MD, DMD; David Lionberger, Esq.

IN MEMORY OF:

NAME	CITY	DATE OF DEATH	AGE
Dr. William Cline	Abingdon	January 5, 2015	89
Dr. Theron Dikeman	Arlington	November 11, 2014	94
Dr. H. Jackson Payne	Culpeper	November 25, 2014	83

WELCOME NEW MEMBERS *Continued from page 48*

Kevin Noall – Alexandria – University of Maryland 1984/TX-Wilford Hall Med. Ctr. 1990

Shilpa Regatti – Herndon – NY University 2013

Maria N. Salnik – Arlington – University of Maryland 2011/2012

Kaur Sandeep – Herndon – SGRD Institute of Dental School (India) 1997/GPR 2014

Ashley Seals – Alexandria – Howard University 2010

Vladimir Soyfer – Fairfax – University of Pennsylvania

Ryan Taylor – Springfield – Oregon Health Science University 2005

Peng Kevin Wang – Washington DC – University of Pittsburgh University 2009

Mesfin Zelleke – Fairfax – Howard University 2006/2007

Tingting Zhu – Fairfax – University of Kentucky 2008

2015 VCU SCHOOL OF DENTISTRY WHITE COAT CEREMONY

Dr. George Deeb

The D.D.S. Class of 2017 and the dental hygiene Class of 2016 at the VCU School of Dentistry recently received their first white coats. To mark the important rite of passage, the friends and families of these young professionals were invited to join the faculty members in "coating" the students.

Dr. George Deeb, associate professor, Department of Oral and Maxillofacial Surgery, VCU School of Dentistry, presented the following remarks and invited students to practice ethical, mindful dentistry.

These young professionals are about to begin the very important phase of their education in which they manage their own assigned patients and provide comprehensive oral healthcare to them. In so doing, they hone their clinical skills in their chosen profession of dentistry or dental hygiene and start building relationships with their patients. Their participation in this important white coat ceremony marks the beginning of their transition into professionals.

This is what your next educational years are about. Not only will you change your coat, but change your mindset. You'll need to learn to accept responsibility for your decisions and be a professional.

Simply put, a professional is an individual engaged or qualified in a profession.

Here is a list of some qualities that have been attributed to those who practice a profession:

1. A professional has respect for human beings;
2. A professional is competent;
3. A professional has integrity;
4. A professional's primary concern is service, not prestige or profit.

Contributing to the care and healing of others is a privilege and an awesome responsibility. The white coat placed on each future dentist and dental hygienist here today is more than just a white lab coat. The coat is representative of your competence, communication, caring, curiosity and character. Wearing the white coat also means that you are a trusted member of a community. This day and this rite of passage are celebrated by students, their families, alumni, faculty and staff.

Dental and dental hygiene professional life starts at the beginning of studies in the first year. Dental students and hygiene students are bound by the same professional commitments that bind all doctors. Make no mistake about this white coat gowning and why you're getting it today. Let me come right out and tell you about the values and identity we encourage and expect you to embrace. The core idea of professionalism is fiduciary. Our society grants the dental profession a special position of trust that includes this fiduciary responsibility. The idea is that one person with expertise and special equipment performs an important task for someone else who cannot fully understand the situation or take care of it themselves without help. Patients must be able to trust you to do the right thing for them and to do it well. In return for this trust, dentists and dental hygienists make a commitment to society that our members will adhere to strict ethical standards of conduct. We expect all of you to move up hierarchies from selfishness to social good and from rule-following to independent, ethical behavior.

It's the reason we take the Hippocratic Oath and the dental pledge as we enter the profession.

Ethics is a course of study dealing with what is the proper course of action for man. Ethics is a branch of both philosophy and theology. It is the systematic study of what is right and good with respect to character and conduct. It is the method by which we categorize our values and pursue them. Ethics seeks to answer two fundamental questions:

1. What should we do?
2. Why should we do it?

In short it means asking how well you could sleep at night if you did it. That's not a precise definition, but it will do to start out with.

Ethics is a requirement for a healthcare provider. The terms ethical and moral have been used synonymously and used to mean only that the issue, question, reflection or judgment to which they apply concerns what ought or ought not be done or what is a matter of someone's obligation.

Ethics affects virtually every decision made in a dental office, encompassing activities of both judging and choosing. Ethics affects relationships with patients, the public, office staff and other professionals. As a dental professional, you have to make numerous decisions. Some decisions are straightforward and easy; others are not. A system of ethics must further consist of not only emergency situations, but the day-to-day choices we make. Ethics is inextricably linked with these decisions and your day-to-day activities in and out of your office. At a minimum, unethical conduct seriously compromises your service to patients and compromises your reputation as a professional. An emphasis on ethical conduct clearly distinguishes your standing as an individual and reflects upon all of us as members of the profession. Without a solid ethical foundation, you simply cannot be a true professional.

2015 VCU SCHOOL OF DENTISTRY WHITE COAT CEREMONY - Continued

We give you these white coats to encourage you to adopt the identity of a dentist or dental hygienist. We often call you "doctor" in the clinic for the same reason. It is expected that you start to behave like a doctor, to think of yourself as a doctor and to assume the identity of a doctor.

The first three hours of my day today were devoted to the Mirmelstein ethics program, which some of you attended this morning. The focus of the program today dealt with the premise that, by taking better care of ourselves, we are better able to take care of our patients and our families. Dental school and dental hygiene school are stressful professional programs and, more often than not, we can neglect ourselves physically and emotionally.

By adopting wellness as a value and the goal of leading a balanced life, we can optimize our performance and be resilient to stress and burnout. Take care of yourselves during these next years and beyond into your careers. You owe it to yourselves, as well as your patients. There is a growing body of research that shows that burnt-out physicians and health care providers give worse care, have less empathy, make more medical errors and are less likely to report these errors. These practitioners may ultimately end up treating their patients as objects and have low job satisfaction and a low sense of self worth.

My challenge to you is to be both mentally and physically fit. Keep a sound mind and body. By adopting healthy principles now you'll enjoy these next years and get the most out of your dental education. You'll carry these same lifestyle choices forward and ultimately be a better healthcare provider, and your patients will benefit as well.

Here are some questions that you can ask yourselves during the next years that might give you some insight into how well you are taking care of yourselves. Depending on your answers you might get an action plan and adopt some changes.

- Are you exercising three to four times per week?
- Are you eating a healthy balanced diet?
- Are you getting enough sleep?
- Do you do something fun at least two times a week?
- Do you have balance between your work and school and other areas of your life?
- Do you take some time for yourself every day?

- Are you guided by a sense of principles and ethics?

If you can adopt these behaviors now you'll be able to continue them throughout your career. You should strive to be an ambassador of both physical and mental health.

Each of you has been awarded a coveted position in this school because you have that capacity to transition from student to doctor and from student to dental hygienist, and congratulations are in order. Each of your families has put in countless hours of parenting, raising you into a caring, educated young adult. Along with your determined effort, it is your families' support that made this day possible.

It is a great honor to talk to the next generation of dentists and dental hygienists as you take this next step in the great journey that life is. Welcome to the profession. Wear these white coats with honor.

References:

Ethics handbook for dentists, American College of Dentists, Gaithersburg, Maryland: Copyright 2000-2013

Principals of ethics and code of professional conduct, American Dental Association Council on Ethics, By-laws and Judicial Affairs, April 2012: Chicago IL

40 UNDER 40

DR. CURTIS G. DEAN

A 2013 graduate of West Virginia University School of Dentistry. He currently practices as a full-time associate in a private practice in Harrisonburg, VA. Dr. Dean looks forward to joining the practice as a partner in the summer of 2015.

