Virginia Dental Journal

Volume 91, Number 2 • April, May & June 2014

15th Anniversary

Missions of Mercy

Virginia Dental Association Foundation

We gave them back **their smiles.**

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61 - Elected Leadership Candidates

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VDA
Virginia Dental Association

Virginia Dental Journal

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On The Cover

A Message from your President...

We are battered by waves of disruptive change:

Commercially oriented group practices

Mid-level providers

Decreasing reimbursement rates

Student debt

Decreasing Dentist Income

The survival of our traditional model of practice, under these immense pressures, depends on our willingness to adapt. But for those willing to understand these changes, using the VDA/ADA Storm resources we create this year, working together, we construct a safe harbor, where there will be the ability to thrive in the midst of the Storm.

Yes! We are transforming the VDA!

With our Strategic Plan, in conjunction with the ADA, we are constructing useful resources so that our members can flourish in the turbulent times we are facing. We are not interested in just reacting to the Storm of change, we are focused on the future: what do we need to do now to secure our members' success and build their reputation in the future? When Wayne Gretzky was asked why he was the best of the best, he said that he skates to where the puck will be, not where it is. The Storm we face lasts as far as we can see into the future. To build the safe harbor that not just helps our members survive, but to prosper well into the future, we must base our work on the core principals of the past - like ethics, advocacy, and service to those who most need our help. These are what uphold and differentiate us in turbulent times. We also recognize the need for change as we adapt by creating a new culture around our membership efforts, building the reputation of our members and the Association, and identifying and training our next generation of leaders. Our one-year Plan begins the transformation and your Board of Directors is monitoring each step of the way through our Goal Tracking initiative to insure its completion. I am extremely thankful for all of you who are working so hard to execute our initiatives. It is the success of our Strategic Plan, where dentists work together, that builds the safe harbor and the opportunities for members to create the profession that thrives in the future.

We all walk in the footsteps of those who came before us. Thanks to them, we will create our own new destiny. Whether we're well seasoned or wet behind the ears, we each owe it to our profession's future to work together. For it is together that we will reach our dreams while the Storm ravages those outside our membership. The work we do now is about who we've been in the past, and what we can be in the future.

To learn more on the Storm, the Strategic Plan, or Goal Tracking; go to www.vadental.org/pro

Trustee's Corner

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

The 2013 Board of Trustees Meeting

The meeting began on a Thursday, for some of us, as the second-year Trustees joined the new Trustees for their orientation. The second-year Trustees were there to give perspective and insight to the first-year group. The Board is fortunate to have a great new Trustee class, very engaged and very eager to perform the duties of The Board. The new class consists of Drs. Red Stevens, Alabama; Jeff Cole, Delaware; Andy Kwasny, Pennsylvania; Gary Jeffers, Michigan and Second VP Dr. Jonathan Shenkin of Maine. Participants were again asked to fill out a survey so that the orientation can continue to be improved from year to year.

Saturday was a busy day during which our standing committees met to begin their work for the year. The work formed the basis for many of our later discussions on audit, financial, compensation, governance and strategic planning issues. I would like to acknowledge Drs. Bob Plage and Ted Sherwin who serve on the Audit and Finance Committee respectively as HOD members. Their contribution and insight are invaluable.

On Sunday, we took an in-depth look into our draft strategic plan, Members First 2020. Council chairs and co-chairs were invited to the session. This was a tremendous opportunity for collaboration for volunteer leaders from the councils, committees, commissions and ADA staff. The Strategic Planning Steering Committee did a great job presenting this strategic session. As a result of these discussions, the Steering Committee now has guidance to further develop the draft plan.

On Monday morning, as a part of the BOT's oversight responsibility, we heard a report from Dr. Jim Mercer, the chair of ADABEI. The ADA's for profit arm is performing above budget in revenue and below budget in expenses. ADABEI continues to increase the diversity of its revenue streams and plans to continue that effort into the coming year.

We discussed the need to improve alignment across the tripartite. This is an integral part of the future of our new strategic plan. We learned that alignment is not the same as integration, which could be viewed as a loss of autonomy by constituents. Alignment is based on trust and involves the tripartite moving forward together in the same general direction toward common goals. It is clear that the Board is unified in recognizing the need for alignment in order to reverse the recent membership trends.

Alignment will improve member experience and all efforts must be member centered. All constituents and component societies need to recognize the importance of alignment and work in full partnership with the ADA on these efforts. Communication will be the key to these efforts and will be important to our success. We all need to be flexible in our communication and change as the discussions continue. One suggestion is to use the words "shared partnership to better serve the member", instead of "alignment" which may be a threat to tripartite autonomy. This shared partnership will involve many dimensions, such as branding, technology, member service, member value and more. However, the most important aspect of this partnership is TRUST- trust between all aspects of the tripartite.

The Council on Members Insurance and Retirement Plans is continuing its work on improving member value. The council is looking into a web portal our members can use to navigate options under the Affordable Care Act. Subsequently, earlier this month, the council did recommend to the Board that we move forward with this recommendation and via a BOT conference call the Board, after much discussion, voted to move forward with the councils recommendation. You will hear more about this decision in the near future.

