Virginia Dental Journal

Volume 91, Number 3 • July, August & September 2014

THE Virginia MEETING®

September 17-21, 2014

Southern Charm, Virginia Hospitality

In This Issue:

MEET Delta Dental's Dr. Joseph Dill

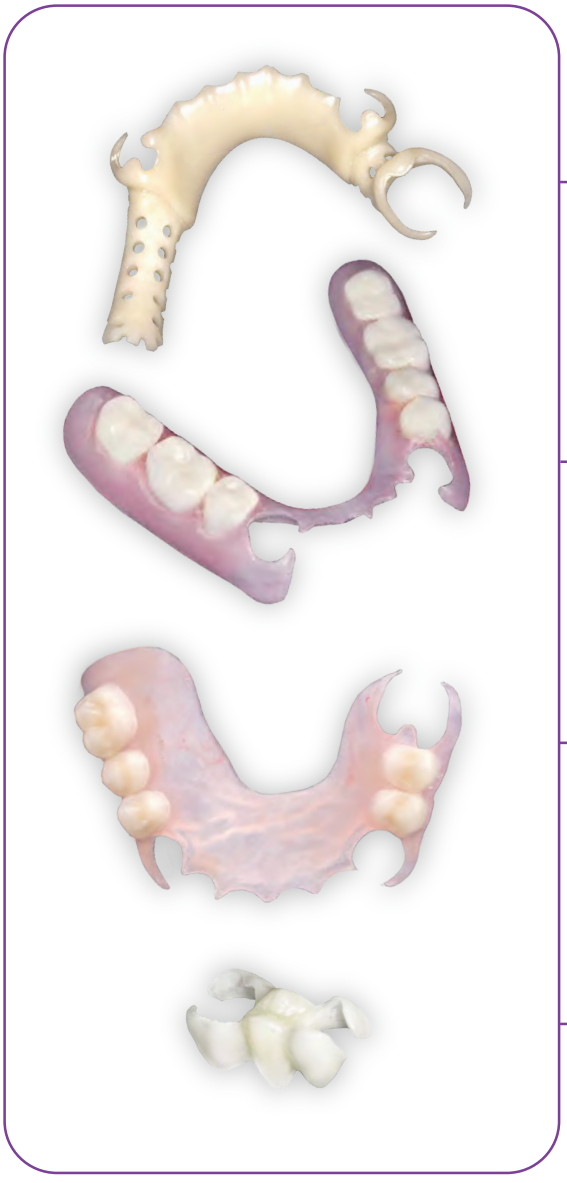
LEARN About the Afghanistan Dental Project

Plus **4 Practice Management Myths Debunked**

www.vadental.org/pro

MEET THE FLEX FAMILY.

Experience the Drake Difference.



Duratek Partial Frame

Valplast Partial

Duraflex Partial

Duratek Implant Provisional

DRAKE LABORATORIES

704 845 2401 , 800 476 2771
8510 Crown Crescent Court
Charlotte, NC 28227
www.drakelab.com

DAMAS Dental Appliance Manufacturers Audit Scheme

Certified Dental Laboratory

Virginia Dental Journal

Contents

April-June 2014 - Vol. 91, NO 2

Columns

14


40

Features


43

Advocacy (17-20)

Scientific (22-26)

Virginia Meeting (28-41)

Outreach (42-43)

University Connections (50-52)

Membership (50-52)

VDA
Virginia Dental Association

Virginia Dental Journal

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

Member Publication
AADE
American Association of Dental Editors

Volume 91, Number 3 • July, August & September 2014

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

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

Second class postage paid at Richmond, Virginia.

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

MANUSCRIPT & COMMUNICATION Editor, 3460 Mayland Ct, Unit 110, Henrico, VA 23233.

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

On The Cover

The Homestead Resort in HDR
By: DreAminginDigiTal -
dreamingindigital.deviantart.com

New on vadental.org/PRO

The VDA is hard at work on new resources to help you with your work/life balance. If you haven't taken a look at the new resource available to VDA Members, now's the time. Simply go to www.vadental.org/pro and **LOGIN**. Once you're in click the **"Resource Center"** tab. 1 Our resources are divided up in three sections Practice, Live and Learn, similar to the ADA Center for Professional Success (success.ada.org). 2 Clicking on the Practice, Live and Learn buttons will provide resources within that category only. You can also narrow down your search by entering a keyword or filter by tag (topics). 3 We are adding new resources all the time so check back frequently. If you have a question that isn't answered by one of our existing resources, simply send in your question. 4

Let us know what you think about our newest addition to the website. Send comments to Shannon Jacobs at jacobs@vadental.org.

GET PAID FASTER!

Sign up for

FREE DIRECT DEPOSIT!

Get your claims payments transferred directly from Delta Dental to your checking or savings account.

Available to all dentists.

"I love Delta Dental's Direct Deposit; it's awesome! It's right there, right now! You get paid within a week. It's easy and simple! It makes my life easier and is one less thing I have to worry about!"

Melinda Marlow
Office Manager
Dr. William Hefele
Ashland, VA

To sign up, call

800.367.3531 EXT. 3328

or visit

DELTADENTALVA.COM/DENTISTS.ASPX

THE DENTAL COVERAGE EXPERTS

DELTA DENTAL®

Brought to you by Delta Dental of Virginia.

Lower Insurance Reimbursement Rates slated for Virginia?

This year your VDA leadership has focused on the storm of changes facing our profession and the immense pressures that these changes put on us as individual practitioners and, collectively, as the Association.

The VDA, with its 2014 Strategic Plan, has set a strong course for helping our members be successful in these turbulent times. So it is within that vein that I would like to discuss what might be the single most disruptive change - lower reimbursement rates. Nothing is more troublesome than doing the same procedure and getting paid less for it, particularly in the face of rising expenses. For many practices, a decrease of 10% in reimbursement rates might translate to a 30% loss of income. Yet, that is what is happening in other states right now. With the mounting evidence of cuts to reimbursement rates by 3rd party payers around the country, we want to educate our members about this disruptive change we are seeing in other states. Having an intimate understanding of your practice and its metrics will prepare you for the decisions necessary if, or when, we see erosion in reimbursement rates in Virginia.

Our investigation on this subject shows the following:

- California: The CDA is currently challenging a potential 8-12% cut for Delta Premier
- Missouri: Delta cut rates on average 7% in 2013
- Washington : Delta cut rates 15% in 2011 – ADA stated Washington Dental Service reduced fees by an average of 15% for dentists participating in the premier network and 5% for those in the PPO network.
- Idaho: Delta cut reimbursement rates an average of 8%
- New Jersey: Delta cuts rates up to 5% in 2013
- Connecticut: Delta cuts rates up to 5% in 2013
- Nationally: United Concordia Companies, Inc. has made revisions to its maximum allowable charges (MAC) which has resulted in an overall decrease in fees.

Based upon the trends we are seeing, what are your options?

- You can always choose to continue to participate. If, and when, there are cuts, dentists might work longer and harder to mitigate the lost income. It is unlikely that 3rd party payers will guarantee that there won't be further cuts in the future.
- You can choose to not participate in a plan that cuts reimbursement rates to the point that the numbers and aggravation simply don't make it worthwhile. In addition to their Contract Analysis Service(free to members through the VDA), the ADA is developing a financial analysis tool that dentists can use to assess the financial impact of signing participating provider agreements. It is anticipated that the tool will be available in September.
- You may think about merging your practice with one or more other practices that you share similarities with. This may provide you the 'economies of scale' and might give you and the group a better ability to negotiate with 3rd party payers. Emerging models of this trend show that Practitioners may still be able to enjoy many of the advantages of their individual practices even after joining a larger group.
- We are following closely an effort by the Arkansas State Dental Association's For Profit arm to form a state wide 'rentable' network made up of Arkansas dentists. This would allow them to 'rent' their network to companies or brokers- just as other networks are rented. This is the first attempt by a dental association to become a competitor, so to speak, with Delta, the Blues, MetLife and United, etc. They are in the very early stages of this process and we will continue to keep a close eye on their progress and how it will affect the market place in Arkansas.
- You may want to create an in-house program for the growing number of patients without a traditional dental benefit plan (and even those who currently have a dental benefit plan but are not happy with it.). For a set fee, those patients might receive a re-care and discounted fees. This is not a dental benefit plan nor is it dental insurance.

We are beginning to see models like these pop up in different parts of the country. Again, we will keep a close eye on these types of plans as they may be an option for you.

For those who want to hear more on the innovative solutions above, be sure to attend the panel discussion at the Homestead ~ **The Changing Face of Dentistry.**

This session will feature three speakers who have decided to chart a new path in terms of how they are responding to the decreasing reimbursement rates. It will be worth the trip, I assure you. The panel will be held on Sunday, September 21, 2014 as part of the Virginia Meeting.

We each need to choose our own course. Some dentists have proactively made changes they feel are necessary to survive the changes we are already seeing. The first key is to educate yourself and learn what your options are, settle on what makes sense for you, and then decide: do you take proactive steps now, or wait until the cuts actually happen.

It is unfortunate for those outside our membership that they do not have the resources and insights available to you through the VDA/ADA. They may not get the heads up, or have the opportunity to be educated, know their options and prepare to thrive in the storm of change. The ravages of the storm are not kind to those who don't prepare. VDA members and the Association will work together to provide a safe harbor, where we advocate and create trusted resources that will help you succeed and build our reputation by virtue of your membership. VDA members are dentists who want to be masters of their own destiny and the VDA is here to be that resource.

Trustee's Corner

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

We had a very productive Board meeting in March. The following is a brief summary of our work. The Strategic Planning Steering Committee has been working for over two years on our new strategic plan. At this BOT meeting we passed the new Members First 2020 plan. It will take effect January 1, 2015. This plan will guide all of our work and will drive our budgets. All of us thank Dr. Israelson and his entire committee for their hard work. On a related note, the Board also approved the creation of a new standing committee to oversee implementation of Members First 2020, demonstrating the Board's commitment to fully implement our new plan.

One of the duties of the BOT is to nominate members of the Council on Scientific Affairs. We had a full slate of candidates this year. After multiple ballots, the Board nominated the following four individuals: Dr. Anita Aminoshariae, Ohio; Dr. Paul Moore, Pennsylvania; Dr. Howard Roberts, Federal Dental Services; and Dr. Lawrence Wolinsky, Texas. The names of these nominees will be submitted to the 2014 House of Delegates.

At this meeting, we again devoted significant time for the Board to engage in an in-depth strategic discussion. We addressed the issue of the optimal role of the ADA within the tripartite. We recognized that we currently play a direct-to-member role and a client service role with the state societies. Presently, our client service role takes up a significant portion of our resources, but that work is probably not sufficiently managed in an intentional way. We do more in reaction to what we are asked to do. During our discussion, we asked ourselves what the ADA should look like in five years. There was general consensus that, while we will continue direct member work, our focus will begin to shift more heavily toward service to our state societies in an intentionally managed way. This conversation will continue and will, I am certain, help shape our future budget decisions.

Another major topic at this meeting was the proposed Membership Growth Plan. Both the Chair and Vice Chair of the Council on Membership were able to join us. The Board was fully briefed about the Council's proposal and had an opportunity for questions and discussion. The Board voted to support the Membership Growth Plan. Based on the recommendation of the Budget and Finance Committee, the Board decided to fund the plan this year at the level of $500,000. This represents a reduction in the original request from the Council and no additional full-time equivalents (FTEs) in 2014. Our action was based on the need to assess the resources currently available to the Division. That assessment will be completed in time for approval of the 2015 budget.

Also related to membership, the Board approved recommendations from the Council on Membership to create three temporary, one-time dues incentive programs. The programs target non-members who have not been active members for at least two years. The purpose of the programs is to attract non-members to join the ADA.

Continuing our pilot program with the Committee on the New Dentist, the CND chair attended our meeting and shared his thoughts on how to maximize the benefits from the relationship between the Board and CND. Our Governance Committee has been asked to look into the Board's relationship with the CND and how to maximize the positive impact of that relationship.

The Board authorized funding to support the Alaska Dental Society during a time of strong need by that Society. The funds will be used to conduct a comprehensive needs assessment on behalf of ADS to help determine what additional needs, if any, exist to protect the viability of that state society.

The Board heard a report from the Diversity Committee. A self-assessment survey has been completed. The committee wants to identify institute graduates who become leaders in Dentistry and to expand monitoring in the states to both follow the institute graduates and identify new potential students.

The report from Mike Graham was positive. He gave several examples on how the Action for Dental Health was having a positive effect in many states and that the Power of Three was energizing both state and local components.

I am also the Liaison to the Council on Membership for this year. This council met two weeks later followed by the Recruitment and Retention Conference.

1. The council discussed the strategy for the Power of Three roll out
2. The Rule of 95 that last year's House of Delegates referred back to council was discussed and the council did not recommend passage
3. Tactics were discussed to include and invite dentists from large group practices into organized dentistry
4. Student debt was discussed and practice choices and opportunities for new graduates.
5. An Aptify update was given and it was stressed how important this is to a unified membership base
6. Newly launched apps were introduced, the roll out of the new ADA website, and the possibility of using apps as a recruitment tool was discussed

The council should be commended for their dedication and hard work. They are performing an excellent job doing the work of our membership and the ADA.

As mentioned, the R and R conference followed the council meeting. This conference allowed the council members to give valuable input to the attendees. We began with a message from Dr. Norman followed by Dr. O'Loughlin. Both stressed the importance of a unified membership at all levels of the tripartite: Local, State and National all working together as one ADA with the member being at the center. Membership was stressed. To really make membership grow we must have an easier way for nonmembers to join, AN EASY BUTTON, so to speak, not an easy task as it would require by-laws changes throughout many components and constituents. This is doable and probably necessary for long term growth and stability of the ADA.

Finally, it needs to be known that the South Carolina Dental Association received three awards at the R and R conference for constituents with membership between 1000 and 2000.

- Greatest Net Gain in Membership
- Greatest Net Gain of New Dentists
- Greatest Percentage of Nonmembers to Membership

Congratulations to the SCDA and especially to Maie Brunson of the SCDA staff who spearheaded the membership drive.

MESSAGE FROM THE EDITOR

Dr. Richard F. Roadcap

Mary Barra made headlines this year when she was chosen as the first female CEO of a US automaker. She also was in the news as she was grilled by members of Congress over defective parts and safety problems in General Motors vehicles. It remains to be seen if her tenure is successful. A recent article in *Forbes* chronicled her rise up the career ladder at GM.[1] One story recalls her assignment as head of the money-losing Hamtramck plant near Detroit. To cut costs, she proposed turning off the Christmas lights in the driveway. The union rep at the meeting spoke up: "You mean we're in such bad shape we can't have Christmas lights?" The lights stayed on.

There's much to fret about in dentistry these days. Student debt; corporate dentistry; healthcare reform; ethical lapses; new dental schools churning out ever-increasing numbers of graduates; third-party hegemony; and declining utilization of dental services by adults are some of the things that go bump in the night. Before we reach for yet another 750mg calcium carbonate tablet, we'd do well to remember how far we've come.

Nowadays, who'd want to be a dentist? According to the American Dental Education Association (ADEA), a lot of folks do.[2] Of the 58 dental schools reporting in 2010, over half (37) reported receiving between 15 and 34 applications per slot. Nationwide, there were 2.4 applicants for every available position in dental school. ADEA says the way to determine demand for a dental education is "to examine the number of applications received for each open slot at a dental school." In the decade ending in 2010, the number of applicants (not applications) rose 55% from year 2000 levels. During that same period US population rose 9.7%, according the Census Bureau.[3] Applicants and their interest may subside due to the increasing cost of a dental education (see above: student debt), but demand for a career in dentistry remains high.

But haven't dental incomes stagnated, and in some cases declined? It's fair to say the income of dentists in the US have shown little or no growth in the past five years.[4] However, the figures provided by the both the US Department of Labor and the ADA show dentists in the top 5% of wage earners. The Bureau of Labor Statistics says the median salary for a dentist in 2012 was $145,240, while the ADA says general dentists made an average of $192,392 in 2011.[5] The latest five-year trend is worrisome. Dr. Marco Vujicic's brilliant research on behalf of the ADA has reported declining adult dental visits, dating back to at least 2005. His findings conclude that only low-income children have increased their utilization of dental care since then, with all other groups showing flat or decreasing demand for dental care. Right now it's hard to predict how the decade ending in 2020 will appear in retrospect.

The public continues to hold the profession in high esteem. Despite the handwringing over the Gallup Poll's Survey of Honesty and Ethical Standards in the Professions, the most recent (2012) survey gave dentistry high marks for being trustworthy, with 62% of respondents rating dentists as "High" or "Very High".[6] It was the second highest score for the dental profession in the history of the survey. In a previous editorial, I pointed out why some professions (i.e., nursing) will always score above us. Our ethical shortcomings cause us to lose respect for one another. But the public's trust mandates us to police our own profession, lest we cede control to others.

Thirty years ago ('84) a cover story in *Forbes* predicted the imminent demise of the dental profession.7 Events since have proved this forecast wrong, as the dental profession has gone on to achieve excellence in practice and the trust of the public. We have much for which to be thankful: high incomes; public trust; and a legacy that begs young adults to follow us. Let's leave the lights shining on the driveway.

1 Muller, Joann. "Power Shift." *Forbes,* June 16, 2014. 64-75.

2 http://www.adea.org/publications/library/ADEAsurveysreports/Pages/ADEASurveyofUSDentalSchoolApplicantsandEnrollees20102011.aspx

3 http://www.census.gov/prod/cen2010/briefs/c2010br-01.pdf

4 http://www.ada.org/en/publications/ada-news/2014-archive/january/dentists-remain-cautious-about-economic-conditions

5 http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0213_1.ashx

6 http://www.gallup.com/poll/1654/Honesty-Ethics-Professions.aspx#2

7 http://www.slate.com/articles/briefing/articles/1999/08/defining_decay_down.html

Guest Editorial:

Membership has its Privileges

By: Dr. Paul Leary, Editor, Suffolk County Dental Society (New York)

Leaving the Washington Leadership Conference, after two days of ADA lobbying our individual Congressional and Senatorial representatives, I found myself riding the MARC train back to Baltimore for a quick commuter flight to Islip. I recognized a passenger who shared the train from Union Station. I have seen this gentleman at many ADA events and he has one of those faces you don't forget. We both got off the train in Baltimore for the Shuttle to BWI and boarding the Shuttle I introduced myself, embarrassed that I had forgotten his name. The awkwardness left when he politely said "I'm Dr. Ron Rhea, dentist from Texas."

"Thank you for approaching me because you have one of those faces that you can't forget but your name escapes me." I asked why he would be going to Baltimore and it was for the same reason as me, Southwest flies directly to his hometown and the commute to his home was much better than the major airports in his area. Our conversation was cordial and I asked where did he call home? If you have ever had the pleasure of working with anyone from Texas, it is hard to deny they are some of the most hospitable people on this planet and Ron was no exception. He said his home was Houston but the city is almost 90 miles across so that is as general as saying your hometown is almost as big as the state of Rhode Island!

Those who know me well understand one of my older brothers is battling pancreatic cancer. The care he has received from the MD Anderson Cancer Center in Houston has been fabulously successful and its reputation is world renowned. I said to Ron that the only association I have with Houston to date is that my brother is being treated at MD Anderson. He frowned, and sheepishly asked, "What type of cancer?" I said pancreatic. He winced and said, "I'm sorry, I'll keep him in my prayers". The shuttle stopped, we cleared our luggage and separated to different parts of the airport to board our connecting flights.

Thirty minutes later I sat in front of my boarding gate typing notes into my laptop and someone was standing in front of me. When I looked up, Ron had crossed the airport because of a delay in his flight, and handed me his business card. He said, "Paul, if your brother has any issues, and you need someone to get to him fast, please call me and I would be happy to get anything you need to him. My trip would be certainly easier than yours!"

This is a story about my experience as a person. About my experience with the people who represent our profession. About why my dues payment could never pay me back a small percentage of the value being a part of this great profession has brought me. Dr. Ron Rhea is a general dentist, past President of the Texas Dental Association, advocate in Washington, and a person who decided it was time to step out of himself and offer a hand to a colleague only because it's the right thing to do. He would be embarrassed to know I am penning this letter yet I will forward it to his association because he alone, that day in May, stepped up the level of our profession higher than he could ever know.
I wish to pay his courtesy forward somehow, somewhere, when a colleague of ours needs me. I thank him for his career choice and feel privileged to be part of a profession where we are both considered members!

Reprinted with permission from the Suffolk County Dental Society (New York)

University at Buffalo
The State University of New York

L-R: Dr. Constance Jin, Dr. Sarah Sciarrino, Dr. Fahd Aljarbou, Dr. Neil Small, Dr. Nathan Schoenly, Dr. Michael Gengo, Dr. Hani Ghabbani, Dr. Khalid Almadi

Dr. Neil Small, member of the VDA Board of Directors, professor at the University at Buffalo School of Dental Medicine, is pictured above with the post graduate endodontic residents after receiving a gift from the international residents from Saudi Arabia.

LETTER TO THE EDITOR

A Specialty on the Move

Marvin E. Pizer, DDS, MS, MA (Ed)

History tends to repeat itself! The history of oral and maxillofacial surgery (OMS) in the US goes back over 200 years when only physicians performed surgery of the mouth and adjacent structures. There were no dental institutions or dental schools even though the need for dental knowledge existed. In the middle and late half of the 1800s Dental Schools made their appearance with formal education leading to a DDS or DMD degree. The faculties in these years were primarily MDs. This explains why the early oral surgeons were dually educated![1] As time passed, oral surgery became a specialty of Dentistry. Following graduation from Dental School and a 2-3 year hospital residency these dentists limited their practice to the surgery of the mouth, face, and jaws (oral surgery). In the middle of the 1970s the name oral surgery was changed to a more descriptive title of oral and maxillofacial surgery.

There are now two post-graduate programs each acceptable by the American Board of Oral and Maxillofacial Surgery. One is a 4-year residency in OMS, leading to a certificate of OMS training and the second program includes the same 4-year residency with the option of two additional years in medicine concluding with a MD degree. The "Commission in Dental Accreditation standards for oral and maxillofacial programs support the dual degree, but only address the dental part of the integrated curriculum"[2]

After 60 years of private practice, research, and teaching OMS in Dental Schools, I definitely am in support of the dual degree program for all future OMSs. As of now (2013-2014) 46% percent of the OMS residents are in the dual degree programs.[3] Both programs are still being utilized which I feel are counter-productive to this specialty. I think the two programs will produce a division in the specialty with jealousy and combativeness between the practitioners.