VCU ASDA HOSTS INAUGURAL PROFESSIONAL DEVELOPMENT SEMINAR

Kandice L. Klepper, Class of 2015, VCU School of Dentistry; Student Body President

Can you guess the number one complaint nationally among dental students? It's lack of business classes and practice management knowledge. In an effort to increase student awareness, the VCU American Student Dental Association teamed up with the Virginia Dental Association to host our inaugural Professional Development Seminar!

With over fifty dental students in attendance, the event offered a multitude of topics aimed at providing attendees navigational tools to thrive in the profession. Following a networking breakfast, the event began with a keynote address from Immediate Past VDA President, Dr. Ted Sherwin.

Other presentations focused on how to utilize social media effectively, general practice management, and tips on hiring and firing, and the group practice model. Dr. Ralph Howell gave valuable insight into preserving the traditional dental model in a radically changing environment. During the sponsored lunch, students had the opportunity to have a professional composite photo taken. In addition, Eastern Dentists Insurance Company generously provided tote bag and information flash drives for transitioning students.

Following the event, attendees had great feedback and suggestions for next year. The VCU ASDA Executive Committee is looking forward to teaming up with the VDA in hopes of expanding the event in the future.

L-R, at podium: Drs. Ralph Howell, Gloria Ward, Ted Sherwin

40 UNDER 40

DR. DONALD MURRY, III

Dentist, owner, and marketing guru at Murry + Kuhn Dentistry in Richmond, he has helped grow the practice from one office in 2010 to three in 2015. Active in the community/social media, blogger for the AGD and was recently featured in *Inc. magazine*.

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VIRGINIA "GIVE KIDS A SMILE!" 2015

Jessica Park, Interim Executive Director, VDA Foundation

ADA American Dental Association®

Every February, to mark National Children's Dental Health Month, many volunteers come together to provide a continuum of services to children at Give Kids a Smile! (GKAS) events across Virginia. The purpose of GKAS is two-fold; first, it provides an opportunity for children to learn about the importance of oral health and to obtain treatment (when provided). Second, GKAS events bring attention to challenges faced by children and families in accessing and utilizing services.

Although final GKAS event reports are still coming in, we wanted to share with you pictures and some data that has been reported to date.

A special "thank you" goes out to all of the dedicated volunteers that invest their time and energy into planning, executing, and participating in all GKAS events!

Interested in holding your own GKAS event? No event is ever too small and it's never too early to start to plan; in fact we encourage you to! For more information about getting involved, please contact Jessica Park at the VDA Foundation at 804-523-2182 or at park@vadental.org.

TIDEWATER DENTAL ASSISTANTS SOCIETY GKAS 2015

- 697 students served at a Virginia Beach elementary school
- Provided oral health education through videos, demonstrations on brushing and flossing, and talked about the importance of good nutrition
- Volunteers included Tidewater assistants, Tidewater hygienist, school nurse, 6 gym teachers, 32 teachers and aides
- Kindergarten class made posters with teeth made from mini marshmallows and labeled each one with what they learned

SOUTHSIDE DENTAL SOCIETY GKAS 2015

- Worked with targeted Title I schools in Chesterfield County (elementary through high school) to screen/identify children that are presenting with dental needs and matches them with dentists for treatment
- 343 children were examined and received fluoride varnish; value of care totaling $31,920
- 107 children required follow up care
- 32 assigned to a dental home
- 29 children treated at local dentists offices; value of care $13,747

SOUTHSIDE DENTAL SOCIETY IN PARTNERSHIP WITH CHESTERFIELD COUNTY PUBLIC SCHOOLS' TECHNICAL CENTER'S DENTAL ASSISTING PROGRAM

- 528 children
- Exams, prophys, and fluoride
- $83,424 value of care

RICHMOND DENTAL SOCIETY GKAS 2015

- 300 children seen from Richmond area public schools
- $53,100 value of care
- Exams, education, toothbrush prophys, and fluoride provided
- Children identified dental needs will be followed up with

SOUTHWEST VIRGINIA REGIONAL DENTAL CENTER GKAS 2015

- 23 children served
- 20 volunteers
- $6,723 value of care

DONATED DENTAL SERVICES (DDS):

HIGHLIGHTING OUR VOLUNTEERS

Sherrell Bouldin; DDS - Access Partnership

This issue's article was submitted by Sherrell Bouldin, DDS Referral Coordinator/ Oral Health Navigator from Access Partnership in Norfolk. Access Partnership manages the Virginia DDS program in dental components 1 and 2 for the VDA Foundation.

Ms. Bouldin had the pleasure of interviewing Dr. Robert Simmons, a long time DDS Volunteer, who practices in Chesapeake. Here's an introduction to one our valued DDS volunteers!

ABOUT DR. SIMMONS' PRACTICE

Dr. Robert Simmons is a General Dentist with a practice where he provides a variety of dental services to everyday people.

HOW DID HE GET STARTED WITH THE DDS PROGRAM?

Dr. Robert Simmons feels that is important to give back to the community. He has been involved with the DDS program for many years (since 1997 to be exact!) and takes cases on an ongoing basis.

WHY DOES HE CONTINUE TO VOLUNTEER?

He has been very blessed over the years and he understands that some people cannot afford dental care. He does not mind helping people with dental services when he can.

WHAT IS MOST REWARDING?

Providing assistance and not expecting anything in return. His gratitude comes from being able to provide people with a smile that they did not have before.

IS THERE A MOST MEMORABLE DDS PATIENT?

Dr. Simmons had a patient who made a CD for the dental office to show his appreciation. The patient played his own guitar and sang a song on the CD. He thought that was a very heartwarming gesture.

WHAT WOULD HE SAY TO DENTISTS WHO ARE CONSIDERING VOLUNTEERING WITH THE DDS PROGRAM?

The rewards from the DDS program are not monetary, but the rewards will come in the form of a blessing from being able to assist people in the community.

Thank you Dr. Simmons for your commitment to the DDS program and for helping people smile again!

If you're interested in volunteering for the DDS program, please contact Jessica Park at the VDA Foundation for more information, 804-523-2182, park@vadental.org, or visit www.vdaf.org. We are in desperate need of volunteers from across Virginia.

If volunteering just doesn't work for you right now, please consider making a donation to the VDA Foundation. Your donation, small or large, will help support our three outreach programs: Mission of Mercy (MOM), Donated dental Services (DDS), and Give Kids a Smile! (GKAS).

40 UNDER 40

DR. SARA BUNIN

I am a passionate and caring Board Certified Pediatric Dentist in Fairfax, Virginia working to foster a strong foundation of great dental care and healthy habits at an early age to make patients love the dentist throughout their lives.

VDA DENTISTS AND STAFF MAKE SUFFOLK M.O.M. A HUGE SUCCESS

Joel Rubin; President, Rubin Communications Group

Charlie Jackson, 80, did not come to the Missions of Mercy event at Kings Fork Middle School in February for a teeth cleaning. He came for teeth.

The Suffolk resident's dentures were broken. Fortunately he had won a lottery to receive new Benchmark upper/lower dentures. Earlier in the week he had his impressions done. At MOM, Dr. Leslie Richmond of Virginia Beach, Dr. Carmen Cote of Norfolk and Dr. Donald Wheless of Powhatan completed the two-hour delivery and adjustments. Admiring his new look in a handheld mirror, Mr. Jackson said he was heading to a restaurant for "a steak."

More than 550 other western Tidewater citizens filled the gym floor for dentures, exams, extractions, crowns and other procedures that would allow them to eat, smile, be employable or just pain-free. "Because we go to college in an inner city like Norfolk and work in clinics, we know that there are many people out there with little or no access to quality oral care," said Angela Damergis, a senior in the School of Dental Hygiene at Old Dominion University. She and nine fellow students were at the Suffolk MOM, learning, said Community Health Professor Sharon Stull, how to "use both their practical and critical thinking skills in a non-office setting when supplies and tools may not be readily available."