The Board also discussed the issue of specialty recognition and the fact that other organizations and groups are beginning to move in this direction. What is the risk to the ADA, can they bypass state laws and practice acts, and will there be lawsuits? These were some of the questions asked and discussed. Dr. Anthony Ziebert presented some valuable background information and we will continue to monitor this situation.

The Board also discussed the need for greater continuity in our representation on the Dental Quality Alliance. The Board urged councils with DQA representation to consider succession planning for that representation.

The Board also enjoyed meeting and having lunch with the current class of the Diversity Institute. The Institute continues to be a visible commitment of the ADA to fostering leadership growth and membership within diverse populations. The Board has recommended increasing the class size in the future.

And now, on a somber note, I would ask that you all join me in expressing my condolences and heartfelt sorrow to Dr. Terry Dickinson in the loss of his son, Kevin.

Virginia Department of Health Professions

Virginia's Prescription Monitoring Program (PMP) Update:

Virginia and West Virginia now work together across state lines in the fight against prescription drug abuse as part of the National Association of Boards of Pharmacy Prescription Monitoring Program InterConnect (PMPi). The online system allows physicians and prescribers in both states as well as several other states to mutually review a patient's use of controlled substances, reduce drug diversion and make doctor shopping more difficult. As of early March 2014, practitioners in Virginia have access to prescription data in West Virginia's PMP. West Virginia has also implemented reciprocal capabilities with Virginia's PMP.

Other PMPi states as of 2014 include:
Arizona, Connecticut, Delaware, Illinois, Indiana, Kansas, Louisiana, Michigan, New Mexico, North Dakota, Ohio, South Carolina, South Dakota, Tennessee

For more information about Virginia's Prescription Monitoring Program (PMP) visit: http://www.dhp.virginia.gov/dhp_programs/pmp/default.asp

MESSAGE FROM THE EDITOR

Dr. Richard F. Roadcap

After losing his bid to be re-elected President in 1912, Teddy Roosevelt embarked on a descent of the last great uncharted river in South America. The trip nearly cost him his life. Malaria, impassable rapids, and hostile Indians with poison-tipped arrows were only some of the dangers he and his crew of explorers faced as they navigated the Rio da Dúvida. Roosevelt explained to a friend, "I had to go. It was my last chance to be a boy." [1]

Why did you want to be a dentist? The reasons for applying to dental school are as varied as the applicants themselves. For some there's a legacy: perhaps a parent, or a close relative was a member of the profession. Such influences are hard to ignore. Or maybe, an aspiring student saw in a dental professional a role model or mentor, and sought to follow in their footsteps. A young man or woman may feel the career is a logical extension of their gifts and their interests, and find themselves irretrievably drawn to its pursuit. But for many of us, there was an intrinsic desire to help others. I suspect many applicants commit this idea to paper (or now, in electronic format), not to burnish an otherwise gleaming resume', but as a result of a character trait needed to succeed in a world short on leadership. The American Dental Education Association (ADEA) lists "service to others" as the second most important reason for pursuing a career in dentistry, close behind "control of time". [2]

Along the way, somehow our concerns were re-aligned. There were loans to pay back, practices to open, children to raise, homes to buy, and homes to sell, and then move yet again. Practicing dentistry never seemed to leave enough time for anything other than, well…practicing dentistry. Just when it seemed we couldn't be any more short of time, life became busier still. Our youthful idealism lay (mortally) wounded. We can be forgiven for thinking that our lives were not what we expected.

In 1999, a dialogue between a nun, a lobbyist, a registered nurse, a local politician, and a dentist from Texas who'd moved to Virginia to take a new job, developed. Their discussion centered on the lack of access to dental care in a remote corner of the state. A visit that year to southwest Virginia, by Dr. Terry Dickinson, led to the first Missions of Mercy in 2000. Patients and dental volunteers came in droves. What started as a makeshift dental clinic in the hangar of the Lonesome Pine Airport grew, in fifteen years, to be the largest dental outreach project in the US. I doubt that any of the parties involved saw, in 1999, that the Missions of Mercy would grow to include 30 states, and in Virginia, treat over 50,000 patients who couldn't otherwise afford dental care.

A disinterested party may say there's no explanation for the appeal of the MOM projects. After fifteen years there's certainly been no sign of compassion fatigue. I've been asked more than once to give up my chair to another doctor who'd volunteered, but for whom there was no place to work. Like applicants to dental school, each volunteer doctor may have his or her own reason for serving. I'll invite you to read the comments from MOM volunteers in this issue. Lisa Lloyd, RDH, says she finds "every patient that I have been blessed to treat" grateful for her service. Dr. David L. Jones, now an orthodontist, says his experience prior to dental school "literally changed my life." We know our lives have been changed; we hope the lives of the patients have been changed also.

To serve as a MOM project volunteer, we don't risk death from piranhas or indigenous tribesmen. But we do need to step beyond our comfort zone, from our tightly controlled environment of our offices, to a world where we don't have complete control, and where patients who have no other resources need our help. Nearly two-thirds of prospective dental students say they seek to help others, but after graduation, life gets in the way. Service is a necessary part of becoming the consummate dental professional. The MOM projects provide that part of their portfolio that has gone missing. That's the appeal of MOM: we had to go, it might be our last chance to be a doctor.