Even though I lean towards the dual degree program, I would not object to making changes in the present dual degree program. The initial objective would be to obtain a medical degree followed by a one-year residency in general surgery. Upon completion of this residency I would then strive for the dental degree, which should be obtained in two years. You are now the ideal candidate for the 4-year residency program approved by the American Board of Oral and Maxillofacial Surgery and the ADA. This would complete the training with a well-rounded doctor and highly skilled surgeon. The advantages of this approach it would give the residents more time to do oral and maxillofacial surgery. They could bypass many of the medical rotations in the 4-year ADA residency program because these residents had this experience in medical school and the one-year general surgery residency. This resident's background might well be practiced in medical management of OMS patients. This proposed program is not new or unique as it has been in effect in many European countries.

In conclusion, some of the obvious advantages of the dual degree OMS are:

- More patient referrals from dentists and physicians.
- A welcome active member of both medical and dental associations.
- More recognition by the general public
- Fewer problems with Insurance Companies.
- Hospital privileges without questions regarding scope of practice.
- More immunity against aggressive other head and neck specialists in surgery.
- A desirable candidate for a Faculty position in Dental or Medical Schools.
- A highly qualified professional seeking to join a private or group practice.
- The dual degree surgeon may wish to expand the scope of OMS and train in adjacent areas considered medical specialties.
- With this background almost every state would offer this doctor a dental and medical license.

Formerly:
Clinical Professor of Oral and Maxillofacial Surgery, Virginia Commonwealth University

Professor of Research, Adjunct Professor Medical Physiology, Director of Professional Health Program, The American University, Washington, DC

1- Laskin, D.M.; The Past, Present, and Future of Oral and Maxillofacial Surgery. Oral Maxillofac. Surg. 2008; 1037-1040

2- Editor's Note: ADA News, May 4, 2009; Pizer, M.E.: Future OMS?

3 - Communication, Am. Assoc. of Oral and Maxillofacial Surgeons, No of Residents in Dual Degree Programs for 2013-14, March 4,2014.

When it's time to start thinking about tomorrow...

Practice Sales
Practice Appraisals
Transition Consultation

We customize a plan FOR YOU to maximize patient and staff retention, minimize your tax liability, and ensure a smooth and successful transition.
Call us today for a free initial consultation!

Amanda Christy
Regional Representative
a.christy@NPTdental.com
877.365.6786, x230

F: 877.641.0808
www.NPTdental.com
info@NPTdental.com

Trust your dental practice with a brokerage firm that has...

- ***Successfully transitioned hundreds of dental practices over the past decade.***
- ***An impeccable reputation for experience, service & results.***
- ***Achieved its success with unparalleled service & a face-to-face approach.***
- ***A 100% success rate post-closing; we've never had a buyer fail or default.***

Peace Of Mind Knowing Your Practice & Family Are Protected
NPT's Practice Protection Plan (PPP)

In general, following the unexpected death or disability of a dentist, practice value immediately begins to decline approximately 25% per month until a transition occurs. Unfortunately though, it could be weeks before a grieving loved one contacts the appropriate professionals to begin the search; and then additional weeks if not months before a proper transition is completed. By then, the practice could have little to no value remaining.

Contact us for more details or to start protecting your practice & family today!

We may not be the biggest, but we are committed to being the BEST!

An interview with:

Joseph M. Dill, DDS, MBA; Vice President Professional Services, Delta Dental of Virginia

VDA Journal: Other than an employment opportunity with Delta, what lured you to Virginia from the west coast?

Dr. Joseph Dill: Virginia is one of the most beautiful states, especially here in southwest Virginia. It allows me to pursue my hobbies of biking, and hiking. It's good to be close to such a large part of American history. We just don't get that on the West Coast.

VDAJ: If you were a practicing dentist in Virginia at this time and had just signed up to be a provider with Delta's PPO, how would you structure your practice to deal with a reduction in reimbursements?

Dr. Dill: That's a great question and before we delve into specific structural changes one can make, I think it's important to step back a bit and understand why so many employer groups are demanding PPO plan designs. As one might suspect, with ever increasing costs on the medical side, employers are searching for the best ways to maximize their dental benefit dollars. Additionally, they are always very interested in how they can help their employees save on their out of pocket expenses. So, in-network utilization becomes a key measure of those savings and employers are really looking at who has the largest PPO networks in their key locations. And, given that many of the larger employers are self-insured, these network savings become increasingly critical to them.

Now, as far as structuring one's practice, I think we can look at what is happening in the dental market as a whole for clues. We are seeing the same thing that happened in the medical world 20 years ago occurring in the dental space today. We are seeing a pretty significant rise in the percentage of practices that are multi-location and multi-specialty. Additionally, venture capital is supporting the rapid expansion of the corporate-owned or DMSO model practices. It wasn't that long ago that 90% of dentists were practicing solo or sharing an office with one other dentist. Today, that number has declined to around 70%. Fewer of today's dental school graduates see the solo practice model as an option because of the heavy debt burden from school loans that they are carrying.

Efficiency is at the core of all of this. The market is demanding more cost effective dentistry as well as more transparency. One of the best ways for our profession to effectively respond is to look to increase our efficiency and lower the cost of doing business. One way of doing that is to spread overhead amongst a larger group of dentists. Now, I say this as a dentist who owned a small two-dentist practice in the 80's and 90's; but if you look at that solo model objectively, it isn't the most cost effective way to deliver care. For example, having two solo practices next door to each other that each has a receptionist, insurance coordinator, office manager, three assistants, practice management system, and so on is rather inefficient and full of redundancy. Having those practices share personnel, facility costs and supplies, saves a lot on overhead. Also, as practices grow in size, their bargaining power on prices for supplies and lab costs increases. I'm not pretending to have all the answers but I do think we, as a profession, have an opportunity to respond to these challenges in a way that allows us to shape our own future instead of someone else deciding for us.

VDAJ: How would being a Delta PPO provider be beneficial to a Virginia dentist?

Dr. Dill: Employers are actively encouraging their employees to seek care at PPO offices for the reasons noted previously. So joining the PPO directs more patients to your office. Obviously, the tradeoff is lower fees. What I always tell my colleagues who ask; "busyness" is the key. If you have empty chair time on a fairly regular basis, or your practice is so mature that most of your existing patients are on a maintenance schedule, or you are looking to expand or bring on a new associate dentist, then joining the PPO is a positive way to address those issues. I believe that having a discounted patient in the chair is better than no patient at all. A lot of your overhead is fixed costs that continue to accrue even if there is no patient in the chair. On the other hand, if you are booked for weeks/months in advance (and I'm not talking about the hygiene schedule) and you have not seen patients leave your practice to go to your colleagues who have already joined the PPO, then it probably doesn't make sense for you.

VDAJ: Is Delta phasing out the Premier Plan and if so, why?

Dr. Dill: That question really gets to a common misconception around what is and what is not within Delta Dental's control. We still actively promote our Premier Plans; however, it's the marketplace that is not as interested in the Premier products anymore. As I mentioned before, the market wants PPO products. The overall breakdown of dental insurance is about 70% PPO with the rest being split among indemnity (in which Premier is counted), DHMO and discount plans. The indemnity market has simply seen an enormous decline over the last 20 years because it is more expensive than PPO products. The marketplace determines what is selling, not Delta Dental.

VDAJ: If Delta doesn't sign up a large enough PPO network to fulfill its contractual agreements, will the company alter its business plan? If so, how?

Dr. Dill: This is an interesting question. It was about a year ago that I read an opinion piece from a practice sales broker who claimed that Delta Dental was promoting its PPO network to doctors because we had "oversold" the product. The entire notion that one can "oversell" the product or not meet one's contractual obligations is an erroneous premise. As I mentioned, employers look at the size of the PPO network as one of the numerous deciding factors for which dental carrier to select. We simply wouldn't be the largest dental carrier in Virginia if our network was somehow inadequate to meet our obligations.

VDAJ: What other insurance companies does Delta view as its biggest competitors?

Dr. Dill: Our competitors really differ in varying market sizes, group size, type of employment (part-time/full-time) and type of benefits (voluntary or compulsory). So on a given day, any one or two of the top 20 carriers could fit that description.

But what I will say is this; we see a lot of dentists joining competitors' PPO networks but who are only willing to join our Premier network. This short term thinking that Delta's Premier fees will subsidize the discounts that they are taking with the other carriers will simply drive more business to those carriers that can pay the same dentists a lower fee than they accept from Delta Dental. Those higher fees they get from Delta will be a smaller and smaller piece of their revenue because their actions are leading employers to the carriers from whom those dentists are accepting the lower fees. Delta Dental doesn't have the power to charge the market more for a

AFTCO

TRANSITION CONSULTANTS

WWW.AFTCO.NET

Helping dentists buy & sell practices for over 40 years.

AFTCO is the oldest and largest dental practice transition consulting firm in the United States. AFTCO assists dentists with associateships, purchasing and selling of practices, and retirement plans. We are there to serve you through all stages of your career.

Michael J. Covaney, D.D.S. &
Sharon Covaney, D.D.S.
have acquired the practice of
Michael E. Sagman, D.D.S.
Newport News, Virginia

Bradley D. Wiltbank, D.M.D.
has acquired the practice of
John T. Dewinkler, D.D.S.
McLean, Virginia

Christine F. Stang, D.D.S.
has acquired the practice of
Frederick N. Dibbs, D.D.S.
Reston, Virginia

AFTCO is pleased to have represented all parties in these transitions.

Call 1-800-232-3826 today for a free practice appraisal, a $5,000 value!

product that competitors can offer at a lower rate.

VDAJ: Is Delta planning to offer capitation plans?

Dr. Dill: We already offer the DeltaCare product, which is a DHMO and have done so since the mid-nineties. It's not a product for everyone but it:

- Offers employers a cost effective plan option
- Many employers demand that kind of product
- From the employee's perspective - No annual maximums and
- Predictable costs with set copayments

We offer this plan as an overall part of our total product offering. Again, it's the purchaser and the marketplace that determines what needs to be offered and what type of plans are purchased.

VDAJ: How can dentists who participate in PPOs and other reduced reimbursement plans provide quality dental care to their patients?

Dr. Dill: I think the only way to answer that is exactly the same way you currently offer quality care to every one of your patients. I've yet to meet a dentist who says they treat insured patients differently than their cash paying patients. I think we as dentists sometimes get caught in a way of thinking that how much we pay for lab costs and the use of high noble metal is what makes for "quality dentistry." I would suggest that the right lab tech is important, but quality involves far more than the margins of a crown. Quality involves every aspect of the patient experience and includes an effective recall system, ensuring kids are receiving sealants, at-risk adults receive needed periodontal care and the list goes on. Quality doesn't always cost more money and we get back to running a practice efficiently. The market has a limit on what it will spend on dentistry. Trust me, I know that dentists' costs are going up year after year, but the purchasers are not going to endlessly accept increases in their costs as a result of higher dentist fees.

VDAJ: Would Delta like to see midlevel providers become members of the dental care delivery model and if so, how would their reimbursements compare with dentists?

Dr. Dill: I'm not aware of any position we have or would proactively take on midlevel providers. I think that is a decision best left to the profession and guided by organized dentistry. I don't think I could answer the fee question since it is a hypothetical and would really depend on how any enabling legislation might be written. I suppose the issue of direct, general or no dentist supervision would play into the calculation but beyond that, I really couldn't say.

VDAJ: How will healthcare reform (ACA) alter the dental benefit plans you offer?

Dr. Dill: First, let me preface anything I say here with the knowledge that I am in no way an expert on the ACA. Given that the rules are constantly changing, it's a challenge for anyone to keep up. I think the simplest answer to this is that healthcare reform does not impose requirements on standalone dental plans like it does on the medical side and we will continue to offer the same kinds of plans that were offered before the ACA became law. The ACA does impact the types of health plans that can be sold in the individual and small group markets. Health plans sold to individuals and to groups with 50 or fewer employees must contain Essential Health Benefits, one of which is pediatric dental benefits. However, in Virginia, beginning 1/1/2015, as long as there is a standalone dental plan containing the essential pediatric dental benefits available for purchase, health carriers are not required to include pediatric dental benefits as part of the individual or small group health plan. In 2014 and 2015, Delta Dental, and presumably other dental carriers, will be offering "Exchange Certified Pediatric Dental Plans" containing the essential health pediatric dental benefits for those small groups that desire them. We anticipate that most groups will continue to choose one of our existing small group plan options.

VDAJ: Why does Delta, or any other carrier, care what dentists charge for services, such as tooth whitening and cosmetic dentistry, that will never be part of a dental benefits plan?

Dr. Dill: I would suggest that it is the purchasers of dental plans that care. As I mentioned previously, employers not only care about their bottom line, they are actively looking for cost savings for their employees. All carriers have tried to respond to these demands. Network participation is always a two-way street. There are benefits to being a participating network dentist and there are trade-offs for those benefits through the acceptance of a fee schedule. And by the way, there are some groups that do cover bleaching and some cosmetic procedures so, never say never.

VDAJ: How prevalent, in your opinion, is dental insurance fraud?

Dr. Dill: Great question and I always tell my fellow dentists, it's a bigger problem than you probably think. First of all, it's important to understand that "fraud" is a bit of a charged word and there are issues we deal with that might technically be categorized as fraud but we try to stay away from that term except under the most extreme cases. In cases where we see a clear intent to defraud and on a large scale, we work collaboratively with our contacts at the FBI and Dental Board to address those. I wouldn't say that is a very large part of what we do. Most of the time, we are dealing with more contractual type violations and questionable billing practices that need to be addressed and we would rather deal with those directly with the dentist to correct the issues.

If we remove the word "fraud" from the conversation and look at the range of what we see, it includes billing for services not rendered, using clearly erroneous codes to receive benefits that would not have otherwise been covered, upcoding, unbundling, altering dates of service to circumvent frequency limitations, not submitting a claim for services that are known to be considered included in the fee for a billed procedure and not collecting patient copayments. Again, most of these are technically fraud but we really look at the magnitude of the problem and the intent of the dentist. Intent is really critical because it can range from an innocent misunderstanding to a calculated scheme. I think there are of number of dentists and office staff that think they are doing the patient a favor by misrepresenting a treatment in order to get more money from the insurance company. The one thing I would really like to stress to your members; just bill for the treatment you provide and resist the temptation to play games. It's just not worth losing your license to get a few extra bucks for a patient.

But it's not just fraud or billing irregularities that we should all be concerned about. We also see a problem in what would be termed "dental abuse." This is the systematic overtreatment of patients and I believe this is just as big a problem for our profession as is fraud. We see it all the time where every patient that walks through the door gets four bitewings and two PAs every six months regardless of their risk status, practices where all of their patients get occlusal restorations on virtually all of their posterior teeth. By the way, in those practices, the restorations are never just an occlusal, they are all OLBs. Crowns on asymptomatic teeth that have nothing more than an enamel craze line. Unnecessary endo. The list goes on and on and the outside world is really starting to take notice. Dentistry has always been regarded in the highest esteem, but this problem is adversely affecting all of our reputations.

Fortunately, we have an incredibly sophisticated Fraud and Abuse system, MAARS (Metric and Analytic Research System) that easily finds these statistical outliers. When we find them, we have several steps we can take to determine whether the pattern is truly a problem or there is a perfectly logical explanation for the statistical variance and then what intervention, if any, is necessary.

VDAJ: What is Delta's current policy regarding date of service, and have dentists been notified of any change?

Dr. Dill: The policy has always been that the correct date of service for a multistage procedure is the completion or delivery date and that has just not changed. Now, one of my goals in leading the claims review area is to look at ways we can simplify and streamline the process for dentists and their staff. To this very issue, we used to spend a lot of time and resources policing the seat date on crowns. We were doing this to the point where we were keeping track of which dentists had a Cerec or other type of CAD/CAM system. We would send

DILL (Continued on page 48)

Afghanistan Dental Relief Project

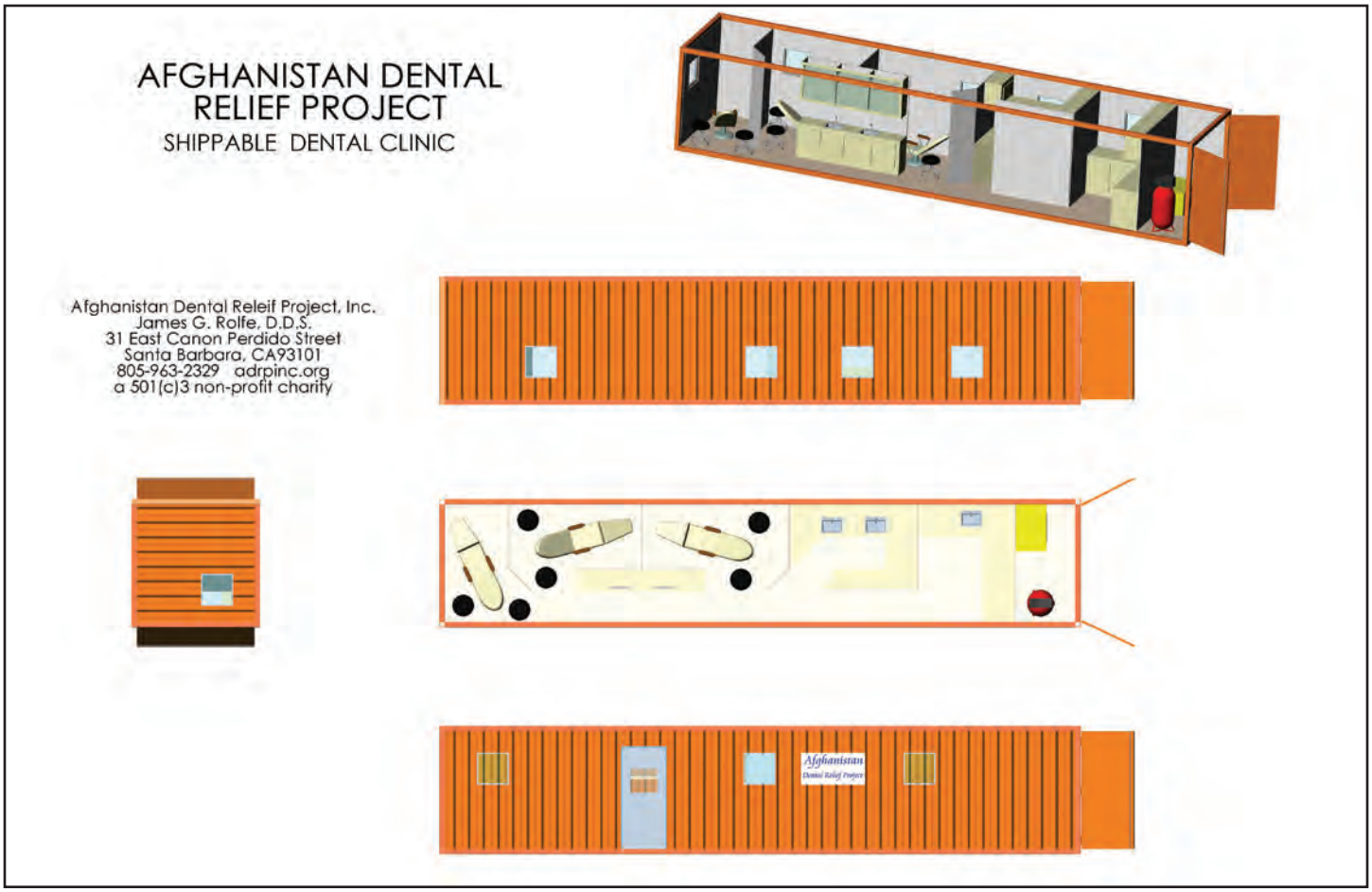
By: James G. Rolfe, DDS

Hello, fellow dental colleagues, and greetings from Afghanistan. For eleven years, I have been working as a dentist and humanitarian in Afghanistan. I started just after the Taliban were expelled from the government, in 2003. Afghanistan's technical and economic infrastructure were destroyed by the invasion of Afghanistan by the Soviet Union in 1979, when almost all of the businessmen, educators, scientists, manufacturers, doctors, investors, and dentists left the country to save their lives.

They never went back, leaving Afghanistan with only workers and poor people. This is basically the way it still is, a nation incapable of sustaining itself independently. For Afghanistan to recover, its infrastructure needs to be rebuilt. There are a little over 100 dentists in Afghanistan to serve a population of over 34 million, or one dentist for 250,000 patients. Most Afghans live in rural areas, while most dentists practice in urban areas. In Afghanistan ninety percent of the population cannot access a dentist in their area. As a result, dentally-induced septicemia is common, and a significant factor in the high mortality rate.

I personally saw that the military approach was not going to aid the poor people, so I planned a trip there to help out. Putting together a flyable dental clinic, I went from sea-level California to 11,000-feet Wardak Province in the Hindu Kush, where I provided treatment for about 40 orphan boys for two weeks, and the local population for the next week. I did not speak the Pashto language, but they were very interested in what I was doing, so I had each one assist me for one treatment, and I was amazed by each boy's aptitude for the task. Seeing them in that remote place without promise of a future, without shoes, abandoned, impressed me deeply. I learned that there are over three million orphans in Afghanistan.

After the two weeks passed, I began to see people from the local village for dental problems, and observed that many of them were on the verge of death, with seven or eight chronically abscessed teeth. I inquired how this condition could occur chronically, and was told that there was no dental care available in the entire province (with the exception of the local barber, without anesthetic or any sterility). Seeing the need of the Afghan people, the enthusiasm of the orphan boys coupled with their aptitude for dental work, I returned to California and constructed a modern dental clinic in a shipping container, sent it to Afghanistan filled with supplies, hired dentists and staff, and opened a free clinic for poor Afghans which provided basic dental care. A school was started at the same time, training orphans, widows, handicapped, disadvantaged young adults, and socially-disadvantaged class of Hazara to be students at no cost to study dental assisting, dental lab technology, and to be a dental hygienist. Students with the highest aptitudes were hired to work in the clinic, which now has twelve



employees and has treated over 100,000 patients since its inception. All this was done at no cost to the patient. In addition, the Kabul School of Dental Technology has graduated many classes of dental assistants, lab technicians, and hygienists, all of them the first professionally-trained dental technicians in Afghanistan.

The Afghanistan Dental Relief Project, Inc. is working to restore the missing dental infrastructure in Afghanistan. Using the existing dentists to their full potential is an essential part of our plan. We can provide trained technicians to assist Afghan dentists to treat more patients more safely and better. To do that, we are taking our project to a new level now.

We have obtained permission from the Afghanistan Ministry of Public Health to self-fund our project. We are now allowed to provide certain non-basic, more complex services to Afghans for a fee, such as endodontic treatment or prosthetic restorations. This fee can be used to provide free care to poor Afghans. In addition, we can provide treatment for non-Afghans for the fee that they would pay in Dubai, UAE. Building this clinic will allow us to not only provide more free care, but also to expand the project. Only sixteen treatments of non-Afghans will pay for all the monthly expenses of the project. So we are building a new clinic to provide this treatment. It will be the stellar dental facility in Kabul, and its existence will guarantee vital funding for our program to help rebuild the dental infrastructure in Afghanistan.

