Virginia Dental Journal
Volume 92, Number 1 • January, February & March 2015

Navigating the Storm With the VDA as Your Guide

In This Issue:

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Virginia Dental Journal

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VDA Virginia Dental Association

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Virginia Dental Journal

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

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President's Message

Wikipedia defines a lighthouse as the following: "A lighthouse is a tower, building, or other type of structure designed to emit light from a system of lamps and lenses and used as a navigational aid for maritime pilots at sea or on inland waterways. Lighthouses mark dangerous coastlines, hazardous shoals, reefs, safe entries to harbors, and can also assist in aerial navigation." The VDA serves as a lighthouse for you, our members.

Gordon Lightfoot wrote and sang a popular song back in the 1970s, "The Wreck of the *Edmund Fitzgerald*", to commemorate its crew and ship. During a massive storm on Lake Superior, the crew of the *Edmund Fitzgerald* looked to the Whitefish Point Light Station for guidance. The beacon of light suddenly went dead and the crew was unable to detect the correct direction. The ship and all crewmen aboard were lost.

Does anyone see the parallel between this song and dentistry? Last year, Dr. Sherwin wrote extensively about being prepared for the onslaught of endless storms. The ADA and VDA are committed to your success as demonstrated by the numerous programs that have been instituted over the past few years. The motto "Members First 2020" is the common theme in our organization that will help you, as an individual practitioner, survive and thrive in spite of the dramatically changing dental landscape. The ADA/VDA is the only Association that stands up for our profession; it is like a lighthouse that guides ships through hazardous situations. It is the only organization that cares for you and me.

Since leaving the Homestead, your VDA staff and Board have participated in a Leadership Conference and a Strategic Planning session. The Leadership Institute had its first training session, and we were pleased to have over 25 young members in attendance. For one year, these individuals will attend ongoing educational sessions provided by the VDA and will end up with a certificate in leadership education. This Institute will prepare our younger members to be successful in their practices, their communities and yes, our organization. Are they our future or are these individuals in fact here to lead now? We will see!

The Strategic Planning session has been completed and the VDA is prepared for 2015. The group turned its attention to what is needed for the upcoming year, which includes maintaining the momentum developed in the 2014 Strategic Plan and moving forward successfully. Programs created last year are continuing and are not forgotten. However, this Strategic Plan is our guide, our lighthouse, for our association for the upcoming year! Please take a look at the exciting 2014-15 Strategic Plan at this link: https://vadental.org/pro/resource-center/Strategic-Plan

The New Dentist Conference was held in mid-November and again we had over 20 young Dentists involved. This planning conference was held at the VDA office with ADA staff in attendance. The New Dentists are planning an incredible CE event August 7-8, 2015, at Wintergreen Resort. Please place these dates on your calendar and plan on attending this event.

VDA CLASSIFIEDS

The launching of VDA Classifieds in September 2014 has been a huge success. If you are looking for a dentist, hygienist or an assistant, I encourage you to consider an advertisement on VDA Classifieds. It is an amazing value and free of charge for members! Check it out at www.vdaclassifieds.org.

We are currently in the process of interviewing a firm which will research the possibility of the VDA coordinating buy-sell agreements and which will offer practice management advice and the realistic valuation of practices. The firm we are negotiating with has credentials nationwide. Our intent is to be able to discount this service to our members. There'll be more to come on this endeavor.

President John F. Kennedy, at his inauguration, said,

> "And so, my fellow Americans: ask not what your country can do for you — ask what you can do for your country".

My question to our members, both engaged, not engaged, and to our non-members is this: How are you protecting dentistry's future? I say this on the heels of the Joint Commission's vote to study the expansion of the alternate dental provider in Virginia. This very close vote by the Joint Commission, to expand the duties of a non-dentist with the possibility of a mid-level provider in the state of Virginia, should concern everyone. When I say it was a close vote, it was! If not for our advocacy efforts, we could be placed in the position of looking at a study into alternative providers for Virginia citizens. Both our members and non-members need to stand together to speak with one voice. We gain strength in numbers and have a greater impact in Richmond and D.C. when we work together. We especially need to keep this in mind when considering how much money to contribute to VADPAC. Remember- a few votes the other way and we could have been looking at a study in a totally different landscape! Way to go, Dr. Bruce Hutchison and the VADPAC committee!

Now, on to another endless inquiry into alternate providers in dentistry: the Board of Health Professions voted unanimously at its November 25, 2014 meeting to continue its review of the scope of practice of dental hygienists. A public hearing will take place sometime in January 2015. We will post the date on our website and will send appropriate e-mails to component leaders and to the membership so that each member will be aware of the date, time and place of the hearing. We need you to attend this public meeting and voice your concerns. We will be there, how about YOU?

Continued on page 4

As most of you know by now, the Board of Dentistry instituted unannounced office inspections for those who hold a conscious sedation permit. These inspections started November 1. The VDA first informed the membership of the Board of Dentistry's plans in April 2014. We encouraged members to write the Board of Dentistry with any concerns or questions and to attend their meeting in June. After NO concerned members showed up at the June meeting, we emailed the membership an alert asking that they submit questions to us that we in turn would submit to the Board of Dentistry to be addressed. In August, an email was sent to all members with their listed questions and the Board of Dentistry's answers. We encouraged all members to review the answers, email the Board directly and to attend the full Board of Dentistry meeting in September. Our VDA Leaders spoke to the components leaders about this issue and stressed the need for members to attend the Board meeting to reinforce concerns.

Unfortunately, after the component meetings and multiple emails, our members simply did not show up at the Board of Dentistry meeting. Our VDA Leadership was present, but members were needed for reinforcement. At this meeting, against our strong and vocal opposition, the Board went forward with its inspection protocol. Since the implementation of this policy, I have received numerous phone calls on this issue. Rest assured that the VDA Leadership is active and doing everything it possibly can. However, as a Virginia dentist, you need to be engaged in the process. Please take the time to express your opinion to the Board of Dentistry on this issue or any issue over which you have a concern. Show up at a Board of Dentistry meeting and ask questions! They won't bite YOU! Again, I ask the question: This is your profession- what are you doing to protect it?

See how YOU can become more involved with the VDA to ensure the success and the future of our profession. What are you willing to commit to in order to ensure the safety of our profession? It is easy to sit back and criticize the VDA, but, we need your help, commitment and support especially on issues that concern you! Just like the lighthouse that helps identify dangers for ships, you have to be on board the ship in order to survive and be helped!

Mail or call the Board of Dentistry members if you are concerned about any issue that will affect you.

Here is a list of the current Board members:

Virginia Board of Dentistry Roster: November 2014

Melanie Swain, RDH
Bruce Wyman, DMD
Surya Dhakar, DDS
A. Rizkalla, DDS
James Watkins, DDS
Charles Gaskins, DDS
John Alexander, DDS
Evelyn Rolon, DMD
Tammy Swecker, RDH
Sharon Barnes, Citizen Member

Correction

In our October, November & December 2014 issue we incorrectly printed the title of the article by Dr. James Schroeder on page 25. The correct title is "Change: A Bumpy Pathway to Growth".

Message From the Editor

Dr. Richard F. Roadcap

Since 2007, most dentists have found it gratifying to forego prescriptions for prophylactic antibiotics for many previously covered heart conditions. With the revised ADA/American Heart Association guidelines, we no longer need to prescribe for mitral valve prolapse (with or without regurgitation), heart murmurs, or patients with a history of rheumatic heart disease. We need only to pre-medicate patients with prosthetic heart valves, or a history of infective endocarditis (IE). No longer do we need to send patients for echocardiograms, or find that physician or nurse who told our patient they "heard a heart murmur". But a study conducted in England, and reported November 18, garnered the headline "Study Ties Dental Drugs, Heart Infection Risk".[1] Published in the British medical journal *The Lancet,* the study tracks IE cases since 2008 against a background of declining antibiotic prophylaxis.

1 http://www.elpasotimes.com/health/ci_26960998/study-ties-dental-drugs-heart-infection-risk

The research found that as pre-medication prescriptions declined to one-fifth of previous levels, there were about 35 more cases of IE per month than had been expected. The authors acknowledged that the incidence had been increasing prior to 2008, and there was no proven cause-and-effect regarding fewer dental prescriptions. Also, no link was established between the new IE cases and dental treatment. It was noted that medical procedures that may cause IE, such as kidney dialysis, had become more frequent.

Although the content of the Associated Press article, written by chief medical writer Marilynn Marchione, was fair and balanced, AP's headline bordered on libel. The inference is made that dentists' prescriptions are the cause of heart infections. An online search of keywords revealed that all of the major news outlets carried the story with AP's content and headline. Since "Study Ties…" was the headline in every case, there's no way to blame a newsroom drudge for sacking our profession. The Associated Press owes us an apology, but it's likely none will be forthcoming.

If there's a silver lining in this most recent media eruption, it's the validation of our current practice of pre-medicating only high-risk patients and sparing low-risk/no-risk patients multiple trips to a pharmacy, along with the attendant risks of allergic reactions, pseudomembranous colitis, and other adverse consequences. History suggests that our patients will be less concerned about this most recent dustup than we are. They're just glad that instead of swallowing 2 grams of a ß-lactam antibiotic, they can take this with a grain of salt.

"Baby boomer dentists are beginning to leave the profession in droves."[1] So says an article on dental retirements in a recent issue of *Dental Economics.* The conventional wisdom states that the dentists who entered the profession en masse in the '70s are now departing in similar fashion, creating a buyers' market for recent graduates and established dentists wanting to relocate. A graphic[2] in the November 17, 2014, edition of *ADA News* casts doubt on what many would like to believe. Between 2001 and 2013, a twelve year span, the average age of dentists' retirement increased by nearly four years, from 64.8 to 68.7.

According to the Social Security Administration, Full Retirement Age (FRA) for most boomers begins at 66, and can be as late as 67 years for the youngest, or those born in 1964. If the bar graph cited fails to startle, consider this: average dental retirement age increased 6% during the 12-year period; for each calendar year, the retirement age increased four months; and if the current rate of increase continues, in ten years a dentist can't expect to lay down his or her burden until 72. (According to the World Health Organization US life expectancy in 2012 was 79.8 years.) How can we account for the sharp rise in retirement age?

It's easy to assume that more dentists are postponing retirement because they can't afford it. We've witnessed some of the most turbulent economic times in US history in the last decade. So, what may be some of the reasons for this disturbing trend?

- Stagnant or declining incomes from dental practices since 2006
- Poor performance of investments
- Failure of housing markets to recover pre-crash values
- Tuition increases (particularly for undergraduate education) that have outpaced the rate of inflation
- A profound shift in the procedure mix performed by many dentists, away from operative and surgical treatments, and towards diagnostic and preventive measures, thereby allowing older dentists to extend the life of their clinical practice (At the Virginia Meeting in September, Dr. Albert H. Guay, Chief Policy Advisor - Emeritus for the ADA, reported that diagnostic and preventive procedures today account for nearly three-fourths of all treatment.)
- Burgeoning student debt, reducing the pool of qualified practice buyers, and thereby increasing the time a dental practice remains for sale
- A well-documented disinclination on the part of recent graduates to assume practice ownership

I could go on: declining insurance reimbursements; increasing overhead and staff salaries; regulations that increase operating costs; or a lifestyle one step ahead of our ability to earn a living.
It's unlikely any of us envisioned surviving only a decade after retirement when we left dental school. I'd hope that any septuagenarian doctors are practicing because they enjoy dentistry, and not to meet living expenses. Bankers will say that they have money to lend, and practice brokers will say it's a good time to buy (or sell) a practice. If the ADA is correct, it appears the game has gone into extra innings and we're not sure when it will end.

1 Hufford, Brian. "Practice Transitions: My Favorite Tax Strategies." *Dental Economics,* November 2014, 50.

2 http://www.ada.org/~/media/ADA/Publications/ADA%20News/Images/2014/_November2014/20141117_SNAPSHOT_L.ashx

Three times in two weeks I had to return to the office after hours to write a prescription. Why not order it by phone? Each time it was to prescribe hydrocodone, a narcotic pain reliever that was reclassified in October 2014 by the Drug Enforcement Administration as a Schedule II drug.[1] Lorcet® and Vicodin® (and other brand names for hydrocodone) have been a part of the dental pain relief arsenal for many years. Since 1999 there has been a 300% increase in the sale of opioid pain relievers, according to the Centers for Disease Control.[2] The DEA estimates that more people in the US die from prescription drug overdoses than from auto accidents.

Of course, the prescriptions were written for legitimate dental emergencies. And in each case, I felt that the pain warranted an opioid pain reliever. At this point I could digress about increasing government regulation, added overhead costs, and how ethical and honest practitioners were being punished for the transgressions of a few deviant

Continued on page 6

1 http://www.ada.org/en/publications/ada-news/2014-archive/november/snapshots-of-american-dentistry-november-17

2 http://www.cdc.gov/homeandrecreationalsafety/rxbrief/

Continued from page 5

doctors. However, a 2010 national study on drug use and health found that 1) nearly all prescription drug overdoses came from (legal) prescriptions and not drug theft and 2) over half of the overdoses were the result of drugs obtained from a friend or relative.[3] It's not hard to imagine our own dental prescriptions ending up in the wrong hands. (Dr. Terry Dickinson, VDA Executive Director, was appointed in November to the Governor's Task Force on Prescription Drug and Heroin Abuse.[4])

The change in drug classification by the DEA may prompt changes in behavior by dental practitioners. For example: prescribing/dispensing non-steroidal anti-inflammatory drugs (NSAIDs) as an alternative to opiates; enrolling in the Virginia Prescription Monitoring Program (PMP); ordering fewer tablets or capsules on each prescription; careful scrutiny of refill requests (I've found requiring an office visit by the supplicant works wonders); and recommending over-the-counter pain relievers for most uncomplicated dental procedures.

Dentistry is not without blame: some time back, a patient of record was arrested for possession of a narcotic I'd prescribed for another patient. I suspect we'll be making more after-hours visits to write prescriptions until this national epidemic of prescription drug abuse is conquered.

3 http://oas.samhsa.gov/NSDUH/2k10NSDUH/2k10Results.htm#2.16

4 https://vadental.org/pro/news/3324

Letters to the Editor

Continued Lack of Effective Leadership in VDA/VA Board of Dentistry?

By: Dr. Bob Allen

PDS hosted a Board of Dentistry member and Sandra Reen, Executive Secretary of Virginia BOD, last week at our November dental society meeting.

I asked the first question: my same old thing - "Who may own and operate a dental practice?" She nimbly dodged the question.

Then the fun began. Many were furious that the BOD has already begun unannounced inspections of the sedation dentists. Many consider it completely uncalled for, asking that things be done another way to certify that patients are protected.

I was told when she went to Richmond, the reaction was more hostile than PDS.

She made a statement early in the presentation that, "Dentists are not doing what they are supposed to do." That says a lot about her dominant regulatory attitude towards practicing dentists. (She reminds me of Lois Lerner at the IRS.) She is of the opinion that all dentists are trying to skirt the BOD rules and regulations, and it is her personal job to prevent any dentist from getting away with anything. We must educate her that most dentists do a good job, that a few come before the board, and that a certain percentage of those are repeat offenders.

More than that, we must get to the dentist members now serving on the BOD and request that they take a stronger role in BOD decisions and not default to the Executive Director, Sandra Reen, for advice. The BOD members have not demonstrated strong leadership to date. It is time for that to change. We need stronger dental leadership on the BOD.

The VDA should have been deeply involved in this attempt to do unannounced inspections.

The VDA needs to address concerns of the sedation dentists right now!

It is time for the BOD to stop unannounced inspections of sedation dentists who have broken no laws.

The VDA was involved when the Department of Health wanted to inspect and register all dental x-ray machines many years ago. VDA managed to offer an alternative that was satisfactory to all parties and one that has been successful for many years.

On looking the at the BOD web site and reviewing Board actions against offending dentists, I cannot understand how the reprimands of the BOD to some of the most egregious offenders, demanding that they take many hours of remedial continuing education, is going to make them a better dentist. They are bad dentists to begin with – half the most egregious offenders should not be allowed to practice. If the BOD cannot revoke licenses, then offending dentists should be prevented permanently from doing procedures that they have already proved to be incompetent at, i.e., root canals, surgery, endo, etc. There is precedent for it.

By the way, as I looked over the actions taken by the BOD this quarter, I see two dentists who were reprimanded for overtreatment. So they do investigate overtreatment. I guess a patient complained. I am told the BOD will not investigate reports from dentists. Take a look at some of the actions this quarter on the BOD website.

Some of the things dentists do are so "stupid" and crazy? Almost as stupid as the BOD on which our colleagues serve!

Seeking Candidates for Secretary-Treasurer

By: Dr. Steve Forte

Since September 2011, I have had the honor and pleasure to be the Secretary-Treasurer of our fine organization. At the close of business at the 2015 House of Delegates in Norfolk, my position as treasurer will come to an end. I have thoroughly enjoyed the interactions with the Board of Directors, Committee Chairpersons, our Financial Directors and the HOD. This is a rewarding position to be entrusted with. Service and commitment to the organization is a choice and working with the outstanding members gives me an overwhelming sense of pride. In these times when all organizations struggle with membership, value, finances and strategic planning, know that your VDA leadership is working hard to provide a sound future for the dental profession in Virginia.

The VDA is looking for a member to take on the responsibility of Secretary-Treasurer. This is an elected position, which is a two year term. The position does not require that you be from Richmond or an immediate surrounding community. Many of the ongoing responsibilities are managed by email messaging and conference calls. You would work directly with Jill Kelly - our financial director, Leslie Pinkston – our membership director and the Board of Directors. As treasurer, you would also hold position on the VDSC Board and the VDA Investment Committee Board. The position does require that you participate in the BOD meetings in Richmond, make a presentation to the House of Delegates at the Annual Meeting and visit each of the components as part of the Executive Delegation.

Our organization has a bright future. Be part of the Executive Board spearheading ways to carry the VDA into the future. If you have interest in this position, please contact Steve Forte with any questions. You can call my office at 757-599-8393 or email me at sgf@vaendoforte.com. You can also contact Bonnie Anderson to inform her of your intent to run for this position. She can be reached at 804-523-2190 or Anderson@vadental.org. I wish you all the very best for a healthy and prosperous 2015.

Trustee's Corner

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

Since my last article the 2014 House of Delegates has taken place and I will devote most of this message to the actions of the HOD. First I would like to commend our 16th District Delegation on their dedication and careful deliberations of all of the resolutions that we were presented both at our caucus in Washington, DC and at our Annual Meeting in San Antonio. The Virginia Delegation was a great host in DC and all that attended had a wonderful time. Likewise San Antonio proved to be a great choice for ***America's Dental Meeting***. I would also like to thank our Delegation Chair, Dr. Ralph Howell for a superb job in leading us through our deliberations.