1 Candice Millard. *River of Doubt*. (New York: Doubleday, 2005)

2 http://www.adea.org/uploadedFiles/ADEA/Content_Conversion/publications/Trendsin-DentalEducation2009/TDEStudents/Documents/Choosing_Dentistry_files/ReasonsWhyStudentsPursueCareerinDentistry.pdf

VDA Foundation's MOM Project Awarded $5,000 by BJ's Charitable Foundation

Richmond, VA –The Virginia Dental Association Foundation (VDAF) recently received a generous $5,000 grant from the BJ's Charitable Foundation (BJCF) to purchase disposable dental supplies and one-step denture unit templates and to repair or replace small dental equipment for the Mission of Mercy (MOM) program.

In 2013, eight MOM projects were completed in Virginia and 4,256 patients were treated. The value of donated care was over $3.3 million, with more than 2,585 volunteers. To learn more or volunteer with a 2014 MOM project, please visit, www.vdaf.org.

"BJ's Charitable Foundation was established with the mission to enrich every community BJ's Wholesale Clubs serve. The foundation supports nonprofit organizations that primarily benefit the underprivileged in the area of basic needs (hunger prevention, self-sufficiency, education and health). For more information about BJ's Charitable Foundation, please visit, www.bjs.com/charity."

Thank you to BJ's Charitable Foundation for awarding Virginia Dental Association Foundation a grant to help us provide dental care for underserved Virginians through the MOM program. Your partnership is greatly appreciated!

Understanding and navigating the storms of change in our profession

By: Dr. James R. Schroeder

It is truly a dynamic stage of life in our dental profession with many implications for us as individual ractitioners. Currently I have the unique opportunity to work with young graduates entering the world of dental practice, coaching established practices making decisions to strengthen their practice and the senior group of dentists contemplating their exit strategy. Each of these groups has different needs but they all share the common denominator of entering the road of the unknown. Skills and tools required for successful decision making go far beyond those acquired in our professional training. Hopefully you have read the excellent information provided by the VDA leadership that the changing landscape of our profession will impact all of us in different ways depending on our stage in the life cycle of our profession.

Regardless of the stage of your career, the knowledge base for decision-making has increased dramatically. How does one begin to understand the new tool box necessary to navigate the storm taking place in the health care profession? We start with our own self-assessment of our skill and knowledge base outside dentistry.

Allow me to share a recent experience with two dental students to illustrate a critical skill needed to begin planning and developing our personal tool box. Student A comes to me with a vigorous complaint that all of his patients are lousy and everyone cancels their appointment! Student B presents to me that he has too many patients and they all want to come in as soon as possible! This story has great implications for each of us to examine how we draw conclusions and make strategies to move forward in our practice.

Student A drew the conclusion that his patients were at fault. Although we are all taught **self-assessment** in our technical skills, rarely are we engaged in the self-assessment of our leadership, communication and ability to navigate our changing environment. My challenge to Student A was examining his communication and ability to build effective relationships and value with his patients. We have a billion dollar industry competing for our patients' time and money. Student B invested considerable time in development of his patient relationships and recognized delivering information does not guarantee patient understanding and ownership of the information. Unless understanding has been created communication did not occur.

How does this story apply to our own practice situations?

Self -Assessment is an important part of our development as a professional. Understanding our leadership style and decision-making process is often overlooked leaving blind spots that your staffs, partners or family are reluctant to point out. Unintended negative consequences of our decisions are often overlooked and are a hindrance to practice growth. Regardless of your stage of professional growth I encourage you to be a life-long learner in development of your leadership skills. Failure to understand the development of this important skill will be the rate limiting factor in the growth of you practice and professional development. *The Truth about Leadership*, by James M. Kouzes and Barry Z. Posner, highlights ten principles:

1. You make a difference
2. Credibility is the foundation of leadership
3. Values drive commitment
4. Focusing on the future sets leaders apart
5. You can't do it alone
6. Trust rules
7. Challenge is the crucible for greatness
8. You either lead by example or you don't lead at all
9. The best leaders are the best learners
10. Leadership is an affair of the heart

A colleague asked me "Jim what does any of the above have to do with dentistry?" My explanation was we work so hard doing dentistry and the technical aspects that our glasses fail to see beyond the mouth. This is a very dangerous condition as we are unable to see the change taking place around us and the impact it will have on our practice. Just a few examples are:

A. Blindly signing on as a provider with all insurance programs without understanding the financial and quality implications on your practice.
B. Corporate dentistry and government are impacting the delivery of health care.
C. The experience your patient encounters will be greatly impacted not only by your dentistry but by our ability to develop your staff.
D. Future associate needs are changing as we see the class make-up of 55% female with a growing debt upon graduation ranging from $150,000 -$250,000. Failure to understand and vet a new associate's expectations and clarify your expectations can trigger a tremendous storm.
E. Careful examination of your employee handbook to assure compliance with the ever-changing labor law.
F. Compliance with HIPAA and OSHA.
G. Regular and careful data analysis of both the expense and revenue side of your business. From that data analysis make targeted strategies to impact the metrics you want to change.