We can do this simply, by building another shipping container clinic, only larger and more modern, or we can build a permanent structure. We have the land now, given to us by the Kabul Government at no cost. We have completely developed the land with utilities, and our free clinic is now on that land, providing the so-vital free services.

We have, ready to ship, two modern operatories of Chinese top-of-the-line equipment, as well as thirty tons of new and used dental equipment and supplies, valued at over $2 Million. Included in this shipment are five new x-ray machines, a complete removable metal lab, programmable porcelain oven and two porcelain kits, denture processors, implant kits, and about five years' worth of dental and lab supplies.

Being involved with this project is a lot of fun for me, and quite an adventure. You can imagine some of the challenges that you would have to deal with, to do this. I cannot think of a more-rewarding experience, however, one that has certainly changed my life. You might find some interest and satisfaction working with us to achieve our goals. We need to raise some money to build the new clinic, ship the equipment and supplies, and train the Afghan dentists to do modern high-tech procedures. Would you like to be a part of it? We really need some financial help, whatever you can spare. If you can help us a lot, we can even put your name on the clinic. Want to teach? We will be having dental practitioners of all persuasions coming as guests to teach and to provide treatment. Dr. Martin Kim, a periodontist from Canada, recently volunteered for two weeks, teaching grafting techniques and flap designs. He said he had a great time and wants to go back soon. How about being a part of this exciting and meaningful project by considering what you can do, and let me know at email adrp@verizon.net? You can contact me by telephone at 805-963-2329. Please access the Website at www.adrpinc.org, which has a PayPal donation site for your convenience. Don't hesitate to contact me personally for any reason.

Thank you for your consideration, and I look forward to working with you soon.

Afghanistan Dental Relief Project, Inc.
A 501C3 Non-Profit Charitable Corporation
31 East Canon Perdido Street
Santa Barbara, CA 93101
adrp@verizon.net
www.adrpinc.org
805-963-2329

VDA Advertising and Public Relations Campaign

A Year in Review

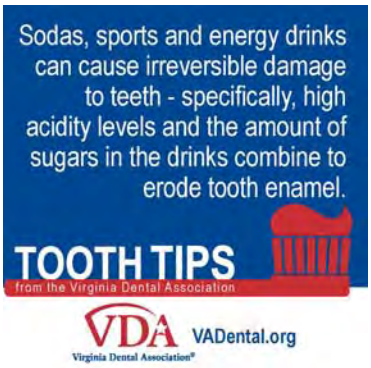
The VDA launched its first ever statewide advertising and public relations campaign in May 2013. As the program is now a year old, it is a good time to reflect on the progress and success we have had as a result of this new campaign. Thank you all for your support on this innovative and exciting new campaign aimed to enhance member value, provide education to the public about oral health and to establish the VDA as the place in Virginia for information on dentistry and to find a dental provider.

— Dr. Mike Link, Chair, VDA PR Task Force

SOCIAL MEDIA

FACEBOOK— Posts include Tooth Tips every Tuesday and a VDA Member photo each Wednesday. Since the launch of the campaign Likes of the page have jumped from 240 to 556!

YOUTUBE— The commercial has been viewed by 1137 unique viewers.



TWITTER — Followers have gone from 191 before the campaign to 656!

COMMERCIALS

7 Media Markets

40+ Million Impressions

20,228 Spots

The "Want a Healthy Body? Start with a Healthy Mouth" ads have been running statewide. Ads were on air May-June 2013, September-October 2013 and in April 2014. The ads relate the importance of oral health as part of overall health.

PUBLIC RELATIONS

In addition to paid advertisements, the campaign has included a comprehensive public relations campaign. Oral health topics like facial protection month, keeping oral health in mind at Halloween and important role that dentists play in overall health have been covered.

Eight VDA members have been interviewed on TV and stories have appeared nine times in print.

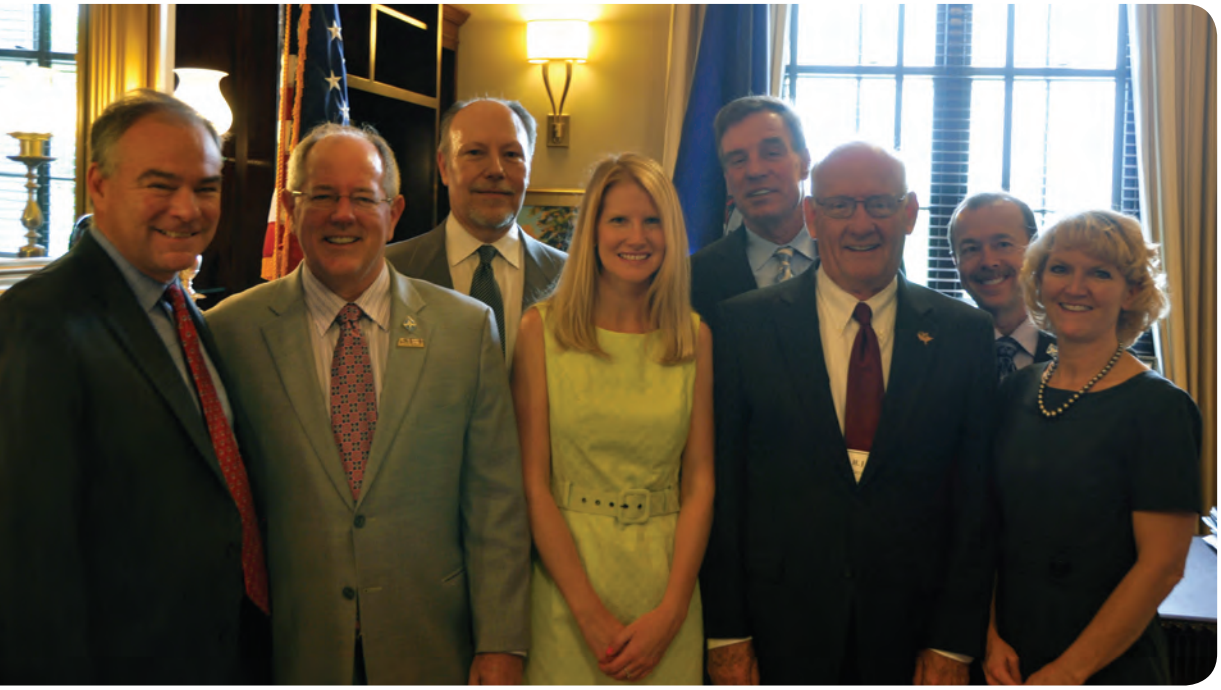
WEBSITE

Information about the campaign has been added to the public side of the VDA's website. Also, a large-scale Search Engine Marketing (SEM) campaign has been done with the advertisements to encourage the public to visit vadental.org to find a member dentist for their dental care. The results have been impressive. Prior to the campaign, on average 202 people visited the website's Find a Dentist feature monthly. The average is now 3,327 pageviews on Find a Dentist per month with higher averages when the ads are on television.

Speak with One Voice United: Save Your Profession and Your Future,

Washington Leadership Conference Meets May 19-21, 2014

By: Dr. Bruce Hutchison; Chair, Virginia Dental Political Action Committee; Board of Directors, ADPAC



L-R: Senator Tim Kaine, Dr. Bruce Hutchison, Dr. Ted Sherwin, Ms. Laura Givens, Senator Mark Warner, Dr. H.J. Barrett, Dr. Ralph Howell and Dr. Elizabeth Reynolds

Are you concerned about the economic downturn, health care reform, the overspending by Congress, and the apparent disconnect between political leaders and the American people? Have you wondered if Congressmen are listening and if they really understand the problems you are now facing on a daily basis? No matter how you feel about them, you can't afford to write them off as a lost cause. Your congressmen--whether you like them or not--have the power to dramatically change how you will practice dentistry. When they consider legislation they often fail to realize the unfortunate consequences of their actions unless someone steps in to educate them.

Fortunately your colleagues--volunteer dentists in conjunction with the American Dental Association's expert team of professional lobbyists--have stepped in to do just that. More than 500 dentists, and members of the Alliance of the American Dental Association from every state in the union--came together on May 19-21 in Washington DC to participate in the Washington Leadership Conference. The Conference is hosted by your voice in Congress—the American Dental Political Action Committee (ADPAC)-- under the direction of Dr. Ken McDougall along with the ADA Council on Government Affairs chaired by Dr. Carmine LoMonaco. The opportunity to personally make a difference for the future of our profession is what distinguishes this conference from all others. It is an exhilarating and rewarding experience to participate in the democratic process. Never forget that this privilege is not possible in most of the world's countries.

The annual conference prepared volunteers on the current issues in Congress and provided insight on how to navigate the political landscape. Featured workshops included:

- **How to Effectively Meet with Your Member of Congress:** ADA Consultant Judy Sherman and Emily Porter, Vice President, the Nickles Group, covered the do's and don'ts of meeting with a congressmen or a congressional staff member. The ADA also provided toolkits, issue sheets, and updates for conference attendees.
- **Grassroots Activism Training:** ADPAC Grassroots Committee Chair Dr. Bruce Hutchison, along with ADPAC Grassroots manager Nick DeSarno, and grassroots activists Dr. Gary Oyster (NC), Dr. Mark Derosiers (CT) and Dr. Zacharias Kalarickal (FL) provided clear examples of how to influence members of Congress through grassroots activism.
- **Advocacy through the Power of Three** (Using the tripartite system to advance advocacy): Michael Graham, ADA Senior Vice President; David Owsiany, Executive Director of the Ohio Dental Association; Vaughn Collins, Executive Director of the Vermont Dental Society demonstrated how shared information enables state and local associations to make use of previous experiences to successfully fight harmful legislation.
- **Issue Review:** This year's issues were covered in depth by members of the Council on Government Affairs, including New York's Dr. Michael Breault.

The keynote speaker for the event was Dana Perino, former White House Press Secretary and Political Commentator and Co-Host of Fox's The Five. She provided insight into the current political landscape and relayed stories about her experience with the nation's chief executives. Following her keynote, ADPAC hosted a Diamond Club Cocktail Reception in her honor.

Conference attendees also received insight from our two dentists in Congress: Representative Dr. Paul Gosar (AZ) and Representative Dr. Mike Simpson (ID). They also heard from Representative Peter Roskam (IL), Senator Ben Cardin (MD), and Representative Robin Kelly (IL).

After the intense preparation, teams of dentists invaded Capitol Hill under the direction of Action Team Leaders (ATLs) to take dentistry's message directly to each member of Congress. The VDA was represented by Drs. David Anderson, H.J. Barrett, Mark Crabtree, Ralph Howell, Bruce Hutchison, Rod Klima, Elizabeth Reynolds, Ted Sherwin, Ron Tankersley, Mrs. Tammy Howell, Mrs. Gladys Tankersley, and Ms. Laura Givens (VDA's Director of Legislative Affairs). When these teams came calling with a unified chorus of testimony from all areas of dental practice, legislators took notice and the congressional visits were publicized all over the political press on Capitol Hill. One message congressmen received was loud and clear: Dentistry is committed to advancing the level of care and access to care for the public. The Action for Dental Health 2014 Report to Congress that was distributed to them outlines how dentists are making a difference to provide care to people who suffer from untreated dental disease, to strengthen and expand the public/private safety net and to

bring disease prevention and education into the communities.

ADA Senior Vice President Mike Graham remarked that a great deal of planning had been previously accomplished by ADA staff and ADPAC Board members to choose the best issues for advocacy this year and to prepare Congressmen for the ADA's positions on those issues. The issues that were chosen for this year's conference were the ones likely to be voted this year with a realistic chance of passage and the ones that will prepare congressmen for future debates. This year's reality, Mr. Graham explained, is that very little can be accomplished by Congress before the November elections because of the political landscape.

The grassroots action team delivered testimony loud and clear on these issues:

1. Student Loan Debt Relief Student indebtedness from educational loans has risen dramatically over the past ten years; increasing by 68% for private institutions and by 104% for public institutions. The average student loan debt for graduating seniors now stands at $250,000. This debt severely impacts postgraduate career planning and may ultimately affect how recent graduates support their profession. At a time when new dentists need to focus on building knowledge and skills, many are forced to make career decisions based on student loan repayment. These decisions have the power to influence how they feel about their chosen profession and whether they choose to support it.

   a. Federal Student Loan Refinancing Act, S. 1066 (Sponsored by Senator Kirsten Gillibrand, D-NY): S. 1066 eases the burden of dental student loan debt by enabling dental school graduates to consolidate or refinance their Direct Unsubsidized Stafford Loans (and/or Federal Direct Consolidation Loans) at a fixed rate of 4.0 percent. The bill retroactively applies to these loans created after July 1, 2006.

   b. Student Loan Interest Deduction Act H.R. 1527 (introduced on April 12th, 2013 by Representative Charles Rangel D NY-13). This bill eases student loan debt by increasing the deduction allowed for student loan interest for all individuals regardless of income. H.R. 1527 increases the deduction ceiling from $2500 to $5000 for individuals and $10,000 for those filing joint returns. It also removes the ceiling of deduction after the individual reaches a $60,000 yearly income.

2. **Medicaid Recovery Audit Contractor Review.** Congressmen are being asked to sign a "Dear Colleague" letter written by one of our two dentists in Congress: Dr. Paul Gosar (AZ-4). The letter requests that the Centers for Medicare and Medicaid Services (CMS) issue guidance to the states concerning the Medicaid Recovery Audit Contractor (RAC) review process to ensure that it is transparent and fair. The current process is arbitrary and unfair, levying hefty fines for innocent mistakes. As the letter points out "Ensuring participating providers are educated about the demands and requirements of participation (beyond a notification that the Medicaid provider manual has been updated) would go a long way in helping increase awareness of all providers. With enrollment numbers increasing on a regular basis, now is the time to make changes to the Medicaid RAC audit process to ensure adequate numbers of providers are available to serve this underserved population."
3. **Action for Dental Health Act 2014 (H. R. 4395)** This bill funds two $10 million grant programs annually for a period of five years:
   a. Volunteer Support: An annual grant to qualified state and local organizations offering free dental services for the underserved. This grant would help fund programs like Give Kids a Smile® and Missions of Mercy that allow dentists to provide direct care on a volunteer basis. These programs provide an estimated $2.6 Billion worth of free care to those in need.
   b. Support for Action for Dental Health Initiatives: A grant designed to deliver care and dental health education now to people who have fallen through the safety net of existing programs. This grant would reduce the number of people who visit the emergency room for a dental problem, expand access to care for the elderly in nursing homes, allow private practitioners to contract with Federally Qualified Health Centers, fight for increased access to Medicaid, and strengthen collaboration with Community Dental Health Coordinators and other health practitioners and organizations.

Virginia dentists have historically contributed to VADPAC very generously. We understand the importance of being politically active and having our interests represented in our state and federal legislatures. What they do in Richmond and in Washington, DC affects us and the way we practice dentistry every day. Elections are becoming increasingly more costly- it isn't enough to do what we have done anymore- we need your help more than ever. Others are not letting up. We will be challenged from every angle. Dentistry needs your help more than ever in these trying times. Here's what you can do:

1. **Contribute to ADPAC:** Congressmen understand two things—money and votes. The money is important to help them run their re-election campaigns. An opportunity to further relationships with a member of Congress can be afforded because of ADPAC donations. Money doesn't buy Congressional votes, but it does buy the right to be heard. Dr. Hutchison pointed out that as a result of Citizens United vs. the FEC, unlimited amounts of money can now be spent on federal election campaigns and recent electoral cycles have become more contentious and more expensive. On average, $1.6 million was required to secure a House seat in 2012. In 2012, winning Senate candidates required over $10.3 million. The club level giving programs have become more important because the $50 ADPAC dues money is no longer enough. ADPAC—Dentistry's national political action committee--needs every dollar it can get just to make our voice heard. If you want to do the best by the profession that has stood by you, join the ADA's Capitol Club. There is no better money you could spend to ensure for yourself a bright future.

Basic VADPAC (includes $50 to ADPAC)	$100
Commonwealth Club (includes ADPAC Capital Club)	$285
Governors Club (includes ADPAC Capital Club)	$685
Appollonia Club (includes ADPAC Capital Club)	$1,010
ADPAC Capitol Club (included in VADPAC Club memberships)	
ADPAC Capitol Elite	additional $250
ADPAC Diamond Club	additional $750

VADPAC and ADPAC have payment plans for those who wish to pay installments.

Contribute online on ADPAC's advocacy site at www.ada.org/ADPAC or Mail Contribution to ADPAC, 1111 14th Street, NW Ste 1100, Washington, DC 20005) Question? Call 202-898-2424 or send email to ADPAC Director Sarah Milligan at milligans@ada.org.

2. Join the ADA's Grassroots Team: The concerted effort of thousands of dentists speaking to the same side of an issue speaks volumes when the vote comes down. Your voice will make our "roar" deafening. Being a member of the team is not time-consuming, since most correspondence is done by E-mail. Contrary to skeptical opinion, e-mails are seen by congressmen and they are effective. Whenever a critical issue is due for a vote, the ADA's Washington Office issues an e-mail action alert. More than 36,000 dentists already receive this action alert. Special software (ENGAGE, formerly CAPWIZ) provides participants with all the necessary information and talking points. The software also sets up the E-mail response letter and automatically sends it to the appropriate senators and representatives. To sign up, visit the legislative action center on www.ada.org/ENGAGE.

3. Contribute to our Dentists in Congress. There's no better way to make a difference in Washington than to elect dentists to Congress. Imagine having legislators on the inside who really know what you face every day! Our two dentists in Congress have authored numerous pieces of legislation on behalf of the ADA. While ADPAC does a great deal to help dentists running for Congress, you can help ensure their successful election bids by contributing directly to your colleagues.

   a. Paul Gosar (AZ) [www.gosarforcongress.com] Dr. Gosar is serving his second term in Congress. Prior to running for Congress he chaired the ADA Council on Government Affairs. He serves on the House's Natural Resource Committee and on its Oversight and Government Reform Committee.

   b. Mike Simpson (R-ID); [www.simpsonforcongress.com] Dr. Simpson is currently serving his 8th term in Congress. He serves on the powerful House Committee on Appropriations.

   c. Brian Babin (Candidate in the 36th District, Texas) [www.babinforcongress.com] Dr. Babin is the former mayor of Woodville, Texas and has practiced dentistry since 1979. He has served in the United States Air Force, the Army reserve and the Texas Army National Guard. Dr. Babin recently won his primary election and will be the Republican candidate for this congressional district.

Note that all three have won their primaries and are in very Republican districts. Unless something strange happens- we will likely have three dentists representing us in Congress! That is amazing!

4. **Go to Campaign School.** Of the 535 members of Congress, more than 215 are attorneys. There are 13 physicians and only 2 dentists. Our profession could certainly use more representation—not just at the national level, but at state and local levels as well. Running for a local election is a great way to meet people who might wind up being patients in your practice! ADPAC's Campaign School is there to help any member who is seeking public office. It certainly worked for Dr. Paul Gosar, and he'll be the first to tell you! It also helped ADPAC's former chairman Denny Zent, who now serves in Indiana's state legislature. (There are at least 22 dentists who are serving in state legislatures or running for state office). Campaign school will be held in Washington DC on August 1-2. If you are interested in running for public office at any level, you should consider attending. Contact Sarah Milligan at the Washington office (milligans@ada.org).

FOR IMMEDIATE RELEASE

July 2014

"Insurance Companies in Virginia Can Now Mandate Fees for Non-Covered Services & Patients Stripped of Right to Assign Benefits!"

[Richmond, VA] Don't like this headline? Then take ACTION NOW! If VADPAC does not get the contribution support it needs from you and your component colleagues, the insurance companies could very well be emboldened to try and make it a reality in the years ahead. VADPAC is $96,000+ BEHIND our target goal for 2014 and, make no mistake, the lobbyists and stakeholders on the other side are watching and hoping our position as one of the leading PACs in Virginia begins to show signs of waning. Our charge to you is to not give our political foes the motivation or an ounce of hope to believe that 2015 is the year to try an end-around on us in Richmond.

Instead, let's finish stronger than ever. Whether you have never contributed to VADPAC, have been hit and miss throughout your career or just haven't found the time or treasure this year after being consistent for many years, don't wait a moment longer and give TODAY. The amount does not matter – whether you give $100, $285 or $1,010, take responsibility and be an advocate and champion for our profession.

Participating could not be easier – visit https://vadental.org/pro/vadpac to pay online or contact Laura Givens today at 804-523-2185 or givens@vadental.org to contribute over the phone or have a contribution form sent to your office. Together, we can keep the headlines reading more like this:

"The VDA Wins Another Hard Fought General Assembly Battle that Fortifies the Profession and Bolsters the Quality of Patient Care."

Thanking you in advance for your contribution,

Bruce Hutchison, DDS

VADPAC Chairman

VADPAC Contribution Update

See where YOUR Component is and what you need to do to meet YOUR goal!

Component	% of Members Contributing to Date	2014 VADPAC Goal	Amount Contributed to Date	Per Capita Contribution	% of Goal Achieved
1 (Tidewater)	32%	$45,500	$28,980	$246	64%
2 (Peninsula)	38%	$27,500	$20,367	$251	74%
3 (Southside)	42%	$14,000	$10,180	$243	73%
4 (Richmond)	34%	$67,750	$56,798	$294	84%
5 (Piedmont)	32%	$30,000	$22,378	$238	75%
6 (Southwest VA)	43%	$25,250	$19,638	$298	77%
7 (Shenandoah Valley)	32%	$30,000	$22,444	$281	75%
8 (Northern VA)	33%	$135,000	$97,700	$280	72%
TOTAL	**35%**	**$375,000**	**$278,585**	**$266**	**74%**

Total Contributions: $278,585

Amount Needed to Reach Goal: $96,415

2014 Goal: $375,000

Make a contribution by visiting https://vadental.org/pro/vadpac.
Contact Laura Givens at givens@vadental.org or 804-523-2185 with questions.

The Growing Gap Between Communicating and Understanding

By: Dr. James R. Schroeder

Our world of technology has created a tsunami of information with very little emphasis on personal understanding. Healthy relationships require understanding of each other. As professionals, we live in a performance driven world. High performance teams are often characterized by healthy relationships built on common understandings. Relationships and understanding don't show up on the spread sheet or line item expenditure, but they have a great impact on the bottom line of an organization. There is one common denominator in organizations that grow with a purpose, maintain a cutting edge presence in their industry or simply bring resolution between partners or families. That common denominator requires an across-the-board communication style that creates understanding among all parties involved.

A hundred years ago, a person might expect to receive two letters in a month. Now, the Sunday newspaper alone holds more information than a person of that era might have experienced in a year. Never before have we had so many modalities or methods of communication. While we experience many of the joys and capabilities that the instant access to information and communication provides, we also need to be aware of how we share our time with perhaps the most important aspect of life: our relationships. Relationships bring both the greatest joys and sorrows to what we call life, but we know so well what a "*disconnect*" with those closest to us feels like.

My question is: Does it have to be this way?