We opened our first session of the HOD with our own Dr. Chuck Norman's President's Address. His speech led us through his year and the strides that we have made in implementing the Power of Three and our new 2020 Strategic plan. He reminded us that as ADA members, we are dedicated to several core values:

- **An adherence** to a strict code of ethics.
- **A commitment** to evidence and scientific-based dentistry in our profession and our practices.
- **And a dedication** to enhancing Americas' dental health.
- His advice to all of us was this: "Don't be complacent, stay involved, and keep challenging yourself to find new ways that you can make a difference."

The second session of the HOD began Monday morning with the election of Dr. Carol Summerhays of San Diego, California as the President-Elect of the ADA. Afterwards we began the business of the HOD.

Some of the Resolutions of interest were:

- Res.6H Adopted by two-thirds vote: Establish a commission for continuing education provider recognition. This moves CERP out of the purview of CDEL and into a commission that has oversight by the BOT and the HOD. The HOD instructed the BOT to review the results of this by-laws change and report its findings back to the 2019 HOD
- Res.34RC Adopted: Establish a policy for dental schools and state societies to incorporate the ADA policy on emotional health, drug and alcohol abuse into dental education curriculums and state society policies.
- Res.63H Adopted: Resolved that the appropriate ADA agencies conduct research to determine the feasibility of developing guidance on new administrative demands relating to claims submission from dental benefits embedded in medical plans sold through the federal and state marketplaces mandated by the Affordable Care Act
- Res.101H Adopted: Resolved that the ADA implement a proactive social media campaign and websites to promote to the public, the safe, positive effects of optimal water fluoridation to decrease the incidence of decay in communities
- Res.104H Adopted: Resolved that the BOT monitor and evaluate the New Dentist Conference, as a meeting coinciding with America's Dental Meeting 2015, 2016, and 2017 ensuring that it will foster inclusiveness, leadership development, and provide opportunities for interaction with the ADA BOT. Afterwards the BOT will report back to the 2018 HOD whether the New Dentist Conference shall remain a part of the Annual Meeting or be reinstated as a stand-alone conference.
- Res.110H Adopted: The ADA pursue appropriate legal, administrative and other actions to oppose and prevent third parties from developing and using cost and non-validated utilization patterns as a way of rating dentists

And finally, the last business of the HOD was to adopt the ADA 2015 budget. Res21H, the approval of the budget, was adopted including the net capital requirements and Res.22H was adopted by a 60% affirmative vote that the dues shall remain at $522, effective January 1, 2015.

The ADA treasurer discussed our financial situation and as of now we are indeed financially stable. We had a $600,000 surplus from 2014. We have total projected revenue of $136,077,000 for 2015, with projected expenses of $128,270,913. We will transfer $7,200,000 into the Royalty Reserve fund leaving us with a surplus operating fund of $606,087 for 2015. The BOT plan is to grow the Royalty fund to $100,000,000 and cap it for special use in projects to reduce or help stabilize dues.

Finally, if you were not in San Antonio and have not read the transcript or seen the video of Drs. Norman, Feinberg, and O'Loughlin, I urge you to go to ADA.org and view them. Dr. Feinberg is committed to continuing the Power of Three and growing our membership and also to the dental student and the new dentist and the challenges they face.

Our first Board meeting with the new Board is in December and as I write this I am preparing to leave for Chicago in a few days. We will have a Strategic Planning Session that will include the BOT and the Council Chairs and Vice Chairs on Sunday. In my next article I will report on this meeting.

2015 Positions Open for Election

Candidate information will appear in the April-May-June 2015 issue of the VDA Journal. Due to space limitations, the Editor reserves the right to condense biographical information.

The following positions are up for election during the 2015 Annual Meeting at the Marriott Waterside Hotel in Norfolk.

President-Elect – 1 year term (2015)

Secretary/Treasurer – 2 year term (2017)

4 - ADA Delegate Positions - 3 year terms (2016, 2017, 2018) – Positions currently held by Drs. David C. Anderson, Mark A. Crabtree, Elizabeth C. Reynolds and Gus C. Vlahos.

5 - ADA Alternate Delegates* - 2 year terms (2016, 2017) – Positions currently held by Drs. Vince Dougherty, Paul T. Olenyn, Maynard Phelps, Danielle H. Ryan and Cynthia Southern.

**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 C. 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.*

VDA Creates Fun "Kid Dentist" Video for Halloween

By: Elise Rupinski, VDA Director of Marketing and Programs

This past Halloween, the VDA recruited four dental "experts" to educate parents and their kids on how to have a fun and healthy Halloween. In the short web video (1:40), child actors wear white jackets and gloves to impart advice like:

- *"Candy is not dinner. Your sons and daughters need a healthy meal before they go chocolate hunting."*
- *"Have you ever considered giving out something healthier to those ghosts and goblins, like raisins or pretzels?"*
- *"I know candy corn SOUNDS like a vegetable, but that stuff is pure sugar!"*

In only one week, the video amassed over 1,000 views and today has over 1,250.

View the video on:
www.vadental.org/pro/videos.

On behalf of the VDA, Rubin Communications Group in Virginia Beach produced the video in coordination with Hurrah Players, a theater troupe based in Norfolk. The children perform throughout the year with Hurrah Players and were excited to "play dentist" for the production.

"Halloween is a great opportunity for the VDA to educate the public about oral health," says Dr. Michael Link, president of the VDA. "We think kids posing as dentists and lecturing parents on Halloween candy is a fun way to make our point." The Halloween video is part of the VDA's larger mission to talk with Virginians about oral health and the connection to overall health.

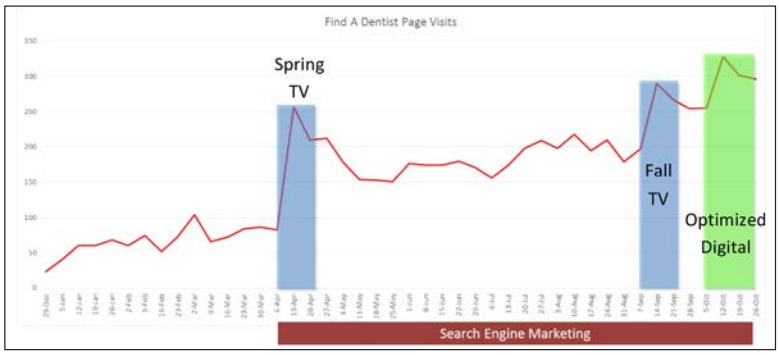
We had so much fun with the Halloween video, and we hope you enjoy watching it!

2014 Advertising Campaign Highlights

The Year At A Glance

The Virginia Dental Association needed to create value for its member dentists, and connect them to prospective patients.

An integrated media plan, capped with a dynamic, optimized digital component, took results to an ever increasing high.



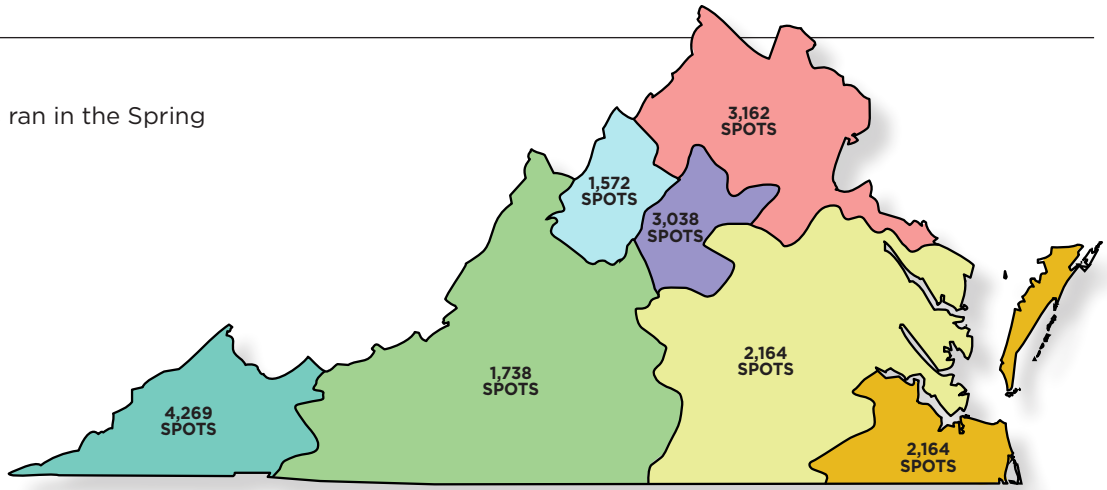
Total number of visits to find a dentist site April - Nov.

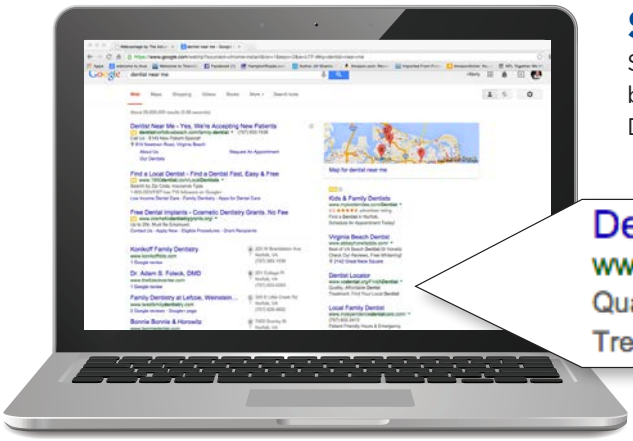
49,496

Television

A mix of :15 and :30 TV spots ran in the Spring and the Fall in 2014.

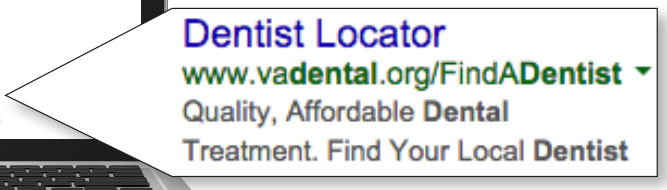
PERCENTAGE OF SPEND	
Northern Virginia	41.10%
Richmond	20.58%
Hampton Roads	17.08%
Tri-Cities	5.89%
Harrisonburg	5.36%
Charlottesville	5.26%
Roanoke	4.73%





Search Engine Optimization (SEM)

Search Engine Marketing Keyword ads ran continuously beginning in April 2014, driving 14,654 visits to the Find a Dentist portion of the VDA website.



Digital Display

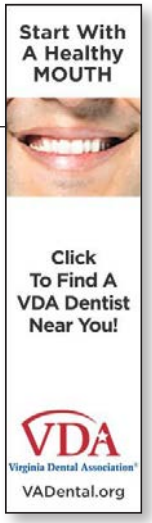
A digital display campaign was introduced in October 2014, with a mix of digital display banner ads and video pre-roll spots.

Total number of impressions served in October:

1,730,031

Number of clicks to the Find a Dentist page in October:

3,738



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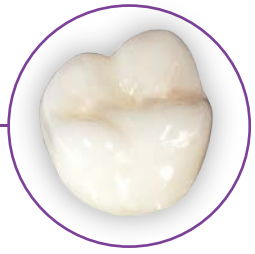

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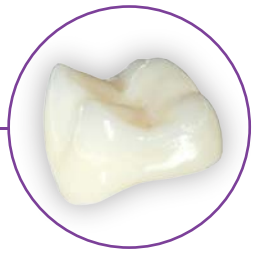

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Six Ways You Can Help Patients Move Forward with Treatment

By: Mark T. Murphy, DDS, FAGD

When you look critically at most practices that say "they are not busy enough," there is usually plenty of dentistry left to do. The problem is, it is still in the charts! Incomplete treatment, work not accepted and undiagnosed procedures can be worth hundreds of thousands of dollars in your practice. The good news is you don't have to get all of them to say yes; just a few more will do. There are some very predictable BEHAVIORS that we can choose to change that will impact RESULTS. Let's look at six things we can do that shift the odds in our favor. Do these, and you will see quick change in your case acceptance and fewer holes in your schedule.

Try to Ask More and Tell Less

It is easy to do an exam, develop a treatment plan, and then TELL someone what they NEED (more on that later). But patients are not usually aware of, interested in, or concerned about the long-term consequences of non-treatment. Many believe the absence of pain or dysfunction means health. Our goal is to ask them questions about the problem, its progression, and the ultimate outcome until they take ownership and ask, "What can I do about that?" a colleague of mine used to say, "Stay in the question. Talk about the problem until they become curious and figure it out with you."

Create a Co-discovery and Curiosity Examination Experience

By asking about the problem and staying in the question, most patients will start to figure things out with us and become curious. Letting patients co-discover and see things using the intraoral camera or hand mirror gives them the opportunity to really learn about their mouth. Just telling them what you see is passive education whereas letting them figure it out is much more active and creates ownership. Instead of discussing solutions, talk about the problems and their progression until the patient asks you for your recommendations.

Think Wants Not Needs

Because people may have money for what they want, but not always for what they need, let's focus on helping them want better dentistry and a more complete solution. A great deal of money is spent in the U.S. on alcohol, tobacco and gambling compared to dentistry. It's also common to hear complaints about gasoline prices or to pay $1 per pint, or $8 per gallon, for bottled water that is available from the tap for pennies. With patience, the patient will come to understand the problem and consequences of inaction. They will eventually "want" to know, and ask for a solution.

Remember it is About Value

Luxury goods, high-end cars and fine jewelry are examples of patients paying for 'upgrades' that they value. Although we can live without teeth, most people place a level of value on having a healthy dentition and being able to chew, and they want to look good. As this new process for case acceptance evolves, remember that the value proposition for patients is very different than it is for the dentist. Patients did not go to dental school. Helping them see, understand, and want a healthy mouth and smile creates a value proposition that makes them more likely to use discretionary dollars to achieve. Going beyond the limited coverage of dental reimbursement and maintenance plans requires that they value it like a better car or expensive watch. People spend money on things they want ... especially if they value it highly.

Offer Individualized Options

Today, consumers often finance automobile and other large purchases, so they can make monthly payments. By offering payment options and making patient financing available, we can broaden the field of patients who can manage payment for recommended dental care. I prefer to discuss payment options in terms patients understand. "The total fee for your treatment will be $13,000. There are three different ways you can pay for that: prepayment with a bookkeeping adjustment because we will not have to send statements, pay as we go, or the CareCredit credit card." Most people understand the idea of credit. And when the total cost of care is more than they have readily available or they would find it more convenient to make monthly payments, they ask, "What is CareCredit?" That opens up a dialogue about healthcare financing and the special financing options available with the CareCredit credit card. I share with them that when approved, they will be required to make monthly payments and then direct them to CareCredit's website (carecredit.com) for more details and to apply. It is much easier for most folks to digest a monthly payment for 36 months (for example) than a one-time payment of $13,000.

Make sure Patients Understand the Real Role of Insurance

Here is where the rubber hits the road! Many patients have an insurance entitlement mindset and only want to "do what is covered by insurance." I suggest you have a discussion about the role of dental reimbursement or maintenance plans (see the nomenclature change again) before you look in their mouth. Help them understand three things: First, typical insurance plans, like the kind we have for cars and homes, provide coverage in the event of a catastrophic loss. Their dental insurance only provides for $1,500 in care a year, so it's better to think of it more like a maintenance plan. It's good to have it but it does NOT cover all necessary dental care. Second, car insurance does not cover oil changes twice a year, new wiper blades every three and new tires every five! Home insurance does not cover yearly maintenance for your air conditioning or a new disposal in the sink. And finally, dental insurance started in Washington state 60 years ago and, for the most part, yearly benefits have remained unchanged. If we adjusted $1,500 worth of coverage for inflation, it would have grown to $7,000-$14,000 (using 3% and 4% as bookends). Now that would be catastrophic insurance coverage.

Use these six constructs regularly and you will see your case acceptance improve. There will be more dentistry, the kind you love to do, getting done in your chairs than sitting in your charts. And you will be able to help more of your patients have healthier mouths and create greater success for you and your team.

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~ Thomas M. Hendley, DMD

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PEDIATRIC Abstracts

Coll J, Campbell A, Chalmers N. Effects of Glass Ionomer Temporary Restorations on Pulpal Diagnosis & Treatment Outcomes in Primary Molars. Pediatr Dent 2013; 35 (5): 416-421

Background & Purpose: According to the Academy of Pediatric Dentistry, pulp therapy has been utilized to "maintain the integrity and the health of teeth and their supporting tissues." Traditionally, large carious lesions near the pulp have been successfully treated with two forms of vital pulp therapy (VPT): indirect pulp treatment (IPT) and the pulpotomy. Studies have demonstrated that the success rate in both the formocresol pulpotomy (FCP) and the IPT is greater than 90 percent. Specifically, the IPT has demonstrated a significantly better success rate than the FCP.

Proper diagnosis and awareness of the tooth's pulpal status is critical when deciding to perform VPT because a vital pulp is needed to perform either a pulpotomy or IPT treatment. Deep lesions without frank clinical pulp exposure or radiographic findings make diagnosing difficult. Contraindications for VPT include signs of irreversible pulpitis and inflammation or necrosis. Furthermore, in order to ensure proper diagnosis is made, adequate radiographs and a thorough patient history covering signs and symptoms must be obtained.

Currently, interim therapeutic restorations (ITRs) using glass ionomer are used as a caries control tool for teeth with open cavitated lesions and reversible pulpitis. Once it is determined that a pulp is vital, the interim therapeutic restoration can be removed and the pulpotomy or indirect pulp treatment can be performed. There has been current research suggesting that there was significantly more inflammation in primary teeth with deep proximal caries compared to primary teeth with occlusal caries. This research also suggests that there is no difference in inflammation when the caries was less than 50 percent of the total dentin thickness. Other studies support that ITR placement before FCP or IPT enhanced their success rates. At this time, there are no studies that have investigated the effect of caries location or the use of ITR to assist in diagnosing pulpal health and subsequent VPT success. For this reason, this study aimed to assess the following:

- To determine if using glass ionomer cement (GIC) for ITRs before performing definitive VPT in primary molars with deep carious lesions, enhanced a dentist's ability to determine a pulp's clinical diagnosis and subsequent VPT success.
- To determine the effect of the location of the carious lesion (proximal vs. non-proximal) on VPT success.

Methods: This was a retrospective study which utilized radiographs and clinical data from a private pediatric dental office located in York, PA. Beginning in 2000, the abovementioned dental office treated patients without signs of irreversible pulpitis and large carious lesions with GIC ITR's before definitive VPT. From January 1, 2000 to December 31, 2004, patients included in this study were treated with ITRs before definitive VPT of IPT (indirect pulp treatment) or pulpotomy. These patients received a stainless steel crown (SSC) the same day of the final treatment and included 42 children. The next set of patients (48 total) was treated before 1993 and did not receive ITR prior to VPT of IPT or pulpotomy.

The primary teeth included in this study had the following characteristics: 1) caries that extended more than fifty percent of the dentin depth and received VPT (IPT or FCP) and a SSC the same day and 2) diagnostic radiographs to allow visualization of the furcation and periapical region. Primary teeth were excluded from this study if: 1) the ITR did not last until the time of VPT treatment, 2) there was less than one year of clinical or radiographic follow-up, 3) there were poor radiographs or notes, 4) a SSC needed to be replaced, 5) there was an existing restoration, 6) the tooth was near exfoliation, 7)there were signs of irreversible pulpitis, or 8) if a composite or amalgam restoration was placed after pretreatment with ITR or VPT.