Your approach to increasing your income may center on expense reduction which can also have unintended negative consequences of poor service and low morale. Cost reduction alone will not lead to prosperity. Innovative strategies must be developed with your team to increase revenue. This can be an opportunity to move outside your comfort zone and acquire new skills.

> The resources I am suggesting in this article have nothing to do your technical skills,but everything to do with your professional and practice development. At 65 years old and 30 plus years in practice I would be so bold as to say they will be the rate-limiting factor to the growth of your practice.

Regardless of your current practice status I encourage you and your team to do a book study over the next month. *Our Iceberg is Melting* by John Kotter and Holger Rathgeber, about understanding change, is another tool necessary to navigate our current environment. I always found change within the dental team exciting but challenging. As a leader your understanding of change is important to be effective and lasting.

Planning and **execution** on a daily basis is a requirement and usually a strength for a successful dental practice. Often it is so consuming we fail to take the time to plan for next year in the area of growth, and examination of accurate data to make decisions on strategies that will ensure continued success. The inability to execute a desired plan often leaves us scratching our head when we realize we are in the same place as last year.

I am encouraging you to examine your glasses to assure your sight not only includes the immediate care of your patients, but the swirl of external forces exerting pressure on our profession and your practice. Critical areas for your growth and understanding to respond to this external swirl of pressures are **self-assessment, leadership, planning and execution.**

Please contact my office for a free personal profile to start your own self-assessment and leadership development. Help your staff develop through your book study.

Editor's Note: Dr. James R. Schroeder practiced dentistry in Richmond and is the founder of Leadership by Design. He can be reached at (804) 307-5108, drjimschroeder@gmail.com.

LETTERS TO THE EDITOR

Why Palpate?

Marvin E. Pizer, DDS, MA, MS, FACOMS (hon)*

To the misfortune of some patients, too many health professionals have been negligent when performing a physical examination of their patient's mouth and adjacent tissues. This includes the dentist and the physician who evaluate oral health.

Inspection without palpation is an inadequate clinical examination of the mouth. There are significant lesions that cannot be visualized by the best inspection because these lesions are submucosal. Only thorough palpation will detect these lesions and determine what needs to be biopsied and diagnosed for treatment.

The patient whom I describe is an example of a missed significant malignancy. Seen by a primary care physician, and a family dentist who did inspect her mouth, they assured her of "no evidence of cancer". Both doctors forgot the hard and soft tissues, intra- and extra- orally that need to be palpated.

A few weeks later the patient had some very mild discomfort in her lower lip. She inserted her finger on the lower lip intra-orally and felt a small "lump". Since her dentist and physician recently had assured her of no mouth disease, she felt no reason to be concerned. Somewhere between six months and one year, the lump was still present. Finally she returned to her physician, who confirmed our finding and referred her to our office.

After doing a complete medical history, I did a complete inspection and palpation of the neck and mouth. I noted a very palpable mass, submucosal in the midline of the lower lip. The mass felt well-circumscribed, heart-shaped, and measured 2.5 cm by 2.5 cm. The mass was firm, but not indurated and not tender to palpation.

I advised an excisional biopsy within the next week. Apparently I did not advise the patient that this could be a very serious lesion, as she did not return to the office until six weeks later. At this visit I did an excisional biopsy and much to my surprise, the pathology report revealed a malignant mucoepidermoid carcinoma – intermediate grade. The excisional biopsy did not remove the lesion completely as the margins contained malignant cells. I did the usual consultations with the pathologist, radiation oncologist, medical oncologist, and surgical oncologist. They all agreed that a wide local resection would be the procedure of choice.

This was accomplished under general anesthesia. The area was excised wide and deep – even involving skin. This pathology report stated all margins clean "with no malignant disease near margins". To be certain, the patient was worked-up again to rule out regional or distant metastases.

The patient was followed closely for the next two years at which time she left this area and moved to a distant state. She was strongly advised to have an oral and maxillofacial surgeon or surgical oncologist to continue close observation of her mouth, head and neck, plus chest.

Fortunately, she did this, because four years later, she developed metastases to the right and left submandibular regions of her neck. The surgical oncologist did a bilateral suprahyoid resection and found malignant lymph nodes on both sides. These lymph nodes were diagnosed as metastatic adenosquamous carcinoma. Post-operatively both sides of her neck were irradiated. Following irradiation she was followed closely by her surgical oncologist. Her oncologist wrote me after following her three years after irradiation and there were no complications since. He also advised me that he would follow her indefinitely and if there were any changes he would inform me. I practiced 16 years before retiring and have not received any communication from the oncologist.

This is a very unusual malignancy of the lip. If it was noted and diagnosed earlier, and the mass was smaller, the excisional biopsy could have excised the entire tumor then, and perhaps it would have not metastasized. In retrospect, now I would follow with irradiation after surgery, even if it is a controversial modality for this cancer.

It is a generally accepted fact that early diagnosis and treatment leads to a better prognosis. That is why it is important to palpate as well as inspect the hard and soft tissues in the mouth and neck. Who knows what evil lurks in the submucosa of our domain of expertise?

DO NOT HESITATE TO PALPATE!