As I watch conflict arise out of misunderstanding or a lack of investment into one another, I realize that merely communicating information or words – whether text, email, twitter, telephone, shouting – does not necessarily create understanding. A key skill we are losing is the ability to stop, focus on one person, and listen. We have an avalanche of information, overwhelming all sensory mechanisms in the human body. Never in the history of mankind have the senses been so attacked. Is it having an impact on quality of relationships? Is this *hyper-connectivity* a factor in the breakdown of the family, friendships, and the workplace? As people focus in on the urgency of communicating with everyone else and connecting to updated information, they isolate themselves, texting at the dinner table, emailing before bed – where does it stop? Is there less one on one time, just listening and talking with a significant other without any other interruptions?

One of the most exciting things we can bring to our relationships is a focused, listening ear. It lights up a relationship, and is probably the greatest respect we can pay somebody. Whether we listen to a three-year-old that wants to babble, while we sit on the floor looking at her intently, or with an 80 year-old man sharing his memories from a time long gone, we find a quiet richness that isn't accessible from the twenty-second news feed. These important qualities require intention if they are to be preserved and built upon. Without intentionality, we get carried away by the tyranny of the urgent, which is often not as important as sitting with a three-year-old and listening to a day through her eyes, finding out what her world looks like. Listening with understanding fulfills one of the greatest human needs of acceptance and affirmation.

Although we have much emphasis on the valuable resource of money – how to spend it, how to save it – a more precious resource that is often overlooked is time. Growing in the skill of prioritizing someone over the distractions and pressures, offering undivided attention, and listening to understand, will – I guarantee it – greatly enrich all of our relationships and satisfaction in the course of a day. The subsequent challenge we face is the tug of war between being self-centered or people-centered. As we take our eyes off of ourselves and reach out to others, we find our life takes on a great meaningful purpose for which everyone is searching.

Deep in our bucket of meaningful needs is the desire to be significant – to do something significant, to be significant to somebody else. As we invest undivided attention into those closest to us, helping to fill their need, we will see a different sort of response. While it takes two people's investment for any relationship to grow, as we strengthen the one-on-one connection, that so common occurrence of disconnect will begin to fade, and intimacy will return.

If you found this article helpful, then check out Dr. Schroeder's blog at www.drjimschroeder.com. Learn about the coaching, workshops, webinars and consulting services available through his consulting firm, Leadership by Design, or call 804-897-5900.

Periodontic Abstracts of Interest

Allon I, et. al. Metastatic Tumors to the Gingiva and the Presence of Teeth as a Contributing Factor: A Literature Analysis. J Periodontal 2014;85(1) :132-139.

Purpose: Analyze cases of metastatic lesions to the oral cavity and review the pathogenesis of gingival metastases and its relationship to chronic inflammation.

Methods: Searched articles from 1916 and 2011 to cases of metastatic lesions to the oral mucosa, gingiva and periodontium. Only cases reported to metastasize to the oral mucosal tissues with detailed clinical information were included in the analysis. Information on the presence of teeth was derived from either a photograph or written reference to teeth. Cases were associated with inflammation when there was specific mention to gingivitis, periodontitis, chronic inflammation, periodontal disease or cases with poor oral hygiene.

Results: There were 207 cases utilized for this review. Most metastatic tumors were found in patients in the 5th to 7th decade with a male: female ratio of 2:1. Gingiva was the most common site (60% of cases) followed by tongue (18.4%) and tonsil (8.2%). Common primary sites were lung, kidney, skin and breast. The primary site differed between sexes; males presented with lungs (29.5%), kidney (14.4%) and skin (12.2%). In females, this was the breast (26.5%), genital organs (14.7%) and lungs (13.2%). In 56 cases, the oral metastasis was the first sign of malignant disease. Lesions were described as exophytic and ulcerated. Risk habits included heavy smoking (12.6%) daily alcohol consumption (5.3%) and a combination of alcohol and smoking at (3.4%). Presence of teeth was significantly associated with gingival metastases.

Conclusion: Gingiva is the most common site for metastases to oral soft tissues with strong association to the presence of teeth. Chronically inflamed gingiva may play a role in attraction of metastatic cells to the gingiva.

Jessica S. Allen, DMD; Resident in Periodontics, Virginia Commonwealth University

Buser D, et. al. Long-Term Stability of Contour Augmentation with Early Implant Placement Following Single Tooth Extraction in the Esthetic Zone: A Prospective, Cross-Sectional Study in 41 Patients with a 5- to 9- Year Follow-Up. J Periodontal 2013; 84(11): 1517-27

Purpose: To analyze the stability of esthetic treatment outcomes in 41 patients following single tooth replacement in the anterior maxilla using the concept of early implant placement with simultaneous contour augmentation. Special emphasis was put on assessing the stability of the facial mucosa because it depends directly on the stability of successful contour augmentation using guided bone regeneration (GBR).

Methods: Forty-one patients were examined twice, once in 2006, as part of the previous retrospective study, and again in 2010, to allow for a direct comparison between the two cross-sectional examinations. The patients were 17 to 66 years; (mean age: 38.8 years) and required a single tooth extraction in the anterior maxilla. The treatment sites included twenty-five central incisors, eleven lateral incisors, one canine, and four first premolars. All patients were free of systemic diseases that could have compromised wound healing following surgery. Thirty patients were non-smokers, seven light smokers (<10 cigarettes/day), three heavy smokers (>10 cigarettes/day), and one was a pipe smoker. The procedure consisted of low-trauma tooth extraction without flap elevation, a 4- to 8-week soft tissue healing period, and implant placement in a correct three-dimensional (3D) position. Ten parallel and thirty-one tapered implants with a sandblasted and acid-etched (SLA) surface in the endosseous portion and a regular neck with a diameter of 4.8 mm were used. Implant placement was combined with a simultaneous contour augmentation on the facial aspect with the GBR technique using a bioresorbable collagen membrane. This membrane was combined with two bone fillers to perform local contour augmentation: as a first layer, locally harvested autogenous bone chips were used to cover the exposed implant surface; second, a superficial layer of deproteinized bovine bone mineral (DBBM) was used. A collagen membrane was applied to serve as a temporary barrier, and the surgeries were completed with a tension-free primary wound closure. For all implant surgeries, perioperative antibiotic prophylaxis was initiated 2 hours prior to surgery and maintained for 3 days post-surgically. After a healing period of 8 to 12 weeks, a small additional surgery was performed without flap elevation to gain access to the osseointegrated implant and to initiate the phase of soft tissue con-ditioning. The first cross-sectional ex-amination included implants with a 2- to 4-year follow-up period. During the second cross-sectional examination in 2010, these implants had a 5- to 9-year follow-up (average 7 years). The following measurements were taken: Plaque Index (PI), Bleeding Index (BI), Probing Depth (PD), distance between the implant shoulder and mucosal margin (DIM), cast measurements with a millimeter grid, Pink Esthetic Score (PES), White Esthetic Score (WES), and the distance between the implant shoulder and the first visible bone to implant contact in millimeters (DIB), and cone-beam computed tomography (CBCT) of facial bone thickness at 2nd follow up in 2010. Measurements were taken by two independent examiners.

Results: None of the patients presented with suppuration in the peri-implant sulcus. Overall, the patients exhibited good to sufficient oral hygiene, documented by a mean PI of 0.31. The mean PD was 4.26mm. The mean DIM was -3.42 indicating submucosal implant margin position. The facial DIM was an average of -2.21 at the second exam. Thus, the implant shoulders were slightly more submucossaly located compared with the first exam with a mean DIM of -1.94. The mean PES value was 7.49 and the mean WES was 6.88. The PES score was reduced slightly by 0.3 whereas the mean WES was the same. All implants showed semilunar crestal bone saucers on the mesial and distal. The mean DIB at exam 1 was 2.09mm and 2.18mm at the second exam. 85% of implants exhibited either a slight bone gain or loss within -0.8 to 0.8mm. Six implants exhibited bone loss >0.8mm with the max bone loss at 1.26mm. The mean CBCT facial thickness was 1.58-2.33mm. At the 2mm level, representing the beginning of the SLA surface, 8 of 41 showed no facial bone. At the 4- and 6-mm levels, no facial bone was detected for 2 implants, one of which was clearly malpositioned.

Conculsion: The obtained DIB values indicated overall stable peri-implant bone crest levels on the mesial and distal aspects of the implants. The mean DIB values did not change over time (2.18 mm versus 2.09 mm). In the present study, 35 of 41 implants (85%) show minimal changes in bone crest levels, whereas six implants (15%) displayed >0.8 mm bone loss during the 4 years between the two examinations. The esthetic outcomes of the 41 single crowns were assessed with the PES/WES indices. The mean total PES/WES value of 14.3 indicated a satisfactory esthetic outcome overall, with a slight reduction of 0.36 when compared with the first examination in 2006. This reduction was mainly observed for the PES index. This is not surprising because the PES values are influenced mainly by the local anatomy, the surgical skills and experience of the clinician inserting the implant and augmenting the implant site, and the bone remodeling events in the peri-implant bone. In the present study, an experienced implant surgeon placed all implants.

Thomas F. Glazier, DDS; Resident in Periodontics, Virginia Commonwealth University

Tsourounakis I, et. al. Effect of essential oil and chlorhexidine mouthwashes on gingival fibroblast survival and migration. J Periodontol 2013; 84(8): 1211-1220

Purpose: *In vitro* study to investigate the effect of effect of commercially available mouthwashes, chlorhexidine and essential oil, on the survival and migration of human fibroblasts

Methods: Human gingival and periodontal ligament fibroblasts were obtained from individuals receiving oral surgery treatments, but otherwise periodontally healthy. The periodontal ligament (PDL) tissues were isolated from the middle third of the root surface to minimize possible contamination with gingival fibroblasts. Once cells were isolated and cultured, they were treated with either chlorhexidine (CHX) or essential oils (EO) at various concentrations. Cellular assays were conducted to examine the effects of the mouthwashes on cellular survival and migration, as well as, long-term effects on cell viability.

Results: CHX and EO induced cell death induced in a concentration-dependent method. Undiluted mouthwashes induced an almost complete cell death 24 hours after a 60-sec treatment. Diluted concentrations of 15% to 20% for both CHX and EO mouthwashes resulted in 50% cell death. With respect to the effect of mouthrinses on cellular migration, a dilution of 10-15% EO did not affect cellular migratory capacities, but a 15% dilution of CHX resulted in noticeable reductions in cell motility. Meanwhile, concentrations of 10% of both EO and CHX retained majority of their antibacterial capacity.

Conclusion: While CHX mouthwashes have been shown to be effective against plaque formation and gingival inflammation reduction, use of such an agent to enhance healing after periodontal surgery has not been proven. Rather, based on the results of the present *in vitro* studies, prolonged exposure to CHX may actually have a deleterious effect on fibroblasts and may delay wound healing. However, EO mouth rinses do not affect cellular migratory capacity while still maintaining antibacterial properties. Therefore, it could be suggested that using commercially available EO diluted up to 10% after surgery may be a viable option since it does not appear to affect the cellular properties of the fibroblasts.

Cho Yi Wong, DDS; Resident in Periodontics, Virginia Commonwealth University

Kim SM, et. al. Analysis of the Esthetic Outcome after Root Coverage Procedures Using a Comprehensive Approach. J Esthet Restor Dent 2014; 26(2): 107-118

Aim: To evaluate the esthetic outcome of root coverage (RC) procedures by means of objective methods: % of root coverage (RC), recession esthetic score (RES); and subjective methods via patient and clinician-based questionnaires. A secondary outcome was to relate initial recession depth and width, Miller class, biotype, surgical procedure, and follow-up periods to esthetic outcomes.

Methods: Fifty-eight (58) sites of buccal recession ≥2mm in 31 patients underwent either Subepithelial Connective Tissue Graft plus Coronally Advance Flap (SCTG + CAF), Subepithelial Connective Tissue Graft plus Envelope Flap (SCTG + ENV), or Free Gingival Graft (FGG) to correct Miller I, II, and III recession defects in the esthetic zone over a period of 10 years. Sites were enrolled retrospectively if they had at least a 6 month follow up with a pre-op and post-op photograph. Percent of root coverage (RC) and root coverage esthetic score (RES) system was used as objective measurements and a 5-point questionnaire given to both clinicians and patients was used as subjective measurements. All patients were healthy non-smokers and defects were treated due to esthetic concerns not sensitivity. Clinical measurements were made by one examiner with a UNC-15 probe and no stent. All other data was derived from photographs that were analyzed by third-year perio residents.

Results: After a period of at least 6 months, patient-perceived outcomes showed higher correlation with RES than RC alone. As recession depth becomes greater and the Miller Class increases, the objective values for %RC and RES decrease. The subjective outcomes, though, were comparable throughout, possibly owing to patient-expectation management. All four esthetic results were lowest for the FGG and comparable with SCTG+CAF and SCTG+Envelope.

Conculsion: From the patient's perspective, esthetic outcomes for soft tissue grafting for recession are not always consistent with the clinician's perspective. In addition, partial root coverage may be viewed as a positive outcome by patients and clinicians in cases of deep gingival recession and high Miller class. Esthetic outcomes and percent root coverage were greater for the subepithelial connective tissue grafts compared to the free gingival graft.

Fadi K. Hasan, BDS, DDS; Resident in Periodontics, Virginia Commonwealth University

Rams TE, Degener JE, van Winkelhoff AJ. Antibiotic resistance in human chronic periodontitis microbiota. J Periodontol 2014; 85(1) :160-169.

Purpose: The aim of the study was to examine the occurrence of in vitro antibiotic resistance of selected periodontal pathogens in patients with chronic periodontitis to therapeutic antibiotic breakpoint concentrations of clindamycin, doxycycline, amoxicillin, and metronidazole, as well as to both amoxicillin and metronidazole.

Methods: Subgingival plaque samples were collected and processed from 400 adults with severe chronic periodontitis. The samples were collected before treatment from three to five periodontal pockets (>6mm deep) per patient that exhibited bleeding on probing (BOP). Samples were collected with paper points. Putative periodontal pathogens examined for in this study include Aggregabacter actinomycetemcomitans, Porphyromonas gingivalis, Prevotellaintermedia/nigrescens, Parvimonas micra, Fusobacterium nucleatum, Streptococcus constellatus, Staphylococcus aureus, Enterococcus faecalis, Gram-negative enteric rods/pseudomonads, and Candida species. In vitro antibiotic resistance testing was performed on primary isolation plates and tabulated across all test periodontal pathogens positive within each study patient. Antibiotics were added to the isolation plates: amoxicillin at 8 mg/L, clindamycin at 4 mg/L, doxycycline at 4 mg/L, or metronidazole at 16 mg/L and incubated anaerobically for 7 days. These antimicrobial concentrations represent non-susceptible/resistant breakpoint concentrations against anaerobic bacteria. A. actinomycetemcomitans isolates from selective tryptic soy serum bacitracin vancomycin (TSBV) plates were subcultured onto these media.

Results: P. gingivalis was rarely resistant to any of the test antibiotics. For A. actinomycetemcomitans,76 of 81 (93.8%) patient strains exhibited in vitro resistance to clindamycin at 4 mg/L and 38 of 81 (46.9%) strains to doxycycline at 4 mg/L, whereas relatively few were resistant in vitro to either amoxicillin or metronidazole (3.7% to 6.1% of patient strains). Gram-negative enteric rods/pseudomonads in nine positive patients were resistant in vitro to each of the four test antibiotics but were susceptible to ciprofloxacin in disk fusion testing. Each of these individuals was co-colonized by one or more metronidazole-susceptible periodontal pathogens, including P. gingivalis, intermedia/nigrescens, and P. micra, and one patient additionally had metronidazole-resistant S. constellatus. Overall, antibiotic-resistant subgingival periodontal pathogens were detected in 297 (74.2%) of the 400 study patients. One or more test periodontal pathogens resistant in vitro to doxycycline were found in 220 (55.0%) patients, to amoxicillin in 173 (43.3%) patients, to metronidazole in 121 (30.3%) patients, and to clindamycin in 106 (26.5%) patients. In addition, 60 (15.0%) of the

study patients harbored subgingival test periodontal pathogens resistant in vitro to both amoxicillin and metronidazole.

Conclusion: Patients with chronic periodontitis in this study frequently had subgingival periodontal pathogens resistant in vitro to therapeutic concentrations of antibiotics commonly used in clinical periodontal practice. There is a high prevalence of bacteria resistant to antibiotics in patients with chronic severe periodontitis. The lowest resistance was to the combination of Metronidazole and Amoxicillin (15% of study patients) .

Anya Rost, DMD; Resident in Periodontics, Virginia Commonwealth University

---

Coomes AM, Mealey BL, Huynh-Ba G, et al. Buccal Bone Formation After Flapless Extraction: A Randomized, Controlled Clinical Trial Comparing Recombinant Human Bone Morphogenetic Protein 2/Absorbable Collagen Carrier and Collagen Sponge Alone. J Periodontol 2014; 85 (4): 525-35

Purpose: To evaluate the bone-regeneration capacity of recombinant human bone morphogenetic protein-2 /absorbable collagen (rhBMP-2/ACS) carrier versus collagen sponge (CS) alone placed in a flapless extraction site with ≥ 50% of a buccal dehiscence defect.

Methods: Thirty-nine (39) patients requiring extraction of a hopeless tooth with ≥ 50% buccal dehiscence were enrolled in the study. Patients were included in the study if they were systemically healthy individuals over the age of 18 and had a hopeless tooth with buccal bone destruction requiring extraction (due to previous endodontic infection, vertical root fracture, or being facially positioned in the arch). Patients were not included if they were systemically unhealthy, mentally incompetent, or pregnant; or were taking medication that altered bone metabolism or bone healing such as bisphosphonates, chemotherapeutic drugs, or immunosuppressive agents. After flapless extraction and randomization, either rhBMP-2/ACS carrier or CS alone was placed in the extraction site. A customized measuring stent was fabricated for each site. After extraction, a baseline cone beam computed tomography (CBCT) scan was obtained of the site, and a similar scan was obtained 5 months postoperatively. Medical imaging and viewing software were used to compare the baseline and 5-month postoperative images of the study site and assess ridge width measurements, vertical height changes, and buccal plate regeneration.

Results: Radiographically, cone beam computed tomography(CBCT) analysis showed that with ≥ 50% of buccal bone destruction, rhBMP-2/ACS was able to regenerate a portion of the lost buccal plate, maintain theoretical ridge dimensions, and allow for implant placement 5 months after extraction. The test group performed significantly (P <0.05) better in regard to clinical buccal plate regeneration (4.75 versus 1.85 mm), clinical ridge width at 5 months (6.0 versus 4.62 mm), and radiographic ridge width at 3 mm from the alveolar crest (6.17 versus 4.48 mm) after molar exclusion. There was also significantly (P <0.05) less remaining buccal dehiscence, both clinically (6.81 versus 10.0 mm) and radiographically (3.42 versus 5.16 mm), at 5 months in the test group. Significantly (P <0.05) more implants were placed in the test group without the need for additional augmentation. The mean loss in vertical ridge height (lingual/palatal) was less in the test sites but was not significantly (P = 0.514) different between the test and control groups (0.39 versus 0.64 mm).

Conclusions: rhBMP-2/ACS compared to CS alone used in flapless extraction sites with a buccal dehiscence is able to regenerate lost buccal plate, maintain theoretical ridge dimensions, and allow for implant placement 5 months later.

William R. Trahan, DMD; Resident in Periodontics, Virginia Commonwealth University

---

Froum SJ, Khouly I, Favero G, Cho SC. Effect of Maxillary Sinus Membrane Perforation on Vital Bone Formation and Implant Survival: A Retrospective Study J Periodontol 2013; 84 (8): 1094-99

Purpose: The present study evaluates the percentage of vital bone and implant survival in sinuses that had perforations repaired during surgery versus a non-perforated sinus group

Method: Data were obtained retrospectively from an Institutional Review Board–approved anonymous database at New York University. There were 23 patients who had undergone sinus augmentation procedure (SAP) with a total of 40 treated sinuses. Sinuses were grafted with mineralized cancellous bone allograft(MCBA), anorganic bovine bone matrix(ABBM) , or biphasic calcium phosphate (BCP). Perforation complications occurred in 15 sinuses with 25 non-perforated sinuses. All perforations were repaired during surgery with absorbable collagen membrane barriers. Histologic cores were taken from all treated sinuses 26 to 32 weeks after surgery. The implant success rate of 79 placed implants was recorded

Results: There was no statistical significance in implant failure between non-perforated sinuses and implant failure in the perforated group. There was no statistically significant effect for treatment. The average percentage of vital bone was 28.25% for MCBA, 12.44% for ABBM, and 30.6% for BCP. Implant failures occurred in non-perforated sinuses. The implant survival rate is inversely proportional to the size of the maxillary sinus membrane perforation (MSMP). They found significantly higher implant survival rates when perforations were <10 mm compared with perforations >10 mm. In the present study, MSMP is observed in 15 sinuses, representing an incidence of 37.5%.

.

Conclusion: The augmented sinuses in this study that exhibited MSMPs that occurred during the SAP (which were treated during surgery) show statistically significant (SS) greater vital bone percentages compared with the non-perforated sinus group. There were no SS differences in implant survival in the perforated versus non-perforated groups. In this study, sinus MSMPs, when properly repaired during surgery, do not appear to be an adverse complication in terms of vital bone production or implant survival

Sam Bakuri, DMD, BDS; Resident in Periodontics, Virginia Commonwealth University

---

Faveri M, et. al. Clinical and Microbiologic Effects of Adjunctive Metronidazole Plus Amoxicillin in the Treatment of Generalized Chronic Periodontitis: Smokers Versus Non-Smokers. J Periodontol 2014; 85(4):581-91

Purpose: To evaluate the clinical and microbiologic effects of the adjunctive use of metronidazole (MTZ) and amoxicillin (AMX) in the treatment of smokers and non-smokers with generalized chronic periodontitis (CP).

Methods: Sixty four patients were evaluated (32 smokers and 32 non-smokers). Patients selected received scaling and root planing (SRP) combined with MTZ (400 mg TID) and AMX (500 mg TID) for 14 days. Smokers considered/included, smoked at least 10 cigarettes per day for a minimum 5 years before initiation of the study. Prior to commencement of the experimental interventions, all patients received full-mouth supragingival scaling and oral hygiene instructions; then complete full mouth SRP was conducted in 4-6 appointments, each treatment lasting at least 1 hour, all within 14 days. Antibiotic regimen started immediately after first treatment of mechanical debridement. Subgingival plaque samples (9 samples per patient from interproximal sites) were collected and analyzed using checkerboard DNA–DNA hybridization. Clinical and microbiologic examinations were performed at baseline and 3 months after SRP.

Results: Both groups presented a significant improvement in all clinical parameters at 3 months after therapy (P <0.05). All therapies led to a significant decrease in mean probing depth (PD), clinical attachment level (CAL), and the percentage

of sites with visible plaque, gingival bleeding, bleeding on probing (BOP), and suppuration.