There were three pediatric dentists that treated the children in a similar, standardized manner, while two pediatric dentists reviewed and evaluated the records. One of the dentists involved in evaluating the records was not involved in patient treatment. Any disagreements in the evaluation process were discussed until an agreement was reached. If patients exhibited postoperative pain or sensitivity, increased mobility, sinus tract, or gingival swelling, then those teeth receiving pretreatment IPT were considered a failure. To be considered a radiographic failure, evidence of internal or external root resorption, widening of the periodontal ligament, radiolucencies, or bony destruction must be observed. If the primary molars did not exhibit any of the abovementioned characteristics, then pretreatment pulpal diagnosis was considered successful. The location of the carious lesion was also noted from the description given in the clinical note or from radiographic evaluation. The locations were classified as proximal (P) or non-proximal (NP). The Pearson's chi-square and Fisher's exact statistical tests were used.

Results: A total of 117 molars (52 second molars and 65 first molars) from 90 patients ages 27-102 months received the VPT treatment. 65 molars (56 percent) received IPT and 52 molars (44 percent) received FCP treatment. Results demonstrated no significant difference between the success rates for IPT (88 percent) and FCP (83 percent). Additionally, there was no significant difference in the success rates of IPT and FCP within each tooth type (first molar versus second molar).

ITR Group Prior to VPT: Of the 117 molars, there were fifty-three primary molars that were treated with pretreatment ITR. The final outcomes showed no significant difference in the outcomes for pretreatment ITR in place from one, two, or ≥ three months. Three of the fifty-three molars with pretreatment ITR failed and were considered pretreatment diagnostic failures, whereas the remaining 50 molars were considered pretreatment diagnostic successes. Sixty-four teeth did not receive pretreatment ITRs. Of this group, 14 failed (4=IPTs, 10 FCPs) and were labeled as clinical pretreatment pulpal diagnostic failures. These results indicated an improved success in pulpal diagnosis when ITR was utilized in the pretreatment stages. Additionally, this study found that pretreatment ITR significantly improved the success of VPT in first molars (65 percent success with no ITR vs. 89 percent with ITR). Contrastingly, there was no effect on the success rate of VPT in second molars with pretreatment ITR (96 percent success with no ITR vs. 100 percent with ITR).

Location of the lesion: There was data available on the caries location of 88 primary molars. Twenty-nine teeth had equally large proximal and NP lesions, so they were not categorized. A total of thirty five first molars had 29 proximal lesions and six NP lesions, whereas a total of 53 second molars had 20 proximal lesions and 33 NP lesions. The data revealed that primary first molars had significantly more proximal lesions compared to second primary molars. Additionally, there was no significant difference in the frequency of ITRs used in both proximal and NP lesions. The results showed only one tooth failed in the NP group and eight teeth failed in the proximal lesion group. Vital pulp therapy success was statistically superior in teeth with NP lesions.

The success of pretreatment ITR vs no ITR was also assessed in the 49 molars with the proximal lesions. Pulp therapy success was significantly better in teeth with proximal lesions when ITR was utilized. Moreover, out of a total of 39 teeth with NP lesions, there was a 100 percent success rate in the 24 teeth that were treated with pretreatment ITR and only one failure in the 15 teeth that were not treated with ITR. The Fischer's exact test *(P=0.38)* exhibited that pretreatment ITR in teeth with NP lesions did not significantly influence the success rate of VPT.

Discussion: In summary, this study by Coll et al found that:

- ITR placement before VPT significantly improved pulpal diagnosis and VPT outcomes. This is important because the success of VPT greatly depends on the correct pulpal diagnosis. This study also found no significant difference in the success rate of IPT's (88 percent success) and FCP's (83 percent).
- VPT was less successful when there were proximal lesions. Lesions classified

as NP demonstrated higher success rates for VPT in comparison to proximal lesions. Even if the caries extended more than 50 percent of the dentin depth, NP lesions demonstrated less inflammation and symptoms of pulpitis than proximal lesions. The data in this study supports that the amount of residual dentin thickness can assist in determining pulpal response to therapy. Again, ITRs improved the success rates.

- There were more primary first molars that required VPT compared to primary second molars.
- ITRs may be helpful in preventing food impaction and in decreasing exposure to bacteria, which allows the formation of reparative dentin to protect the pulp.
- There were no significant differences in success rates from the time of ITR placement to the time of VPT treatment. The authors concluded that pretreatment with ITR prevented microleakage and permitted the remineralization and formation of reparative dentin, so that the length of time the ITR was in place did not considerably change the outcome.
- ITR is also beneficial because it allows the pulp to form an obvious radiographic lesion or fistula to indicate an irreversible disease process. Only normal radiographic and clinical findings will be observed in vital and reversibly inflamed pulps.

Conclusions: There were several conclusions that can be made from the results of this study:

1. More primary first molars demonstrated proximal lesions and demonstrated more vital pulp therapy failures compared to primary second molars.
2. Those primary teeth that received pretreatment glass ionomer interim therapeutic restorations for one to three months had improved pulpal diagnosis and vital pulp therapy outcomes.
3. The success of vital pulp therapy improved when pretreatment interim therapeutic restorations were utilized, especially in primary teeth exhibiting proximal lesions.
4. The location of the carious lesion plays an integral role in vital pulp therapy success. Specifically, primary teeth with proximal lesions exhibited greater vital pulp therapy failures, despite tooth type (primary first versus primary second molar).

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Townsend JA, Martin A, Hagan J, Needleman H. The Use of Local Anesthesia during Dental Rehabilitations: A Survey of AAPD Members. Pediatr Dent 2013; 35 (5): 422-425

Background: Although the dental benefits of general anesthesia (GA) include safe and efficient delivery of dental care, dental procedures can potentially cause postoperative discomfort. Studies have shown that 95% of children undergoing dental rehabilitations under GA had postoperative pain of moderate intensity. The use of local anesthesia (LA) in conjunction with GA has been advocated to improve the quality of recovery and reported to be successful. However, some studies have shown no difference in postoperative pain with the use of LA in conjunction with GA.

Purpose: The purpose of this study was to document the current practices of AAPD member pediatric dentists (PD) and general dentists (GP) regarding their use of local anesthetics on children undergoing dental rehabilitations under general anesthesia.

Methods: A survey was administered via email to AAPD members to document the use of LA during dental rehabilitations under GA and the rationales for its use. The 16 question survey was emailed to 6,159 PDs, GPs, and dental residents.

Results: Of the 6,159 email addresses provided, 952 useable responses were generating yielding a 17% response rate. 84% were PDs, 12% were pediatric residents and 4% were GPs. Most dentists (86 percent) treated children younger than 12 years under GA for dental rehabilitation. Fentanyl was the most commonly used drug for systemic analgesia for GA cases, with Toradol® IV NSAID being the second most common. Nearly half (51%) of dentists administer LA less than half of the time. The majority (89 %) of dentists administered lidocaine. GPs were significantly more likely to use articaine. Dentists who completed either a GP or PD residency tended to use LA less frequently but this association did not achieve nominal statistical significance (P=.08). Improved patient recovery, hemorrhage control and stabilization of vital signs were the top three items cited as "very important" factors in deciding to administered LA. For dentists who administered LA sometimes, the factors most commonly cited as "very important" were: need for extraction of permanent tooth; need for extraction of primary tooth; and need for hemorrhage control. For those that never administered LA, the following factors were cited as "very important": postoperative lip and cheek biting; unnecessary for pain control; and increased patient agitation upon recovery.

Discussion: Only 8% of the responding dentists always use LA during GA rehabilitation, while 21% never use it. The remaining and majority (71 %) make the decision to use LA on an individual basis. Dentists who use LA part or all of the time report that they do so for improved patient recovery. Practitioners tend to use LA for extractions of teeth. Askenazi et. al. found that patients receiving stainless steel crowns with or without pulpotomy had a significantly higher incidence of pain compared to extraction, restorations, and sealants. This survey's authors disagree with most participants in the survey who feel that children would benefit from LA administration at least part of the time, especially with the extraction of primary and permanent teeth. The authors prefer to use both intraoperative and postoperative systemic analgesics to reduce postoperative lip/cheek biting and increased post operative agitation.

Conclusions:

1. 79% of responding pediatric and general dentists use local anesthesia at least part of the time during dental rehabilitations under general anesthesia.
2. "Improved patient recovery" was the most commonly cited rational for administering local anesthesia.
3. Extractions of permanent and primary teeth were the two most common procedures cited for the use of local anesthesia.

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Davidovich E, Wated A, Shapira J, Ram D. The Influence of Location of Local Anesthesia and Complexity/Duration of Restorative Treatment on Children's Behavior During Dental Treatment. Pediatr Dent 2013; 35(4): 333-336.

Background: Behavior management is important for the success of pediatric dental procedures. It is critical for the patient to be relaxed and calm during administration of local anesthesia and after dental treatment. Pediatric dentists face the challenge of successfully completing complex treatment and delivering local anesthesia without creating any psychological or physical repercussions and still establishing a good rapport with the patient. It is important to identify reasons for uncooperative behavior during dental treatment. One study shows that understanding a child's temperament may prepare a clinician for behaviors likely to occur during treatment. Another study showed the ability of 6 year old children to cope with dental treatment was associated positively with their degree of psychological development and negatively with their mothers' fear of treatment. While Aminabadi concluded that treatment duration should be a consideration in the development of a dental treatment plan and Brill concluded that children's negative behavior increased during restorative appointments, neither of the study considered the effects of treatment complexity or delivery of local anesthesia.

PEDIATRIC Abstracts

Purpose: The purpose of this study was to see whether the region of local anesthesia injection and the complexity of the treatment being completed were associated with children's behavior during and immediately after dental treatment.

Methods: Charts of all 2 to 5.5 year old children who were treated under conscious sedation with oral premedication and 50 percent nitrous oxide/oxygen sedation at the postgraduate dental clinic of the Department of Pediatric Dentistry, Haddassah School of Dental Medicine in Jerusalem, Israel and at two private practice offices of the two authors were reviewed. Inclusion criteria for this study included American Society of Anesthesiology Class I, no prior experience with local anesthesia, and preoperative behavior assessed as uncooperative based on Frankl score of 1 or 2. Ninety children met the inclusion criteria. Children were divided into two groups based on age. The first group was 2-3.5 years old and the second group was 3.5-5.5 years old. The following variables were accessed from the dental charts: region of local anesthesia (maxillary infiltration or mandibular block), behavior during treatment, and behavior after treatment. Dental treatment that lasted 15 to 30 minutes was considered short and dental treatment that lasted 30 to 60 minutes was considered long. Treatment complexity was classified as simple (fissure sealants, prophylaxis, class 1 and class 2 restorations) or complex (stainless steel crowns, pulp therapy, dental extractions). Associations were analyzed between delivery of local anesthesia and treatment complexity and children's behavior. Comparisons were made between the two different age groups.

Results: No statistically significant difference was observed in children's behavior during or after dental treatment, within or between age groups, when children received maxillary infiltration or mandibular block. No statistically significant difference was observed in behavior during or after dental treatment within and between age groups according to complexity of treatment. Behavior during treatment was associated with treatment duration for both the younger and older groups. In a logistic regression model, treatment duration and not the region of local anesthesia or complexity of treatment as associated with behavior after treatment in the younger group. Behavior after treatment was not associated with any of the independent variables.

Discussion: This study examined possible associations between the behavior of lightly sedated children during and after a dental appointment and three independent variables: region of local anesthesia, complexity of treatment, and duration of treatment. Variables were selected that could help the pediatric dentist in planning a comprehensive restorative treatment of the uncooperative child. This study's main finding was that treatment duration was the variable that most affected children's behavior at the dental office, both for younger and older children. The association of treatment duration with behavior remained in a regression model that accounted for complexity of treatment and region of local anesthesia. The findings concur with those of Aminabadi et al., who showed that treatment duration exhibits an age-dependent effect on the behavior of pediatric patients. In the current study, the duration of treatment was associated with behavior during treatment in both age groups, yet with behavior after treatment only in the younger age group. The proposition that children's attitudes toward dentistry are largely shaped by emotional meaning and that this changes with emotional development could explain the effect of age observed in this study.

Conclusions: Lightly sedated 2 to 5.5 year olds behaved less cooperatively during longer than shorter dental treatments. Two to 3.5 year olds behaved less cooperatively after longer than shorter dental treatments. The region of local anesthesia and complexity of treatment did not affect children's behavior.

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Chen CF, Hu JC, Estrella MR, Peters MC, Bresciani E. Assessment of restorative treatment of patients with amelogenesis imperfecta. Pediatr Dent 2013; 35(4):337-42.

Background: Amelogenesis imperfect (AI) is an inherited condition affecting the genes involved in enamel formation, mineralization, maturation, and calcification, and includes only those cases occurring in the absence of other conditions or systemic disorders. Due to the abnormalities of enamel structure in AI patients, they present with unique clinical manifestations including rapid attrition, excess calculus deposition, as well as anterior open bite. Furthermore, the reduced quality of the enamel makes it difficult to restore these patients using standard restorative techniques. AI-affected individuals are concerned with poor esthetics, tooth sensitivity, and difficulty with mastication and hygiene, all of which contribute to low self-esteem and reduced quality of life. The mixed dentition stage is a critical time in a person's life not only in terms of dental development, but also psychosocial development. AI patients report being teased, and are unhappy with the appearance of their teeth. Although definitive treatment cannot be completed until eruption of the permanent dentition is complete, interim treatment can be completed to preserve tooth structure, and improve esthetics and function. Treatment options have been reported in the literature, but there is a lack of reporting on long-term follow-up of restorative outcomes in AI patients. Furthermore, there is currently no standard of care established to manage the AI patient, especially during the mixed- dentition stage.

Purpose: The purposes of this study were to evaluate the outcome of various treatment modalities for AI patients in the mixed-dentition stage, and to determine their outcome on post-rehabilitation oral health status, and patient satisfaction regarding appearance, function, and sensitivity.

Methods: Eight AI patients at the University of Michigan Children's Dental Clinic met the inclusion criteria and gave consent: ages 8-18 years old, had no other systemic disorders, and had a history of restorations placed in the permanent incisors and/or permanent first molars at least 6 months prior to the study. Patients were excluded if they had systemic disease, were undergoing orthodontic treatment, had a restoration placed or underwent periodontal surgery less than six months prior to study. After informed consent was obtained, dental history data were collected by initial chart review. Two calibrated examiners, according to defined parameters for both restorative and periodontal characteristics, evaluated the restored permanent teeth clinically. Subjects were also asked to answer a 10-question survey regarding smile, tooth esthetics, function and sensitivity using the Wong-Baker FACES Pain Rating Scale. A senior pediatric dentist calibrated the examiners. Descriptive statistics summarized the findings, and a mixed model analysis was used to compare the periodontal status in the direct and indirect restoration groups. A paired t-test compared survey responses. Results with a p-value of <0.05 were considered statistically significant.

Results: Among the 74 restorations evaluated, seven were lost. There were 31 posterior and 36 anterior restorations remaining for evaluation. Ten were rated clinically unacceptable; teeth with stainless steel crowns had moderate gingival (mean=2.3) and plaque (mean=2.0) index scores according to a modified Quigley-Hein index. Radiographically, widening of the PDL and pulp canal obliteration were common findings. According to the survey, subjects' recall of satisfaction showed a statistically significant difference before and after treatment regarding esthetics ($P<.002$) and sensitivity during brushing($P=.03$) and eating($P=.01$). Frequent retreatment was required for the direct restorations, defined in this study as composite resin strip crowns and fewer than four surfaces of composite resin restorations on the permanent incisors only. Direct restorations exhibited a failure rate of 52 percent (12/23). Three SSCs out of 27 had been replaced.

Discussion: Most subjects enrolled in this study had hypoplastic AI, which is consistent with other studies reporting that this type accounts for 60-73 percent of the AI cases evaluated. This study supports previous literature suggesting that SSCs are the treatment modality of choice for AI-affected molars; in this study 22 of 23 SSCs, 96 percent, were judged as clinically acceptable. Due to

the small sample size, no conclusions could be drawn regarding amalgam. Direct restorations are commonly placed in incisors that are partially erupted in the mixed dentition, which can lead to difficulty in isolation, leading to failure. The bond strength plays a role as well, as resin bonding depends highly on the enamel surface modification. Bond strength is lower in those patients with hypocalcified AI. Glass ionomer cement (GIC) is reported to be the ideal interim direct restorative material, but none of the teeth in this study had been treated with GIC. The indirect restoration group showed a statistically significantly greater pocket depth than the direct restoration group, while the direct group showed a statistically significantly higher plaque index score than the indirect group. Limitations to the study include the small sample size, and evaluation of restorations at one time point, in the absence of baseline data. Therefore, oral health status was not compared before and after treatment. Also, subjects were concurrently asked survey questions related to their feelings and observations both before and after-treatment, when treatment had been completed for at least six months.

Conclusions: During the mixed dentition stage, permanent teeth affected by AI can be successfully restored using conventional treatment modalities. Resin strip crowns and resin fillings including three or less surfaces demonstrated a higher percentage of failure, requiring additional repairs and replacement. These restorations should be considered interim treatment. Gingival inflammation and plaque accumulation were observed following all restorative treatment for the study patients. After treatment, subjects reported increased satisfaction in esthetics, and decreased sensitivity during brushing and eating.

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Juntgen LM, et al. Factors Influencing Behavior Guidance: A Survey Of Practicing Pediatric Dentists. Pediatr Dent 2013; 35(7): 539-545.

Background: The American Academy Of Pediatric Dentistry (AAPD) describes a variety of basic and advanced behavior guidance techniques within its Guidance for the Pediatric Dental Patient. Basic behavior guidance incorporates communicative techniques aimed at strengthening the dentist-patient relationship. These basic techniques include tell-show-do, voice control, nonverbal communication, positive reinforcement, parental presence/absence, distraction, and nitrous oxide/oxygen inhalation. Advanced behavior guidance is sometimes necessary to safely treat children with more complex emotional, physical, and /or cognitive/developmental disabilities such as oppositional defiant disorder, cerebral palsy, autism, and intellectual disability. These advanced techniques include protective stabilization, sedation and general anesthesia.

Purpose: The purposes of this study were to

- identify and describe specific factors influencing behavior guidance technique selection and utilization among currently practicing pediatric dentists.
- explore the willingness of practitioners to modify their existing technique armamentarium with the clinical incorporation of previously unused American Academy of Pediatric Dentistry-endorsed behavior guidance techniques.