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1. Pizer ME, Dubois DD. Mucoepidermoid carcinoma of the lower lip. J Oral Maxillofac Surg 1986; 900-902
2. Healy WV, et. al. Mucoepidermoid carcinoma of salivary origins: classification, clinical- pathologic correlation and results of treatment. Cancer 1970; 26:368

*Formerly:
Clinical Professor of Oral and Maxillofacial Surgery, Medical College of Virginia, Virginia Commonwealth University, Richmond.

Research Professor and Adjunct Professor of Medical Physiology, The American University, Washington, DC

The Storm

Dr. Bob Allen

I was impressed to receive notice that the VDA is swallowing a very large pill necessary to meet the coming "tsunami" that is overwhelming the dental profession. I would hope that the plan is reviewed at all levels of progress and tweaked from time to time as goals are re-assessed and as priorities change.

Please keep the membership involved at all levels.

This "storm" also involves the Board of Dentistry. I did not see anything in the plan with the BOD mentioned.

Did I miss something?

The dental school is included, as it should be. There are too many dentists seeking too few "willing' patients.

The patients that need dentistry at the most fundamental levels have no money. The thinking of graduating students must be directed at the population that needs the care the new dentist is trained to provide and that the new dentist wants to deliver.

There is plenty of dentistry to be done, but patients are not well informed of what they can do to prevent dental disease at home with simple changes in personal hygiene and diet.

Many consider it inevitable that they lose all their teeth. Dentistry is not doing a good job of changing that mind set.

The dentists selected to serve on each goal are well suited to help solve the plan; expectations are high. Keep this Strategic plan on the front burner with monthly or weekly updates of the progress at each level.

Dr. Bob Allen, VCU 1959
Life member, VDA and ADA

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Miles Global — Dental Consulting
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Thank you to the Faculty at the VCU School of Dentistry!

Left: Members of the VCU School of Dentistry Faculty who are also members of the VDA.

Right: Dr. Ted Sherwin, VDA President, presenting at the March 7th meeting.

Thank you to the VCU School of Dentistry Faculty for inviting Dr. Ted Sherwin, VDA President, to present at their faculty meeting on March 7th. So many members of the faculty at the VCU School of Dentistry are members of the VDA and their participation in organized dentistry is sincerely appreciated. Recent data from the ADA has shown that the membership trends among faculty at dental schools has a direct correlation with the future membership patterns of their students — the faculty at VCU are setting an excellent example for the profession's next generation!

Dr. Sherwin presented a program titled: "A Storm is Here, Survival is Optional." Focused on very dramatic shifts that are occurring in the dental profession, the presentation not only addressed the changes but also highlighted resources that the VDA is providing to members to help them during this time of unprecedented change. For more information on this presentation and the resources available to members, please visit: www.vadental.org/pro.

2014 Legislation Centers Around One Core Principle: Increasing Access to Dental Care For Virginia's Most Vulnerable Citizens

By: Laura Givens

The VDA's Day on the Hill began early on January 17 for the more than 100 dentists and VCU dental students gathered at Richmond's downtown Omni Hotel. Before heading to the Capitol, the assembled member dentists and students received a briefing from VDA lobbyists and heard the remarks of Delegate Bobby Orrock (R-Spotsylvania), Chairman of the House Committee on Health, Welfare and Institutions.

In his prepared remarks, Delegate Orrock underscored the important role played by provider professionals in helping the General Assembly formulate Virginia's health care policies.

For his part, Delegate Orrock's commitment to the health care of his constituents is well known, witness his service as a Board member of Fredericksburg's Lloyd F. Moss Free Clinic. This clinic provides medical and dental care and prescription medications to uninsured residents of that city and nearby counties, including those in Delegate Orrock's House district.

The issues covered in the VDA lobbyists' presentation and the results of VDA lobbying on these topics are discussed below.

Incentivize Dentists to Continue Participation in *Smiles for Children* Dental Medicaid Program

Virginia's children have benefited enormously from the state's *Smiles for Children* dental Medicaid program. Even Uncle Sam agrees: recognizing *Smiles for Children* as one of the best dental Medicaid programs in the country! Virginia's dental Medicaid utilization rate was 58% in 2012 compared with 26% in 2005, the year *Smiles for Children* was launched. Providers have increased 260% since then, too.

Smiles for Children is well known to Virginia legislators as well as Uncle Sam, helping to produce broad bipartisan support this year for identical legislation offered by the Shenandoah Valley's Senator Emmett Hanger (SB412) and Henrico Delegate John O'Bannon (HB147). Both bills accomplish the same purpose: authorizing the Department of Medical Assistance Services (DMAS) and the Virginia Retirement System (VRS) to establish a plan that will enable dentists and oral and maxillofacial surgeons participating in the dental Medicaid program to deposit a portion of their reimbursed Medicaid payments into tax-deferred VRS accounts.

Final Legislative Action: Both bills were well received, without a single negative vote cast against either measure. Both bills contain a delayed effective date of January 1, 2015; both measures will expire on January 1, 2020 unless the program is renewed by the General Assembly. After passage by both the House and Senate, Governor McAuliffe has signed Delegate O'Bannon's bill; the Governor's signature is expected soon on Senator Hanger's legislation.