Non-smokers (NS) showed lower mean number of sites with probing depth (PD) ≥ 5 mm after therapy. Non-smokers (taking MTZ + AMX) exhibited a greater reduction in PD and gain in CAL (primary outcome variable) in initially deep sites (PD ≥ 7 mm; P <0.01) compared with smokers. Furthermore, NS showed the greatest reduction in the mean PD of initially intermediate sites (PD = 4 to 6 mm).

The most beneficial changes in the microbial profile were also observed in the non-smoker group, which showed the lowest proportions of the orange complex at 3 months. Eubacterium nodatum was the only species from the orange complex that was reduced in the smoker group, whereas (6) species (C. gracilis, E. nodatum, Fusobacterium nucleatum ssp. nucleatum, F. nucleatum ssp. vincentii, Prevotella intermedia, and Prevotella nigrescens) were reduced in the non-smoker group. Overall counts of orange complex were not really reduced in the smoker group, whereas a drastic reduction was seen in non-smokers. Non-smokers also showed a significant increase in the proportions of Actinomyces (oris) species (which can be bacteria associated with health) after treatment. Both groups did show a striking reduction in the mean levels of the three red complex pathogens (T. forsythia, P. gingivalis, and T. denticola), as well as in the proportions of this complex. These results are in agreement with studies that have also demonstrated the adjunctive effects of these two antibiotics in reducing red complex species in populations mainly comprising smokers or non-smokers with CP.

Conclusion: Although both groups may benefit, smokers with CP benefit less than non-smokers from treatment by the combination of SRP, MTZ, and AMX. However, there were still significant changes in microbial profiles and changes in PD and CAL for both groups. Thus, both groups can benefit from antibiotics, primarily in microbial profile shifts. Additionally, these results suggest that: other adjunctive therapies, such as lasers, alternative antibiotic protocols, or even host modulators focusing on the enhancement of the healing process, could be further explored for improving the clinical and microbiologic outcomes of this group of patients.

Diego A. Camacho, DMD; Resident in Periodontics, Virginia Commonwealth University

PathologyPuzzler

with Dr. John Svirsky

A 43 year old white female presented to the Virginia Commonwealth University School of Dentistry with a slowly expanding lesion of the left mandible with separation between teeth numbers 19 and 20 and fractured teeth #s 30 and 31 (figure 1). Her past medical history was uneventful and the patient was in no discomfort. She stated that her bite was off since the teeth had moved and felt that this occurred over the last four months. Her laboratory studies were not significant. Your differential diagnosis would include which of the following prior to radiographs:

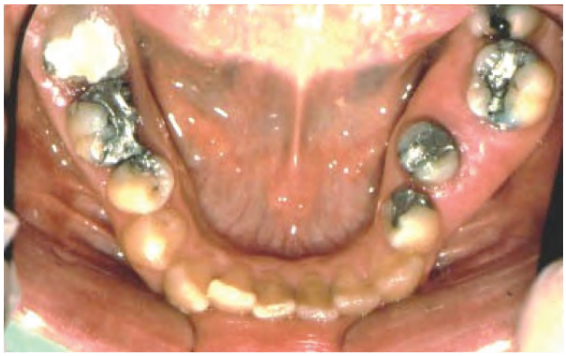


Figure 1

1. Adenomatoid odontogenic tumor
2. Ameloblastoma
3. Ameloblastic fibro-odontoma
4. Calcifying epithelial odontogenic tumor (Pindborg tumor)
5. Central Ossifying fibroma
6. Exostoses
7. Fibrous dysplasia
8. Osteogenic sarcoma/chondrosarcoma
9. Padget's disease
10. Squamous Cell carcinoma

SVIRSKY (Continued on pg 27)

FIRST AID

FOR YOUR PRACTICE ACHES AND PAINS

Dental Care Alliance
STRONGER TOGETHER

FOR IMMEDIATE HELP, CALL 888.460.5067 OR VISIT DENTALCAREALLIANCE.COM

PROTECT YOUR VISION

1. Better balance between work and life
2. Use DCA's support to achieve your professional, personal and financial goals
3. DCA offers flexible options to help you realize your equity while protecting your patients and staff

RELIEVE HEADACHES

1. Enjoy autonomy and maintain control over your clinical decisions
2. Practice the scope of dentistry you want to practice
3. Maximize your earning potential by focusing on patients, not paperwork

DON'T CHOKE UNDER PRESSURE

1. Human resources, payroll & benefits
2. Marketing and accounting
3. Insurance management and negotiations
4. Facility management, staff training, C.E. courses and OSHA complaince

List with Henry Schein Professional Practice Transitions,

WE'LL HELP YOU CROSS THE FINISH LINE.

When it's time to transition your practice, trust the experts. Best practice value, confidentiality, care for your staff and patients— you'll breeze through the finish without breaking a sweat.

HENRY SCHEIN®
PROFESSIONAL PRACTICE TRANSITIONS

1.800.988.5674
www.henryschein.com/tsg

- BROKERAGE SERVICES
- VALUATIONS
- PARTNERSHIPS
- MERGERS
- ASSOCIATESHIPS

SVIRSKY (Continued from pg 25)

PathologyPuzzler
with Dr. John Svirsky

From just the expansile nature I would include ameloblastoma, calcifying epithelial odontogenic tumor , central ossifying fibroma and osteogenic sarcoma as my primary choices. The separation of the teeth after the occlusion is set is worrisome and could be a tumor growing in a circular motion such as a central ossifying fibroma or a malignancy such as an osteogenic sarcoma. Fibrous dysplasia cannot be completely excluded but would be more diffuse with an earlier onset. I would eliminate the adenomatoid odontogenic tumor based on location, presentation and age. Ameloblastic fibro-odontomas would present before age 15 and not cause separation of teeth. Squamous cell carcinoma would not present as an intact expansile entity and the teeth would not have the regular separation seen in this case. In Padget's disease patients are much older and not as localized. With Padget's disease she would also have an elevated serum alkaline phosphatase. Clinically an exostosis would not have this appearance, location or separation.

Two radiographs were then examined :

Figure 2 shows a radiopaque lesion between teeth numbers 19 and 20 causing separation of the teeth. Additionally there is a widened periodontal ligament space on the mesial of number 19.

Figure 3 shows a radiopaque lesion with areas appearing to be a periosteal reaction developing on the buccal plate which may be the beginning of a sunburst appearance.

After reviewing the radiographs, I would eliminate all except a central ossifying fibroma and an osteosarcoma and would be extremely concerned that it is an osteosarcoma from the suggestion of a sunburst appearance and the widened periodontal ligament space. Osteogenic sarcomas tend to grow up the periodontal ligament of the associated teeth.

The biopsy was done and histologically diagnosed as a chondrosarcoma (Figure 4).

The patient was treated with a partial mandibular resection (figure5) and reconstructed (figures 6&7).

An oral chondrosarcoma is an unusual lesion for our practice and we see one every 5-10 years (one in 40,000 to 80,000 cases). Osteogenic sarcomas are seen every three years (one out of 24,000 cases). The separation of the occlusion once the bite is set is a worrisome situation and must be thoroughly evaluated to rule out a malignancy as occurred in this case.

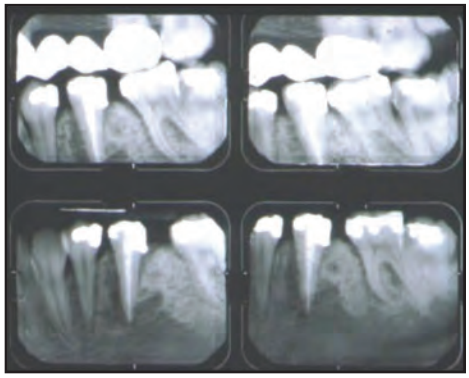


Figure 2

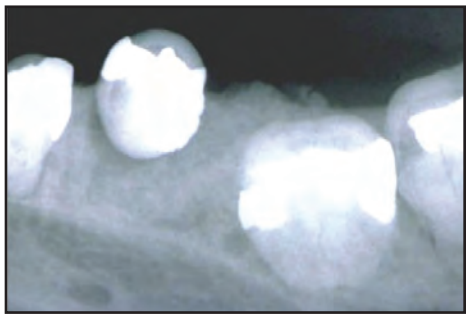


Figure 3

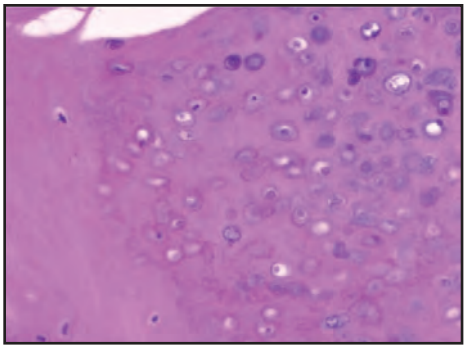


Figure 4

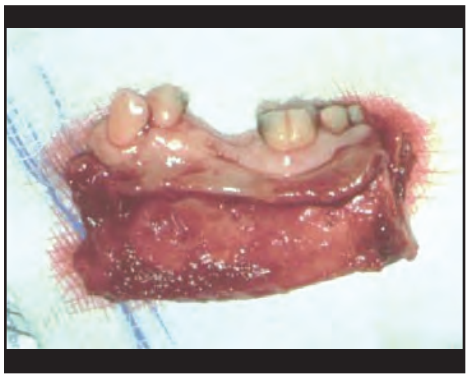


Figure 5

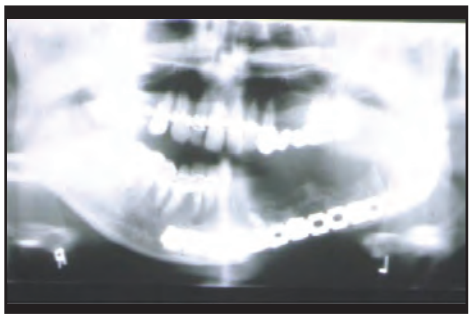


Figure 6

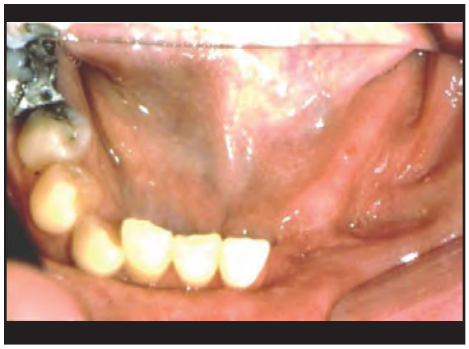


Figure 7

SEPTEMBER 17-21, 2014

THE Virginia MEETING®

A Program of the Virginia Dental Association

DATES TO REMEMBER:

PRE-REGISTRATION DEADLINE: AUGUST 30, 2014
ONSITE REGISTRATION: SEPTEMBER 17-21, 2014

OMNI® RESORTS
the homestead
HOT SPRINGS, VIRGINIA

ADDITIONAL VIRGINIA MEETING INFORMATION ON THE FOLLOWING PAGES

PLENTY OF FUN TO BE HAD!

Annual VDA Golf Tournament – *In Memory of Dr. Donald Martin*

Saturday, September 20, 2014
12:30pm shotgun start
Cascades Course

The Cascades Course at The Omni Homestead is annually considered the finest Virginia mountain golf course and has been the home for many PGA Tours and USGA championships.

Opening Reception

Thursday, September 18, 2014
4:0pm-6:00pm
Exhibit Hall

Join us in the exhibit hall for a chance to unwind and catch up with friends and colleagues after a day of continuing education and meetings! There will be food, free margaritas, and it will be your first chance to see what our vendors have to offer for the 2014 meeting! Our many exhibitors have quite a bit to showcase – new products, meeting specials, prizes, and giveaways. Don't miss out on a great opportunity!

Now You See It, Now You Don't! – Dinner & Magic Show

Thursday, September 18, 2014
6:0pm-8:00pm
The Omni Homestead

Join Jonathan Austin – a magic, juggling, comic sensation – for non-stop entertainment as he moves from table to table inspiring laughter, conversation, and plenty of fun. As you dine on an Italian feast, he will be armed with the tools of his trade; a deck of cards, rapid-fire banter, and the driest of wits. The Jonathan Austin experience promises laugh out loud fun for all! Food, fun, and magic – it doesn't get any better than that!

REGISTER ONLINE: WWW.VADENTAL.ORG/PRO

President's Party

In honor of Dr. Ted Sherwin,
2013-2014 VDA President

Date: **Friday, September 19**

Time: **7:00pm-10:00pm**

Where: **Casino Lawn** *(In case of rain, Regency Ballroom)*

Cost: **$65 for adults (F36) and $30 for children 3-12 (F36A).** *Children under 2 are free and do not need to register.*

Theme: **Caribbean**

Attire: **Hawaiian shirts, sundresses, sandals, sunglasses –** *be ready to spend an evening in the islands!*

Join our president Dr. Ted Sherwin for an undersea adventure! You will be transported away to a Caribbean island to spend the evening with your friends and colleagues! Our pinnacle social event, the party is sure to be one you won't soon forget.

Some highlights of the evening:

- Scrumptious cuisine, including a mixture of traditional Caribbean fare and other tasty favorites to satisfy every appetite!
- Photo booth – and our annual photo contest with prizes sure to please!
- Fabulous music provided by the talented DJ Lew Wright who knows how to create fun with fantastic music tailored to the crowd and event. There's a reason that he's one of Choice Entertainment's top DJs!
- See Dr. Sherwin as you have never seen him before! (Curious? Come to the party and find out what we mean!)

COMPLETE SCHEDULE OF EVENTS

Wednesday, September 17, 2014

Code	Course Title/Topic	Speaker/Event Host	Time	Credits	Cost
–	Registration Open	VDA	10:00am-5:00pm	0	varied
–	VDA Board of Directors Meeting	VDA Board of Directors	Noon-5:30pm	0	$0
–	VDA Board of Directors Dinner	VDA Board of Directors	7:00pm-9:00pm	0	$0

Thursday, September 18, 2014

Code	Course Title/Topic	Speaker/Event Host	Time	Credits	Cost
–	Exhibit Set-Up	Vendors	6:00am-1:00pm	0	$0
–	Registration Open	VDA	7:00am-5:00pm	0	varied
T35	Pierre Fauchard Breakfast	Pierre Fauchard Academy	7:00am-8:00am	0	$40
–	House of Delegates Registration	VDA House of Delegates	7:15am-8:00am	0	$0
–	Business Meeting/House of Delegates Opening Session	VDA House of Delegates	8:00am-10:45am	0	$0
T2	Posterior Composites: A Rapid, Simplified Placement Technique	Dr. Ron Jackson	8:00am-11:00am	3	$0
T10	Focus on Profitability for the Efficient Practice	Dr. Charles Blair	8:00am-3:00pm	6	$0
T11	Blood, Threat, and Fears: OSHA's Bloodborne Pathogens	Ms. Linda Cannon	8:00am-11:00am	3	$0
T14	The Less-Than-Perfect Dentist-Patient Relationship: Case Studies…	Mr. Ted Passineau	8:30am-10:30am	2	$0
–	Reference Committee Hearings	VDA	11:00am-1:00pm	0	$0
T15	Composite Artistry: Give Your Patients Something to Smile About	Dr. Ron Jackson	Noon-3:00pm	3	$0
T6	Boxed Lunch Pick-Up	VDA	11:30am-2:00pm	0	$28
T16	Rock Your Communication and Image Within Your Practice	Ms. Anastasia Turchetta	1:00pm-4:00pm	3	$0
–	Exhibit Hall Open	VDA	2:00pm-6:30pm	0	$0
T46	Heartsaver CPR	Tidewater Center for Life Support	2:00pm-4:00pm	2	$65
T17	Expanding Your Practice Through Early Childhood Dental Care	Dr. Tegwyn Brickhouse & Sarah Holland	2:00pm-4:00pm	2	$0
T32A	Putting Tournament	VDA	2:30pm-4:30pm	0	$20
T44	The Madow Brothers Live!	The Madow Brothers	3:00pm-4:00pm	1	$0
T12	Exhibit Hall Opening Reception	VDA	4:00pm-6:00pm	0	$0
T33	Ping Pong Tournament	VDA	5:00pm-7:30pm	0	$15
–	VADPAC Reception (invitation only)	VADPAC	6:00pm-7:00pm	0	$0
T13/13A	Now You See It, Now You Don't! (Dinner and Magic Show)	VDA	6:00pm-8:00pm	0	$50/$25
–	ACD Dinner (invitation only)	American College of Dentists	6:30pm-10:00pm	0	n/a

Friday, September 19, 2014

Code	Course Title/Topic	Speaker/Event Host	Time	Credits	Cost
–	Registration Open	VDA	7:00am-5:00pm	0	varied
F34	AGD Breakfast	Academy of General Dentistry	7:00am-8:00am	0	$0
–	Invisalign Registration	Align Technology	7:00am-8:00am	0	$0
–	Exhibit Hall Open	VDA	8:00am-6:00pm	0	$0
F3	Invisalign Fundamentals	Dr. Ben Miraglia	8:00am-noon	4	$1,695
F3A	Invisalign Breakout *(4 staff free with doctor)*	Shannon Pace Brinker	8:00am-noon	4	incl.
F8	What's New in Endo: Biochemical Irrigation, Rotary Instruments,…	Dr. John Olmsted	8:00am-11:00am	3	$190
F7	Healthcare Provider CPR	Tidewater Center for Life Support	8:00am-noon	4	$75
F18	Are You Ready to Love Dentistry, Have Fun, and Prosper?	The Madow Brothers	8:30am-4:00pm	6	$0
–	VDA Election - Voting Station Open	VDA	8:30am-2:00pm	0	$0
–	Cascades Gorge Tour	VDA	9:30am start	0	$31/$11

REGISTER ONLINE: WWW.VADENTAL.ORG/PRO

Friday, September 19, 2014 *(continued)*

Code	Course Title/Topic	Speaker/Event Host	Time	Credits	Cost
F1	Composite Artistry Workshop (T15 is a pre-requisite)	Dr. Ron Jackson	9:00am-12:30pm	3.5	$165
–	Exhibitor Clinics	VDA	9:30am-11:30am	0	$0
F21	Boxed Lunch Pick-Up	VDA	11:30am-2:00pm	0	$28
F28	VDA Fellows Lunch	VDA Fellows	Noon-1:30pm	0	$55
F22	Gourmet Safari	VDA	Noon-1:30pm	0	$75
F19	Starting a Practice Versus Buying a Practice – Which is Right for Me?	Stephen Trutter & Brian Cogan	1:00pm-4:00pm	3	$0
F4	Invisalign Intermediate	Dr. Ben Miraglia	1:00pm-5:00pm	4	$199
F5	Invisalign CORT	Shannon Pace Brinker	1:00pm-5:00pm	4	$29
F9	What's New in Endo: Biochemical Irrigation, Rotary Instruments,…	Dr. John Olmsted	1:30pm-4:30pm	3	$190
F20	Exhibit Hall Closing Reception	VDA	4:00pm-6:00pm	0	$0
–	VDA's 16th District Delegation	VDA	4:30pm-5:30pm	0	$0
F39	New Dentists' Reception	New Dentists Committee	5:00pm-6:00pm	0	$0
F37	MCV/VCU Reception	MCV/VCU	6:00pm-7:00pm	0	$0
F36/36A	President's Party in honor of Dr. Ted Sherwin, VDA President	VDA	7:00pm-10:00pm	0	$65/$30

Saturday, September 20, 2014

Code	Course Title/Topic	Speaker/Event Host	Time	Credits	Cost
–	Registration Open	VDA	7:00am-2:00pm	0	varied
S38	ICD Breakfast	International College of Dentists	7:30am-8:30am	0	$36
S47	Confronting 3 Controversies in Implant Dentistry	Dr. John Cavallaro	8:00am-4:30pm	6	$0
S26	Healthcare Provider CPR	Tidewater Center for Life Support	8:00am-Noon	4	$75
S23	Sex, Breath, & the Hygienist's Role	Ms. Anastasia Turchetta	8:00am-11:00am	3	$0
S24	Treating the Worn Dentition	Dr. James Wooddell & Dr. Joe Passaro	8:30am-4:30pm	6	$0
–	VDA Election - Voting Station Open	VDA	8:30am-2:00pm	0	$0
S29	The Less-Than-Perfect Dentist-Patient Relationship: Case Studies…	Mr. Ted Passineau	8:30am-10:30am	2	$0
S25	Metal-Free Crowns: Status Report	Dr. Ron Jackson	9:00am-noon	3	$0
S27	Stay Out of Jail: Coding and Excellence in Administration	Dr. Charles Blair	9:00am-5:00pm	6	$0
S30	35 Endo Tips from 35 Years of Practice - Part I	Dr. John Olmsted	9:00am-noon	3	$0
–	Cascades Gorge Tour	VDA	9:30am start	0	$31/$11
S31	Mentoring Pre-Dental Students: A Guide for Practitioners	Dr. Riki Gottlieb	9:30am-11:30am	2	$0
S42	Boxed Lunch Pick-Up	VDA	11:30am-2:00pm	0	$28
S32	Annual VDA Golf Tournament	VDA	12:30pm start	0	$195
S40	From Regulatory Facts to Mandatory Forms: HIPAA HITECH to…	Ms. Linda Cannon	1:00pm-4:00pm	3	$0
S26A	CPR Refresher Course	Tidewater Center for Life Support	1:30pm-3:30pm	2	$75
S41	35 Endo Tips from 35 Years of Practice - Part II	Dr. John Olmsted	2:00pm-5:00pm	3	$0
S45	2nd Annual MOM Awards Dinner (and DDS, too!)	Virginia Dental Association Foundation	6:30pm-10:00pm	0	$65

Sunday, September 21, 2014

Code	Course Title/Topic	Speaker/Event Host	Time	Credits	Cost
–	House of Delegates Registration	VDA House of Delegates	6:45am-7:30am	0	$0
SUN43	Past Presidents' Breakfast	VDA	7:00am-8:00am	0	$0
–	Annual Business Meeting	VDA House of Delegates	7:30am-10:30am	0	$0
–	House of Delegates Meeting	VDA House of Delegates	10:30am-12:30pm	0	$0
–	VDA Board of Directors Meeting	VDA Board of Directors	12:45pm	0	$0

REGISTER ONLINE: WWW.VADENTAL.ORG/PRO

HOW TO REGISTER:

PLEASE NOTE: You MUST register for any course, activity, or event you would like to attend to be granted access.

Again this year, all CE records will be recorded electronically and sent to you immediately following the Virginia Meeting! We will also be eliminating paper tickets by scanning all attendees into courses and events using a barcode printed on each badge. We recommend that you pre-register in order to guarantee space in your preferred course, activity, or event. Onsite registration will still be available and you may make changes to your registration at any time during the pre-registration period or once you arrive at The Omni Homestead. We are thrilled about this opportunity and feel confident that it will enhance your Virginia Meeting experience!