Methods: The Institutional Review Board at Indiana University Indianapolis approved this research. The data for the study was obtained from a web survey sent to all North American AAPD members. The survey contained a brief description of 11 behavior techniques currently endorsed by AAPD and 15 multiple choice questions concerning the practitioners' past, current and anticipated future behavior guidance technique utilization. Pearson chi-square tests were used to examine the associations of the demographic variables with the treatment preferences when both variables were nonordinal, and mantel –Haenszel chi- square tests were used when at least one of the variables was ordinal.

Results: The majority of respondents received didactic, observational, and hands-on training for tell-show-do, voice control, nonverbal communication, positive reinforcement, distraction, parental presence/absence, nitrous oxide/oxygen inhalation, protective stabilization, oral/nasal sedation and general anesthesia through the course of their pediatric dentistry programs. Only 49 percent of respondents however reported receiving didactic training for IV sedation with only 36 percent reporting hands-on practice. Another 39 percent reported no training in IV sedation during residency. Practitioners were then questioned as to their personal comfort with each technique. Upon completion of a pediatric residency program, most respondents reported that they were "very comfortable" or "somewhat comfortable" with 10 of the 11 basic and advanced behavior guidance techniques, with the exception of IV sedation. Only 25 percent of respondents indicated comfort with IV sedation upon graduation, with another 52 percent reporting no use of the technique.

Discussion: The AAPD describes behavior guidance as an interaction between patient, dentist, and dental team aimed at easing fear and anxiety while promoting optimum treatment for good oral health. The majority of respondents utilize basic behavior guidance techniques with greater than 50 percent of their patients in any given month. Survey respondents most frequently cited personal comfort as a variable strongly influencing technique selection. Continuing education of the pediatric dentist is necessary to review current guidelines and treatment recommendations and critically analyze scientifically based research in the field of dentistry to incorporate new skills and clinical techniques into practice. There are several limitations to the current study, including those inherent to self-reported data and a cross sectional design. Residency training and comfort levels upon graduation were reliant upon respondent memory and subject to error. Reported use of behavior guidance techniques was also based on respondent account and subject to bias.

Conclusions: Based on this study's results, the following conclusions can be made:

1. Residency training in intravenous sedation is lowest among the AAPD recommended behavior guidance techniques, and residency type impacts behavior guidance training.
2. Hands-on behavior guidance training during pediatric dental residency has changed over the course of the last 41 years.
3. Comfort level with behavior guidance technique utilization changes over a practice career, and comfort level with a given technique is associated with its frequency of current use.
4. Practice type impacts the frequency of behavior guidance technique utilization.
5. Currently practicing dentists cite legal concerns, parental acceptance to change, and limited resources as perceived obstacles in the incorporation of new techniques.

Shinjni Razdan, DDS; Resident, Pediatric Dentistry, Virginia Commonwealth University

2014- A Successful Year for VADPC

By: Dr. Bruce Hutchison; Chair, Virginia Dental Political Action Committee

2014 has been a banner year for VADPAC and ADPAC. Despite a decline in VADPAC contributions, we were successful in helping to elect the first dentist to the Virginia General Assembly in many years. Dr. Todd Pillion, of Abingdon will represent the 4th District of Virginia starting with the next General Assembly meeting in Richmond in January 2015. He was elected on Dec 9, 2014 in a special election to fill the spot vacated when Delegate Ben Chafin was elected to the state senate in November.

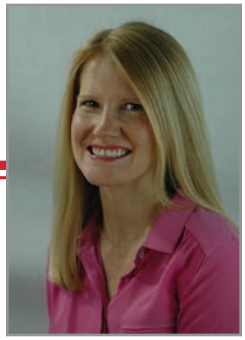
Also in November, Dr. Brian Babin of Texas was elected to be the third dentist serving in Congress. He joins Drs. Mike Simpson- ID and Paul Gosar- AZ.

VADPAC and ADPAC were instrumental in assisting these dentists, winning each of these elections. This is a great victory for VADPAC, for dentistry, and for the patients we serve. We all know and understand that legislators in Richmond and in Washington pass the laws that govern us and directly impact our ability to treat our patients and run our practices. The decisions that they make will make a difference in our lives. How valuable is it to have these gentlemen in the halls of the legislature every day, watching to see how every bill would affect dental care and our ability to provide it? I can promise you, they are invaluable to us and our patients. I am so excited to be able to report that these men will serve our profession well as they serve their constituents who elected them. There is no better way to influence the legislature than to be a part of making it.

So thank you to those who have supported VADPAC this year and in years past. I hope you see now how important your contributions have been. And how important it is to continue to support VADPAC

Dr. Todd Pillion VDA Member Dentist, Wins 4th District Election

By: Laura Givens, Director of Legislative & Public Policy



The Virginia Dental Association is pleased to share the news that Dr. Todd Pillion, a VDA member dentist, won the 4th district seat in the Virginia House of Delegates in a special election on December 9. The VDA wishes Dr. Pillion the best of luck and looks forward to visiting with him next month as he begins his first General Assembly session. Below are articles relating to his election victory as well as the announcement from Speaker Bill Howell.

PILLION WINS 4TH DISTRICT ELECTION FOR VIRGINIA HOUSE OF DELEGATES SEAT - http://www.tricities.com/elections/article_c53efd04-8007-11e4-9684-1f98f98f6791.html

ABINGDON'S PILLION WINS SPECIAL HOUSE RACE - http://www.tricities.com/elections/article_c53efd04-8007-11e4-9684-1f98f98f6791.html

Speaker Howell congratulates Todd Pillion on election to the Virginia House of Delegates

RICHMOND, VA – Virginia House of Delegates Speaker William J. Howell (R-Stafford) congratulated Todd Pillion on his election to the Virginia House of Delegates on Tuesday. Pillion will represent Virginia's 4th House of Delegates District, which was vacated by Ben Chafin's election to the Senate of Virginia.

"Congratulations to Todd, his family and his entire campaign team on their victory tonight. Todd ran a great campaign focused on the issues important to the people of Southwest Virginia. I know he will be a strong voice for their concerns in Richmond," said Speaker Howell. "Todd is an experienced businessman with a record of service to his country and community. His experience and expertise will allow him to bring valuable insight to the House and I look forward to working with him in the future. I also want to thank all of the election officials and volunteers who helped organize this very quick special election. I appreciate your work on behalf of the Commonwealth."

Virginia Dental Political Action Committee (VADPAC) Final Contribution Report for 2014

Component	% of Members Contributing to Date	2014 VADPAC Goal	Amount Contributed to Date	Per Capita Contribution	% of Goal Achieved
1 (Tidewater)	41%	$45,500	$33,571	$243	74%
2 (Peninsula)	49%	$27,500	$26,712	$281	97%
3 (Southside)	43%	$14,000	$20,305	$374	145%
4 (Richmond)	39%	$67,750	$71,304	$322	105%
5 (Piedmont)	41%	$30,000	$24,898	$255	83%
6 (Southwest VA)	56%	$25,250	$40,957	$331	162%
7 (Shenandoah Valley)	34%	$30,000	$24,810	$285	82%
8 (Northern VA)	33%	$135,000	$115,527	$305	83%
Other Contributions			$500		
TOTAL	**40%**	**$375,000**	**$358,584**	**$300**	**96%**

Total Contributions: $358,584

2015 is an important election year with members of both the House of Delegates and Senate up for re-election. As many of you know, campaign funding is an essential ingredient in the political process to make sure that dentistry's voice is heard and to insure that the interests of your patients are foremost in the General Assembly's eyes. If you haven't already contributed for the 2015 year, please make your contribution today!

You can contribute when paying your VDA dues or pay online at **http://www.vadental.org/pro/vadpac**.

If you have questions regarding VADPAC, please contact Laura Givens at **givens@vadental.org** or 804-523-2185.

VADPAC Fundraisers

Dr. Todd Pillion in Abingdon

VDA members and guests gathered at Heartwood in Abingdon on October 30, 2014 to lend their support to Dr. Todd Pillion, who happens to be a fellow VDA member dentist. Dr. Scott Miller chaired the event. VDA members and others from the community were there to recognize Dr. Pillion's commitment to the oral health profession and his understanding of the needs of citizens in the Southwest Virginia area. VDA members and guests attending were able to wish him the best as he prepared for his impending special election, which occurred on December 9 and which Dr. Pillion won in a landslide.

Delegate John O'Bannon in Richmond

Drs. Charlie Cuttino and Anne Adams hosted a VDA fundraiser for Delegate John O'Bannon at their home in Richmond on September 12, 2014. Delegate O'Bannon represents House District 73, which encompasses parts of both Henrico County and the City of Richmond. A practicing physician, Delegate O'Bannon is one of only a handful of health care providers serving in the General Assembly. He has been especially attentive throughout his legislative career to the concerns of dentists and the interests of our patients. His voice is imperative in representing the views of physicians, dentists and other members of the health care community before his legislative colleagues.

Senator Rosalyn Dance in Colonial Heights

On October 28, 2014, Dr. Sam Galstan and a hard-working group of Southside Dental Society members hosted a fundraising reception at the Swift Creek Mill Theatre in Colonial Heights for then Delegate Rosalyn Dance. Delegate Dance had been a serious member of the House of Delegates for a number of years, and the VDA wanted to help in her efforts to move to the Senate. As a senior member of both the key health care committee in the House and the Appropriations Committee, Delegate Dance rarely missed an opportunity to make sure that legislation and budget initiatives important to dentistry and our patients received a fair review. She was elected Senator on November 4, 2014.

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FTC Staff Urges Dental Accreditation Commission To Adopt Dental Therapy Accreditation Standards

From A Press Release

Federal Trade Commission staff submitted comments to Dr. Sherin Tooks, Director of the Commission on Dental Accreditation (CODA), urging CODA to finalize and adopt accreditation standards for dental therapy education programs, which will likely benefit consumers.

The staff comment is in response to CODA's request for public comments on the 2014 version of its proposed accreditation standards. In December 2013, the FTC staff commended CODA's then-proposed standards as an important first step in encouraging the development of a nationwide dental therapy profession, and recommended revisions to portions of the standards that may have limited competition for dental services. Now that many of those concerns have been addressed, the FTC staff comment urges CODA "to finalize and adopt proposed standards without unnecessary delay, so that the development of this emerging service model can proceed, and consumers can reap the likely benefits of increased competition."

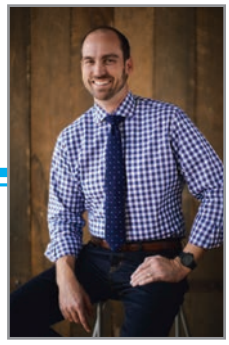
The staff comment states that the timely adoption of accreditation standards "has the potential to enhance competition by supporting state legislation for the licensure of dental therapists, and also to encourage the development of dental therapy education programs consistent with a nationwide standard, which would facilitate the mobility of dental therapists from state to state to meet consumer demand for dental services. . . . [A]ny further delay in the adoption of accreditation standards could discourage and delay the development of education programs, reduce the availability of these new professionals, and hinder their ability to practice in different states."

The Commission vote approving the comment was 5-0. (FTC File No. V150000; the staff contact is Karen Goldman, Office of Policy Planning, 202-326-2574.)

http://www.ftc.gov/news-events/press-releases/2014/12/ftc-staff-urges-dental-accreditation-commission-adopt-dental?utm_source=govdelivery

Technology: Accelerated Orthodontic Treatment Just Got Easier

By: Dr. Larry Scarborough



"How long will my treatment take?" This common refrain has taken on greater significance as more adults are pursuing treatment. For years, orthodontists have sought an acceptable way to offer patients uncompromised treatment in less time. Newer technologies have made this possible.

There is no magic bullet to substantially shorten treatment times, as bone remodeling is the rate-limiting step. However, efficiencies in quality treatment planning, precise bracket placement, and improvements in the detailing phase can reduce overall treatment time.

The most obvious way to reduce treatment time is to limit treatment goals, focusing only on aesthetics. This narrow approach can leave patients with a malocclusion and possibly increased overjet; making chewing difficult and limiting long-term dental health benefits and stability.

Rather than compromising, practitioners should consider implementing an accelerated orthodontic treatment option. In the last decade, the manipulation of bone metabolism has become the most exciting focus in the pursuit to cut treatment time while delivering the most stable, aesthetic, and functional result possible for patients.

The rate-limiting step: tooth movement occurs by applying static forces, gently moving teeth into a favorable position. There is a fascinating interplay between both osteoblasts and osteoclasts that is largely controlled by the recruitment of cytokines interleukin-1 and 6 (IL-1, IL-6) to activate nuclear factor-kappa ligand (RANKL) receptors responsible for bone remodeling. Tooth movement is most significantly limited by the rate of this cellular activity. In order to significantly reduce orthodontic treatment time, this cellular process must be exploited.

As early as the 1950's, periodontists have used corticotomies to increase tooth movement. This process consists of localized trauma and produces a regional acceleratory phenomenon (RAP), causing an increased cytokine response. This is the principal process in bone remodeling and tooth movement. In the 1990's, Dr. Wilkco patented the Accelerated Osteogenic Orthodontics™ (AOO) technique. This technique requires decorticating the surrounding bone via a full thickness flap. Cuts and perforations are made interdentally along the roots of adjacent teeth; many times requiring a bone graft to allow for the proliferation of osteoblasts. While the bone is healing, it is in a state called osteopenia, where mineral content is temporarily decreased for up to 6-10 weeks making the bone "soft" and allowing teeth to move more efficiently. Numerous studies have illustrated the effectiveness of AOO™, however, patient acceptance is low as it requires periodontal surgery, bone grafts, lengthy recovery and significant expense.

Orthodontists and patients alike have long awaited other options to improve patient acceptance, and the overall experience of accelerated orthodontic treatment. Recently, the following technologies have emerged as additional options to improve the rate of bone metabolism: Propel (micro-osteoperforations) and AcceleDent® (bone modulation).

Propel is a device that creates micro-osteoperforations (MOPs) and is essentially the modern day approach to Dr. Wilkco's AOO™ procedure. Propel was developed to limit surgical intervention, reduce recovery time and expense. MOPs are completed in-house and produce a similar level of cytokine expression as AOO™. Propel is a FDA Class I device designed for single use only. It comes equipped with a surgical stainless-steel leading edge, similar to an orthodontic mini-screw. It perforates the alveolus directly through the gingiva and moveable mucosa. Patient acceptance is high due to known clinical benefits, reduced morbidity and expense.

AcceleDent® is a promising removable device, used twenty minutes daily to accelerate tooth movement. It's gaining in popularity due to its reported clinical success and ease of use. AcceleDent® uses high frequency mechanotransduction, by way of micropulse therapy and is thought to make the interplay between osteoblasts and osteoclast more efficient. Acceledent is largely used by Invisalign® providers. Treating doctors recommend changing trays every 5-7 days, versus the typical fourteen-day protocol. Compliance is critical. Interestingly, patients describe less pain when switching trays and tracking is improved. Perhaps most importantly, treatment time is cut in half.

When treatment time is a concern, the patient's best interests should be the highest priority. For example, AOO™ may be the treatment of choice in cases where bone grafts would provide additional benefits. Propel and AcceleDent® are viable options when shorter treatment times are desired. Accelerated orthodontics is here, and the benefits of it are real. As these treatment options gain more traction in our offices and communities, accelerated orthodontic treatment will become commonplace.

Editor's Note: Dr. Larry Scarborough, a VDA member dentist, owns and operates James River Orthodontics in Richmond. He completed his dental and orthodontic training at the Virginia Commonwealth University School of Dentistry and is a certified orthodontist. Dr. Scarborough is an active member of the Richmond community and is supported by his wife Emily and two children Jackson and Sophia.

Complications From Implant Lead to Paresthesia and Malpractice Suit Against Dentist

By: Mario Catalano, DDS, MAGD

Malpractice MINUTE

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Background: This edition of Malpractice Minute discusses a case involving an implant placed by a dentist who had limited experience with implantology, which resulted in injury to the inferior alveolar nerve and paresthesia.

Case Discussion: The patient was a 28-year-old female who presented to Dr. E with a chief complaint of pain associated with tooth number 30. After a visual and radiographic examination, the doctor determined that the patient had a deep carious lesion on the tooth. The lesion had penetrated through the floor of the pulp chamber, necessitating removal of the tooth.

A treatment plan was developed and discussed, and it was decided that the tooth would be removed and an immediate implant would be placed. Although Dr. E was only in her third year of private practice, she had been trained to place implants and bone grafts in her residency program. The patient accepted the plan, and she was then placed on antibiotics and pain medication and scheduled for the procedure.

On the day of the appointment, Dr. E verbally discussed the expected benefits and known risks of the procedure, and she responded to the patient's concerns. Lidocaine anesthetic was administered, the tooth was extracted, and the implant was placed. A graft was also accomplished, and the patient was sent home.

On the second postoperative day, the patient called the office to inquire about the fact that she still had some numbness in her lip. She was scheduled for an exam that day, and the area of paresthesia was confirmed. Suspecting an inflammatory cause, Dr. E prescribed a steroidal solution and an antibiotic to assist with the healing process. The patient was then scheduled for a follow-up appointment.

The patient was followed closely, but the paresthesia persisted. A radiograph taken after the surgery indicated at least 2 millimeters between the apex of the implant and the superior border of the inferior alveolar nerve (IAN) canal, so the doctor did not suspect traumatic nerve damage. She followed the patient for 6 months, with no improvement. At that point, she referred the patient to an oral and maxillofacial surgeon for evaluation.

The oral surgeon charted the area of altered sensation and concluded that the IAN had been injured. A cone beam computed tomography (CBCT) scan of the area was obtained, which confirmed that the implant was not in the IAN canal. However, the scan indicated a small perforation of the cortical bone superior to the canal, and it showed that the IAN had been transected. Unfortunately, due to the time that had elapsed, it was too late to attempt a nerve repair.

Although the patient had been verbally informed of the risk of this complication, she insisted that she was unaware of the potential problem — and, unfortunately, Dr. E failed to enter the actual information that was explained to the patient into her record. The patient was also quite displeased to discover that a potential remediating treatment might have been possible with a timely referral.

The patient sued Dr. E for lack of informed consent and failure to timely refer to an appropriate specialist. With the doctor's consent, the case was settled in the midrange.

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"Brushing Up" Your Memory

Canine, Central Incisor, and 3rd Molar are all names we know. But what about the names we may not know; the names of our patients, their kids' names, and information about them? For our patients, these are the most important names. **Brushing Up Your Memory** is a session that will improve your recall for names and lists, as well as your ability to stay on task without the fear of forgetting.

This fun and interactive webinar will show you how easy it is to build a trained memory for recalling all sorts of information. You'll learn time-tested techniques that will jumpstart your memory, proving that the answers to your memory cavities are all in your head. You'll be amazed as to what you can remember with a little "brushing up".

By participating in this course, you will be able to:

- Shed the myth that memory can't be improved. It can!
- Demonstrate that a trained memory can build your practice.
- Prove the importance of establishing mental anchors for remembering.