Harness Technology to Improve Children's Oral Health

With the VDA's support, Senator Dick Black introduced SB647, to authorize a teledentistry pilot program for Medicaid-eligible children. As our readers know, teledentistry is the use of information technology and telecommunications for dental care, consultation, education and public awareness. The legislation stipulated that the pilot program protocol be memorialized in a Memorandum of Understanding involving the VDA and an experienced telemedicine vendor. If enacted, the pilot program will be limited to children in school districts where more than 50% of elementary aged children have no recent history of dental care.

Final Legislative Action: The VDA worked closely with various stakeholders as the bill proceeded through the Senate and House. As the session neared its end, however, SB647 was pulled into the legislature's ongoing concerns about Medicaid expansion, and the measure was sent to the Medicaid Innovation and Reform Commission (MIRC) for additional study later this year. This action will give the VDA and other stakeholders the opportunity to further flesh out the specifics and costs of the program before formal consideration in the 2015 General Assembly.

Preserve Dental Clinics Transition Safety Net

In 2012 and 2013, the General Assembly appropriated funds to enable the Virginia Department of Health (VDH) to transition its local dental clinics from a treatment model to a preventive care model. The VDA advocated for these appropriations and has worked with the Department and stakeholder groups to facilitate the transition during the past several years.

The budget introduced by Governor McDonnell before his departure in early January contained funds for each year of the biennium to facilitate local dental clinic transitions.

VDA members and VCU dental students attending the Day on the Hill event lobbied legislators to support the Governor's introduced budget. Further, they asked that legislators insist that those funds specifically earmarked for dental services be used only for these purposes.

Final Legislative Action: The General Assembly adjourned on March 8 without approving either a budget for the six months ending June 30 or the biennium budget to take effect July 1. This means that the fate of appropriations for transitioning local VDH dental clinics are yet to be finalized. Stay tuned!

Funding for the Missions of Mercy (MOM) Project

Governor McDonnell's introduced budget included appropriations of $16,280 for FY 2015 and $16,280 for FY 2016 for the Missions of Mercy (MOM) Project. The VDA asked that legislators support these important MOM appropriations.

Final Legislative Action: Like funds for the VDH clinic transitions, appropriations for MOM are yet to be determined. The Governor has already announced that he will summon legislators for a special session on March 24. This session will address a budget for the six months ending June 30 and the biennium budget beginning July 1.

The VDA thanks all member dentists, VCU dental students and other members of the dental community who participated at this year's Day on the Hill. We had a wonderful large group of participants this year and hope that this event will continue to grow in the years to come. The success that the VDA had during this past General Assembly session and many before it certainly gives proof to the incredible importance of the Day on the Hill activities.

Please mark your calendars to attend the 2015 Day on the Hill: January 16, 2015.

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

Check out our photo gallery
https://vadental.org/pro/gallery/1929

The Virginia Dental Political Action Committee (VADPAC) Contribution Update

In 2013, VADPAC raised $377,065. Thanks to the contributions from many members, VADPAC was able to contribute to incumbents and candidates during a very important election year and to continue relationship-building with lawmakers. Your generosity has played a large part in protecting the dental profession and our patients and we are confident that it will continue and the goal of $375,000 will be reached in 2014. As noted in the previous article, the VDA once again had a very successful 2014 General Assembly and our membership is often held up as a model for legislative accomplishment. Your continued participation in VADPAC will ensure we maintain the very positive reputation that our members have in the halls of the Capitol and protect our patients and the profession.

Component	% of Members Contributing to Date	2014 VADPAC Goal	Amount Contributed to Date	Per Capita Contribution	% of Goal Achieved
1 (Tidewater)	31%	$45,500	$23,380	$239	51%
2 (Peninsula)	38%	$27,500	$18,511	$257	67%
3 (Southside)	42%	$14,000	$9,125	$240	65%
4 (Richmond)	34%	$67,750	$48,448	$278	72%
5 (Piedmont)	32%	$30,000	$19,423	$240	65%
6 (Southwest VA)	43%	$25,250	$19,527	$300	77%
7 (Shenandoah Valley)	31%	$30,000	$18,485	$280	61%
8 (Northern VA)	33%	$135,000	$91,509	$281	68%
Other Contributions					
TOTAL	**34%**	**$375,000**	**$248,408**	**$264**	**66%**

Total Contributions: $248,408

Amount Needed to Reach Goal: $126,592

2014 Goal: $375,000

As you are aware, our profession continues to face an economic downturn and many threats from insurance companies, both of which impact our ability to serve the most vulnerable patients. And, it is for that reason that we must remain more focused than ever in protecting patients and our profession. We need your generous support today! If you have not already contributed to VADPAC for the 2014 year or, if you would like to increase your contribution, please visit https://vadental.org/pro/vadpac. Please contact Laura Givens at givens@vadental.org or 804-523-2185 with questions.

VADPAC and the VDA, 2014: A Successful Legislative Session!