Online:

Visit **www.vadental.org/pro** to register. We recommend this method as it provides you with a quick easy way to register your dental team for the Virginia Meeting. You will receive an email confirmation of your registration – and you may log back in at any time and easily make changes to your registration. (This is a change from our previous system, which required you to contact VDA staff to make changes after your initial registration was processed.)

By Phone:

Call **(877) 205-1943** between 9:00am-6:00pm EST. Representatives from Custom Registration will be standing by to assist you at any time. For this method, payment can only be processed by credit card.

By Fax:

Fax your registration to **(817) 277-7616** and the staff at Custom Registration will be happy to process this for you. Please include all credit card information (VISA, MasterCard, or American Express).

By Mail:

Mail your registration form and payment to: **The Virginia Meeting c/o Custom Registration, 2020 E. Randol Mill Rd., Suite 307, Arlington, TX 76011**

Please include all credit card information (VISA, MasterCard, or American Express). Make checks payable to The VDA.

Questions?

Call us at **(804) 288-5750** or email Carter Lyons, Director of CE and the Virginia Meeting at **lyons@vadental.org**

VIRGINIA MEETING EXHIBITORS:

3M ESPE
A-dec
ADS South
AFTCO
Asset Protection Group, Inc./Fortress Insurance Co.
B&B Insurance Assoc., Inc.
Bank of America Practice Solutions
Benco Dental
Brasseler USA
CareCredit
Carestream Dental
Delta Dental of Virginia
Demandforce
DentaQuest
DENTSPLY Implants
DENTSPLY North America
Dentsply Tulsa Dental Specialties
Designs for Vision, Inc.
Doral Refining Corp
Drake Dental Laboratories
Great Expressions Dental Centers
Healthcare Professional Funding
Henry Schein Dental
Implant Direct International
Ivoclar Vivadent
Johnson & Johnson
Kerr Corporation
LumaDent, Inc.
Medical Protective
National Practice Transitions
NIH Federal Credit Union
Norfolk Waterside Marriott
Northeast Dental Management
OneMind Health
Patterson Dental Supply, Inc.
Porter Royal Sales
ProSites
RK Tongue Co., Inc./ Tongue/Gerner Financial Services, LLC
SciCan, Inc.
Solmetex
Solutionreach
SCC-Bureau of Insurance
Sunstar
Surgi-Tel/General Scientific Corp.
The Gideons International
Transworld Systems
Ultradent Products, Inc.
VADPAC
VDA Services
VDA Services Gloves/Association Gloves
Virginia Dental Assistants Association
Virginia Dental Association Foundation
Virginia Department of Health, Office of Family Health Services - Dental Health Program
Virginia Oral Health Coalition
Zoll Medical Corporation

REGISTER ONLINE: WWW.VADENTAL.ORG/PRO

THE Virginia MEETING®
A Program of the Virginia Dental Association

SEPTEMBER 17-21, 2014

✓	Registration Type	On/Before June 30	July 1 - August 30	On Site Sept. 17 -21
	First Time Attendee Dentist	$168	$221	$274
	VDA Member Dentist*	$258	$310	$363
	ADA Dentist (non-VDA)*	$363	$415	$468
	Local District Member Dentists (4th, 6th, 16th Districts)*	$258	$310	$363
	VDA Member Dentist (1st year out of dental school)*	$50	$63	$77
	NON Member Dentist	$557	$594	$630
	Active Military Dentist (non-VDA)*	$258	$310	$363
	ODDS Member (non-VDA)*	$258	$310	$363
	Retired Life VDA Member*	$0	$0	$0
	Assistant - VDAA Member*	$58	$63	$69
	Assistant - Non-VDAA Member	$69	$74	$79
	Spouse/Guest of Registrant	$32	$37	$42
	Guest (ages 12 and under)	$8	$11	$14
	Student (Dental, Hygiene, Assisting)*	$0	$0	$0
	Office Staff	$58	$63	$69
	Lab Technician	$58	$63	$69
	Hygienist - VDHA, CDHA Member*	$84	$90	$95
	Hygienist - Non-VDHA, Non-CDHA Member	$90	$95	$100
	Exhibitor	$0	$0	$0

*membership verification required

REGISTRATION SPONSORED BY

VDA SERVICES

Register

Please use this page and the next to register for the 2014 Virginia Meeting. Please note that each registrant will require a separate form. Feel free to make copies of this form as needed.

Virginia Meeting Mailing List

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

Annual VDA Golf Tournament

Code **S32** - *Additional Information*

Handicap: _____

I would like to be grouped in a team with the following players:

_____

_____

Prefix: Mr. Mrs. Ms. Dr. *Required

*First Name: _____

*Last Name: _____

Specialty: _____

Component: _____

*Phone: _____

*Mailing Address: _____

_____

Membership #: _____

*Email: _____

❑ VISA ❑ MC ❑ AMEX **Total Cost** $

Expires: _____

Card#: _____ 3 or 4 digit code: _____

Name on Card: _____

Address on Credit Account: _____

_____

Signature: _____

Print Name: _____

*Emergency Contact Name: _____

*Emergency Contact Phone: _____

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

If paying by check, make payable to VDA • **Mail:** The Virginia Meeting c/o Custom Registration, 2020 E. Randol Mill Rd., Suite 307, Arlington, TX 76011 • **Phone:** (877) 205-1943 • **Fax:** (817) 277-7616 • **Online:** www.vadental.org/pro

REFUND AND CANCELLATION POLICY: All refunds requests must be submitted in writing by August 29, 2014. Conference badges and materials must accompany request. All refunds are subject to a 20% per registration fee that will be processed within 15 business days to the primary registrant. Refunds will be processed via check to the original payee within 10 business days for receipt of request. No refunds will be given after August 29, 2014.

REGISTER ONLINE: WWW.VADENTAL.ORG/PRO

Please register for any course, activity, or event you would like to attend to be granted access.

THURSDAY, SEPTEMBER 18, 2014

✓	Code	Course Title/Topic	Speaker/Event Host	Time	Credits	Cost
	T35	Pierre Fauchard Breakfast	Pierre Fauchard Academy	7:00am-8:00am	0	$40
	T2	Posterior Composites: A Rapid, Simplified Placement Technique	Dr. Ron Jackson	8:00am-11:00am	3	$0
	T10	Focus on Profitability for the Efficient Practice	Dr. Charles Blair	8:00am-3:00pm	6	$0
	T11	Blood, Threat, and Fears: OSHA's Bloodborne Pathogens	Ms. Linda Cannon	8:00am-11:00am	3	$0
	T14	The Less-Than-Perfect Dentist-Patient Relationship: Case Studies and Tips	Mr. Ted Passineau	8:30am-10:30am	2	$0
	T15	Composite Artistry: Give Your Patients Something to Smile About	Dr. Ron Jackson	Noon-3:00pm	3	$0
	T6	Boxed Lunch Pick-Up - **Circle Type: Club Ham Roast Beef Veggie None**	VDA	11:30am-2:00pm	0	$28
	T16	Rock Your Communication and Image Within Your Practice	Ms. Anastasia Turchetta	1:00pm-4:00pm	3	$0
	T46	Heartsaver CPR	Tidewater Center for Life Support	2:00pm-4:00pm	2	$65
	T17	Expanding Your Practice Through Early Childhood Dental Care	Dr. Tegwyn Brickhouse & Sarah Holland	2:00pm-4:00pm	2	$0
	T32A	Putting Tournament	VDA	2:30pm-4:30pm	0	$20
	T44	The Madow Brothers Live!!	The Madow Brothers	3:00pm-4:00pm	1	$0
	T12	Opening Reception	VDA	4:00pm-6:00pm	0	$0
	T33	Ping Pong Tournament	VDA	5:00pm-7:30pm	0	$15
	T13/13A	Now You See It, Now You Don't! (Dinner and Magic Show)	VDA	6:00pm-8:00pm	0	$50/$25

FRIDAY, SEPTEMBER 19, 2014

	F34	AGD Breakfast	Academy of General Dentistry	7:00am-8:00am	0	$0
	F3	Invisalign® Fundamentals	Dr. Ben Miraglia	8:00am-noon	4	$1,695
	F3A	Invisalign® Breakout (4 staff free with doctor)	Shannon Pace Brinker	8:00am-noon	4	incl.
	F8	What's New in Endo: Biochemical Irrigation, Rotary Instruments, & Obturation	Dr. John Olmsted	8:00am-11:00am	3	$190
	F7	Healthcare Provider CPR	Tidewater Center for Life Support	8:00am-noon	4	$75
	F18	Are You Ready to Love Dentistry, Have Fun, and Prosper?	The Madow Brothers	8:30am-4:00pm	6	$0
	F1	Composite Artistry Workshop (T15 is a pre-requisite for this course)	Dr. Ron Jackson	9:00am-12:30pm	3.5	$165
	F21	Boxed Lunch Pick-Up - **Circle Type: Club Ham Roast Beef Veggie None**	VDA	11:30am-2:00pm	0	$28
	F28	VDA Fellows Lunch	VDA	Noon-1:30pm	0	$55
	F22	Gourmet Safari	VDA	Noon-1:30pm	0	$75
	F19	Starting a Practice Versus Buying a Practice – Which is Right for Me?	Stephen Trutter & Brian Cogan	1:00pm-4:00pm	3	$0
	F4	Invisalign® Intermediate	Dr. Ben Miraglia	1:00pm-5:00pm	4	$199
	F5	Invisalign® CORT	Shannon Pace Brinker	1:00pm-5:00pm	4	$29
	F9	What's New in Endo: Biochemical Irrigation, Rotary Instruments, & Obturation	Dr. John Olmsted	1:30pm-4:30pm	3	$190
	F20	Exhibit Hall Closing Reception	VDA	4:00pm-6:00pm	0	$0
	F39	New Dentists' Reception	VDA	5:00pm-6:00pm	0	$0
	F37	MCV/VCU Reception	MCV/VCU	6:00pm-7:00pm	0	$0
	F36/36A	President's Party in honor of Dr. Ted Sherwin, VDA President	VDA	7:00pm-10:00pm	0	$65/$30

SATURDAY, SEPTEMBER 20, 2014

	S38	ICD Breakfast	International College of Dentists	7:30am-8:30am	0	$36
	S47	Confronting 3 Controversies in Implant Dentistry	Dr. John Cavallaro	8:00am-4:30pm	6	$0
	S26	Healthcare Provider CPR	Tidewater Center for Life Support	8:00am-Noon	4	$75
	S23	Sex, Breath, & the Hygienist's Role	Ms. Anastasia Turchetta	8:00am-11:00am	3	$0
	S24	Treating the Worn Dentition	Dr. James Wooddell & Dr. Joe Passaro	8:30am-4:30pm	6	$0
	S29	The Less-Than-Perfect Dentist-Patient Relationship: Case Studies and Tips	Mr. Ted Passineau	8:30am-10:30am	2	$0
	S25	Metal-Free Crowns: Status Report	Dr. Ron Jackson	9:00am-noon	3	$0
	S27	Stay Out of Jail: Coding and Excellence in Administration	Dr. Charles Blair	9:00am-5:00pm	6	$0
	S30	35 Endo Tips from 35 Years of Practice - Part I	Dr. John Olmsted	9:00am-noon	3	$0
	S31	Mentoring Pre-Dental Students: A Guide for Practitioners	Dr. Riki Gottlieb	9:30am-11:30am	2	$0
	S42	Boxed Lunch Pick-Up - **Circle Type: Club Ham Roast Beef Veggie None**	VDA	11:30am-2:00pm	0	$28
	S32	Annual VDA Golf Tournament *(see additional information on Reg. Form pg. 1)*	VDA	12:30pm start	0	$195
	S40	From Regulatory Facts to Mandatory Forms: HIPAA HITECH to Omnibus	Ms. Linda Cannon	1:00pm-4:00pm	3	$0
	S26A	CPR Refresher Course	Tidewater Center for Life Support	1:30pm-3:30pm	2	$75
	S41	35 Endo Tips from 35 Years of Practice - Part II	Dr. John Olmsted	2:00pm-5:00pm	3	$0
	S45	2nd Annual MOM Awards Dinner (and DDS, too!)	VDA Foundation	6:30pm-10:00pm	0	$65

SUNDAY, SEPTEMBER 21, 2014

	SUN43	Past Presidents' Breakfast	VDA	7:00am-8:00am	0	$0

Your Name:_____ **Total Cost** $

SPONSORS *as of May 20, 2014*

Thank You!

The VDA thanks all 2014 Virginia Meeting Sponsors for their generous support!

TITANIUM *PLUS*

$20,000 CE Sponsorship

VDA SERVICES

Axis | SybronEndo
ROTARY MEETS ENDO

PLATINUM

$5,000+ CE Sponsorship

Medical Protective
a Berkshire Hathaway company
Strength. Defense. Solutions. Since 1899.

Virginia Family Dentistry
FAMILY DENTISTRY & ORTHODONTICS
formerly Dr. Baxter Perkinson & Associates
VAdentist.com

DELTA DENTAL

Implant Direct
simply smarter.

BVDL
Bay View Dental Laboratory

DIAMOND

$2,500+ CE Sponsorship

AMERICAN COLLEGE OF DENTISTS
FOUNDED 1920

Nobel Biocare®

Bank of America

REGISTER ONLINE: WWW.VADENTAL.ORG/PRO

SPONSORS *as of May 20, 2014*

GOLD

$1,000+ CE Sponsorship

Commonwealth Endodontics
Practice Limited to Endodontics

Commonwealth oral & facial surgery

Drs. Whiston, Patterson, Corcoran

Hampton Roads Oral and Maxillofacial Surgery

ICD International College of Dentists

Northern Virginia Dental Society

PNC

CareCredit
Making care possible...today.

Richmond Dental Society

Joe Niamtu, III, D.M.D.
Cosmetic Facial Surgery
LOVETHATFACE.COM

Virginia Tidewater Dental Association/ Ferris-Donne Foundation

BRONZE

$500+ CE Sponsorship

Bivins Orthodontics

VAO

ORTHODONTICS
For Children & Adults
Drs. Shivar, Peluso & Andersen

Jeffrey Friend, DDS

Meares·Bernier Endodontics

HRGI LABS
Your Partner in Restorative Art & Design

VDAA

WorldPay

LifeNet Health
Tissue Services Division

McPhillips Roberts & Deans PLC

DONATIONS

$1,000-$2,500 Sponsorship

Medical Protective
a Berkshire Hathaway company
Strength. Defense. Solutions. Since 1899.

Fairfax Oral and Maxillofacial Surgery

VSOMS
Virginia Society of Oral & Maxillofacial Surgeons

Full Service Personal & Business Insurance Agency
B&B
B&B Insurance Associates, Inc.
1-877-832-9113 • www.bb-insurance.com

Drs. Wood, Dunlevy & Lombardozzi

DONATIONS

$100-$250 Sponsorship

premier

Colgate

Dr. Andrew Zimmer

Hilton
Virginia Beach Oceanfront

REGISTER ONLINE: WWW.VADENTAL.ORG/PRO

EVENT

$2,000 Sponsorship

PATTERSON DENTAL

EVENT

$1,500 Sponsorship

SVDA

Shenandoah Valley Dental Association

EVENT

$500 Sponsorship

Atkins, Maestrello, Miller & Assoc.
Pediatric Dentistry

Southwest Virginia Dental Society -
In Memory of Dr. Don Martin

Suntrust Bank Medical Specialty Group

Brown Reynolds Snow Dentistry

Fitz Vital
581 B Southlake Boulevard
Richmond, VA 23236

CREATIVE DENTAL LABORATORIES

Howell Comprehensive General Dentistry

Associated Printing Services, Inc.

Fairfax Oral and Maxillofacial Surger

Endodontic | Partners

west end orthodontics
Frank P. Iuorno, Jr., DDS, MS
"Embrace Life"

HDJN Hancock, Daniel, Johnson & Nadle, P.C.

Virginia Academy of General Dentistry

Drs. Kaugars & Miller, P.C.

HARRIS, HARDY & JOHNSTONE, P.C.
CERTIFIED PUBLIC ACCOUNTANTS

RICHARDSON, DMD - OVERSTREET, DDS, Ltd.

EVENT

$300-$350 Sponsorship

Dr. Alonzo Bell
Ted Sherwin, DDS
New England Handpiece Repair

Ray Orthodontics
Specializing in Treatment for Children & Adults

LAB ONE

Goodwin Dental Laboratory, Inc.

REGISTER ONLINE: WWW.VADENTAL.ORG/PRO

GOLF TOURNAMENT

$425-$1500 Sponsorship

Anthem

HENRY SCHEIN® DENTAL

WorldPay

DOCTORS MORRIS & TAYLOR, LTD. Orthodontics for Adults & Children

MIDGETTE Family Dentistry Brian P. Midgette, D.D.S., P.C.

Jeffrey N. Kenney, DDS
Norbo Dental
Gus Vlahos, DDS
Link, Jacobs, & Link
Patrick D. King, DDS
Virginia Dental Lab
Southwest Virginia Dental Society
Hutchison & Gorman, DDS, PLLC

Blue Ridge Endodontics

OFS

Yorktown Periodontics Periodontics & Implants

OYSTER POINT Oral & Facial Surgery

PATTERSON DENTAL

Commonwealth oral & facial surgery

Goodwin Dental Laboratory, Inc.

HRH HENRY R. HORTENSTINE, III, CPA, P.C.

Commonwealth Endodontics PRACTICE LIMITED TO ENDODONTICS

Donated Dental Services Virginia Dental Association Foundation

Missions of Mercy Virginia Dental Association Foundation

give kids a smile! ADA American Dental Association

THE 2ND ANNUAL MOM AWARDS PARTY

We're rolling out the red carpet to celebrate the stars of our Mission of Mercy (MOM), Donated Dental Services (DDS), and Give Kids a Smile! programs. Put on your black tie, dress as your favorite movie actor or actress, or pick up some vintage formal attire for the walk down the red carpet. You will probably be interviewed on the way down the carpet and maybe your picture will be snapped by the paparazzi! Enjoy a plated dinner and join us in celebrating our most valuable asset, our volunteers.

DATE:	SEPTEMBER 20, 2014
TIME:	6:30 PM - 10:00 PM
LOCATION:	THE OMNI HOMESTEAD
TICKETS:	$65 PER PERSON

REGISTER ONLINE: WWW.VADENTAL.ORG/PRO

Over and Under – Sporting Clays at the Homestead

By: Dr. Austin Westover

I attended the Virginia Meeting for the first time last year in 2013. My partner and a local orthodontist said that I absolutely, positively, needed to try the sporting clays range. They were right. I've only shot skeet a couple times and that was several years ago, but I have never participated in sporting clays. Apparently the Homestead's course is world-renowned. They set me up with a guide that competed for years who was able to coach me through the course. For those who have never done sporting clays, this was a fantastic way to experience it. There were 25 stations with two clay pigeon launchers. Each clay pigeon comes from a different location, has a different speed, different angle, and a different challenge. I only hit about one out of two, but really enjoyed it. If you have an interest in shooting, you absolutely, positively need to try the sporting clays range.

Editor's Note: *Dr. Westover practices general dentistry in Winchester.*

A Tour Worth Taking - The Cascades Gorge

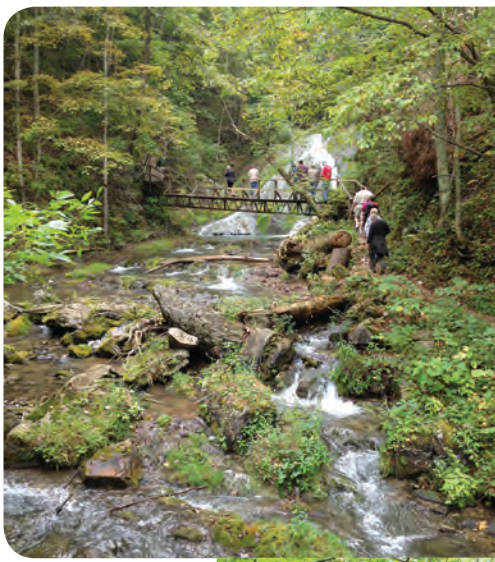
By: Dr. Michael E. Miller

When contemplating how to spend some of your "free time" at this year's VDA Meeting at the Homestead, you will undoubtedly be presented with a plethora of tantalizing outdoor activities to choose from. Golf, tennis, sporting clays, horseback riding, fishing, relaxing by the pool or just meandering around the beautiful grounds of the Homestead Resort are all worthwhile occupiers of the precious few hours that we devote to recharging our mental and physical batteries. At last year's meeting, Benita and I elected to spend one of our afternoons on the highly acclaimed Cascades Gorge hiking tour, something we had heard would be quite fun and enjoyable. And by "fun and enjoyable" I mean EXTREMELY breathtaking, hilarious, educational, and entertaining and well worth the price of admission. This three-hour tour (remember the S.S. Minnow from Gilligan's Island?) was like having a "Ted Talk" by Robin Williams as you strolled through some of the most pristine sub-tropical scenery in the Appalachian mountains.

This description was made possible by our tour guide Brian La Fountain in conjunction with a surrounding of flora and fauna that merged synergistically with his love and knowledge of nature along with his theatrical presentation of each tidbit of scientific data or historical folklore. La Fountain, part professional naturalist, part thespian, has been guiding and teaching at the Homestead for over 25 years, a vocation encouraged by his father, a die-hard naturalist. The 2.5 mile hike through the twelve-waterfall Cascades Gorge was frequently halted by Brian setting up his outdoor classroom and profoundly educating his students on some fascinating aspect of a plant, animal, insect or other natural or geophysical phenomenon in his own Broadway-style, humorous delivery that would predictably set off a cacophony of laughter from his personal peanut gallery. His variety of prodigious bird calls elicited amazement in the audience, and his lecture on the dandelion (dent de lion),whose leaves are part of the spring mix in our salads in addition to the source of a widely used Alzheimer's medication, gave us pause in relegating this plant to level of a weed. I will never forget how Brian showed us how to make a whistle out of an acorn cap - the smaller the cap, the higher the pitch- and how this information, having been instilled in a young boy's brain, helped the boy save his own life and that of a friend after being lost in the woods.

There is no way to relate the serene beauty, or the sound of the waterfalls, or the smell of the wildflowers, or the feel of the hundreds of mosquito bites (just kidding, there were no mosquitoes) that one will experience on the hike through the Cascades Gorge. I will say: take this three-hour tour, and unlike Gilligan, you will not regret it.

Editor's Note: *Dr. Miller practices oral surgery in Richmond.*



Brian La Fountain

Hidden Treasure

By: Richard F. Roadcap, DDS, Editor

Over 8,000 years ago Native Americans were drawn to upper reaches of Virginia's Jackson River by abundant springs, fertile soil, and plentiful game. European settlers arrived in what is now called Hidden Valley in the mid-18th century, and found much to their liking. Modern-day outdoor enthusiasts enjoy camping, hiking, horseback riding, mountain biking, and fishing. The Hidden Valley Recreation Area of the George Washington National Forest[1] lies just off State Rt. 39, less than a 30-minute drive from the Omni Homestead Resort.