There is no prior skill-level, experience, or knowledge required for participation in this course. Mr. Mellor is the author of *Memory! How To Remember Anything,* and *You're Almost There!*

Paul Mellor

Richmond resident Paul Mellor was a finalist in the USA Memory Championship where he remembered the names of over 90 people in less than 15 minutes; recalled over 100-single digit numbers after a five-minute review; and successfully recalled the exact order of a shuffled deck of playing cards after studying for less than 3 and a half minutes. His seminars have been presented to dental associations nationwide, including programs to the Arizona Dental Association, Oregon Dental Association, Michigan Dental Association, and to the American Association of Women Dentists, to name a few. He is the author of *MEMORY! How-to Remember Anything*, and *You're Almost There* about his journey as having run a marathon in all 50 states.

Course Details:

Date: Thursday, January 22, 2015
Time: 5:00pm-6:15pm
Cost: **FREE** to VDA Members & their staff
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Ethics Past and Present

By: Dr. Daniel Grabeel; Member, Ethics and Judicial Affairs Committee

What does ethics mean to you? Or, what does dental ethics mean to you? Webster defines "ethics" as a discipline dealing with what is good and bad with moral duty and obligation; a set of moral principles.

Do we have these anymore? Do we need these in this period of dentistry? Who sets these and in what way do we enforce these? I do not claim to have the answers and I do not believe anyone else does either. I would like to explore some thoughts with you on these subjects.

When I started my dental practice I was invited to become a member of my local dental society by present members. The met with me and explained what I could do and what I couldn't do. One was I would be allowed one picture, preferably a family photo, and one article in the local paper, and after all this I waited for patients to call for appointments. Today we have newspapers full of advertisements, which is a big change from my beginning.

Some might say I was a wimp, others would say I believed in the system and the standard for ethics for that period of time. I feel I have always been taught to respect others and obey laws that are used in that time period.

The ADA (in our state VDA) sets these rules of ethics and they are to be enforced by the state board. Does this happen? The guidelines are set but how do you enforce the guidelines? At one time the guidelines were not challenged but not today. All forms of the media are full of advertisements. More dentists are graduating and competition is greater. Is the advertising working? How do patients find out what you do or don't do if not using advertising? I see no problem with doing the ads it they are tastefully done, truthful and not insulting to a fellow dentist.

How about dentistry itself? Are we using good materials and modern equipment? Do we continue to take the continuing education courses to keep our skills at a high level? I know that I do and it is very expensive, but I feel that it is necessary to attend them.

Do we try to do procedures we are not trained to do or don't do well? I believe as a general dentist we should do all procedures we are trained to do and feel competent doing. I hear some dentists say that they just don't like or feel confident about some procedures. That's okay, refer out to the appropriate office or get yourself further trained.

If that DDS degree doesn't mean that much to you, that is OK, go do something else. But don't drag it down from the position of respect, where those before us have raised it. The ones that can help keep the standard high are us, by doing what we need to do, practicing good, honest dentistry in a friendly manner and help those around us to do the same. At the end of every day I hope we all feel good in what we have done and how we have done it.

Let's all share and help each other to practice better dentistry and keep our head and our ethics.

I'm a new dentist... what does the ADA/VDA do for me?

By: Dr. John "Cappy" Sinclair

I hope you found the last issue's article insightful on what the ADA does for the dental student. From supplying life insurance, advice on which board to take, and resources to make your CV shine; the ADA has many benefits to offer. In this issue I'll be focusing on what the ADA can do for the recent graduate as well as a dentist entering an associate or partnership position. This was myself a few years ago. Unfortunately I was unaware of these items below that the ADA offered; however, I would have utilized almost all of them...hopefully the resources that I go over in this issue will be useful to you...the new dentist!

VDA CLASSIFIEDS

VDA Classifieds

Finding a job after graduation was much harder than I originally anticipated. During dental school I consistently heard about the rapid retiring rate of general dentists and the lack of new dentists entering the job scene creating a huge demand. Well if you add in a recession and a few more dental schools opening up in the US, let's just say jobs weren't as plentiful as I initially believed. Besides, even if there were jobs out there, where was I supposed to look? I had never seen a job posting for a dentist on the pages of monster.com or craigslist. Did you know that VDA has its own classified section for dental jobs? While writing this article, I paused to take a moment to check out the listings. With the help of the VDA I was able to view over 25 postings for general dentist jobs in almost every part of the state. This consolidated area of postings is a great way to see what positions are available as well as a fantastic resource for posting that CV you worked so hard on! www.vdaclassifieds.org

Contract review

Congratulations!!!....You've been offered a job, or maybe two or three. Well how do you know this contract agreement you are getting ready to sign is fair? Do you have a 5, 10, 20 mile non-compete, and do you know what that entails? Just imagine if there was a non-compete clause in your contract that made job locations in a 20-mile radius around your current employment location off limits. If this was the case, you could find yourself having a 30-45 minute commute for any future employment opportunities. How will you be paid...on production, collections, or salary? Are you going to be an employee or an independent contractor? Are you or your employer responsible for paying lab fees? These are just some of the questions I had to answer looking over my initial contracts, and I was unfamiliar with almost all of these terms. Each one of these choices listed above has its own pros and cons, and that is where the ADA comes in. The ADA will evaluate the contract and help determine if it is appropriate for the job you are applying for. However, remember this is not a substitute for legal advice or a lawyer's review of your contract. That scenario above about a 20 mile non-compete creating a long commute happened to a fellow dentist. I think that makes this one service by itself worth every penny of your ADA membership...at least from all the gas money you would save!

Ethical Hotline

Chances are, after you have signed your employment contract you will end up working with at least one other dentist. Many of these dentists have gone through very similar, if not the exact, training that you went through. What happens though if you start seeing shared patients, and you disagree with the recommended treatment plan? The first step would be to discuss the plan with the other dentist(s), but afterwards if you still feel as is if it excessive or unnecessary treatment where do you turn? The ADA created their ethical hotline (1.800.621.8099) for instances like this. The ethical hotline is in place to discuss (anonymously) questionable issues that may arise in the day-to-day life of a dental office. Personally I have never needed this, but I find it very comforting that the ADA offers this resource to its members.

Reduced Dues

One of the most common, talked-about, items as a new dentist is the amount of debt that has been incurred. I, like many of you, had to take out student loans to cover the cost of my education as well as my living expenses. I read just the other day where the average dental student debt upon graduating is around $240,000. The ADA and its components understand this as well. As a new dentist, the membership rates are drastically reduced the first five years of practice and are even free the first year of practice!
http://www.ada.org/en/education-careers/dental-student-resources/membership-after-dental-school

Being an associate can be very challenging and rewarding at the same time. It will give you the opportunity to develop your speed and skills as a dentist while in many cases working with a mentor. An associateship will introduce you to the fellowship of dentistry that the ADA embodies. I had the privilege of working alongside several great dentists in varying office environments during my associateships and call many of those dentists great friends today. In the next issue, I'll be discussing what the ADA does for those new dentists entering into ownership in either a startup or transitioning practice!

Editor's Note: Dr. Cappy Sinclair, a VDA member dentist, practices in Virginia Beach, and writes on subjects relating to dentists who are beginning their careers. He may be reached by email, csinclair@smilevabeach.com

HPV Prevention and Detection: Our Role as Individual Dentists and as the Dental Community

By: James Willis, D.D.S.

Oral cancer is a serious problem in our country. Dentists are positioned to provide primary, early detection of this known killer. We are not merely tooth-repair mechanics; we are doctors. As such, we have a responsibility to our patients to inform them of health risks associated with the oral cavity—information that could very well prolong or even save their lives. I cannot imagine a dentist belittling our profession so far as to claim that we have no such responsibility.

We are all aware of data set forth by the Centers for Disease Control (CDC) regarding the strong association between cancers of the oropharynx and behaviors such as tobacco smoking, tobacco chewing, and alcohol consumption. It has become commonplace for dentists to openly discuss with our patients tobacco cessation plans and programs available to address alcoholism. It seems to me that we should be just as comfortable with a professional discussion about oral cancers and the risk factors for contracting them, no matter what the nature of those factors.

The fact is that the CDC has repeatedly stated that not only are tobacco and alcohol known risk factors for oral cancers, but that substantial evidence indicates a causal association between Human Papillomavirus (HPV) infection and oralpharyngeal cancers. In a recent study out of Johns Hopkins University, Dr. Carole Fakhry and her team of researchers reported that HPV is associated with 80% of cancers in the back of the throat and that over the last 20 years this type of cancer has increased 225% in the United States. The CDC reports that approximately 72% of oropharyngeal cancers were positive for HPV—72%! We also know that there is no treatment for HPV infections; only the resulting lesions are treated. We owe it to our patients to educate them regarding the overwhelming evidence linking HPV with oral cancer. And it's easy to do. So easy, in fact, that to omit it from our routine exam is almost shameful.

For almost four years now, I have incorporated into my periodic exam a discussion on the most common risk factors of oral cancer. And I've never once had a single patient blush from embarrassment or question my professionalism as a dentist when I bring up HPV. In fact, the reaction has been quite the opposite; I've had several patients thank me for educating them and for spreading the word. I've found lesions on patients who previously had no idea that they were infected. I've conducted lymph-node examinations that have led to the discovery of anything from lung cancer to HPV-related oral cancer.

Incorporating a discussion of HPV into a periodic exam is simple: I walk into the operatory and greet the patient. After exchanging a few pleasantries and asking about any dental concerns they may have, I give a brief overview of my routine examination. "Mrs. Jones, I always begin my exam by checking your lymph nodes; do you know what lymph nodes are?"

Inevitably, patients have a vague idea what lymph nodes are, but none of them seem to really know. And that's okay, we aren't out to make biologists of every patient. I continue with, "That's right, Mrs. Jones, lymph nodes are part of your immune system and as such they help fight various infections and diseases. When they are swollen, it means they are working harder than normal due to an infection of some sort. That infection could be as small as a cold or the flu, but certain cancers do cause swelling in these areas, so I always check along your neckline and your collarbone for any swelling." At this point, while I'm talking, I'm already starting my exam, so I'm not adding any time to the visit. After lymph nodes, I examine the TMJ by having the patient open widely and close as I palpate on either side.

I then pick up a 2-by-2 and ask the patient to open. "Now I will check the soft tissues of your mouth—inside your cheeks, your tongue, the roof and floor of your mouth, and your throat; this is an oral cancer screening. Do you have any idea what causes oral cancer?" I pause here for a moment to allow the patient to actively participate in the discussion. The patient may or may not have any idea, but most will at least name tobacco. That gives me the perfect segue, "That's right, Mrs. Jones, tobacco is one of the top three risk factors of oral cancer. The other two are alcohol and HPV, the Human Papillomavirus, which is commonly known as a risk factor for cervical cancer in women, but it's actually quite prevalent in cases of oral cancer. In fact, approximately 72% of oropharyngeal cancers test positive for HPV. I like to emphasize this with all of my patients because, while it may or may not apply to you directly, you may have a friend or a family member who could benefit from the information by talking with your family physician about the vaccine that's available to find out if it's the right solution for the family." Most patients I've talked to are either already aware of the vaccine and think that it's wonderful, or are grateful for the information if they are learning about it for the first time.

I then finish with a statement such as, "Mrs. Jones, if, during either of these two portions of my exam, I ever notice anything out of the ordinary, there would be no reason to be alarmed, it would just means that it'd be worth looking into and I would simply ask you to see the right sort of doctor to have it checked out. And now I'll take a look at your teeth."

That's it. We don't have to be experts. In fact, it's smarter for us to not assert ourselves to be, but to place the responsibility on the patient and primary physician. We don't have to be embarrassed when talking about a cancer just because one of its primary etiologies involves a sexually-transmitted virus. If we speak frankly and directly, the discussion will be taken as an informative, scientifically-sound part of a routine exam. We simply make the patient aware of the facts and encourage them to seek further details from their primary care or family physician. For the inquisitive patient, we may want to be aware that the CDC's Advisory Committee on Immunization Practices (ACIP) has various recommendations for HPV vaccination for males and females between the ages of 11-26 years. There are currently two vaccines licensed for use in the United States: Quadrivalent (Gardasil®, produced by Merck and Co.) and Bivalent (Cervarix®, produced by GlaxoSmithKline).

Editor's Note: Dr. Willis, a VDA member dentist, practices in Burke.


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Thursday, September 17

KEYNOTE SESSION!

Rhonda Savage, DDS
It's A Jungle Out There!

Hal Crossley, DDS, MS, Ph.D	*Avoid Liability: Know Your Patients' Medications and Their Impact on Dental Treatment*
Dr. John Cranham, DDS	*Treatment Planning the Worn Dentition*
William Prescott, EMBA, JD	*Joining and Leaving the Dental Practice*
David Canfield, DDS, FADSA	*Enteral Sedation Re-permit Update (am) Emergency Management & Procedures Update (pm)*
Laney Kay, JD, MPH	*Blood, Spit, & Fears: A Painless OSHA Update (pm)*
Tidewater Center for Life Support	*Heartsaver CPR*

Friday, September 18

Hal Crossley, DDS, MS, Ph.D	*Street Drugs and How They Affect Our Practice and Our Lives*
Dr. John Cranham, DDS	*Occlusion for the Esthetic Restorative Practice*
Roger Levin, DDS	*Set Your Practice on Fire! New Strategies for Increasing Production*
Ronald Morris, DDS	*Everything You Always Wanted to Know About Oral Surgery But Were Afraid To Ask!*
Rhonda Savage, DDS	*Dentistry Dedicated to Excellence: Take a Stand Against Periodontal Disease*

Continued on next page

Friday, September 18

Hamid Shafie, DDS, CAGS	Current Trends in Implant Placement & Loading for Fully Edentulous Patients; Advanced Training on Selection Criteria—Immediate vs. Traditional Loading
Rhonda Savage, DDS	*Dentistry Dedicated to Excellence: Take a Stand Against Periodontal Disease*
David Landwehr, DDS	*Efficient and Effective Endodontics*
David Weber	*The Winner In You: Raising the Bar on Patient Care and Customer Service (am)* *Some Days You're the Pigeon and Some Days You Are The Statue (pm)*
Steve Kelley	*Art Irritates Life: A Syndicated Editorial Cartoonist on Politics and Stuff People Actually Care About (pm)*
Tidewater Center for Life Support	*Healthcare Provider CPR (pm)*
Steven Trutter & Brian Cogan	*How Practice Ownership Can Launch You Over Your Financial Hurdles*

Saturday, September 19

Rhonda Savage, DDS	*Covering Your A$$ets: Embezzlement Prevention*
Hamid Shafie, DDS, CAGS	Principles of Attachment Selection for Implant Supported Overdenture and their Impact on the Surgical Approaches
Ronald Morris, DDS	*Implant Selection & Placement Made Easy*
David Landwehr, DDS	*Efficient and Effective Endodontics*
Roger Levin, DDS	*Build Your Ideal Practice and Dream Team (am)*
William Prescott, EMBA, JD	*Entering Practice - Make the Right Choice First! (am)*
Laney Kay, JD, MPH	*Blood, Spit, & Fears: A Painless OSHA Update (am)*
Tidewater Center for Life Support	*CPR Refresher Course (am)*

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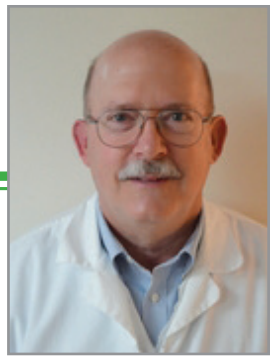
Star City: Roanoke-Area Dentists Coordinate Access-to-Care

By: Dr. David E. Black; VDA Board of Directors, Component 5



With the Commonwealth of Virginia cutting funds to the Dental Division of Virginia Department of Health, the local Health Department offices were left with no dentist in Roanoke and the surrounding area. That does not address the need of those who cannot afford dental care. The cavalier approach of the state suggested that there would be care given from some "safety net" in our region. Who and what is this "safety net" and who pays for it? Obviously, not the state.

Over twenty years ago, some caring people started the Free Clinic of the Roanoke Valley. It started as a medical clinic and added dental treatment to take care of the working poor. It has evolved into the Bradley Free Clinic with a four-chair clinic, and it still works with strict guidelines to take care of this segment of the population. It also has Junior and Senior Dental Students working there approximately 40 weeks per year to give the care along with local dentists who are preceptors and work one evening per week.

Local citizens in Botetourt County started a free dental clinic that works several nights per month to give care for their citizens. The Rescue Mission raised private funds to open the Fralin Free Dental Clinic to reach another segment of the population, centered around the Mission.

Carilion Hospital and subsidiaries have opened a pedodontic clinic and started a graduate GPR residency that takes care of various population groups. There are also several general dentists and pedodontists that take care of the Medicaid children in the area.

CHIP (Children's Health Insurance Program) takes care of many children's medical and dental needs. Through this program children have comprehensive dental benefits, including dental preventive services. CHIP has been able to find dental homes for low income children for 77% of all enrolled children in the valley. CHIP also has dental fairs, in conjunction with VCU dental students, to screen and enroll children and provide fluoride dental varnish, as well as provide oral health instructions and family oral health education. This ensures better dental health for these children even beyond the years they are in the program.

A community coalition for addressing the overall health needs of our valley was the driving force to start the Missions of Mercy here in the valley. The committee worked long hours and obtained many grants to put on the Missions for seven years. In October 2012, the United Way of the Roanoke Valley formed the Healthy Roanoke Valley Committee, which is a coalition of 55 public/private health and human service organizations, educational institutions, and local businesses to address healthcare needs in the valley. Part of that coalition is the Oral Health Work group. This group has identified the dental health needs in our valley and is working toward developing a sustainable oral health safety net.

Grants renewals became more difficult, volunteers grew weary of the year-round effort, so the committee decided to switch the traditional MOM for a Mini-MOM, which is held in private offices, and is very much like clinics that have been held in Roanoke and the New River Valley in private offices. It is to be on a smaller scale, but repeated quarterly with as many dental offices as we can get to volunteer to see patients in their office.

One of the players in the committee, Project Access, has stepped up to administer the Mini-MOM program. Project Access has been, for many years, a physician-centered volunteer coordinating group. It is well organized and has been referring needy patients into private medical offices for years. They are well-versed in getting health care providers to volunteer, to screen patients and assess their needs.

We have held two Mini-MOM projects and have seen in excess of 75 patients to date, doing services including extractions, fillings, root canal therapy, along with the screening and x-rays needed for proper diagnosis. We have just obtained funds held in reserve for the next MOM project, with the consent of the former committee, to be used to hire a part-time coordinator to screen calls, coordinate the volunteers, take care of the paperwork of organizing and reporting to the VDA MOM staff on how much we have done. Our goal is to identify the dental needs of each patient enrolled, and complete the necessary, basic needs they have. We want this to be a part of the larger MOM initiative, because it was created out of the original MOM project.

We are looking for growth in the project when local dentists learn who and what we are, and volunteer to have the project in their offices one or two days per year.