This was the second year that Dr. Ralph Howell and his staff, along with the Virginia Dental Association Foundation, brought MOM to Suffolk. "We had 40 portable chairs in 2014, 70 this year," he said, noting that a major grant from the Obici Healthcare Foundation allowed the project to be held in Suffolk for a second year and to expand the number of patients seen. Fortunately, many more practitioners responded to man the stations, like Dr. Pete Showalter of Yorktown, who wore a scrub top with a University of Virginia logo. "What I didn't expect was that I would be working with a pre-dental student from Virginia Tech all day," said Dr. Showalter, particularly when the Hokies and Cavaliers were preparing to play basketball against each other that afternoon in Charlottesville. Fortunately for the patients, Dr. Showalter and Nicole Rogers of Lynchburg (and Blacksburg) were on the same team this day.

There were more medical screenings at this MOM than the one last winter, performed by volunteer physicians, RNs and student nurses from Virginia Commonwealth University, Eastern Virginia Medical School and ECPI. There were also several undergrads assisting patients. Among them was VCU's Craig Luskey who took a dental assisting class in high school and was immediately hooked. "I look forward to applying and then enrolling in dental school," he said. Being on the floor in Suffolk this day should look good on his application.

It was clear from the Kings Fork MOM that Hampton Roads needs these annual clinics, but they may move around the region, says Barbara Rollins of the VDA Foundation. "We might be in Virginia Beach next year, Chesapeake the following and then perhaps on the Peninsula."

SUFFOLK MOM BY THE NUMBERS

559	Total number of patients
$509,899	Total value care
559	Patient exams
130	Cleanings
130	Fillings
1,219	Extractions
20	Full dentures
8	Denture adjustments/partials
17	Root canals
5	Crowns
591	X-rays

Judging from this day of caring in Suffolk, there will be no shortage of underserved patients or willing providers.

"It's so rewarding to bring comfort to so many," said ODU dental hygiene student Amanda Maredy of Richmond, who traces her desire to help others to the dental anxiety she experienced as a child. "I know I'll be back."

WISE VOLUNTEER AND MISS KENTUCKY CONTESTANT?

Brittany Bentley

Helping people has always been one of my passions as well as learning oral health. I have always loved taking care of teeth, actually being obsessed. Hello, my name is Brittany Bentley and I am a registered dental hygienist and certified dental assistant. Growing up I never really knew what I wanted to do, and one day I got to fill in for my cousin at a dental office for 3 days. After the 3 days I knew I wanted to be acquire some type of a degree in dentistry. I love talking to people, giving advice, helping, teaching, and being a role model to my patients.

In May 2010, I got accepted in the Dental Hygiene Program at Big Sandy Community and Technical College in Prestonsburg, Ky. I was one of 9 students that got accepted out of the 90 applicants. I also applied and was chosen for the Julie Lester Scholarship, which paid for my dental instruments the whole 2 years of hygiene school. I graduated with a GPA of 3.9 and earned my Associate Degree of Science in 2012. I became a Board Certified Dental Hygienist in Summer of 2012.

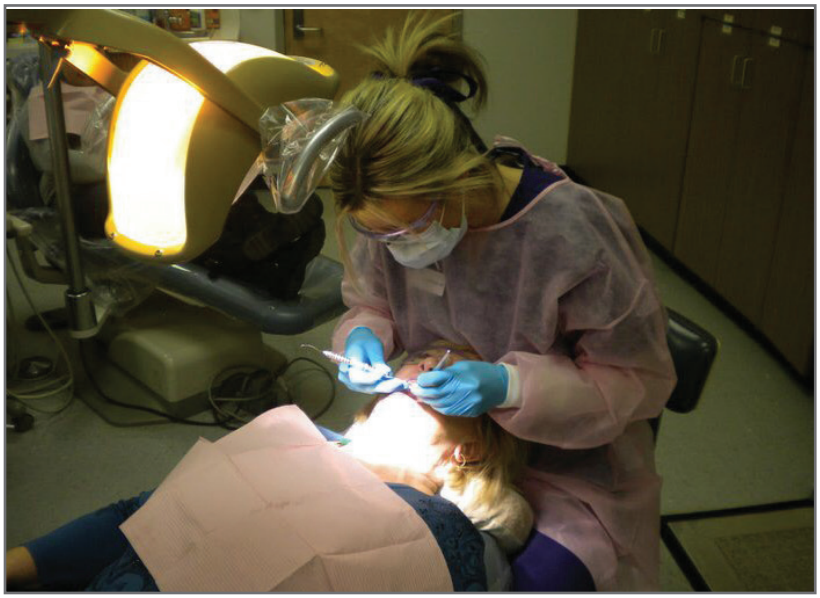
I wanted to further my education in oral health because it wasn't only a job to me, it was a passion and a hobby so I am now enrolled at Western Kentucky University working on my Bachelors Degree in Dental Hygiene by doing online classes.

With my passion of oral health, I got involved with an organization to help children and teens in need , "Esther Wilkins education program", which involves completing many activities for the American Tooth Fairy, from smile drive campaigns to bake sales.

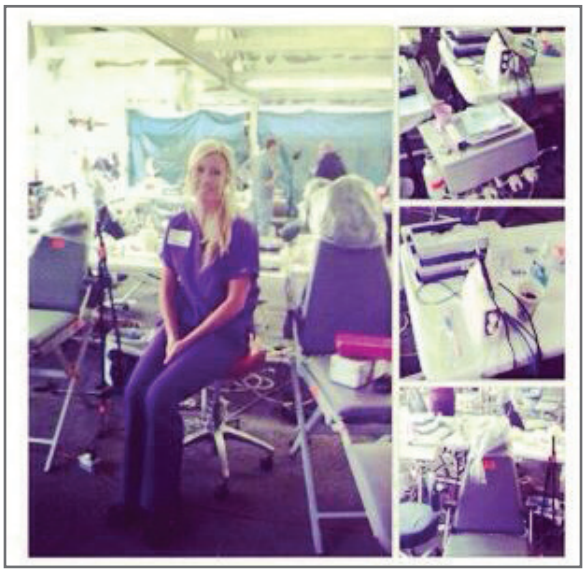
I receive RDH magazines once a month and I read them to keep up with the new technology and articles. I wanted to further my involvement within the community so I found MOM (Missions of Mercy), which was an organization for free dental work for patients that have no insurance and low income. I really wanted to get involved and volunteer and start helping these patients as soon as possible. I e-mailed the Director, Barbara Rollins and she helped me get started. I filled out the required paper work and picked a volunteer date and a place that was close to me to travel for the event. I was then on my way to becoming involved with MOM and do volunteer work.

The early morning of the event in Wise County Virginia, my eyes couldn't believe how many people I got to work with which involved Dentists, dental assistants, oral surgeons, dental hygienists, students, and volunteers. It was such a blessing! I was assigned a station and placed under a tent with a dental chair and supplies that I needed for the day.

I would see each patient 45 minutes to an hour depending on age and status of oral health. I cleaned their teeth, educated about the importance of oral health and periodontal diseases. I also discussed their status of smoking, any history of medical problems they had as well as the medications they were taking. We had toothbrushes, paste, and floss which every patient received after their exam and cleaning. After each patient I had dental students that would clean my operatory and place/stock my area with supplies that I needed or was low on. I worked as fast as I could to see as many patients as I could. The workers got breaks as needed



WISE VOLUNTEER AND MISS KENTUCKY CONTESTANT - Continued



as well as a lunch, a dinner, and snacks at all times with drinks which were provided by the organization.

I have to share one experience I had with one of my patients. A young man, around 27 years of age who was very appreciative for the treatment and education he received through this organization as he didn't have any dental insurance. It is patients like this one that make you feel really good about the volunteer work you do to help people in situations like the one he had.