The campground at the Recreation Area, on the east bank of the river, boasts 30 campsites. Camping is "primitive": there's potable water for washing dishes and clean-up, but no showers or hookups for RVs or towed campers. Campsites are $10 a night, on the honor system. The tent pads are laid out in a large circle and numbered. Most have fire pits, but you'll have to bring your own firewood, as wood gathering is prohibited. The lack of amenities assures quiet evenings and a good sleep for campers.

Hikers will find 20 miles of well-marked trails in Hidden Valley. Although the terrain is mountainous, many trails follow the floodplain of the Jackson River, and the inclines are modest. The Hidden Valley trails are part of the Great Eastern Trail, which parallels the more-famous Appalachian Trail, and is projected to be 2000 miles long when complete. A word of caution: don't hike here alone. This is bear country, and wireless (cell phone) service is almost non-existent. But the spectacular vistas are ample reward for venturing into this remote area.

A one-lane bridge across the Jackson, near the campground, leads to Hidden Valley Bed and Breakfast.[2] Owners Pam and Ronnie Stidham have faithfully restored Warwickton Mansion, built by Judge James Wood Warwick, to its original 1851 condition. There are three guest rooms in the main house, and two apartments in the separate Summer Kitchen. The Stidhams were kind enough to give me a tour of both the main house and the cottage, complete with the oral history of the property. The 1993 movie *Sommersby*[3](starring Richard Gere, Jodie Foster, and James Earl Jones) was filmed here, in part, because the landscape has changed little since the Civil War. Pam told me the main house was original, with no fires in its history, and every attempt has been made to keep the home looking as it did in the years preceding the War.

The upper Jackson River (that part above Lake Moomaw) is well-known to trout fisherman. From the parking area the first two miles upstream are a put-and-take fishery, stocked with rainbow and brown trout. Flat water will yield an occasional smallmouth bass, and abundant rock bass, or "redeyes" as locals call them. Above the Swinging Bridge, a suspension bridge over the river, is the Special Regulations area, where only single-hook artificial lures are allowed, but the chance for a trophy is much greater. Required licenses (fishing, trout, and National Forest) can be purchased online.[4]

I haven't exhausted the list of outdoor recreation opportunities. Horseback riding, mountain biking, and canoeing/kayaking (water levels permitting) also draw visitors to the area. Equestrians trailer their mounts to the parking area near the river. Paddlers will need to locate put-in and take-out locations for their floats – I'd consult DeLorme's *Virginia Atlas & Gazetteer*.[5]

For countless millennia, aboriginal settlers in Hidden Valley proved to be good stewards. European immigrants have been in charge for barely more than two centuries. Let's hope filmmakers a century from today will want to make another movie about Reconstruction here.

The Editor practices general dentistry in Colonial Heights.

1 http://www.hikingupward.com/GWNF/HiddenValley/

2 http://hiddenvalleybedandbreakfast.com/

3 http://en.wikipedia.org/wiki/Sommersby

4 http://www.dgif.virginia.gov/licenses/

5 http://shop.delorme.com/OA_HTML/DELibeCCtpSctDspRte.jsp?section=10096

Virginia State University Mini-MOM

By: Samuel Galstan, DDS, MPH; VDA Board of Directors

On April 10, 11, and 12, 2014 the 3rd Annual VSU Cares MOM project was held at the Daniel Gymnasium at Virginia State University in southern Chesterfield County. This project was a partnership between Virginia State University, the Southside Dental Society, the Old Dominion Dental Society, the Virginia Dental Association Foundation, VCU School of Dentistry, several area Rotary Clubs, several area Lions Clubs, a number of community and civic organizations and Chesterfield County. One hundred and three (103) patients were seen and more than $44,772 in free dental care was provided. This event was made possible by grants received from Rotary International and Chesterfield County. Several years ago Virginia State University conducted a community needs health assessment and found that unmet dental needs were the number one unmet health need in the areas surrounding VSU. As a result of this finding, VSU reached out to the VDA to start this project three years ago. The Virginia Dental Association is well-known for being on the forefront of decreasing barriers to dental care access for all Virginians. The MOM project concept is designed as an emergency, transitional attempt to provide needed dental care to those most at-risk Virginians who are not able to obtain dental care elsewhere. This is not designed as a long term solution, but rather as a way to highlight this crisis to legislators, policymakers and decision makers, so that more sustainable, long-term solutions can be obtained, ultimately resulting in all Virginians finding a dental home where a preventive partnership between dentist and patient can be obtained. Thank you to all of who help make MOM projects a success.

Donated Dental Services
Virginia Dental Association Foundation

Dr. Sharone Ward (right) with her DDS patient, Susan, and Dr. Samuel Galstan.

Take the DDS Challenge

"It has been a privilege to participate in the DDS program. The joy you put on a patient's face and their appreciation can be truly profound. I feel fortunate that I have a gift that I can share that makes such a significant impact to someone who is in need and might not otherwise receive these services." Dr. C. Sharone Ward, Chester, VA

We're gearing up for a new Donated Dental Services (DDS) challenge! More volunteer dentists and specialists are needed across Virginia to provide compassionate, comprehensive treatment for seniors and adults with disabilities living on a fixed income. Not a current DDS volunteer? We'll ask you to consider becoming a part of this well-established, rewarding program. Already a volunteer? We'll need your help in recruiting your peers and colleagues. The DDS Challenge is designed to be a fun, light-hearted contest to recruit new volunteers and help meet the serious dental care needs of more underserved adults. Look for more information at the Virginia Meeting and in VDA and Foundation publications, or contact Jessica Park, DDS Manager, at park@vadental.org or 804-523-2182.

give kids a smile®

ADA American Dental Association®

Foundation Staff Selected for GKAS Leadership Institute

Congratulations to Jessica Park, our Give Kids a Smile and Donated Dental Services Manager, for being selected as a 2014 Give Kids a Smile Community Leadership Institute Ambassador to the bi-annual meeting and access to care event in St. Louis this October. The Leadership Development Institute selects ambassadors through a competitive process and provides resources and best practices to help them reach more children, drive participation of clinical volunteers, and gain local sponsorships and donations.

Fathers and Daughters: Special Olympics Brings Generations Together at M.O.M.

By: Joel Rubin

Dr. Vicky Hale didn't have to twist too many arms to convince her staff of nine, from administrators to hygienists to student assistants, that a day on the concourse of the Robins Center at the University of Richmond, providing free care for some grateful athletes, would be good for everyone.

"We volunteered at the MOM project in Charlottesville last year so we knew how important it would be, but we also were looking for a great team building exercise at the same time," said the Orange, Va. dentist. They got one.

A third of the Hale "team" participating in the Mission of Mercy event during the Virginia Special Olympics Summer Games on June 7 was office manager Becky Rollins and her teenage daughters Baylee and Taylor, who may follow their mom into the oral health care field. Catherine Romano, a dental assistant in Virginia Beach, was there too, along with her father, Frank Romano DDS, from Fredericksburg. Now pursuing a masters in health management at Eastern Virginia Medical School in Norfolk while working in a periodontist's office in Virginia Beach, Catherine is eyeing dental school, for which she is now better prepared than ever after her, and her father's, most recent joint MOM experience.

"It was her idea," recalled Frank. "She said 'I want to do this so we're going.' I really had no choice."

VDA member Dr. Bob Anderson was at this MOM too, as he was at one in Suffolk in March, which was also coordinated by the Virginia Dental Association Foundation. And Bob's daughter and VCU dental school student Ashley was alongside both times too. "All MOM clinics are rewarding," said Ashley, "but helping these young people and adults who come here to compete and are so thankful for the assistance is really gratifying."

No one understands that better than yet another VDA member, Dr. Jim Schroeder of Richmond, who also was among the several dozen volunteers who provided cleanings, exams and other services that Saturday for more than a hundred special Olympians. Yes, he had a daughter with him too, Emily, who is in dental school. Dr. Schroeder, now retired from full-time practice, has made treating special needs Virginians a personal cause. "Many dentists shy away from them because of fear or discomfort," said Schroeder. "It takes a special touch, but if we don't provide the care, it creates yet another disability, poor dental health. So we need to beef up curriculum in dental schools and provide more training." Dr. Schroeder has done just that, conducting hands-on workshops for practitioners and intends to do more.

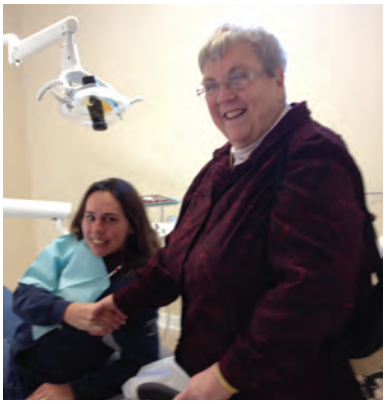
He has a real ally in dentist and physician Dr. Matt Cooke, who established the annual MOM event at the Special Olympics when he was a professor at the VCU Dental School. Though now teaching in the University of Pittsburgh's dental program, he continues to coordinate this Mission of Mercy

and this year, he brought nearly 30 of his students from UP to UR. "This is a real passion for me," said Dr. Cooke. "Special needs populations must have advocates, and we must encourage the next generation of dentists to be there for them."

Dr. Cooke, who still has a home in Virginia, will return to the Special Olympics MOM in 2015 and judging by the enthusiastic support he received from VDA dental teams in 2014, he will not be alone.

Gloucester Mathews Care Clinic's New Dental Wing

By: Babs Zuhowski



In March, Gloucester Mathews Care Clinic opened the doors to its Dental Wing. Three separate operatories, coupled with a panorex, xray room, and lab serve the patients of the Clinic. The dental clinic is currently seeing patients all day on Friday.

Services on site include simple extractions, restorations and cleanings. Though, they hope to be able to provide dentures in the future, they do not currently, nor are they able to do root canals, crowns, wisdom teeth or oral surgery. Luckily, GMCC has another program "Dentists without Walls." Area dentists have partnered with the Clinic to offer the aforementioned unavailable services (on a limited basis) in their own offices.

The Clinic is currently planning a day-long dental event like a mini-M.O.M. (Mission of Mercy). Although the initial event will be for current patients, it is the intent that future dental clinics will be open to the public.

When You Get A Claim, Who Will Defend You The Best?

Your Colleagues!

EDIC's Board of Directors is comprised of dentists and dental educators. We have a network of national experts and the best defense counsel at your disposal at any given time. We will go to the wall to defend you, your reputation, and stand by your side when you need us the most. At EDIC, **we only insure our colleagues** which means you and your claim are our top priorities.

For over 20 years, EDIC has been committed to dentistry and it's colleagues. As a mutual-owned company we give back to our colleagues, our dental societies, and our dental schools. Our 99% customer retention rate proves we are committed to our dental community indefinitely.

Join the "By Dentists, For Dentists"® company for all your dental malpractice insurance needs, and you can be sure EDIC will always stand by your side.

Eastern Dentists Insurance Company
Malpractice Insurance | By Dentists, For Dentists®

A Dental Society Risk Retention Group
edic® EASTERN DENTISTS INSURANCE COMPANY
Malpractice Insurance By Dentists, For Dentists®

EDIA® EASTERN DENTAL INSURANCE AGENCY

ENDORSED BY Massachusetts Dental Society

ENDORSED BY RHODE ISLAND DENTAL ASSOCIATION

1-800-898-3342 • www.edic.com

EDIC Board of Directors 2013 - 2014

New Graduates: Don't Let Your Debt Burden Leave You Ethically Bankrupt

Tonya Parris-Wilkins, DDS; Member, Ethics and Judicial Affairs Committee

What do a $3000 mortgage payment, a $2000 monthly student loan payment and a $650 car payment have in common? For most new graduates these are the financial realities they face soon after receiving a dental degree. The pursuit of a "doctor's lifestyle" is often met with a heavy debt burden upon graduation. According to a May 2014 article titled "Educational Debt and Intended Employment Choice Among Dental School Seniors" in the *Journal of the American Dental Association*, the average educational debt of 2011 dental school graduates was $179,000.[1] Delaying gratification for eight years is suddenly met with the opportunity to purchase the finer things in life. As a new graduate you are often able to purchase a new car for the first time and finance a comfortable living situation. However, in six months your first student loan payment will also become due.

So how will these new financial realities affect your treatment plans? Below are two examples of unethical practices which can be tempting to new practitioners.

From a dentist's perspective:
Advising patients that they have carious lesions which are not present, and recommending treatment with minimally invasive dentistry or other more invasive and costly treatment options.

From a hygienist's perspective:
Advising patients that they have significant probing depths which justify periodontal treatment including but not limited to administration of local antibiotic therapy, quadrant scaling and other adjunctive periodontal treatments. These treatments increase the amount of billable services provided. In scenarios where a hygienist is working on an incentive plan, falsely diagnosing periodontal disease can increase one's personal revenue, both the practicing dentist and hygienist.

The ADA Principles of Ethics and Code of Professional Conduct[2] states the following in reference to performing unnecessary treatment:

> 5.B.6. UNNECESSARY SERVICES.
> A dentist who recommends and performs unnecessary dental services or procedures is engaged in unethical conduct. The dentist's ethical obligation in this matter applies regardless of the type of practice arrangement or contractual obligations in which he or she provides patient care.

In addition to questionable ethical practices, performing unnecessary treatment is also a form of insurance fraud. Remember, your financial burdens should never influence the treatment rendered in practice. The key to a successful practice is always doing what is in the patient's best interest.

1 Wanchek T. et al. Educational debt and intended employment choice among dental school seniors. JADA 2014; 145(5): 428-434.

2 The American Dental Association Principles of Ethics and Code of Professional Conduct. http://www.ada.org/~/media/ADA/About%20the%20ADA/Files/code_of_ethics_2012.ashx. Page 11.

WHEN FACED WITH A MALPRACTICE CLAIM, WHO DO YOU WANT IN YOUR CORNER?

When your career and reputation are on the line, you want the strongest dog in your corner. Many dentists don't realize how important their dental malpractice insurance is until they need it most. Medical Protective has over 100 years of proven experience, national expertise and a balanced defense that focuses on ***your best interest***. And, today, more than ever, the big financial strength, integrity and powerful backing of a Warren Buffett Berkshire Hathaway Company are crucial to the quality of your dental malpractice protection.

One company has strength and experience that towers over the others.

Contact us today for a Protection & Price Check-Up

PROTECTION & PRICE CHECK-UP

Email: dental@medpro.com
Visit: www.medpro.com/dental
Call: 800-4MEDPRO ext.3536

Trust the dental malpractice experts.

Medical Protective
a Berkshire Hathaway company
Strength. Defense. Solutions. Since 1899.

Step up to an Automated Patient Engagement System

By: Dr. Cappy Sinclair

As many dental offices embrace technological advancements in the operatory, they continue to overlook technological advancements at the front desk. It's easy to get excited about revolutionary advancements like CAD/CAM dentistry and cone beams, but text messages that confirm patients' appointments just don't seem as thrilling. An automated patient engagement system that increases communication between a dental office team and their patients is something worth getting excited about though, and I've outlined a few of the reasons why below.

The 24-hour team member

As a small dental office built from scratch, I have an office manager (OM) and an assistant who are responsible for taking care of the guts of the practice. My automated system performs many of the front desk tasks my two employees can't get to: from patient appointment confirmation to recapturing those patients who snuck out of the office without a re-care appointment.

In some offices, a team member will spend three to four hours every day reconfirming patients and filling holes in the schedule, tasks that an automated patient engagement system performs automatically and successfully, via phone, texts and/or emails. It only takes my OM 5 minutes a day to confirm the patients for the day, by simply setting up the automated system to send appointment reminders. Often she'll just go through and confirm patients for the next several days in one sitting.

One of my favorite functions of the system occurs when we have a last-minute appointment cancellation. My patient engagement system sends an email or text to patients announcing the vacancy in our schedule, and all the OM has to do is pick up the phone when someone calls … and believe me, someone always calls.

Delegating these tasks to this platform allows my team to spend their time on things like creating new marketing strategies or discussing treatment plans with patients.

You do that *here*?

Have you ever had a long-standing patient come in with a brand new white smile, and your team learns the patient had their teeth whitened elsewhere because they didn't know you performed whitening procedures at your office?

Newsletters are a great way to let patients know about new and forgotten services you offer in your office. But you're a dentist, not a writer or newsletter designer. Plus, any time you're not with a patient you're probably looking for time with your family. Most platform engagement packages include newsletters. How often do they go out? You get to decide. Instead of asking your team to remember to talk to your patients about all the services you offer in the last two minutes of an appointment, newsletters do it in a friendly way when you're patient isn't trying to get to their next appointment.

SINCLAIR (Continued on page 48)

DILL (Continued from page 13)

back a claim if the buildup and crown had the same date of service and ask that you then resend the claim when you actually seated the crown. Look, we all know the games that can be played with the date of service at the end of one calendar year and the beginning of the next. But from my perspective, we spent too much time and effort and caused far too much aggravation for all of the good and honest dentists with this policy and it just made no sense. The policy remains that the completion/delivery date is the correct date of service but we aren't going to make everyone jump through hoops to prove it anymore. We will find the dentists playing those year-end games through our MAARS system and take the necessary steps to deal directly with them.

VDAJ: Does Delta of Virginia use zip codes to determine reimbursement rates? If so, can those zip codes be made known to participating dentists?

Dr. Dill: We do not use a Zip Code map to determine reimbursement rates. We have identified five distinct regions of the State that each encompass several counties. The Regions are: Northern VA, Central VA- which is the counties radiating out from Albemarle, Richmond – counties radiating out from Richmond, Tidewater and Southwest VA. Historically, there were originally seven Regions but due to changing demographics and costs, we reduced that number to five several years ago. Regional fee schedules and reimbursement determination is the most common methodology used in the industry today and it has worked well for us and our doctors.

It is probably worthwhile to state that we do not currently have any plans for an across the board reduction in reimbursement rates. We constantly work to strike the balance of providing competitive benefits to employers and individuals, while providing reimbursement rates that ensure we provide a robust, quality provider network.

SINCLAIR (Continued from page 47)

Plus, these customizable newsletters can be re-opened by the patient if they forget any details!

Press "0" for awesome customer support

How many times have you called a company only to be directed through a maze of digital voices before hanging up without answers to your questions?

When you set up your account with an automated platform, often your office is paired with a client success representative (CSR) whom you can talk to almost any part of the day. They are there to help your practice succeed. Taylor, our CSR, has a monthly phone meeting with our team to set up our newsletters for the month (the platform company designers do the designing for us), tells us about any new features we aren't using to our full advantage, and is a great sounding board for any marketing ideas we're trying to implement. I believe that these representatives are what have made many of these patient engagement systems so successful. They are out there asking practices what is working and what isn't, and using that info to make our practice better.

These platforms also offer several other great features as well, such as video birthday greetings. One even has a partnership with Care Credit™ and a patient portal for bill payment over the web. So step up to an automated patient engagement platform and let them help take your practice from good to great!

Dr. Cappy Sinclair, a VDA member, is a general dentist in Virginia Beach. He opened his practice, Coastal Cosmetic Dentistry, two years ago. Direct your questions to him at cappysinclair@gmail.com.

Heartiest CONGRATS ON YOUR Retirement

Time Well Spent

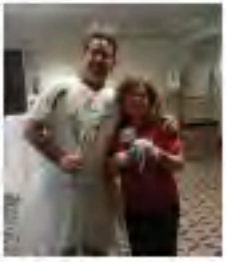
Many of you will be able to identify the VDA staffer pictured to the left as Linda Gilliam. After all, she has spent 23 years loyally serving as our Director of Finance. Linda has seen many changes during her employment including three Executive Directors, two office moves, an office fire, an IRS audit, and 23 different Presidents. She has had the pleasure of seeing some of you graduate from dental school and go on to be great leaders for dentistry. Now she is the one sparking some change by announcing her retirement this summer.

> *"As I prepare to leave I would like each of you to know that the VDA has been a huge part of my life and you all are counted as extended family. We have been through a great many challenges in the last couple of years. It was a difficult decision to make but one that will allow me to pursue my photography business and spend valuable time with my family."*

> *"I look forward to hearing all of the great things that will be accomplished under the leadership's capable hands. Thank you for allowing me to be part of your vision in dentistry for so many years."*

The VDA salutes Linda for her dedication to our mission and wishes her every happiness as she embarks on this new phase in life.

Linda can be reached at: [redacted]



Linda and the "tooth fairy"!

A Global Exchange Program with the VCU Department of Orthodontics

By: Dr. Bhavna Shroff

The orthodontic residency Class of 2014 visited the University of Messina in June 2013. This picture was taken on the terrace of the School of Dentistry in Messina, Sicily.

In recent years, orthodontics has experienced a globalization that is unprecedented in its history. The United States always has assumed a leadership role since the establishment of orthodontics as the first dental specialty in 1900 and the organization of the American Society of Orthodontists, now the American Association of Orthodontists (AAO). It is only in recent years that new teaching programs and departments have opened around the world fostering a need and a desire for international exchange voiced by the international community. The AAO has encouraged this globalization by opening its membership to international members and offering continuing education programs. Also, the AAO created the World Federation of Orthodontists in 1995 in an effort to facilitate this international exchange. The VCU School of Dentistry Department of Orthodontics has been actively engaged in this globalization effort through the VCU International Partnership Programs already established on the VCU campuses.

The partnership between the University of Messina School of Dentistry in Italy and the VCU School of Dentistry Department of Orthodontics was established in December 2007. The initial goals of the program were twofold: (1) to develop and foster a summer school program that involved the participation of both departments and offered a series of evidence-based lectures/seminars and case-based presentations for residents and faculty members and (2) to develop a collaborative research program that involves both departments.

Summer school program: a brief history

The first summer school program between the VCU School of Dentistry departments of orthodontics and oral and maxillofacial surgery was organized for Sept. 22 - 26, 2008 at the University of Messina School of Dentistry. Dr. Attilio Castaldo from the University of Trieste and Dr. Alberto Caprioglio from the University of Insubria were invited to present lectures to both groups of residents and faculty members. The VCU School of Dentistry Department of Orthodontics hosted the program April 25 - 30, 2009, and two of the visiting residents spent additional time in our department over the summer (May - July 2009). In 2010, the summer school program took place the week of May 28 - June 4, 2010 at the University of Messina School of Dentistry.

Since 2010, VCU orthodontic residents have participated in the summer school program every year, and the Department of Orthodontics continues to encourage the exchange of faculty and residents between both universities. Over the years, the format of the program has been changed to allow a more continuous exchange during the academic year. To sustain the program and not disrupt the clinical and academic activities of either department, we sent two residents at a time for a one week visit in 2011 and 2012 and most recently in 2014. The new format allowed residents to be more involved in the host department's clinical and didactic activities. Typically, residents have presented comprehensive reviews of the literature with a discussion of classic and current concepts. They also have presented cases in a seminar format and discussed treatment plans and various aspects of treatments. This approach has initiated and stimulated a healthy conversation on diagnosis, treatment planning and therapeutic approaches for our patients.