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

Ever wonder why you donate money to VADPAC, where it goes, and what it accomplishes? The 2014 Virginia state legislative session is a prime example of how our money, wisely distributed among legislators who will take the time to listen to our views, and act on our requests when our requests are sound and reasonable, makes a difference. Last year, all delegates faced the election process and VADPAC carefully weighed which ones had supported our issues in the past, and which ones had not. VADPAC does not favor a political party – it represents our profession. Our contributions to legislators are more or less equally split between Republicans and Democrats. Some years we lean to one side or the other – because that's who has the power at the moment. But the power changes, and so does the tilt of our political contributions. In 2013, we supported the candidate who won the election to become delegate over 98.5% of the time we got involved. That's a pretty good success rate.

This year we approached the legislators with three main "asks." These were all focused on helping the most vulnerable citizens of Virginia get and maintain the necessary dental care that they require. The three bills have all passed both the House and the Senate of Virginia and have been, or likely soon will be, signed into law by the Governor.

These three bills addressed are summarized here:

1. The Medicaid Deferred Compensation bills (House and Senate versions) will give dentists an incentive to maintain current service levels for the Smiles for Children program. This will allow dentists to put monies to be paid to them for treating Medicaid children into a retirement account (independent of any other retirement account you might have) to grow, untaxed, until it is withdrawn.
2. The budgeting process includes many line items that can easily be trimmed at the whim of anyone seeking to cut a line and save some money in the budget. The Governor, in his proposed budget, included money for the state Department of Health clinics transition program. The VDA asked for that money to be preserved and not spent on other programs. That was approved, making sure that access to oral health services are not denied these underserved populations.
3. Funding for the VDA Foundation's Mission of Mercy projects was left in the budget and will be used to increase access to those in rural and remote areas of the state who are in need of dental care.

These may not seems like large victories, but the budget process is messy and maintaining money in a budget that is increasingly being trimmed to its barest bones is a big accomplishment. VADPAC support of the right legislators, active support by phone calls and personal visits from VDA members, and the work of our exceptional VDA lobbyists made this success possible. The VDA continues to do the right thing and move dentistry in Virginia forward, protecting our citizens' oral health and protecting the way we practice dentistry in Virginia.

Be part of the success and contribute to VADPAC. Be part of a winning team. We need your support to continue to look out for our patients and our practices. Don't know how to get involved? Call me! I can explain how VADPAC works and why it is urgent for every VDA member dentist to contribute.

Doctor, where do you stand?

Daniel L. Orr II, DDS, PhD, JD, MD*

Figure 1. Gila Regional Medical Center Advertising

Sadly, we regularly read about government abuses of one type or another, foisted by less than honored public servants onto innocent citizens, including doctors.[1] Conversely, dentists specifically are viewed as some of the most trustworthy, ethical, and moral citizens in the land, and the public's opinion of our profession has been trending upwards.[2] In contrast, less than half the population trusts the President, and that trust,[3] along with overall approval, continues to trend downwards.[4] The irony that much of the current dissatisfaction with the President is secondary to dysfunctional, and allegedly illegal,[5] health care planning is not lost on health professionals. The majority of doctors rightly cherish their professional reputations, and the primacy of patient centered care, second to nothing else.

All this may help explain why it was so distressing to recently read about David Eckert. Mr. Eckert has claimed in a federal lawsuit that he was forced to submit to several rectal cavity searches, three enemas, a colonoscopy, and two radiographic studies after being pulled over for rolling through a stop sign. The Deming, Luna County, police officer who arrested Mr. Eckert determined to perform, or in this case have performed, a lower gastro-intestinal system search because Mr. Eckert was standing awkwardly. A local judge issued a search warrant to force Mr. Eckert to submit to an anal cavity search. Mr. Eckert was first transported to Deming's Members Memorial Hospital emergency room, where physicians refused to acquiesce to the officer's demand to invade Mr. Eckert, in spite of the warrant. Undeterred, law enforcement then marched Mr. Eckert into Gila Regional Medical Center (GRMC) in Silver City, in adjacent Grant County, where Mr. Eckert was violated. GRMC advertises itself as: "Your Community Hospital," "We believe we are all caregivers," "Patient Centered Care," etc. (Figure 1.)

Mr. Eckert's attorney opines that the search warrant was illegal in Grant County and likely faulty in several other ways, such as breadth and probable cause (Mr. Eckert would have to be creative and agile indeed to effectively conceal illicit drugs as alleged during the officer's walk from his patrol vehicle to Mr. Eckert's car). The search produced no secreted drugs. Tellingly, GRMC did not forget to bill Mr. Eckert for its patient centered care (Deming Police refused financial responsibility for the pre-arrest alleged existing condition). More tellingly, GRMC has now threatened Mr. Eckert with court action for his refusal to pay for the battery of batteries, anesthetics, lab work, radiology, etc. After Mr. Eckert's arrest in January 2013, the now former Deming Police Chief Michael Carillo was deemed qualified to accept employment as the Grant County Detention Center Administrator in March. New Police Chief Brandon Gigante stated: "We follow the law in every aspect and follow procedures and protocols we have in place," possibly mutually exclusive terms according to Mr. Eckert's suit.