The time and work went very smoothly throughout the day as everyone who volunteered worked so hard together to keep things going in order to make sure every patient that showed for any type of treatment or education was seen. Everyone at MOM was beyond amazing, so nice, respectful, and made me feel like I was needed and very important. My experience with Missions of Mercy was a blessing to me. Not only did the directors make me feel appreciated, but they also made me feel like I was a family member, and to me that's exactly what we all were, helping each other, being a team and family for a short weekend! I met so many amazing people, made new friends that would even become lifelong friends as well as my patients! Being a volunteer at MOM as a Registered Dental Hygienist made me realize how many people can't afford to have dental work and how uneducated people are about oral health. I'm so happy and blessed that God gave me the opportunity to work with the MOM Organization to seek out and treat patients that are in need of oral help.

After my job was done that weekend at Missions of Mercy, I received a T-shirt, a certificate of appreciation and a thank you note. Truly amazing experience and beyond a blessed organization. I loved it so much that I am continuing with Missions of Mercy every chance I can and I recently entered the Miss Kentucky United States Pageant (Third runner up) and used Missions of Mercy as my platform and organization that I work with! I hope in the future we have more volunteers and patients that attend, because it is an experience you won't forget, it really opens up your mind and heart. I want to thank a very special lady, Barbara Rollins, for helping me throughout the day at MOM, replying to my thousands of emails, always being there for me when I needed her, and letting me become involved and use MOM as my platform in the Miss Kentucky Pageant. As my thank you card says, "Missions of Mercy, we gave them back their smiles", and we did just that!

JOIN US FOR A MOM PROJECT IN 2015

- NOVA MOM - MARCH 13-14
- SPECIAL OLYMPICS - JUNE 13
- WISE MOM - JULY 17-19
- GRUNDY MOM - OCTOBER 3-4
- HOMELESS CONNECT - NOVEMBER 19

GO TO www.vdaf.org FOR DETAILS AND TO REGISTER

THANKS FOR MAKING US SMILE

ELIZABETH AND MARY - MISSIONS OF MERCY

Elizabeth and Mary are sisters. They both needed dentures. Elizabeth waited outside the denture trailer at Grundy MOM 2013 for two days to add her name to the existing waiting list of 700 for dentures. Both sisters showed up again this year hoping for dentures. To their surprise, and due to several patients who did not show up as scheduled, the sisters were give appointments and restored with complete Benchmark Dentures by members of the MOM Denture Team. Grateful and excited about their new smiles, they both returned the next day with thank you cards in hand.

- Dr. Stephen Alouf and Denture Team

"The dentists were so nice and very respectful, and we will always be so grateful to them for the rest of our lives. Getting these dentures has really improved our lives. I have started changing my appearance, dressing and looking better. Everyone says we look so much younger. I am truly grateful for the MOM project and I have so much respect for the dentists who took their time to work on our teeth!"

- Elizabeth
Grundy MOM Denture Patient

STEPHEN - DONATED DENTAL SERVICES

"We just finished this nice gentleman's case. I will adopt him as a regular patient into our dental home. His change since before we did this case until after this case was completed has been stunning. He seems much more confident and happier with his new smile, and very appreciative. Drs. Jay Slagle (Periodontist) and Paul Brinser (Oral Surgeon) also helped with this case, and Drake Dental Lab kindly donated his dentures."

- Dr. Sam Galstan

You all have done a great job down at the Donated Dental Services. All the dentists that did work on my mouth did a great job. I am greateful for all you and the dentists have done for me. Thank you for making my life better.

- Stephen

ANNETTE - DONATED DENTAL SERVICES

I have always loved the ability we have as dentists to give back to the community and help those who are less fortunate, but I am always nervous about being inundated with people seeking free care. Until recently, I have been able to help others via the Mission of Mercy projects, which I have really enjoyed. In the last 3 years, I have had 2 boys with boy #3 due in 3 months. As such, I haven't had the time to travel to the MOM projects. When Barbara contacted me about the DDS Program, it fit perfectly with my love of service without the time expense of traveling. It is also nice that the patients are pre-screened. The VDAF even coordinates with the various labs for free lab work. In our case, the treatment plan consisted of full mouth extractions (25 teeth total) with upper and lower complete dentures. Annette came in for the evaluation and workup so grateful. We did the necessary diagnostic work and took impressions for her immediate dentures. The VDAF coordinated with Kyle Tuttle of River City Dental Lab. He was kind enough to fabricate the upper and lower dentures at no charge. Annette was so appreciative and grateful throughout the procedure. We removed the 25 teeth and seated the dentures. They look great and fit wonderfully. Thank you Barbara Rollins and Kyle Tuttle for the opportunity to give a little back. It was a wonderful experience, and I look forward to continuing to help!

- Dr. Austin T. Westover

MOM PROJECT CELEBRATES 15 YEARS OF SERVICE TO VIRGINIANS IN NEED

Barbara Rollins; Director, Missions of Mercy

As the 2014 year came to a close we reflected on the patients who relied on MOM for their dental care this year. For many it was their first visit to a MOM clinic but for many it was their annual dental check- up. The seven MOM projects were held in Suffolk, Northern Virginia, Petersburg (VSU mini-MOM), Richmond (Special Olympics), Wise, Grundy and Homeless Connect also in Richmond. Through the 7 completed projects in 2014, 3,400 uninsured and underinsured Virginians received dental care valued at over $2.6 million. Volunteers came from 12 states, as far away as New Hampshire, Nebraska and Georgia to donate their time and expertise, some 1,944 of them! We thank these most outstanding and dedicated MOM volunteers for their continued commitment to this project and making it all possible.

2014 COMPLETED MOM PROJECTS

Project	*# Patients Treated*	*Value of Donated Care*
Suffolk	464	$475,711
NOVA	932	$391,732
VSU mini-MOM	103	$44,000
Special Olympics	123	$19,335
Wise	1,299	$1,408,692
Grundy	435	$341,359
Homeless Connect	54	$18,199
TOTALS	**3,410**	**$2,699,028**

200-2014 DONATED TREATMENT

Type of Treatment	*Amount*
Exams	55,927
Cleanings	12,650
Gross Debridements	2,974
Fillings	53,923
Extractions	106,277
Root Canals/ Pulpotomies	1,875
X-rays	28,608
Fluoride (topical/varnish)	6,307
Complete Dentures	1,419
Partial Dentures	134
Sealants	834
Stainless Steel Crowns	238

TOTAL # PATIENTS TREATED: 55,927
TOTAL VALUE OF DONATED CARE: $35.6 MILLION
COMPLETED MOM PROJECTS: 79

40 UNDER 40

DR. SHAUN L. SMITH

Dr. Shaun L. Smith pioneered the Orthodontics program for Kool Smiles when he moved to Hampton Roads in November 2012. He currently sees patients at three locations in Hampton Roads and also volunteers with VBMRC.

DENTAL CLINIC CONTRIBUTES TO DECLINE OF EMERGENCY DENTAL VISITS

Piedmont Virginia Dental Health Foundation Community Dental Clinic

Emergency dental visits to Memorial Hospital of Martinsville and Henry County continue to decline, contrary to the national trend.

Visits have decreased by 31 percent over the past six years, according to hospital officials. In 2008, there were approximately 1,383 visits compared with 954 in 2014.

"Clearly, the services provided by the Community Dental Clinic are the major reason for the decline," said John Maxwell, Chief Operating Officer, Memorial Hospital of Martinsville and Henry County. "This is one way the Hospital works together with community organizations to improve the health of the community."

The Community Dental Clinic sees emergency patients on an as-needed basis, said Dr. Mark Crabtree, president of the Piedmont Virginia Dental Health Foundation, which operates the Clinic. "We are pleased that low-income patients are using the Clinic for emergency treatment," he added. "It's gratifying that we are contributing to the reduction of the emergency dental visits at the hospital."