In late November, New Horizons Healthcare, a community health clinic, opened the doors to their brand new dental clinic. Although built with grant money over two years ago, no funding was forthcoming to staff the offices. This year they raised enough money through grants to start their operation. They will start working on patients on a sliding scale, and will see Medicaid and self-paying patients. They have three dentists on staff and one hygienist, along with the support staff. They hope to target the medical patients already receiving healthcare in their facility along with a growing new group that will learn of their affordable options.

This past summer, an independent dental group acted on their experience in the last MOM project in Roanoke. Several of the dentists in the group enjoy the surgical aspect of dentistry, and saw that, if modeled correctly, a Medicaid extraction clinic would be viable economically. They purchased a downtown office space that was on the public transportation route, remodeled it, hired staff and purchased the equipment, and opened.

They contacted the Emergency Departments at both local hospitals, who were very excited to have a place to refer Medicaid patients and also self-paying patients who could get a less expensive flat fee for care. The response was overwhelming, and a good model for any community to use to give better access for care.

This may seem like a series of unrelated events, but the community has come together through a series of groups that had the greater need of our community in their hearts, and encouraged doctors and laypersons alike to care for those in need in our community. All of these groups are non-governmental, mostly private, non-profit groups, including the hospitals that have services. The one exception is the Medicaid extraction clinic, which fills a need no one else in our valley was willing or able to do.

We still have people in need, but we continue to look for ways people can have access to care. I personally think we will never serve all the needs because of choices people make in their lives that does not include taking care of their health in general and specifically their dental health. The loss of the state-run dental care system seemed like a huge blow at first, but it may possibly be a blessing to the people of the Roanoke Valley in the long run.

Behind the Scenes of the Virginia Donated Dental Services Program

By: Jessica Park, DDS Program Manager, VDAF

The Donated Dental Services (DDS) program started here in Virginia in 1997. In 2014, our program hit a major milestone-over $10.1 million in care provided to over 3,300 patients throughout Virginia since the program's inception. All of this could not have been accomplished without the support of our amazing volunteers-dentists and dental laboratories alike. As a tribute to the program's volunteers we would like to start spotlighting them in every issue of the *Virginia Dental Journal*. We hope you will enjoy learning more about the people who improve not only the oral and over-all health of so many older adults and adults with disabilities, but their quality of life too!

DDS Volunteer: Saunders Dental Laboratory
Location: Roanoke, VA
Year Started with DDS: 1998
Written by: Marie Britton, Lab Manager

Please tell us about your lab:
Saunders Dental Lab was founded in 1939 by the late Robert (Bob) M. Saunders, Sr. It became a family business over the years as his children became adults and began working in the lab. Eventually Bob retired and left his three sons to run the business. The eldest son, Robert M. Saunders, Jr. (Butch) was a technician in the Crown & Bridge department and had retired from the lab before he passed away in 2009. Mike Saunders was the General Manager until his retirement in 2012. Even though he is not here to run and oversee the day to day operations of the lab he stays in touch by telephone and occasional visits to the lab. The youngest son, Don Saunders, is still with us today and works in our Cast Metal Partial Department. He was manager of the department until last year when he decided to partially retire. He currently works three days a week and loves it! This past October saw us celebrating our 75th anniversary in business. We couldn't have reached this milestone without having and maintaining qualified technicians in each area of the lab. We are a full service, certified dental lab specializing in dentures, partials, and crown & bridge. We currently employ 21 people, 16 of which are technicians in the lab itself. Each department is managed by a Certified Dental Technician and their experience, combined with Don's, totals over 170 years in the dental lab field. I have been with Saunders Dental Lab since 2006, starting out as the Office Manager until Mike's retirement at which time I was promoted to the Lab Manager position.

How did you get started with the DDS program?
We were first contacted by the DDS program asking if we would be willing to participate. We made the decision to participate then and haven't looked back. We have several of our dentists that regularly participate in the program and we are happy to accommodate them as needed. Many years ago the lab did adopt a policy of working only with our active dentists. We felt it necessary at that time to try and support the dentists that support us because we truly value the business that they send our way and feel by doing this it builds a stronger and more lasting relationship with our dentists. What I enjoy about the DDS program is the ability we have to show our compassion and help those that are not in a financial position to help themselves. What we do can be, and often is, life changing for these patients. We often receive thank you notes from the patients and they are so grateful for what has been done to help them, not only by the lab, but by the dentists as well. It truly is a team effort because without our dentists' participation we wouldn't be able to do what we do for the patients. We always strive to treat others as we would want to be treated.

How did you/your team decide to go into the dental lab technician profession?
I spoke with the managers on what made them choose this profession and, as I suspected, was given varying reasons on how they made their decision.

For the Saunders brothers it was a no-brainer. They were born into it. There was a lot of on the job training but, for Don, he received his formal training in the Navy. He was required to learn hygiene first and was able to assist the dentist chair side before he was allowed to start lab school.

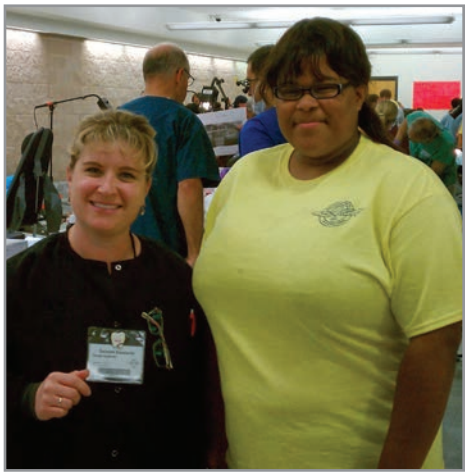
Our denture department manager, Richard Mullins, received his formal training in the Navy as well. He was a student at UVA-Wise and was in their pre-dentistry program when he was drafted into the Navy. He was given two choices, become a medic or dental tech, so he chose the dental field because that was what he was most interested in. Once he returned to civilian life he didn't want to go back to school so he remained in the dental lab field and has been with Saunders for almost 38 years.

For John Cook, our C&B department manager it was a completely different reason. His interest in the field began as a pre-teen because of a baseball injury. He was hit in the mouth by a baseball bat in a freak accident which left him in need of a great deal of dental work. Throughout the course of his treatments, spanning years, he became interested in not only what was done, but how it was done. This ultimately led him into the dental lab field and he received his formal training at Career Academy in Atlanta and Washington, D.C. He has been with us at Saunders for 44 years.

Our cast metal department manager is Brenda Burke and she has been with Saunders for 35 years. She grew up in this area, but had just moved back here from California when she was hired by the lab. Having no formal training before coming into the lab she learned everything on the job. She also wanted to learn as much as she possibly could about the industry and knew the only way to advance within the lab was to learn as much as she could. Once she was here she realized how life changing this field was for people and felt that what she was doing truly made a difference. She studied the books and manuals on dental lab technology, as well as getting all of her hands on experience, and became a certified dental technician.

My experiences with Missions of Mercy

By: Salayne Escalante, RDH



Growing up, my family and I volunteered as individuals and as a family in a variety of ways, including church service and scouts. When I became an active hygienist in 1998, I began volunteering frequently at our local community dental health clinic in Silver Spring, MD. The feeling of satisfaction in working with the community and employing my Spanish skills kept me there for over two years, every other Friday when my office was closed. Once my husband, Robert, and I moved and began our family, volunteering became more of a challenge to coordinate, but I succeeded in volunteering at least once per month.

When we moved to Winchester, I sought out the local dental health clinic to offer hours, and was able to work and volunteer in my new 'hometown'. It wasn't until I began working on my MS-Dental Hygiene that I met Mary Lavigne. We worked at the same educational institution, and she encouraged me to get our students involved with dental assisting through the local M.O.M. project in Northern Virginiasince she had previously volunteered. We had a blast! I supervised the students on Friday, and went back on Saturday to donate my day as a clinician. I was hooked! Mary and I have done Wise, Grundy, and Northern VA for the last couple of years, and I love taking the students--it's a great experience for them, and each project recharges my 'internal batteries' and commitment to my profession.

This last Grundy trip, I took my daughter, Olivia, to be my assistant. She is of an age where she is ready to explore options for a career, and I wanted her to be able to see why I do M.O.M. projects, and how a skilled professional can give back to the community. We as a family have volunteered at other types of events; this was to be her first dental volunteer experience. I was surprised and delighted when she announced that she was going to set up my station, get instruments, seat the patient and take the instruments to the sterilization area! Talk about jumping in with two feet forward! She enjoyed the camaraderie of the dental hygiene students present, talking with patients and truly being an asset to me to serve as many people as possible. She did observe other treatments being performed, and decided that oral surgery is not for her, which made Mary and Dr. Pandolfi smile. I will admit that I was very proud of her--she worked hard, didn't complain and was eager to learn more.

Since Grundy was a great experience for my daughter, my husband and I have decided that all four of us will volunteer with M.O.M., whether clinically or administratively. Volunteering with M.O.M. is so impactful and incredibly worthwhile; the recipient is thankful for the care given and the participant lights up inside with the joy of service to others. Thank you to M.O.M. and Mary Lavigne for bringing this joy to my life.

A Good Way to Serve

By: Dr. Philip Pandolfi

As a career Army officer I have seen the best and worst that society has to offer and realized collectively we can make a difference. I realized how blessed my life has been having the opportunity to serve in our military and become an oral and maxillofacial surgeon in the process. It saddens me that there are people in this country who are deprived of medical and dental care based on their socio-economic status. Having been introduced to the MOM project I believed this was a good way to serve in the poorest regions of the state. Each year I am excited to see more people volunteering in Grundy both medical and dental. I look forward to returning to Grundy to see the friends I have made through out the years, work with the dental students, and most importantly treat the patients who would not otherwise receive dental care. There is nothing more humbling than to have a patient look at me and say thank you. I encourage more dental professionals to take part in this program.

Editor's Note: Dr. Pandolfi, a VDA member dentist, practices oral and maxillofacial surgery in Harrisonburg.

2nd Annual MOM Awards Dinner Honors MOM, Donated Dental Services and Give Kids a Smile Volunteers

By: Barbara Rollins, VDA Foundation

The red carpet was rolled out to celebrate the stars of the Mission of Mercy (MOM), Donated Dental Services (DDS) and Give Kids a Smile (GKAS) at the 2nd Annual MOM Awards Dinner. Held during the VDA Annual Meeting at the Omni Homestead, attendees were interviewed as they walked down the red carpet. As expected, the paparazzi were there snapping pictures!

2014 Star Awards were presented to long time volunteers of the three VDA Foundation outreach programs. Star Award recipients included:

- **Virginia Family Dentistry** – DDS Star Award
- **Commonwealth Oral & Facial Surgery** – DDS Oral Surgery Star Award
- **Southside Oral & Facial Surgery** – DDS Oral Surgery Star Award
- **Drs. Stenger, Cole and Gupta** – DDS Champion for Patients with Special Needs Award
- **Goodwin Dental Lab** – DDS Outstanding Dental Lab Award
- **Tina Bailey** – GKAS Star Award
- **Dr. Frank Farrington** – GKAS Champion Award
- **Dr. Andrew "Bud" Zimmer** – Pin Man Award
- **Dr. Roger Wood** – VDA Foundation Shining Star Award
- **Dr. Richard Roadcap and Mrs. Norma Roadcap** – MOM Partners in Crime Award
- **Dr. Carole Pratt** – MOM Last Woman Standing Award
- **Dr. Stephen Alouf, Dr. Scott Miller, Mr. Greg Gray, Dr. Michael Clark and Dr. Joshua Swanson** – MOM Denture Team Award
- **Pat Finnerty** – Terry D. Dickinson Award for Outstanding Contributions to the MOM Program

Everyone enjoyed the Hollywood-themed night of dinner and music. We wish to thank all who contributed to the silent auction and sponsors who made the evening possible. A special thank you to Dr. Anne Adams, Event Chair for the past two years and Robbie Schureman for his leadership in recruiting sponsors and auction items.

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TELEDENTISTRY: Accessible, Effective and Rewarding

By: Susan J. Daniel, RDH, PhD; Chairman and Associate Professor, G.W. Hirschfeld School of Dental Hygiene, Old Dominion University

Teledentistry is the use of technology and telecommunications for dental care, consultation, education, and public awareness.1 The prefix "tele" derives from the Greek for "at a distance." Electronic health records including chartings, radiographs, and photographs can be stored and forwarded for review, consultation, referral, and diagnosis. Figures 1-3 provide images of caries, orthodontic concerns, and oral lesions, which were obtained for screening purposes with an iPhone 4S. Records can be reviewed in real time or stored and forwarded for remote review by a dentist.

The U. S. Department of Defense Total Dental Access Project was launched in 1994 to increase access and efficacious-quality dental care. Since then, teledentistry is used for oral screening and full examination, consultation, referral, triage, and treatment delivery. 2-5 Telecommunications in dentistry deliver professional education and post-professional licensure with audio, video, motion, still images, and simulation, including haptic technology. Anything that anyone in the oral healthcare profession or patient desires to know about dentistry, techniques, devices, and information of any kind is only a click away with the Internet.

Teledentistry is a legally approved form of care in many states, increasing access to care by providing an extension of a dental practice beyond the confines of a single office environment.6 The use of teledentistry in a dental practice, which employs more than one dental hygienist, can serve more individuals and increase the practice's income.

All stakeholders in the Commonwealth of Virginia are discussing the use of teledentistry. The questions posed during discussions are those that have been vetted by other state's providers who have recognized the benefit to the end users (patients) in improved oral health and to the dental practice financially.

Dental practice in Virginia, as in other states, is at a tipping point with the increased need for oral care among all ages, ethnicities, and socioeconomic status. An increase has been reported in dental caries among young children and young adults.7,8 Gingivitis and periodontal diseases affect more people than was once reported, and oral and pharyngeal cancer is on the rise.

Current models of dental care delivery and improving health literacy are not meeting the needs.

Consider the following model.

Whether in a single professional practice or an associate practice, the following model has merit for the improvement of oral care and health and as an effective means of increasing revenue. Consider teledentistry similar to a satellite preventive practice. Place an experienced (3-5 years) clinical dental hygienist in specified facilities with the equipment to obtain an electronic health record (EHR) including dental and periodontal chartings, radiographs, and intraoral photographs. The dental hygienist performs a thorough clinical and radiographic examination and records clinical notes. This information is forwarded to the supervising dentist where the data can be reviewed immediately or stored for review at an appointed time within the dentist's schedule. The dentist can evaluate the documentation forwarded and identify restorative/operative treatment needs. The number of patients for preventive and operative care has increased, thereby increasing the practice's revenue.

The use of teledentistry coupled with remote supervision provides a significant opportunity for practicing dentists to reach out to new patients not otherwise accessible and to garner additional revenues without significant increase in fixed costs.

Beyond the revenue to be captured through remote clinical examination and teledentistry evaluation, there will naturally flow an additional stream of patients to dentists in need of restoration or other treatments. These patients will continue to seek preventive treatments either in the office or remote setting.

REFERENCES

1. Clark GT. "Teledentistry: What is it now, and what will it be tomorrow?" J Calif Dent Assoc. 2000;28(2):121–7.
2. Daniel SJ, Kumar S, Wu L. Teledentistry: A Systematic Review of Clinical Outcomes, Utilization and Costs. J Dent Hyg 87(6):359-366, 2013.
3. Mandall NA, O'Brien KD, Brady J, Worthington HV, Harvey L. Teledentistry for screening new patient orthodontic referrals. Part 1: A randomised controlled trial. Br Dent J. 2005;199(10): 659-662, discussion 653.
4. Bradley MP, Black P, Noble S, Thompson R, Lamey PJ. Application of teledentistry in oral medicine in a community dental service, N. Ireland. Br Dent J. 2010; 209(8):399-404.
5. Lienert N, Zitzmann NU, Fillippi A, Weiger R, Krastl G. Teledental consultations related to trauma in a Swiss telemedical center: A retrospective survey. Dent Traumatol. 2010; 26(3):223-227.
6. Daniel SJ, Kumar S. "Teledentistry: A Key Component in Access to Care". J Evid Based Dent Pract Jun 14 uppl:201-8, 2014.
7. Tinanoff N, Kanellis M, Vargas C: Current understanding of epidemiology, mechanisms and prevention of dental caries in preschool children. Perdiatr Dent 2002, 24:543-551.
8. Dye BA, Tan S, Smith V: Trends in oral health status: United States, 1988-1994 and 1999-2004. In: Vital Health Stat. Edited by Centers for Disese Control and Prevention, Health and Human Services; 2007, Series 11, no. 248, Washington, D.C.

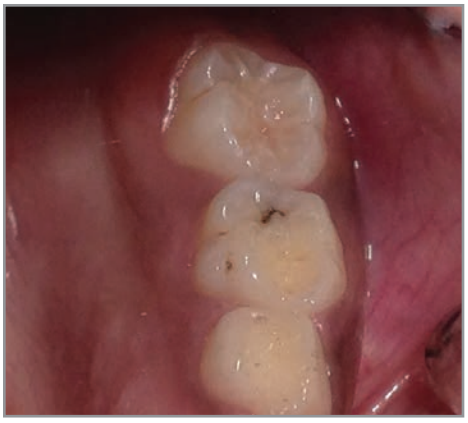


Figure 1. Dental caries

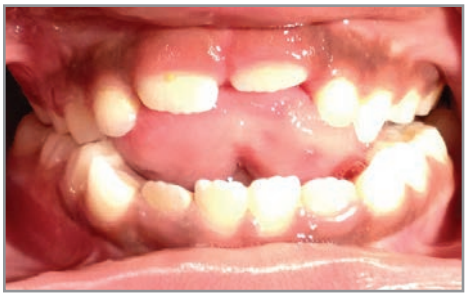


Figure 2. Ankylosed tongue and orthodontic needs

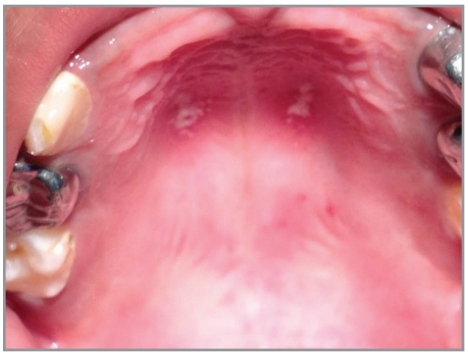


Figure 3. Palatal Lesions

2014 VDA Strategic Planning Session: A Student's Perspective

By: Kandice L. Klepper; D-2015, Virginia Commonwealth University

As I reflect back on my involvement in the 2015 VDA Strategic Planning session, nothing resonates more with me than a quote from my classmate Jeremy Jordan, "Teamwork makes the dream work." This is the foundation of organized dentistry and has quickly become one of my motivating mantras. From my experience thus far, organized dentistry is a collaborative effort to advance the profession through advocacy, education, service, and support. These fundamentals were evident at each level of the 2015 Strategic Planning process. Along side of the talented current and past VDA presidents, Board of Directors, component presidents, committee chairs, and VCU dental student colleagues, we set off to review the accomplishments of 2014 while developing future goals for 2015.