Colleagues from the Univeristy of Trieste (Drs. Castaldo and Contardo) and from the University of Messina (Drs. Nucera and Lo Giudice) visited in the summer and fall of 2014 and lectured to our residents. Their experience was enhanced by the time they spent in our clinic interacting with our residents, faculty and staff. The excellence of our educational program, which simulates a private practice setting, was of utmost interest to them as their institutions are exploring strategies to improve access to care and provide excellence in customer service.

In 2009, the University of Messina acquired an imaging program for their orthodontic clinic (Dolphin Imaging) after experiencing it at the VCU orthodontic clinic. It will be beneficial for the University of Messina to have residents from VCU, experienced with the Dolphin Imaging and Management Programs, demonstrate the use and incorporation of this technology for patient care, teaching programs and research. Thus, both departments will align their clinical record acquisition to facilitate a uniform records format highly desirable for teaching and joint research projects. Also, the clinical interaction will encourage the development of treatment protocols using new appliances such as temporary anchorage systems and self-ligation brackets. We anticipate that the exchange also will continue during the year through videoconferencing of seminars and case presentation in real time.

Research collaborations

The summer school program with the University of Messina also has fostered a number of potential research collaborations for the future. Two specific areas of research have been identified as potential collaborations: (1) the use of Cone Beam Computerized Tomography (CBCT) to assess maxillary asymmetries in patients with posterior crossbites and (2) a multicenter clinical trial on the efficacy of self-ligating brackets in the treatment of Class I and mild Class II dental malocclusion.

Independent studies have been initiated by the University of Messina evaluating the symmetry of

patients after rapid maxillary expansion using CBCT and at VCU evaluating the symmetry of patients after rapid maxillary expansion using 3dMD imaging. These are preliminary and pilot studies that will assist us in developing a long-term research plan. The next step of this research project is to gather a prospective sample of patients and compare the skeletal changes obtained after rapid palatal expansion (using CBCT) with the facial changes that occur during this procedure (using 3dMD) and their long term-stability. Faculty from both universities have collaborated and published one paper on preliminary data collected on this topic called "Effect of Orthopedic Maxillary Expansion on the Nasal Cavity Size in Growing Patients: A Low Dose Computer Tomographic Clinical Trial."1

The second area of research interest may focus on efficacy of treatment of self-ligating brackets in the treatment of Class I and Class II dental malocclusion. A randomized controlled clinical trial designed to compare treatment outcomes of patients treated with self-ligating brackets with patients treated with conventional brackets will be initiated at the VCU orthodontic clinic. It is a multi-center project involving the University of Messina, the University of Rome and the University of Naples in addition to VCU. We plan to enroll a total of 40 patients per site. Outcomes assessment will include time in treatment, patient discomfort, time spent at chair side, periodontal health assessment and evaluation of root resorption. The VCU site also will include an evaluation of the dental interdigitation as reflected by the occlusal scores measurement provides by the American Board of Orthodontics.

The summer school program has been very successful in developing excellent relationships with the University of Messina and a number of other Italian dental schools. It has allowed the VCU School of Dentistry Department of Orthodontics to connect with our Italian colleagues and offer a wonderful and enriching educational experience to the residents who have participated in this program. We hope to be able to continue this program in the future to foster and encourage more exchange between the two universities and schools in Italy, Europe and across the globe.

For more information about this program, please contact Dr. Bhavna Shroff, postgraduate program director, at bshroff@vcu.edu or (804) 828-9326.

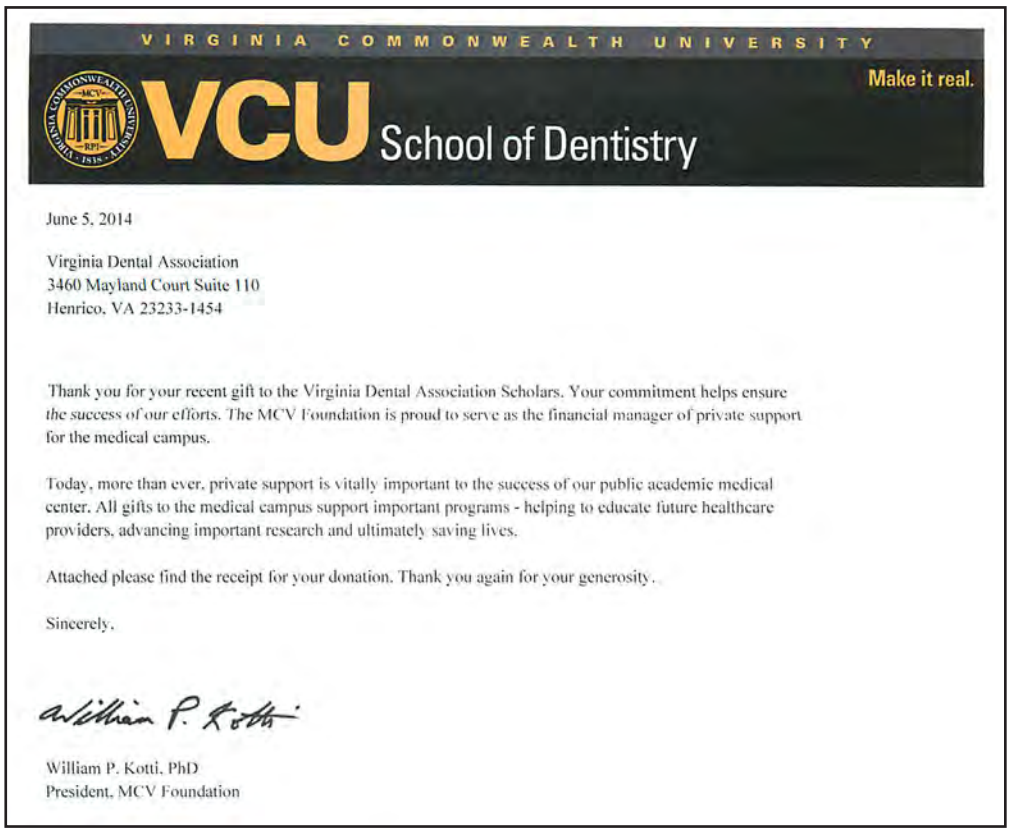
Bibliography:

1. Cordasco G, Nucera R, Fastuca, R, Matarese G, Lindauer SJ, Leone P, Martina R: Effects of orthopedic Maxillary Expansion on Nasal Cavity Size in Growing Subjects: A Low Dose Computer Tomographic Clinical Trial. Int J Pediatr Otorhinolaryngology, 76: 1547-1551.

Graduation from the VCU Department of Orthodontics summer school program.

L-R: Drs. Nucera, Lindauer, Cordasco, Shroff and Artemisia at the first meeting between the University of Messina School of Dentistry and the VCU School of Dentistry.

Virginia Dental Association Scholars



VIRGINIA COMMONWEALTH UNIVERSITY

Make it real.

VCU School of Dentistry

June 5, 2014

Virginia Dental Association
3460 Mayland Court Suite 110
Henrico, VA 23233-1454

Thank you for your recent gift to the Virginia Dental Association Scholars. Your commitment helps ensure the success of our efforts. The MCV Foundation is proud to serve as the financial manager of private support for the medical campus.

Today, more than ever, private support is vitally important to the success of our public academic medical center. All gifts to the medical campus support important programs - helping to educate future healthcare providers, advancing important research and ultimately saving lives.

Attached please find the receipt for your donation. Thank you again for your generosity.

Sincerely,

William P. Kotti

William P. Kotti, PhD
President, MCV Foundation

In April the VDA Board of Directors approved funds for the Virginia Dental Association Scholars Endowment. The VDA would donate $10,000 each year for the next ten years.

Virginia Dental Association Board of Directors

Actions in Brief - April 4, 2014

The following actions are reported as information only:

1. Approved – A resolution recommending the VDSC look into and evaluate the AccessDentist365 plan.

2. Approved – a resolution allowing the External Image Goal Group to spend up to $1,020.00 for a raised plastic VDA license plate frame. The cost would come from the Board of Directors Discretionary Fund.

3. Approved - A Board policy that the goal of the annual meeting is to create a financially successful meeting, yet at the same time, have a high quality CE and social environment.

   Background: Part of the Boards overall fiscal responsibility to the VDA is to look at all sources of income. The annual meeting is one source of income for the VDA and recommends the policy as a guideline for the Council on Sessions:

4. Approved - The gift agreement between the VDA and the MCV Foundation ($10,000.00 a year for ten years) and gives Terry Dickinson the authority to sign on behalf of the VDA.

5. Approved – A resolution reaffirming the February 4, 2014 e-mail vote approving the appointment of Danielle Ryan to replace Mike Abbott as an ADA alternate delegate.

6. Approved – A resolution reaffirming the February 14, 2014 e-mail vote approving the bank resolution required to open a Fidelity account by the VDA Investment Committee.

7. Approved - The request of the Non-covered Services Task Force for authorization to seek legal counsel regarding a possible legislative initiative. The Task Force is authorized to spend up to $2,000.00. At the discretion of the officers an additional $3,000.00 may be used from the Board's Discretionary Fund if needed. Maximum $5,000.00.

An Introduction to the 2013-2014 Component Presidents

Dr. Peter Cocolis

Northern Virginia Dental Society

My goals for the year are to help establish a more cohesive and member-oriented society by creating strong membership value through excellent continuing education programs, sound ethics, engaging our members in new social activities promoting more camaraderie and through our community outreach programs. My hope is to help build the strongest foundation possible for our profession which will inevitably provide our future generation of dental professionals with a solid stepping-stone on which to build and thrive in moving forward."

Member Awards & Recognition

Dr. Benita Miller

Appointed

Virginia Board of Health

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

Welcome New Members

By: Leslie Pinkston, VDA Director of Membership Information

Tidewater Dental Association

Dr. Tarek El-Badawy – Norfolk – MUST School of Dentistry/Egypt 2004, University of Maryland Dentistry 2013

Dr. Donovan Caves – Suffolk - Meharry Medical College 2012/Louisiana State University 2013 (General Dentistry/Moderate Sedation)

Dr. Lindsey Hosek – Virginia Beach – University of Maryland Dental School, 2013

Dr. Rajni Kapoor – Portsmouth – NYU College of Dentistry 2013

Dr. Shaun L. Smith – Norfolk – Howard University 2010/DC Howard University College of Dentistry 2012

Dr. Thomas T. Taylor – Suffolk – University of Pittsburgh 2009/Ohio State University 2012

Dr. Morgan T. Weis – Portsmouth – Virginia Commonwealth University 2001/NY-Children's Hospital 2004

Peninsula Dental Association

Dr. Thomas W. Feild – Hampton – Virginia Commonwealth University 2013

Dr. Brooke A. Hasenfelt – Williamsburg – Howard University 2012

Richmond Dental Society

Dr. Genevieve B. DeVera – Midlothian – Virginia Commonwealth University 1998

Dr. Matthew R. Estes – Midlothian – VCU 2011

Dr. Jazmin T. Floyd – Richmond – University of Medicine & Dentistry of New Jersey 2012/ Mountainside Hospital Dept. of Dentistry 2013

Dr. Justin W. Johnson – Richmond – Nova Southeastern University 2012/VCU School of Dentistry 2014

Dr. Kyle Nordeen – Richmond – University of Minnesota 2010

George A. Oley, III – Richmond – VCU 1979

Dr. Alexander Simon – Henrico – VCU School of Dentistry 2006 – BDS, DDS, MMedSc.

Piedmont Dental Society

Dr. John Guirguis – Roanoke – University of Louisville 2013

Dr. Evan Mitchell Johnson – Roanoke – University of Kentucky 2010/Advanced Ed. Program Orthodontics 2013

Dr. Monica Mosley – Danville – Howard University 2007/OH Metrohealth Medical Center 2010

Dr. Carter Tate – Salem - Virginia Commonwealth University 2013/Wake Forest Baptist Hospital GPR 2014

Shenandoah Valley Dental Association

Dr. Caitlin S. Batchelor – Harrisonburg – VCU 2009/ Wake Forest University School of Medicine 2011

Northern VA Dental Society

Dr. Sridevi Babu – Arlington – Boston University 2010

Dr. Maya Bachour – Ashburn – Loma Linda University 2006

Dr. David Chih-Yung Liang – Arlington – Columbia Univ. 2005/Emory Univ. SOM 2008/Nova SE Univ. School of Dental Medicine 2011

Dr. Quyen Dao – Falls Church – VCU 2000

Dr. Kim-Ngan Do – Falls Church – Romberg School of Dentistry 2013

Dr. Faisal Elhussein – Springfield – Nova Southeastern University 2012

Dr. Roselyne Gichana – Bethesda, MD – University of Pennsylvania 2006/Brigham & Women's Hospital 2007/Children's National Medical Center 2011

Dr. Soumyata M. Heggade – Herndon – New York University 2012

Dr. Brian Y. Kuo – Fredericksburg – New York University College of Dentistry 2012

Dr. Eun Young Lee – McLean – Pusan National University (South Korea) 1992/University of Pennsylvania 2011

Dr. Robert Lobo – Fairfax – VCU 2013

Dr. Joseph Lopez – Washington DC – University of Pittsburgh 2003/Pediatric Dentistry 2005

Dr. Veronica Miller – Vienna – Temple University, Philadelphia, PA 2003

Dr. Zia Rizvi – Ashburn – Guy's Hospital, London (United Kingdom) 1996/AEGD, University of Maryland at Baltimore 2000.

Dr. Sylvester C. Robinson – Sterling - Howard University 1980/ US Army Dental Activity/Fort Gordon 1993

Dr. Joseph A. Ruzzo – McLean – University of North Carolina, Chapel Hill 1989

Dr. Navdeep Sandhu Aulakh – Ashburn – Howard University 2004

Dr. Kesha J. Stephenson – Alexandria – Howard University 2006/Nova Southeastern University College of Dental Medicine 2007/ Howard University College of Dentistry 2011

Dr. Mostafa S. Tolba – McLean – University of Maryland 1986/Egypt-University of Alexandria 1979

Dr. Duy-Anh Vu – Chantilly – New York University 2011

In Memory of:

Name	City	Date of Death
Dr. Raymond Black	Orlando, FL	October 19, 2013
Dr. John Kannar	Vienna, VA	May 30, 2014

VDA Elected Leadership Candidates

Vote NOW at www.vadental.org/pro

President Elect:
1 position available

Dr. Richard L "Rick" Taliaferro
Candidate for the office of: *President Elect*

ADA Delegate:
5 positions available

Dr. David Anderson
Candidate for the office of: *ADA Delegate*

Dr. Alonzo Bell
Candidate for the office of: *ADA Delegate*

Dr. Alfred Certosimo
Candidate for the office of: *ADA Delegate*

Dr. Bruce Hutchison
Candidate for the office of: *ADA Delegate*

ADA Delegate (continued):
5 positions available

Dr. Kirk Norbo
Candidate for the office of: *ADA Delegate*

Dr. Roger Wood
Candidate for the office of: *ADA Delegate*

ADA Alternate Delegate:
7 positions available

Dr. Samuel Galstan
Candidate for the office of: *ADA Alternate Delegate*

Dr. Frank Iuorno
Candidate for the office of: *ADA Alternate Delegate*

Dr. Rodney Klima
Candidate for the office of: *ADA Alternate Delegate*

ADA Alternate Delegate (continued):
7 positions available

Dr. Danielle Ryan
Candidate for the office of: *ADA Alternate Delegate*

Dr. Cynthia Southern
Candidate for the office of: *ADA Alternate Delegate*

Dr. Richard L "Rick" Taliaferro
Candidate for the office of: *ADA Alternate Delegate*

Dr. Brenda Young
Candidate for the office of: *ADA Alternate Delegate*

Four dental practice management myths debunked

By: Laura Edwards

When it comes to clinical challenges, dentists embrace the opportunity to use skills learned throughout dental school and years of experience to positively affect a patient's dental health. Administrative or practice management challenges, however, are not viewed with the same enthusiasm. And, dental practices find it easy to fall prey to four myths that, if believed, negatively affect the practice's patient satisfaction, growth, revenue and sustainability. Here are four dental practice management myths debunked:

1. Waiting is a fact of life in a busy dental practice.

When every operatory is filled and patients are waiting to see hygienists, some dentists believe their practice is extremely productive. But, how much employee time is spent handling patient complaints about wait times, and how many patients won't return for future care? In many cases, it is not just patients waiting – hygienists are waiting for dentists to check their patients – which means their work takes longer than necessary.

One way to address this ongoing "holding pattern" in a dental office is to create a realistic schedule that optimizes productivity and minimizes patient complaints, beginning with the front office. By automating verification of eligibility and benefits, claims filing and payment tracking, practice managers and front office team members are able to decrease time spent in these areas to, in turn, take the time needed to schedule appropriately. Removing these time consuming activities also allows dental team members to communicate with each other and patients throughout the day to identify possible delays. When delays are inevitable, employees can offer patients the option to reschedule, come later in the day or choose to wait.

Ideally, it is a best practice to prevent delays by customizing the schedule to fit the practice. For example, take the five most often performed procedures and have all team members map out each step of a patient's visit. Collect more than just total time – identify start times and "breaks" during which the dentist can check hygienists' patients. Use this information to create schedules that reduce waiting times for patients and team members.

2. Reducing high accounts receivable days is time-consuming for the dental team.

While a practice's accounts receivable (A/R) is one indication of how much revenue will come into the practice, it represents "uncollected" dollars. Although accounts that are less than 30 days old may be paid by the insurer or the patient, there are many more that will age to 60 or 90 days old with no payment received. Attempting to collect on these accounts can take valuable employee time and the practice risks alienating patients and never collecting all funds due.

The first step to productive and efficient collections starts with a payment policy that outlines patient responsibilities and sets patient expectations to pay co-pays or deductibles at the time of service. To properly implement this policy, team members must be supported with technology and tools that enable easy, online verification of benefits, up-to-date information about patient co-pays and deductibles, and accurate payment estimates for patients. Further, find a financial management solution that integrates with the practice management system to enhance rather than disrupt practice workflow.

Another best practice to reduce A/R days is to offer payment options to patients who are unable to pay the full amount of their responsibility initially. Payment plans or dental financing through a third party not only provide patients affordable options but also improve cash flow to the office and reduce collections costs.

3. It is impossible to create a longstanding dental team.

The Bureau of Labor Statistics' data shows the average worker stays at a job 4.4 years, but 91 percent of Millennials – born between 1977 and 1997 – plan to stay three years or less in a job.[1] While these statistics indicate employees' willingness to change jobs for a better location, better pay or other personal reasons, there is one key strategy that improves the likelihood team members will stay beyond three or four years—hiring the right person.

Find the best person for the job as opposed to any person to fill an opening. In some cases, hiring a less experienced person willing to learn is the better choice if the work ethic and personality are a good fit for the practice. For example, be sure the candidate understands the need to cross-train in other areas or help others if there is downtime in one area – assuming this is part of your practice philosophy. Taking the time to hire well reduces stress and improves the work environment for everyone – team members, dentists and patients – which increases the number of employees who choose to stay with the practice.

4. The treatment plan has been explained, now it is up to the patient to accept it.

This case acceptance myth is partially true – the patient makes the final decision. The myth is false, however, if a dentist and the team believe one good explanation is all the patient needs to make that decision. Ideally, the patient hears the recommended treatment plan multiple times – from the dentist who initially presents the plan, from the dental technician who offers to answer additional questions, from the financial coordinator who repeats the recommended plan while providing an accurate estimate of the patient's responsibility and from the scheduler who makes the appointment before the patient leaves the office. At each point, encouraging a patient to ask questions and offering as much information as possible helps a patient feel comfortable making the appointment for follow-up treatment.

There is no magic formula for managing the operational and administrative aspects of a dental practice. But, dental practices don't have to fall flat with these myths. The best approach is to recognize the unique characteristics of the practice, its team members and patients, and develop policies designed to provide excellent patient care in a fiscally sound manner. Then, support team members with the technology and well-designed work processes needed to maximize productivity, improve cash flow, maintain a good work environment and increase patient satisfaction.

About the author
Laura Edwards is director of marketing at OneMind Health, a provider of intuitive, cloud-based software and services that help dental practices large and small improve workflows throughout the revenue cycle.

1 Meister, J. "Job Hopping Is the 'New Normal' for Millennials: Three Ways to Prevent a Human Resource Nightmare" Forbes August 2012 http://www.forbes.com/sites/jeannemeister/2012/08/14/job-hopping-is-the-new-normal-for-millennials-three-ways-to-prevent-a-human-resource-nightmare/ Accessed online June 9, 2014.

How do you want your future to look back at you?

How do you want your patients to look back at you in the future?
Do you know what your restorations are made of? And where?
Trusted quality name brand products, or just a generic knockoff?

“15 Year Limited Warranty on Lava Plus Full Contour Crowns”

“10 Year Limited Warranty on Lava Ultimate Crowns”

We are a Premier Lava Milling Center
Call for details on how we may help serve your restorative needs.

Custom designed
Custom Manufactured
Finished by hand
in Our Laboratory
Here in America

Baran Dental Laboratory

The Choice for Crowns, Bridges & Implants
4433-E Brookfield Corporate Drive, Chantilly, Virginia 20151
703.961.0116/800.941.4291

& Milling Center

Virginia Dental Journal

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

VISIT US ONLINE AT www.VADENTAL.org/PRO

THE Virginia MEETING®

September 17-21, 2014

Southern Charm, Virginia Hospitality

VDA SERVICES

Peer Reviewed • Members-Only Benefits • Supporting the VDA

By utilizing the VDA Services endorsed vendors below, VDA Members receive special benefits and discounted pricing while supporting the VDA and its programs — Help Us, Help You!

B&B Insurance—Insurance Agency
877-832-9113; bb-insurance.com

Bank of America—Credit Cards
800-932-2775; bankofamerica.com

Bank of America Practice Solutions
800-497-6067

ProSites—Website Design
888-466-7975; prosites.com/vda

Miles Global — Dental Consulting
877-343-0909; milesglobal.net

Demandforce—Marketing & Communications
800-210-0355; demandforce.com/vda

Medical Protective—Malpractice Insurance
877-832-9113; medpro.com

OneMind Health—Revenue Cycle Management
866-633-1090; onemindhealth.com

Paychex — Complete Payroll Services
800-729-2439; paychex.com

CareCredit—Patient Payment Plans
800-300-3046 ext. 4519
carecredit.com/dental

SolmeteX— Amalgam Separators
800-216-5505; solmetex.com

Transworld Systems—Collections
804-282-9007;transworldsystems.com/gkurtz

VDA Services Gloves—Gloves
877-484-6149; vdaservicesgloves.com

Worldpay— Credit Card Processing
804-836-6798; worldpay.us