The trend in Martinsville is contrary to the national trend in which most hospital ERs are seeing major increases.

The National Hospital Ambulatory Medical Care Survey reports the number of dental emergency room visits increased from 1.1 million in 2000 to 2.1 million in 2010. The Pew Center on the States estimates a 16 percent increase from 2006 to 2009 in visits to ERs nationwide from preventable dental conditions.

The Medical Care Survey says the increase is driven primarily by younger adults who don't have dental benefits. The ER is a costly destination since the resources and care provided is intended for lifesaving situations.

Often patients are on Medicaid or have no insurance, meaning hospitals provide care and receive little or no payment. The Pew Center on the States study in 2006 found that the cost of treating decay-related ER visits of 330,000 cases was nearly $110 million in the United States. The ER visits add to the financial burdens confronting hospitals and government and private insurance payors.

In the eight years since the Clinic opened to serve low-income patients, the number of visits has grown to 3023 in 2014 from the initial 936 in 2007. "The huge increase in demand for services has resulted in longer waiting times for patients," said Dr. Crabtree. "The wait time for appointments for patients with routine problems now is two years."

With the increase in patients, the Clinic has reached a critical need for funding. Last fiscal year, Fees and Medicaid reimbursements were 44% of the income necessary to operate the clinic, so the Foundation relies on donations and grants from foundations, community organizations, businesses and individuals to make up the difference.

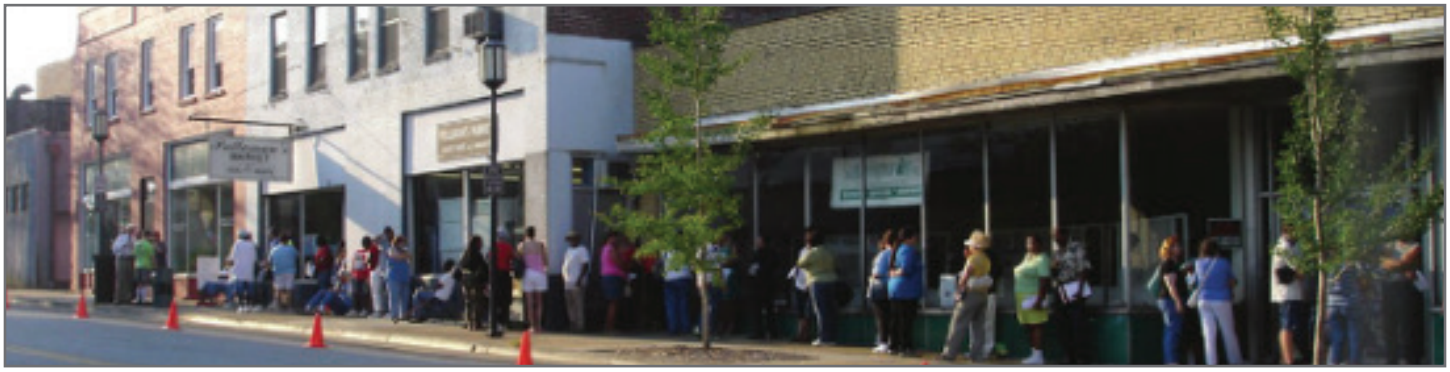
"We're glad to know that organizations in the community recognize we are making a difference, but we must have financial support to continue," said Dr. Crabtree. "We never were designed to be self-sufficient since we serve the indigent."

Unemployed or insured children and adults have received more than $6 million in dental services since the Clinic opened in 2006, said Dr. Edward Snyder, Vice-president of the Foundation. "There have been more than 30,000 patient visits, and the demand continues to increase."

Without significant donations in the next few months, the Foundation must reduce its costs and the level of services we provide the community," said Dr. Snyder. "We need to raise appropriate $200,000 annually to maintain the level of services we provide in the Clinic."

Dr. Crabtree said the Foundation has enough money to remain open with a full- time dentist through August 30. The Foundation has paid for one full-time dentist since the Clinic started full time operations in 2009.

DONATIONS ARE TAX-DEDUCTIBLE. FOR INFORMATION, CALL 276 632-7727 OR VISIT www.piedmontdental.org.



Hundreds wait in line at the 2008 grand opening of the Community Dental Clinic

PAYERS USING CREDIT/DEBIT CARDS FOR PAYMENT

FIGHTING FRAUD, CUTTING COSTS AND KILLING CHECKS?

It is not uncommon today for dental benefit carriers and third party administrators (TPAs) to pay dental offices with a credit/debit card instead of the traditional paper check. In fact, this trend seems to be more popular with TPAs than it is with traditional dental plan carriers and has created concerns for dental offices.

VPay is an example of a company that provides this service and offers a virtual stored-value debit card program designed specifically for claims payments. VPay is delivered to the dental office either by fax or secure email. The dental office can process the payment just like it does any other credit card transaction – by entering the card number, security code, expiration date and amount.

VPay touts quicker reimbursement as an advantage to using the stored-value card; however, dentists have reported that the card may carry a higher processing fee than a traditional debit or credit card transaction.

You do not have to accept the stored-value card as payment if you do not wish to do so. You can request to opt out of using the stored-value card and instead receive a check as payment for services rendered. If that is your choice, you should call the toll-free number provided on the explanation of benefits (EOB) statement which accompanies the stored-value card and inform VPay or the issuing company that a check is preferred and that you are not interested in utilizing the stored-value card for claim payments.

The ADA has received reports from some dentists indicating that some of these companies' customer service representatives are reluctant to waive the stored-value card as payment; thus, you may have to escalate your request to a supervisor or manager with the company.

The ADA's Council on Dental Benefit Programs (CDBP) recommends dentists carefully read the fine print accompanying EOB statements and suggests that members call CDBP staff at 800-621-8099 for additional assistance.

DANVILLE AREA DENTISTS PROVIDE CARE FOR ADULTS WITH DISABILITES

Danville-Pittsylvania Community Services recognized the Danville (Regional) Dental Society in February 2015 for its partnership in the Oral Healthcare Access Program. Local dentists, including oral surgeons, have agreed to treat adults with behavioral health disorders or intellectual disabilities in their office, for reduced fees. Program coordinator Dr. Kevin Snow says treatment includes restorative, periodontal and prosthetic procedures. DPCS has applied for grants each year to fund the cost of the program, with most of the funding used to pay for dental treatment. Grant funding for the program totals $323,360. United Way of Danville-Pittsylvania has given over $272,000, with donations from Community Foundation of the Dan River Region ($30,000), Knights of Virginia Assisting Citizens with Intellectual Disabilities ($20,000) and the Walmart Foundation ($500). Dr. Snow says participating dentists have agreed upon a fee schedule which is approximately 40% of usual fees. Local dentists have donated services or in-kind contributions of over $96,000. He expects the partnership between local dentists and DPCS to continue.

40 UNDER 40

DR. TAREK EL BADAWY

After graduating dental school in Egypt; I completed my post graduate residency at the University of Maryland. Now, I'm fortunate to serve the community of Suffolk in my first brand new state of the art practice.

New Dentists Conference

A mountaintop experience for your career and practice.

VDA
Virginia Dental Association®

Registration Fees
$149 *VDA Members*
$49 *Students*
$249 *Non-Members*

Friday, August 7

1:00pm Welcome Session
Richard Taliaferro, DDS, VDA President-Elect
Terry Dickinson, DDS, VDA Executive Director

2:00pm Implant Dentistry in the Age of Immediate Load
Karen McAndrew, DMD, MS
Chris Richardson, DMD, MS

5:30pm Networking Reception

6:15pm Cookout
Families welcome! Childcare available.

8:00pm 1st Annual Corn Hole Tournament
You won't want to miss this! Families welcome!