On the forefront of the 2015 advocacy initiatives is the Community Dental Health Coordinator (CDHC). Dr. Mark Crabtree unveiled the VDA's proposal to address access-to-care issues in Virginia with the creation of a new dental workforce model. The aim of the CDHC is to decrease the frequency of emergency room visits due to dental pain through preventive measures and education. As of 2014, the ADA's CDHC model successfully graduated over 30 students in over eight states. Under the supervision of a dentist, the CDHC provides preventive services including oral hygiene instruction, application of fluoride varnish, placement of sealants and the dissemination of 'navigation services' that provide affordable care. With the institution of the CDHC, the VDA hopes to increase oral health education while also decreasing the barriers of access to care.

Under the leadership of Dr. Justin Norbo, the New Dentist Committee highlighted the upcoming first annual Virginia New Dentist Conference, which will be held in August 2015 at the Wintergreen Resort. The meeting will provide recent dental graduates and current students the opportunity to learn more about organized dentistry while networking, participating in various continuing education courses, and enjoying the splendors of the Blue Ridge Mountains. This conference is sure to be a success for all who are able to attend!

Photo caption: L-R: VCU dental students Jeremy Jordan, Kristin Edwards and Kandice Klepper; VDA President Dr. Michael Link

In addition to the CDHC and the New Dentist Conference, another key aspect discussed during the Strategic Planning Session was the development of a leadership certificate program. This program will allow new dentists (in practice for 10 years or less) to be appointed to leadership roles on the state level while working with colleagues to learn about the fundamentals of organized dentistry. Though the certificate program is in the early stages of planning, it aims to foster both new leaders and mentors. With the decline of membership in organized dentistry nationwide, it is essential to continue to inspire our members to take an active role in the future of our profession.

Through the diligent efforts of the dedicated participants of the Strategic Planning Session our profession continues to thrive. The accomplishments of 2014 and established goals of 2015 are prime examples of how the collaborative efforts of the VDA are focused toward a brighter future. As a dental student, I was honored to have participated in this process. It was truly inspiring to be amidst such an accomplished group of individuals who all shared one common goal: advancing the profession through advocacy, education, and support. As I look to my forward to staring my career, I aspire to continue my involvement in organized dentistry and encourage each of my colleagues to also take the challenge, reach outside of your comfort zone, and take an active role in the profession; we are the future!

Editor's Note: Ms. Klepper is Student Body President at VCU School of Dentistry

VDA Dentists Gain Skills for "Leadership for Tomorrow's Generation"

By: Dr. Caitlin Batchelor

Dr. Caitlin Batchelor (L), Dr. Sheila Sheinberg

Change is under way for healthcare professions in our country, and dentistry is not excluded from the grasp of these changes. Change is also inevitable within the leadership of organized dentistry and the Virginia Dental Association. Leaders, both new and seasoned, had the opportunity to spend a day developing leadership skills under the guidance of developmental psychologist and President of the Center for Life Cycle Science, Dr. Sheila Sheinberg, whose self-proclaimed passion is "change."

"Leadership for Tomorrow's Generation" embraced the goal of cultivating those leaders who will carry the VDA forward, at a seminar in Richmond on November 7 mediated by the dynamic Dr. Sheinberg and hosted by VDA Executive Director Dr. Terry Dickinson. Up-and-coming leaders of the VDA learned alongside and mingled with those with experienced service to the organization.

Successful organizations know that a plan and a vision for navigating change are keys to shaping the direction of their future. New leaders must be developed and trained to take the place of more experienced ones, as positive leadership is a skill that must be fostered. And beyond the realm of organized dentistry, dentists find themselves as leaders in their practice and community, so leadership training is essential. As one participant said, we as dentists are going to be leaders whether we like it or not, so we have to make the choice whether to improve qualities that will help us lead well, or we will lead poorly.

Utilizing the Margerison-McCann Team Management Wheel, participants in the seminar discovered and explored their individual "work preferences" within the Wheel of Work (types of work required in all high performing teams). Team Management Profiles were rendered for each participant, who learned their strengths as leaders (as Explorers, Organizers, Controllers, or Advisors) based on their work preferences, and also learned which important roles they must seek out in other team members within an organization in order for the team to perform effectively.

Have you ever considered why anyone would want to follow you (as a leader)? Have you written a Mission Statement for your organization or a Vision Statement for its future? Have you ever told your own Leadership Story? Participants were urged to do just that, as they were led through insightful exercises where they considered their personal vision as leaders, developed leadership linking skills, and explored their emotional intelligence.

Passing the torch of leadership in the Virginia Dental Association is no simple, singular act; it is a process through which the knowledge gained from years of hard-earned experience serving the profession as a whole will be dispersed to smart, enthusiastic young dentists throughout the state who hope to carry forward the tradition of outstanding leadership into the future. The process for training those new leaders is happening now, to the benefit of the profession, with a vision of a bright future for dentistry.

Editor's Note: Dr. Batchelor, a VDA member dentist, practices in Harrisonburg.

Minutes of the 144th Annual Business Meeting
Sunday, September 21, 2014, 7:30am
The Homestead Resort, Hot Springs, Virginia

1. President J. Ted Sherwin called the meeting to order and the flag pledge was recited.

2. The following deceased members were remembered:
Component 1: Leonard O. Oden . Component 2: John W. Ames, Harold B. Dumas.Component 4: Raymond S. Black. Component 5: Lori A. Winebrenner. Component 6: Richard D. Gardner, Henderson P. Graham, Ronald D. Jones, Stephen L. Myers. Component 7: George R. Hedrick, Robert M. Lawrence, John F. Worsley. Component 8: Patrick B. Colvard, Mike M. Etessami, Paul E. Halla, Robert B. Hulbert, John P. Kannar, Michael W. Schulte.

3. Recognition was given to:

2014 VDA Fellows Inductees:
Walker W. Shivar (1), Wayne E. Booker (2), Richard W. Bates (3), Scott E. Gerard (3), Tegwyn H. Brickhouse (4), Harold J. Martinez (4), Lawrence J. Kyle (6), Scott A. McQuiston (8).

2014 Recipients of Life Member Certificates:
Component 1: Robert T. Banes, John I. Barney, Marshall S. Bonnie, Townsend Brown, Jr., Thomas O. Dusek, Alan G. Forbes, Arthur C. Hendricks, Grover C. Hill, Jr., Thomas J. Ishom, Jan E. Milner, Demetrios P. Milonas, Robert A. Pope, A. J. Weisberg. Component 2: William J. Bennett, Donald D. Cooke, McKinley L. Price, Richard W. Toth, Kenneth A. Yorgey, James D. Watkins. Component 3: Thomas M. Coghill, David L. Ellis, James P. Webb. Component 4: William D. Crockett, Harold M. Cruse, Nicholas Germane, James O. Glaser, Lindsay M. Hunt, Charles K. Johnson, Fred N. Kessle, Gene C. Mears, Jonathan D. Perkinson, John B. Rose III, James R. Schroeder, Kevin C. Sweeney. Component 5: Gregory T. Gendron, George D. Morris, Marvin E. Perdue, James H. Priest, William C. Richardson, John W. Rhoday, Mark P. Smith. Component 6: Douglas W. Chambers, W. S. Glascock, Henry K. Higginbotham, Neil D. Hollyfield, Joe A. Paget, Jr. Component 7: D. C. Devening, Jr., W. J. Faircloth, Jr., David C. Hall, Robert S. Knierim, Allen D. McCorkle. Component 8: David C. Anderson, Gary V. Avakian, David Bertman, Alvin W. Breeden, Theron L. Dikeman III, Steven Fuchs, James L. Gyuricza, Gerald A. Hoffman, John J. Krygowski, Brian A. Mahler, Paul H. Patterson, James A. Pell, Clark W. Rogers, Peter J. Scelfo, Richard G. Tami, Jack Weil.

2014 Recipients of 50 Year Certificates:
Component 1: Truman D. Baxter, Jr., Charles A. Drescher, Charles B. Hayes, Harvey H. Shiflet III, John A. Syran. Component 2: Harold E. Smith. Component 3: Stuart A. Broth, Frank H. Farrington, Robert L. Grossmann, Kenneth W. Morris. Component 4: Joseph C. Cox, Jr., Lloyd A. Green, Alfred D. Hurt, Jr., James H. Revere, Jr., Edward P. Woodworth. Component 5: Donald R. Alouf, James E. Gosney, Edward Y. Lovelace III, John M. Salmon III, George A. Stermer, Jr. Component 6: Wilson G. Harper. Component 7: James R. Cooke, Jr., James C. Gordon, Jr., James I. Lambert, Willard K. Lutz, Robert E. Wilkerson. Component 8: David J. Cantor, Michael V. Farr, Philip S. Ferris, James H. Forsee, Jr., Ralph E. Gallimore, David W. Metzdorf, David A. Reid, Donald F. Reynolds, Robert K. Rosenberg, Michael J. Ternisky, Jr., Richard M. Waxler, David A. Whiston.

2014 Recipients of 60 Year Certificates:
Component 1: Morton A. Brownstein, Cecil J. Carroll, Jr. John D. DiCiero, Emanuel W. Michaels, Harry S. Riley. Component 2: Roland R. Stall, Jr., Clarence J. Wild. Component 4: Donald S. Brown, Gilbert F. DeBiasi, Hugh R. Rankin. Component 5: George J. Orr, Chris G. Scordas, Charles E. Thaxton. Component 6: Thomas B. Haller, David R. Stanton. Component 8: Robert A. McDonald, Charles F. McKeon, James D. McKittrick, Samuel E. Saunders, Jr.

4. The following VDA awards were presented:
Dental Team Member: Heidi Hessler-Allen
Emanuel W. Michaels Distinguished Dentist Award: William J. Viglione, D.D.S
New Dentist: Sarah C. Wilmer, D.D.S.
Leadership: Michael A. Abbott, D.D.S., Edward J. Weisberg, D.D.S., Kirk Norbo, D.M.D., Samuel W. Galstan, D.D.S., Gus C. Vlahos, D.D.S., Neil J. Small, D.D.S.
Presidential Citations (presented at the opening session September 18, 2014): Richard L. Taliaferro, D.D.S., Roger E. Wood, D.D.S., Anthony R. Peluso, D.D.S., Terry D. Dickinson, D.D.S., Bruce R. Hutchison, D.D.S., Bruce R. DeGinder, D.D.S., Roger A. Palmer, D.D.S., Frank P. Iuorno, Jr., D.D.S., Ronald L. Tankersley, D.D.S., Edwin Lee, D.M.D., Michael J. Link, D.D.S., William V. Dougherty III, D.D.S.
Honorary Membership: Linda Gilliam

5. Bruce Hutchison, VADPAC Chair, gave a committee update and announced the following VADPAC awards:

Category A – Small Component Membership

Percentage of members who contributed to VADPAC (55%)	Component 6
Percentage of Commonwealth Club Members (40%)	Component 6

Category B – Large Component Membership

Percentage of members who contributed to VADPAC (40%)	Component 4
Percentage of Commonwealth Club Members (27%)	Component 8

The Governor's and Apollonia Club members were recognized.

6. The following election results were announced:
President Elect – Richard L. Taliaferro

ADA Delegates – David C. Anderson, Alonzo M. Bell, Bruce R. Hutchison, Kirk Norbo, Roger Wood. (Due to the one year appointment of David Anderson to serve as a delegate for 2014 as the result of an additional delegate allocation by the ADA, all will serve 3 year terms except one who will serve a one year term (to be determined by the delegates). This will keep the rotation as even as possible.)
ADA Alternate Delegates – Samuel W. Galstan (2 yr term), Frank P. Iuorno, Jr. (2 yr term), Rodney J. Klima (2 yr term) , Danielle H. Ryan (1 yr term), Cynthia Southern (2 yr term), Richard L. Taliaferro (2 yr term) Maynard P. Phelps (1 yr term), Brenda J. Young (2 yr term).

7. The out-going component presidents were recognized:

Anthony Meares (1)	Russell S. Taylor (2)	Michael Webb (3)	Kit T. Sullivan (4)
Kevin Snow (5)	Brian C. Thompson (6)	Brian Brumbaugh (7)	Peter K. Cocolis, Jr. (8)

8. Ted Sherwin installed the newly elected VDA officers, ADA delegation members and the following component presidents:

Mary T. Dooley (1)	Donald W. Cherry (2)	Robert J. O'Neill (3)	Alfred J. Certosimo (4)
Risa Odum (5)	Christopher W. Thurston (6)	Corey Burgoyne (7)	Fernando Meza (8)

9. Ted Sherwin presented in-coming president, Michael J. Link, with the president's pin.

10. Michael Link presented Ted Sherwin with the past president's pin, the VDA Torch Bearer Award and the ADA Constituent President's Plaque.

11. The meeting was adjourned.

Board of Directors - Actions in Brief
September 17 -21, 2014

1. Approved: The following Bylaw amendment:

Background: Aptify software has been deployed in the VDA. This software allows for a more seamless interface between the ADA and VDA in key areas like membership data. It will allow for the possibility of the ADA collecting dues for states who request it.

There may be a significant savings in VDA staff time if the ADA were able to collect VDA dues. By making the following changes and updates to our C&B, the VDA House will clear the way for the VDA Board of Directors to make that decision at some point in the future as well as update old procedures where VDA Components collect dues.

Bylaws, ARTICLE I. Membership, Section 2. Election to Membership:
Section 2.A) Election to Membership. An Active Member in good standing in one of the component societies in Virginia shall automatically become an active member of the Virginia Dental Association upon ~~transmittal~~ receipt of State dues ~~through the component secretary-treasurer to~~ by the Central Office of the Virginia Dental Association.

Bylaws, ARTICLE I. Membership, Section 7.

Section 7. Dues: The annual dues shall be paid on or before January first of each year. Dues unpaid ninety days thereafter shall automatically terminate the membership. An installment program will be offered as an alternative method for the payment of dues. Dues unpaid 90 days after a missed payment shall automatically terminate the membership. The Association may delegate its duty to collect dues to the American Dental Association provided that such delegation includes the obligation for the American Dental Association to reasonably remit dues collected for this Association and its component dental societies to those entities together with such information as is required to maintain accurate membership and dues payment records

Bylaws, ARTICLE VIII. Component Societies, Section 5: Strike in its entirety:

Section 5. ~~Each component society shall remit to the Central Office of the Virginia Dental Association dues received from members, along with a list of active, student, associate and life members. Such other pertinent information as is necessary for a complete record shall be forwarded~~.

Bylaws, ARTICLE VIII. Component Societies, Sections 6 through 9:
Renumber as Sections 5 through 8. (The resolution was given to RC 1000)

2. Approved: The Board of Directors feel the House of Delegates should be involved in the selection of the site of the 2017 meeting. Possibilities limited to the Homestead, the Hampton Convention Center or Northern Virginia. (The resolution was given to RC 1000.)

September 21, 2014

1. Approved: 2014-2015 appointments:
   - A. Parliamentarian: Dr. A. J. Booker
   - B. *Journal* Editor: Dr. Richard F. Roadcap
   - C. Executive Director: Dr. Terry D. Dickinson
   - D. Legal Counsel: David Lionberger, Esq. and Scott Johnson, Esq.
   - E. VDSC Board of Directors:
     Voting Members: Dr. Roger Wood -President, Dr. Stephen Radcliffe - Vice President, Dr. Rodney Klima - Secretary/Treasurer, Dr. Alonzo Bell, Dr. Fred Coots, Jr., Dr. Frank Crist, Jr., Dr. Ralph Howell, Jr., Dr. Wally Huff, Dr. Bruce Hutchison, Dr. Jeffrey Levin, Dr. Robert Levine, Dr. Kirk Norbo, Dr. Gus Vlahos, Dr. Leslie Webb, Jr., Dr. Edward Weisberg; Dr. Andrew Zimmer. Non-Voting: Dr. Steven Forte-liaison, Dr. Ted Sherwin-liaison, Dr. Lanny Levenson-advisory, Dr. Harvey Shiflet, III-advisory; Dr. Cynthia Southern-advisory.

2. Approved: A resolution to hold the 2017 Virginia Meeting at The Homestead.

43rd HOUSE OF DELEGATES ACTIONS IN BRIEF
SEPTEMBER 18-21, 2014

1. Approved: A resolution to allow The Virginia Meeting to be held outside the borders of Virginia - delete Article II, Section 1.B) from the Bylaws.

   Article II, Section 1.B
   ~~B. The place of the Annual Membership Meeting shall be within the legal boundaries of the Commonwealth of Virginia.~~

2. Approved: A resolution clarifying that in cases of an ADA Delegate vacating his term after the ADA has certified the Delegation, the successor appointment is made by the Chair of the VDA Delegation. The following Bylaw change will be made:

   Article V – Section 2, B.a
   a. After the ADA certifies the Delegation, ~~in cases of emergencies of short duration when a Delegate or Alternate Delegate cannot fulfill his duties~~, the Chair of the VDA Delegation may appoint any member of the Virginia Dental Association temporarily to fill a vacancy. All such appointments must conform to the rules of the House of Delegates of the American Dental Association.

3. Approved: A resolution clarifying that in cases of notice by an ADA Delegate to vacate a term before the ADA has certified the Delegation, the successor appointment is made by the VDA President. The following Bylaw change will be made:

   Article V – Section 2, B.b
   b. Before the ADA certifies the Delegation ~~in cases of reasonable notice~~: when any Delegate cannot complete his term of office because of resignation, death or other reason, the President of this Association shall appoint his successor from the Alternate Delegates to serve until the next election, subject to the approval of the Board of Directors. When any Alternate Delegate cannot complete his term of office because of resignation, death or other reason, the President of this Association shall appoint his successor from the Association membership to serve until the next election, subject to the approval of the Board of Directors.

4. Approved: A resolution that electronic voting, for VDA elected offices, will begin at a minimum of 60 days before the Annual Meeting. (VDA Policy)

5. Approved: The following Bylaw changes allowing the ADA to collect dues if, at some point in the Future, it is deemed advantageous:
   Bylaws, ARTICLE I. Membership, Section 2. Election to Membership:
   Section 2.A) Election to Membership. An Active Member in good standing in one of the component societies in Virginia shall automatically become an active member of the Virginia Dental Association upon ~~transmittal~~ receipt of State dues through the component secretary-treasurer to by the Central Office of the Virginia Dental Association.
   Bylaws, ARTICLE I. Membership, Section 7.

   Section 7. Dues: The annual dues shall be paid on or before January first of each year. Dues unpaid ninety days thereafter shall automatically terminate the membership. An installment program will be offered as an alternative method for the payment of dues. Dues unpaid 90 days after a missed payment shall automatically terminate the membership. The Association may delegate its duty to collect dues to the American Dental Association provided that such delegation includes the obligation for the American Dental Association to reasonably remit dues collected for this Association and its component dental societies to those entities together with such information as is required to maintain accurate membership and dues payment records.

   Bylaws, ARTICLE VIII. Component Societies, Section 5: Strike in its entirety:

   Section 5. Each component society shall remit to the Central Office of the Virginia Dental Association dues received from members, along with a list of active, student, associate and life members. Such other pertinent information as is necessary for a complete record shall be forwarded.