Saturday, August 8

8:00am Breakfast & Advocacy Moment
Bruce Hutchison, DDS, VADPAC Chair

9:00am Sustainable Aesthetics and the Art of Body Language
Christopher Ramsey, DMD

Noon Lunch & Vendor Fair
Visit with our exhibitors while you eat!

1:00pm Sustainable Aesthetics and the Art of Body Language
Christopher Ramsey, DMD

4:30pm Depart for Brewery
Catch the bus to a local brewery for dinner, drinks, and an evening of fun! Families welcome!

Additional event information coming soon! #VDANewDentists

August 7-9, 2015 | **Wintergreen Resort**

I'M A NEW PRACTICE OWNER

WHAT CAN THE ADA DO FOR ME?

Dr. John C. "Cappy" Sinclair

Opening my own practice from scratch was one of the scariest moments in my life. I knew I had a good portion of dental knowledge amassed over the last few years, but what did I know about running a business? I could sit down and talk to patients about decay and occlusal wear; however, could I sit down and talk to a team about the goals of the practice and how to achieve them? What should my fees be, and what insurance I should accept? How would I go about preparing my office for HIPAA and OSHA protocols? Many of these questions, I later found out, could be answered through the ADA's resources. In this article, I will be discussing several of those resources which can be huge assets when you decide to make the leap into practice ownership. I will also briefly introduce a new event the VDA is hosting, geared towards the new dentist.

THE CENTER FOR PRACTICE SUCCESS

There are very few places where one may find legitimate answers to questions that arise when opening a practice. One of the best resources I have found is the ADA's Center for Practice Success(CPS) http://success.ada.org/en/. Here you can find several "must know" items such as: how to design your office if you are building a new building or remodeling an older space, how to adhere to government regulations regarding human resources issues and employees, and how to navigate the world of filing dental benefits for patients. I used this resource to help with the initial design of my office, as well as creating an employee manual. Furthermore the CPS also includes articles which discuss items outside of work that are equally important. One section I highly recommend is the link which gives suggestions on achieving a work and personal life balance. As the owner of a business, I have found it very easy to be consumed by dentistry and not make time for your personal life. With all of these amazing resources under one roof the ADA prepares dentists for both personal and professional success.

ADA BENEFIT PLAN ANALYZER

Shortly after setting up my own practice, I was contacted by one of the local representatives of a dental benefit plan. They wanted to know which carriers I would be in network with and also inquired about participating with them. Since I was just starting out my own practice without any patients, I knew that participating with insurance plans would provide me with an influx of patients. However, I wondered what would it cost me down the road. Just as a refresher, if I became a contracted provider with this insurance company I would be held to their fee schedule and would only be allowed to charge a patient what they had deemed an appropriate fee. For example, let's say if normally I were to charge $1200 for a crown but the insurance company only allowed a charge of $800 for their patients, then I would be looking at a loss of $400 without even picking up the handpiece. Looking on the opposite spectrum I also had to consider that by becoming a participating provider I may have an increase in 25 new patients a month as opposed to 5 without participation. This raises the question of how do you know when it makes sense financially to participate with an insurance company? Well, good news...the ADA has developed a benefit plan analyzer which gives you information to see if participation with a certain insurance company makes sense. The program will actually sync with your current system and give you a rating from one to one hundred; one hundred being in your best interest (financially speaking) for a dentist to participate. There is nothing worse than starting a practice participating with 10 or 15 insurance plans only to be busy, but not productive. It can be a tough road to recovery from there, which is why I recommend you take a look at this program to help you make those decisions from both a capacity and financial perspective. http://success.ada.org/en/apps

THE ADA STORE

One of the ADA benefits is self explanatory; however, it is just as important as the two previous ones. What if I told you that before the practice doors opened you had to make sure all HIPAA and OSHA guidelines were being followed, and if not you could be subject to fines which could end up costing you tens of thousands of dollars? A few months before I opened my doors I would have had a blank stare on my face. Once again the ADA came to my rescue by having both HIPAA and OSHA compliance manuals readily available. The manuals gave me implementation protocols and procedures to make sure my office was up-to-date and compliant. The ADA Store is an excellent resource where you can find almost any "must have" item for your practice. Some examples: brochures for patient education, CDT code books updating the latest dental codes, and information for an internal marketing program. Many of the items are also customizable.

VDA NEW DENTIST MEETING

Finally, I would like to share with you an amazing event, held August 7-8, 2015, for all new dentists. The VDA, along with the New Dentist committee, will be offering CE and fellowship for the new dentist community. This event will be held in Wintergreen, Virginia and will be headlining Dr. Chris Ramsey. I heard Dr. Ramsey speak at last year's AACD conference, and he was one of the most entertaining speakers I have seen, being part dentist and part magician! I look forward to meeting many of you there. Be on the lookout for future emails and information regarding registration and additional events at the conference.
https://vadental.org/pro/news/3972

I mentioned that opening my practice was one of the scariest moments in my life, but I can also say that it has been one of the most rewarding. With the help of the ADA, I have created an environment that I, as well as my team members and patients, look forward to everyday. I know that I will still have plenty of successes and failures along the road, but I look forward to sharing and celebrating these moments with all of you, my fellow colleagues.

Editor's Note: Dr. John "Cappy" Sinclair, a VDA member dentist, practices in Virginia Beach, and writes on subjects related to new dentists. Contact him at cappysinclair@gmail.com.

DOES HEALTH CARE REFORM MEAN MORE COVERED CHILDREN IN YOUR CHAIR? THINK AGAIN.

Chris Pyle; Vice-President, Marketing & Government Relations, Delta Dental of VA

There's a lot of talk about more children gaining access to dental coverage thanks to the Affordable Care Act (ACA). How this new coverage plays out at the dental office, however, may come as an unpleasant surprise to both dentists and patients. And, since dentists' offices typically fall into the small business category, health care reform will affect dentists on two levels – by limiting the types of health insurance plans they can buy and by resulting in large out-of-pocket costs for their patients.

Dentist practices with fewer than 50 employees are considered small groups from the ACA perspective. As of 2016, groups with up to 100 will likewise be defined as small.

Groups with 50 or fewer employees are free to offer or not offer benefits to their employees without fear of fines. In 2016 and beyond, groups with 51-100 employees are not only required to offer benefits to employees as part of the ACA's shared responsibility provisions (commonly known as the employer mandate), but since they will be defined as small groups for purposes of the ACA, they will have fewer plan options.

Why will these small groups have more limited choice? Because, while the ACA does not require individuals or groups to purchase specific benefits (but will bestow a tax penalty if you don't have minimum essential coverage), it forces carriers to include certain benefits as part of plans offered in small group and individual markets.

It's as if the government said to an individual, you are not required to purchase a car with an infant car seat, but then the government turns around and tells all car manufacturers, "You must include a car seat in every car sold to an individual." You don't have to buy it, you just can't not buy it. You have to buy the car seat whether you need it or not.

From the small group and individual insurance market perspectives, there are 10 car seats – called "essential health benefits." Half of one of those 10 car seats is pediatric dental benefits, and these benefits are treated differently from the rest.

For groups headquartered in Virginia (and a handful of other states), the rules are a bit friendlier when it comes to dental benefits.

In 2014, the Virginia General Assembly passed legislation clarifying that a carrier offering plans in the small group or individual market is allowed to offer health plans without pediatric dental benefits so long as two conditions are met: First, there must be a qualified dental plan available for purchase and, second, the carrier must disclose that the pediatric dental benefits are not included in the health plan.

Since exchange certified dental plans are offered both on and off of the exchanges in Virginia, groups and individuals are free to shop for their dental benefits the way they always have. This applies to all small groups, those that aren't required to purchase any benefits for employees (under 50) and those that must offer benefits (51-100).

Great news, right? Maybe not. As it turns out, almost all medical carriers are forcing small groups to include pediatric dental benefits in their health plans despite the fact that the carrier is not required to do so and small groups may already have a dental plan they like. Just like the car seat analogy, you don't have to buy it, you just can't not buy it.

In some cases, the resulting pediatric dental portion of the health plan premium is small since the dental benefits are subject to a combined medical and dental deductible. Dentists need to understand the implication of a patient's dental benefits being subject to a high medical deductible. In such cases, a parent may take a child to the dentist believing they are covered only to find that they are on the hook for 100 percent of the bill since they have not met a huge medical deductible.

Other insurance carriers are charging a bit more premium to provide what looks like a traditional dental benefit. Buyer beware. Often, even when diagnostic and preventive dental services such as exams and cleanings are covered without having to meet the medical deductible, the other categories of benefits such as basic (including such common services as fillings) and major services are subject to the medical deductible.

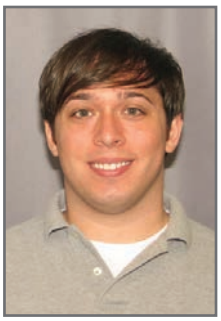
Additionally, any orthodontia benefit must meet strict medical necessity criteria. Furthermore, the coverage levels are not as high as a typical 100/80/50 dental plan. They often look more like a 90/60/50 plan and, in reality, play-out more like a 90/0/0 plan.

Estimating the costs of treating a child who visits the dentist twice in a year and receives some pretty common procedures such as cleanings, x-rays, fluoride, sealants, a couple fillings and a pulled tooth reveals that the person in a plan where the dental is subject to the medical deductible would owe 100 percent of the $746 bill (assuming the high medical deductible had not been met).

The person in an embedded medical plan that covers diagnostic and preventive dental services without having to first meet a medical deductible would owe $407. A person in a traditional standalone dental plan would owe $140. Even taking into consideration the difference in the costs of premium, the person is better off in a traditional standalone dental plan.

It's unfortunate that big health insurance companies are forcing small groups and individuals to buy something that they don't want or need. As small employers, dentists who shop for health coverage will be forced to purchase pediatric dental benefits whether or not they or their employees have children, and many of their patients are likely to pay much more out-of-pocket for their children's care.

Perhaps as groups, brokers and dentists understand what is and is not required, market pressure will be applied and the result will be consumers having the freedom to shop for what they want and need. In the meantime, many groups and individuals will be left with having to purchase duplicative coverage in some cases and will be paying more premium and out-of-pocket costs than necessary.



TAKING THE NEXT STEP:

TRANSITIONING FROM STUDENT TO DENTIST

Jeremy Jordan, D2015, VCU School of Dentistry

It all starts on the first day of dental school—charged with the responsibility of providing a history their own experiences and how they made it through dental school, upperclassmen reaffirm incoming students that it gets better. As almost every dental student will tell you: first year is hard, second year is hardest, third year gets better, and fourth year is great. And to be completely fair, they're right. Fourth year is, by far, the best year of dental school. In our fourth year, dental students transition from the third year didactic-clinical hybrid and spend our time on clinical service learning rotations in different clinics throughout the state, completing cases and requirements, and continuing to build rapport with our patients. When we reach this point, we've finally built enough skill that it no longer takes a full three-hour session to complete an adult prophylaxis or a small class II restoration; we start to feel like the doctors we've been training to become, and we can see the light at the end of the tunnel.

What the upperclassmen don't tell you, is that fourth year comes along with its own stresses. In addition to completing our requirements for graduation and finding patients for our licensure exam, we face one of the biggest transitions of our academic career so far. Upon graduation, we're no longer a student dentist. We are the dentist. Whether we like it or not, we're the ones responsible for the outcomes of the treatment we provide and it can be daunting to realize that even after four years of training there's so much left we could learn. If that realization isn't enough, we must also decide what we'll do after graduation. For some students, the decision is easy—they'll join the family business, and go into practice as an associate with their father, mother, childhood dentist, or family friend. Some will start searching for other associateships or practices to buy, and will go through the arduous process of contract negotiation before jumping head first into managing staff, overhead, and a full schedule while learning how they'd like to shape their practice. Others will enter specialty and advanced training programs. The truth is, there's no one-size-fits-all answer. Despite the uncertainty ahead, I'm sure that I can speak on behalf of the Class of 2015 in saying that it's a decision we're excited to make.

In the months to come, nearly forty-percent of the graduating class will enter some kind of post-graduate training program. Although the application process can differ between specialities, most programs use the American Dental Education Associations Postdoctoral Application Support Service, an online application service that allows applicants to upload their information and apply to multiple programs at once. Generally, applicants are required to submit a personal statement, curriculum vitae, and letters of recommendation. In addition, applicants must pay an application fee through PASS and submit supplemental information directly to the program.

One of the hardest parts of this process is deciding where to apply. Choosing the right residency program is dependent on multiple factors—the location, program reputation, range of experiences, tuition and expenses, or even the stipend. Because of the cost associated with applying to each program, and the cost to travel for interviews, students are careful to choose the programs they're most interested in, which in many instances, means narrowing down their list. Kandice Klepper, D2015, admits "as I continued to research each of my top programs I found it more difficult to narrow down where I wanted to be." While narrowing down programs is a necessary evil, Klepper relied on the advice of current residents and faculty at the VCU Graduate Periodontics residency program, VDA mentors, and her experience on externships, and will be attending a Periodontics residency at the University of Texas Health Science Center at San Antonio.

Rachel Kaplan, D2015, recommends future applicants to apply to a small number of well researched programs, because scheduling can become an issue. Kaplan candidly confesses, "I applied to 10 programs and was only able to attend 7 interviews due to scheduling conflicts. […] If I were to do it all over again, I would apply to fewer programs, maybe 7 or 8, but I wouldn't change anything else." In fact, Kaplan found that scheduling was one of the most difficult parts of the application process. "Balancing my schedule was difficult because I was constantly changing my patients' appointments when I was offered another interview. I found that my patients were very understanding and that my classmates were extremely supportive—they were more than willing to see my patients when I was out of town." Like Kaplan found, interview invitations can mean lost clinic sessions and more time away from school; however, patients and faculty are understanding and excited to help us succeed in our next steps. Kaplan's strategy was successful, and she will begin a one-year General Practice Residency at York Hospital in York, Pa. in late June.

Klepper and Kaplan aren't alone in their experiences. After careful deliberation, I decided to apply to general practice residency programs with the mindset that I would continue to build my skill set, learn advanced procedures, and become more comfortable with treating medically compromised patients. In the early stages of the application cycle, I scheduled several meetings with faculty members so that I could narrow down a list of programs, decide which skills I was most interested in developing, and determine the best way to compare one program to another. One of the most important things I learned in the process is that residency programs can look completely different on paper than they do in person. I relied heavily on the network I developed through active involvement in the American Student Dental Association to choose programs—I applied to programs based on the recommendations of previous and current attendees, and used short phone chats to catch up and ask questions without the fear of seeming disinterested. When I arrived for each interview, I felt comfortable that I had

CONTINUED ON PAGE 68

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INFORMED REFUSAL:
A REVIEW
The Medical Protective Company

Most healthcare providers know that a patient's signature on an informed consent document may not automatically make the consent valid. The same is true of informed refusal. Both of these concepts rely on ethical and legal guidelines that acknowledge the right of competent adults to determine the course of their health care.

This decision-making process requires consultation between doctor and patient to determine the best treatment option and to ensure that the patient has been a partner in selecting the appropriate treatment. A signature merely documents the occurrence of this process; without it, the signature means nothing.

Patient education and documentation are the doctor's best allies for gaining a patient's cooperation in selection of a treatment plan. However, a patient can refuse care even if the consequences might be dire. When a patient refuses urgently needed care, the doctor should scrupulously document his or her efforts to explain the risks associated with lack of treatment.