   Bylaws, ARTICLE VIII. Component Societies, Sections 6 through 9: Renumber as Sections 5 through 8.

6. Approved: The following resolution:
   Whereas the Virginia Dental Association is Virginians strongest advocate for oral health,
   and
   Whereas the oral health of many Virginian's is inadequate,
   and
   Whereas lack of oral-health literacy is a significant factor contributing to inadequate oral health,
   and
   Whereas many patients eligible for government-funded oral healthcare services do not access them,
   and
   Whereas there is the need for community-based dental healthcare coordinators to appropriately match the oral-health needs of patients with available oral health resources,
   and
   Whereas the American Dental Association (ADA) developed a model and curriculum for community-based dental-team extenders, called Community Dental Health Coordinators (CDHCs), to educate, provide selected preventive services, triage patients, and help appropriately

navigate patients who need oral-health services to those who provide those services,
and
Whereas the ADA developed successfully conducted pilot studies that demonstrated the effectiveness of using CDHCs in improving oral health for a variety of underserved populations in several alternative healthcare settings, be it resolved:

That the VDA President appoint a Task-force to determine the feasibility of educating and utilizing CDHCs in Virginia, and be it further resolved:

That the VDA proceed with the establishment of the CDHC in Virginia, and be it further resolved:

That the Task-force report its progress to the VDA's 2015 House of Delegates.

7. Approved: The 2015 Budget as amended.

8. Approved: The following Life Membership in 2014:
Component 1: Robert T. Banes, John I. Barney, Marshall S. Bonnie, Townsend Brown, Jr., Thomas O. Dusek, Alan G. Forbes, Arthur C. Hendricks, Grover C. Hill, Jr., Thomas J. Ishom, Jan E. Milner, Demetrios P. Milonas, Robert A. Pope, A. J. Weisberg. Component 2: William J. Bennett, Donald D. Cooke, McKinley L. Price, Richard W. Toth, Kenneth A. Yorgey, James D. Watkins. Component 3: Thomas M. Coghill, David L. Ellis, James P. Webb. Component 4: William D. Crockett, Harold M. Cruse, Nicholas Germane, James O. Glaser, Lindsay M. Hunt, Charles K. Johnson, Fred N. Kessler, Gene C. Mears, Jonathan D. Perkinson, John B. Rose III, James R. Schroeder, Kevin C. Sweeney. Component 5: Gregory T. Gendron, George D. Morris, Marvin E. Perdue, James H. Priest, William C. Richardson, John W. Rhoday, Mark P. Smith. Component 6: Douglas W. Chambers, W. S. Clascock, Henry K. Higginbotham, Neil D. Hollyfield, Joe A. Paget, Jr. Component 7: D. C. Devening, Jr., W. J. Faircloth, Jr., David C. Hall, Robert S. Knierim, Allen D. McCorkle. Component 8: David C. Anderson, Gary V. Avakian, David Bertman, Alvin W. Breeden, Theron L. Dikeman III, Steven Fuchs, James L. Gyuricza, Gerald A. Hoffman, John J. Krygowski, Brian A. Mahler, Paul H. Patterson, James A. Pell, Clark W. Rogers, Peter J. Scelfo, Richard G. Tami, Jack Weil.

9. Elected: The following Component Directors:

Component 3	C. Sharone Ward
Component 5	David E. Black
Component 6	Cynthia Southern
Component 7	Jared C. Kleine
Component 8	William V. Dougherty III

10. Elected: David C. Anderson 2015 Speaker of the House.

11. The House recommends to the Board of Directors that the 2017 Virginia Meeting be held at The Homestead Resort.

In Memory of:

Name	City	Date of Death
Dr. Roland Drum	Alexandria	January 1, 2014
Dr. Richard Gardner	Abingdon	May 27, 2014
Dr. Ira Gould	Virginia Beach	October 23, 2014
Dr. Thomas Hopkins	Norfolk	October 28, 2014
Dr. Holman Rawls	Virginia Beach	October 9, 2014
Dr. C. Wellsley Smith	Rocky Mount	September 25, 2014

Membership

Welcome New Members

By: Karen Clendenen, VDA Membership and Meeting Coordinator

Tidewater Dental Association

Thomas Harmon – Norfolk – University of Mississippi 2010

Pardeep Kaur – Virginia Beach – University of Illinois 2011/2014

Kelly M. Paxton – Chesapeake – University of Detroit Mercy 2006

Nana Yaa S. Opokuaddo – Chesapeake – New York University College of Dentistry 2014

Peninsula Dental Association

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

Southside Dental Society

Nicole T. Barbour – Chesterfield – VCU 2006

Milan Bhagat – Petersburg – TUFTS University 2010/ University of Detroit Mercy 2011

Lori S. Wilson – Petersburg – Meharry Medical College 1995/FL-Nova Southeastern-Dade County Research Clinic 1996

Richmond Dental Society

Edwin Bell – Richmond – VCU 2013/VT-Fletcher Allen Healthcare 2014

Brian O. Burke – Richmond – Temple University 1993/ VCU 2014

Naveen Chennupati – Glen Allen – Columbia University 2011

Jo Koontz Cronly – Midlothian – VCU 2012/2014

Emeka Kingsley Iloabachie – Richmond – University of Colorado 2013

Rachel Kraft – Midlothian – University of Michigan 2009

Caitlin Kruczek – Glen Allen – SUNY at University Buffalo School of Dental Medicine 2013

Ryan Reopelle – Richmond – University of Minnesota 2013/ UVA 2015

Andrea Rose Onderdonk – Richmond – VCU 2013/ Lehigh Valley Hospital 2014

Claire F. Siegel-Gerhard – Glen Allen - Ohio State University 2011/VCU 2014

Emily Marie Benke Sinclair – Glen Allen – VCU 2013

Jeremiah Sturgill – Richmond – Arizona School of Dentistry & Oral Health 2012/2014 (Orthodontics & Dentofacial Orthopedics)

Amir Tavassoli – Richmond – VCU 2010

Joshua C. Wong – North Chesterfield – VCU 2014

Piedmont Dental Society

Mary Disa Raulfs Allen – Roanoke – VCU 2012/ Minneapolis VA Medical Center 2013

Stephen Bench – Roanoke – University at Buffalo School of Dental Medicine, NY 2014

Samuel Arthur Black, Jr. – Forest – University of Kentucky 2002/Boston University 2009

Sean Eschenbach – Roanoke – VCU 2013/University of Washington Medical Center 2014

Claire Farr – Roanoke – VCU 2013/UAB Hospital Dentistry AEGD 2014

Jennifer Lysenko – Forest – VCU 2013/St. Peter's Hospital 2014

Richard Arthur Oldham – Lynchburg – VCU 2011

Donald R. Villier – New Castle – University of Louisville 2014

Shenandoah Valley Dental Association

Omar Abuhajleh – Charlottesville – Russian Federation-Bashkiria Inst. 1997/NY-Lutheran Medical Ctr. 2009

Kathryn M. Brandt – Charlottesville – University of Iowa 2014

Emily Harding – Harrisonburg – University of Louisville 2010

Debra Horst – Harrisonburg - VCU 2011

Justin P. Karrel – Harrisonburg - Boston University 2010/2011

Brian Podbesek – Charlottesville – West Virginia University 2011/University of New Mexico 2012

Sina Sadeghi – Charlottesville – VCU 2012/NY-Montefiore Medical Center 2013

Northern VA Dental Society

Gheed Jafar Almudhafar – Alexandria – VCU 2013

Mena Saad Botros – Arlington – New York University College of Dentistry 2014

Oliver Chu – Herndon – Boston University 2008/ Peninsula Hospital Center 2011

Patricia M. Dary – Reston – New Jersey Dental School 2013

Jigmey Dorjee – Falls Church – VCU 2011/NY-Montefiore Medical Center 2013

Jennilyn Estell – Woodbridge – Nova Southeastern University 2009/IL-375th Medical Group/SGDTT/Scott AFB 2010

Michelle Keaney Flanagan – Arlington - Temple University 2001

Rifhat Khan – Falls Church – Howard University 2013/ Morristown Medical Center 2014

Derek Galatro – Fredericksburg – VCU MCV 1997

Shemika Gore – Alexandria – Meharry Medical College 2011/Louisiana State University 2012

David Robert Groy – Leesburg – Temple University 2010/DE Christiana Care Health System 2011

Priya Gupta – Oakton – Tufts University 2010

Amr Habib – Alexandria – NY University of Rochester 2011/ Egypt-Cairo University 2013/ University of Iowa 2014

Samuel Hagos – Herndon – Howard University 2013

Katrina Hernandez-Leveriza – Vienna – University of Pennsylvania 2008/DC Veteran Affairs 2009

Farideh Iravani – Vienna - Tehran University (Iran) 1974/ University of Pennsylvania 1979

Kamaljit Kaur – Haymarket – NYU 2010/NY Interfaith Med. Ctr. 2011

Aileen Chyn Kim – Alexandria – MCV/VCU 2012

Kirsten Lee – Arlington – University of Nevada, Las Vegas 2013/VCU 2014

Steven J. Lowe – Sterling – University of Maryland 2010

Tontra Lowe – Haymarket – Howard University 2005/East Carolina University 2006

Tarek Mogharbel – Arlington – Howard University 2000

Riffat S. Saghir – Fredericksburg – Tufts School of Dental Medicine 2014

Nathan Schoenly – Fairfax – NY State University at Buffalo School of Dental Medicine 2012/2014 (Endodontics)

Mary Speicher – Burke – Temple University 1989

Boris Steinbach – Falls Church – MCV/VCU 1993

Benjamin O. Watkins – Washington, DC - University of Maryland 1995/VCU 1997

David Yoon – Springfield – University of Pennsylvania 2008

Ashkan Yousefi – Fredericksburg – Nova Southeastern University 2011

Fahd Yousaf – McLean – Howard University 2014

Member Awards & Recognition

Dr. David Whiston

While honoring its immediate past president, Dr. David Whiston, the ADA Foundation kicked off a new award in his name, the Dr. David Whiston Leadership Program.

Sarah C. Wilmer, DDS

New Dentist Award
Virginia Dental Association

Heidi Hessler-Allen

Dental Team Member Award
Virginia Dental Association

Linda Gilliam

Honorary Membership
Virginia Dental Association

Edward J. Weisberg, DDS

Leadership Award
Virginia Dental Association

Gus C. Vlahos, DDS

Leadership Award
Virginia Dental Association

Kirk Norbo, DDS

Leadership Award
Virginia Dental Association

Michael A. Abbott, DDS

Leadership Award
Virginia Dental Association

Neil J. Small, DDS

Leadership Award
Virginia Dental Association

Send your "Awards & Recognition" submissions for publication in the *Virginia Dental Journal* to Shannon Jacobs, VDA Director of Communications Email: jacobs@vadental.org

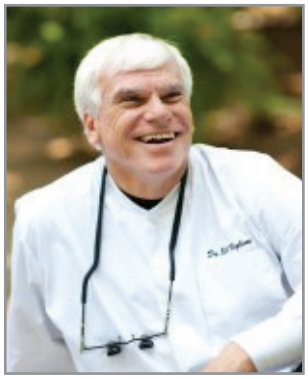
Member Awards & Recognition

Samuel W. Galstan, DDS

Leadership Award
Virginia Dental Association

L-R Top Row: Dr. William V. Dougherty, Dr. Paul Olenyn, Dr. Christopher Richardson, Dr. Graham Gardner
L-R Bottom Row: Dr. Bruce Wyman, Dr. Ross Fuller, Dr. William Bennett (Regent), Dr. James Schroeder, Dr. Richard Taliaferro, Dr. Shohreh Sharif

2014 Fellows
International College of Dentists (ICD)



Dr. William J. Viglione

Emanuel W. Michaels Distinguished Dentist Award
Virginia Dental Association

Dr. Richard Taliaferro

Presidential Citation
Virginia Dental Association

Dr. Roger Wood
Presidential Citation
Virginia Dental Association

Dr. William V. Dougherty

Presidential Citation
Virginia Dental Association

Dr. Ronald Tankersley
Presidential Citation
Virginia Dental Association

Dr. Michael Link

Presidential Citation
Virginia Dental Association

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Member Awards & Recognition

Dr. Frank Iuorno

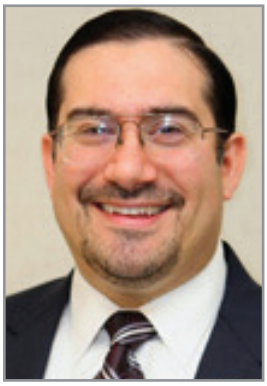
Presidential Citation
Virginia Dental Association

Dr. Bruce Hutchison

Presidential Citation
Virginia Dental Association

Dr. Terry Dickinson

Presidential Citation
Virginia Dental Association

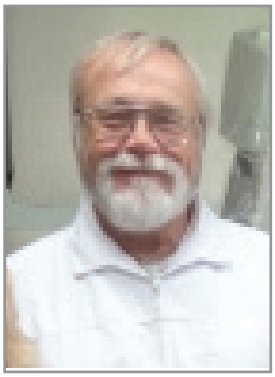


Dr. Anthony Peluso

Presidential Citation
Virginia Dental Association

Dr. Edwin Lee

Presidential Citation
Virginia Dental Association

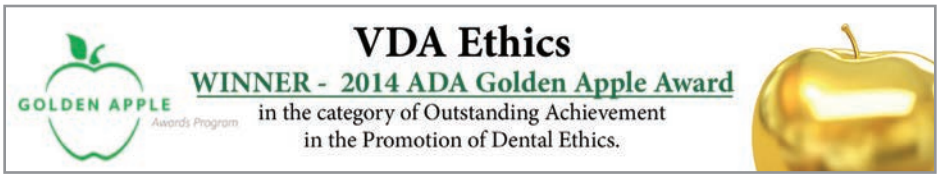


Dr. Roger Palmer

Presidential Citation
Virginia Dental Association

Dr. Bruce DeGinder

Presidential Citation
Virginia Dental Association



While ethics and professional behavior have always been pillars of membership in the Virginia Dental Association (VDA), more recently the Ethics and Judicial Affairs Committee decided to put ethics at the forefront by developing a web-based resource that will be a benefit to all members. The new resource is housed at www.vadental.org/pro/ethics and it includes Ethics in Practice questions, a tool box of resources and an archive of articles written for the *Virginia Dental Journal* by members of the VDA's Ethics Committee.

The VDA has been honored for its efforts in ethics as a recipient of the ADA Golden Apple Award.

We encourage you to take advantage of this award winning resource today.
Go to www.vadental.org/pro/ethics to take a look.

Send your "Awards & Recognition" submissions for publication in the *Virginia Dental Journal* to Shannon Jacobs, VDA Director of Communications Email: jacobs@vadental.org

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Continued from back cover

Dr. Ron Tankersley Retires

By: Catherine Oden Fulton, DDS; Associate Editor, Component 2

what little I've got. As part of this process, I learned to behave like an extrovert. But, like most dentists, I still process information like an introvert."

"Dentistry has been a big part of my life, maybe too big. I don't know. Part of my philosophy of life is that, when I don't get exactly what I want, it often turns out to be a blessing. When the children were small, I started a group practice so I could spend more time with my family. As they got older, Gladys joined me during my professionally-related travels. When we traveled, my interest in photography came into play. I once photographed the various regions we experienced. Now, I now focus on the grandchildren. I am not too concerned about retiring. I've been working just part-time for several years. I have never been one to get anxious about milestones or passages in life. I play the trumpet to unwind at the end of each day."

According to Dr. Tankersley, there are many changes yet to come in the dental field. "Our mission will remain the same: to safely enhance the oral health of the public. Across the country a new generation of dental students is focusing on ethics and professionalism. It is shared values that hold a group together and our behavior is affected by the groups with which we associate. So, the ADA is as important today as it has ever been."

"Upholding the core values of our profession has been vitally important to me," Dr. Tankersley said. "I want to be seen as an oral surgeon who treated my patients fairly, performed well, and was respectful." The standards set by men such as Dr. Ron Tankersley are timeless and worthy of emulation by future generations of dentists.

Dr. Tankersley with his granddaughters in the ADA President's office in Chicago

Playing his trumpet for his oldest granddaughter

Dr. Tankersley with his son Ken, examining a patient

Virginia Dental Journal
Virginia Dental Association
3460 Mayland Ct, Unit 110
Henrico, VA 23233

VISIT US ONLINE AT www.VADENTAL.org/PRO

Dr. Ron Tankersley Retires

By: Catherine Oden Fulton, DDS; Associate Editor, Component 2

Dr. Tankersley as a senior dental student at a health fair

Singer Bob Dylan released his song "The Times They Are a-Changin' " in 1964. The tune became an anthem for a generation facing dramatic social revolution, including the civil rights movement, the Vietnam War and free-spirited resistance to the conventional thinking of the day. Dr. Ronald Tankersley was a pre-dental student at the College of William and Mary preparing to enter the Medical College of Virginia to ultimately receive his training in oral and maxillofacial surgery.

"I believe effective leadership requires remaining objective and helping people to work together."

Fifty years later, Dylan's song is no less relevant to the state of American culture, and Dr. Tankersley would probably agree that it's a pretty good description for what has been happening in the field of dentistry over the last few decades.

Dr. Tankersley was the founding partner in Hampton Roads Oral & Maxillofacial Surgery in Newport News, Virginia. He has also served as an adjunct professor at the Medical College of Virginia. He has provided outstanding leadership in his profession over the years, serving as president of the Peninsula Dental Society, the Virginia Dental Association and the American Dental Association, among other organizations. After recently announcing his plans to retire, Dr. Tankersley reflected on his legacy and the many changes, both negative and positive, he has seen in the dental profession, particularly in the relationship between patients and their dentists.

"When I started in practice, I could do what the patient needed to have done without asking another party for input," he said. "Patients and dentists had far more autonomy than today. Third party payer interference has changed this."

Another significant and on-going change over the years has been the role of technology in patient treatment. "Today's advances in technology have made it so I can do far more procedures than I ever imagined," said Dr. Tankersley. "I enjoy technology." Being able to adapt to changing times has been part of his success.

But advances in hardware and software haven't changed the basic principles by which he delivers service to his patients and his profession. Ethics and professionalism remain the hallmarks of the American Dental Association. "I've been part of the most privileged generation," he said. Our parents were part of the 'Greatest Generation,' which had a strong values system. I believe that one of my more useful skills is understanding people. I try to respect all people and do my best to be objective. Being a dentist is a major part of my identity. Not everyone feels this way. For some, their profession is only a small part of their identity, but not for me."

Dr. Tankersley's commitment to dentistry is evident in his years of service on behalf of the profession. "As ADA president, I was pleased that, after I gave my Health Care Reform report, no one could pinpoint my own personal political persuasion," he said. "I believe effective leadership requires remaining objective and helping people to work together. Each of us sees an issue from our own perspective. I accept and appreciate that fact. I have a 'Type A' personality. I work hard to do the best I can with

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