When the patient has made known his or her decision to refuse treatment, the doctor or staff member should document the information directly into the patient's record. He or she may ask the patient to sign and date the entry. These notes should include the patient's diagnosis, the recommended treatment, and the risks that may occur if the condition isn't treated. The risks may include: (a) treatment options might be lost as the condition deteriorates; (b) the doctor may have less opportunity to affect a successful outcome; (c) the increased possibility of complications; and/or (d) remaining treatment options might be more expensive.

Patients also have the right to change their minds and withdraw consent for treatment they have previously authorized, even when the treatment has already been started. When a patient refuses treatment or wants to abandon a treatment plan, the doctor should carefully document the decision, using the framework of informed refusal. Documentation should include the following considerations:

GET THE REMAINDER OF THIS ARTICLE ON THE NEW VDA RESOURCE CENTER AT:
HTTPS://VADENTAL.ORG/PRO/RESOURCE-CENTER/PRACTICE/3974

TAKING THE NEXT STEP Continued from page 67

done all my research and found solace in visiting with old friends. By comparing programs with my own goals, I was able to solidify what was most important to me and find a program that aligns with how I plan to practice. In July, I'll begin a two-year General Practice Residency at Wake Forest School of Medicine in Winston-Salem, NC.

While each member of the Class of 2015 has chosen a different path, one thing remains true for all: organized dentistry is here to help during that transition. In the next few months, our class will meet up with the Virginia Dental Association for our annual Signing Day, a transition dinner, and other graduation events. We're fortunate that the VDA has such a strong presence at our school, and even more so that they care so much about students' transitions. There's a buzz about the VDA's membership resources, like the online resource center, and I'm excited for my classmates to see the impact their participation can make. Like Klepper said, "I contribute much of my success to the generous support network available at the school, to the mentorship of the VDA, and the plethora of resources available in ASDA, ADEA, and other professional organizations. I look forward to the future, and I plan to continue my involvement in organized dentistry, as well as aspire to be as great of a mentor as I've had along my journey." Klepper hit the nail on the head—I can undoubtedly attribute my own success during the past application cycle to the support of my faculty, and the resources and mentorship found in organized dentistry. As the Class of 2015 takes the next step forward, I hope that we can pay forward the diligence, passion, and mentorship that's been invested in us.

40 UNDER 40

DR. JERI BULLOCK

I am a proud and passionate health center dentist at SVRDC in Saltville, VA and I hope to inspire others to follow their passion and live their mission. Outside of the office I am an avid mountain biker and yogi.

Which Brokerage Firm is Truly Looking Out for YOUR Interests When Selling Your Practice?

Dual-Representation Brokerage Firms?

Dental Supply Companies Who Also Act As Brokers?

Your Accounting Firm Who Offers Brokerage Services?

Is it a dual-rep brokerage firm? ***NO*** You cannot serve two masters. Dual-rep firms charge buyers hefty fees, and as a result, their strategies usually negatively affect the final selling price and/or terms the owners agree to when selling. In addition, if a buyer has to choose between two similar practices- where one requires a substantial fee to a dual-rep firm, and the other does not- which practice and brokerage firm will they choose?

Is it the equipment/supply companies who are also brokering practices? ***NO*** In most cases, the owner is selling and retiring. The supply companies want to please the buyer in order to gain or retain their business post-closing. Whatever the terms, their priority is to get the deal done in order to pick up the buyer as a new client, at whatever cost to the seller.

Is it your accounting firm that also owns a practice brokerage company? ***NO*** This could be the biggest conflict of interest that exists. Sellers look to their accountants for advice asking, "Is the price or tax structure acceptable?" Will the accountant advise their client against a "bad" deal if a large commission is on the line to their firm, or to a brokerage company they are partners with or are profiting from?

Is it the firm that has successfully represented sellers for over a decade? ***YES***

NATIONAL PRACTICE TRANSITIONS has represented hundreds of sellers over the past fifteen years in the sale of their dental practices. We work diligently for our clients to maximize practice value while structuring the sale to minimize tax liabilities, but at the same time creating a fair and equitable transition for the buyers. In fact, we have a 100% success rate post-closing; meaning that we have never had a buyer default or fail. We emphasize to buyers the importance of having separate representation and we work hand-in-hand with their advisors to successfully complete the transaction.

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MEMBER SPOTLIGHT:

AN INTERVIEW WITH DR. BILL HENRY

Dr. Michael R. Hanley, Associate Editor, Component 3

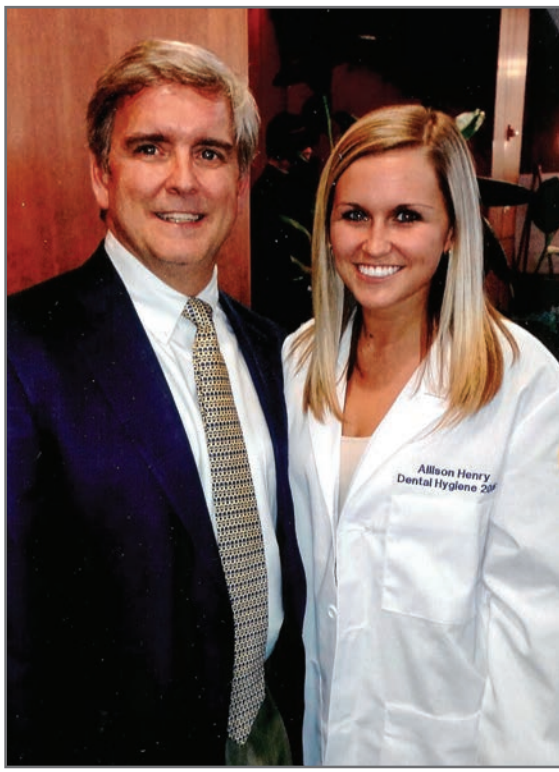
Most dentists put in a mentally, and physically, tough eight hours a day and look forward to the five o'clock hour. But one dentist from Hopewell, Virginia, is always ready for more.

Meet Dr. Bill Henry, chairman for the last three years of the Hopewell School Board.
Bill joined his dad's practice in 1984 and continues to this day. His parents graduated from Hopewell schools. Bill did also, in addition to the University of Richmond and MCV Dental School. He has never lived more than 35 miles from home. You would be wrong if you guessed if his nickname was "Magellan".

In the fall of 2001, with two children in public schools, Bill wanted to get involved and help solve the many problems plaguing 4000 students in what is today the fourth poorest school system in Virginia. He is most proud of the renovations and upgrades to the elementary, middle and high school accomplished during his tenure. He also managed to keep parental discussion at a civil level. Hopewell has good reason to be very pleased with their facilities.

While I was interviewing Bill over lunch, the superintendent called him with a "burning issue" and I lost him for ten minutes on his cell phone as his sandwich got cold. "He knows he can call me anytime between 1:00 and 2:00 p.m." That's just what a chairman does.
Dr. Henry is also a member of Kiwanis, a Past-President, of course. In addition, he is presently chairman of trustees at his church. One daughter, Allison, is graduating in May from dental hygiene at VCU and is thinking about moving beyond the 35 mile perimeter. In what little spare time he has, Bill's a runner and presently holds the title of "Fastest Dentist in Component III." I'll be coming after him in the Monument Avenue 10k, but I suspect he'll have time for a call from the superintendent of schools before I finish.

A salute to one of our VDA members, helping his community in many ways.



Dr. Bill Henry with daughter, Allison

40 UNDER 40

DR. NAHEE WILLIAMS MCDONALD

Dr. Williams has been serving the Northern Virginia community for over nine years. She provides outstanding care in a fun environment. Comprehensive restorative dentistry, sedation, nitrous oxide analgesia and laser dentistry is available for children and patients with special needs.