What is most distressing about Mr. Eckert's case is that trusted doctors were aggressively involved in the promulgation of distrusted regulators' directives, in spite of the patient's clear refusal to consent. What does such conduct do to our image? Frankly, it is chilling. In this case, it is simply not hyperbole to compare GRMC health professionals to Karl Brandt, M.D. (Figure 2) Dr. Brandt was a physician in Germany before the beginning of World War II. Through a series of events, Dr. Brandt eventually became Hitler's personal surgeon. Incrementally, Dr. Brandt's loyalty was transferred from his patients to the Nazi state. He likely was the only person sentenced to death by both the Axis, after unilaterally leaving Hitler's employ, and the Allies, for crimes against humanity.[6] Dr. Brandt was hanged after his trial at Nuremburg. At the end of the Nuremburg doctor trials, it was determined that German doctors were not intrinsically evil, but that they were primarily loyal to the government to the detriment of their patients, and that: "We should never let doctors work for the government again."[7]

Dentists are not insulated from having to answer questions peripheral to situations such as Mr. Eckert's. When the police bring an arrested patient into a private office for court-ordered evidence gathering, what should be done? If the prisoner gives consent, after being informed that evidence obtained might incriminate or exonerate him, the dilemma is solved. But what if the prisoner does not consent?

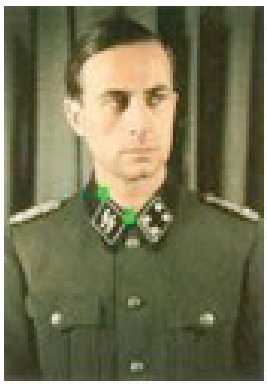

Figure 2. Dr. Karl Brandt

Some dentists have special relationships with the government, such as military doctors, prison doctors, or forensic odontologists. In a limited survey, one of each of these was asked if it was ever appropriate to treat a patient refusing consent. The prison dentist, with over ten years of experience in his state's system, shared that he would absolutely decline.[8] An experienced forensic odontologist felt that if the request was court ordered, he might participate depending on the circumstances, although he had not participated to date.[9] A retired military OMS replied he had never treated a patient without consent but might have, again, depending on the totality of the circumstances.[10] All three independently agreed that intervention with Mr. Eckert would have been inappropriate.

What are the lessons to be learned from Mr. Eckert's case? Do the rights of the body politic supersede the rights of individual patients as far as doctors are concerned? Is altruism for the state's benefit true altruism when innocent until proven guilty individuals are forced to undergo inquisition at our hands? But for operating under the color of law, the alleged regulatory perpetrators and their doctor accomplices would themselves be on trial for conspiracy, false imprisonment, assault, battery, theft (auto and larceny), robbery, and rape/sodomy at least.

Indeed, as in days past, these are interesting times offering interesting questions for doctors.

Doctor ubi stas?

(Endnotes)

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*Dr. Orr is President of the American Association of Dental Editors & Journalists, Board Certified in Oral and Maxillofacial Surgery, Dental Anesthesiology, Legal Medicine, and a member of the California Bar.

Ethics: If The Shoe Were On The Other Foot

Dr. Garrett Gouldin; Member, Ethics and Judicial Affairs Committee

Dr. Henry Botuck, retired restorative dentist and member of the Northern Virginia Dental Society Ethics Committee, was kind enough to forward me an article from the New England Journal of Medicine entitled, "Talking with Patients about Other Clinicians' Errors." (http://www.nejm.org/doi/full/10.1056/NEJMsb1303119). After reading this interesting piece, I am reminded that our friends in the medical community experience many of the same ethical dilemmas we do as dentists, and it is interesting to examine the parallels.

The article explores the challenges practitioners face when disclosing to their own patients that they have made a harmful error in treatment. Additionally, the article describes the issues that often arise when one suspects, or when a patient suggests, that a colleague may have made an error in treatment. Our own Code of Ethics, The ADA Principles of Ethics and Code of Professional Conduct, states that "Dentists shall be obliged to report to the appropriate reviewing agency as determined by the local component or constituent society instances of gross or continual faulty treatment by other dentists." It is rare in dentistry to see gross or continual faulty treatment by other dentists, but more frequent to hear from patients who are angry about their dental condition and who assign blame to their previous dentist. As this article points out, without firsthand knowledge of treatment history, determining if faulty treatment has occurred becomes difficult, if not impossible. The suggestion is made in this article to reach out and talk with the previous physician to get a better understanding of the situation. However, in dentistry, and it appears in medicine, communication among colleagues at this critical juncture often doesn't happen. "Fear of how a colleague will react…reluctance to risk acquiring an unfavorable reputation with colleagues…interprofessional and other cultural differences….dependence on colleagues for referrals…and time constraints"... can pose obstacles that prevent this important conversation from happening.

Such colleague to colleague conversations can be daunting, especially for dentists, many of whom are non-confrontational. Nevertheless, in my experience, making that call and exploring for more information nearly always leads to a better understanding of the situation, an enhanced outcome for the patient, and a strengthening of the relationship with our fellow dentist. After all, if the shoe were on the other foot, we would want to be contacted.

My wife reminded me today that "Ethics is character in action." Many of the ethical matters that are reviewed in this insightful article and that we face in dentistry revolve around strength of character, and this article affirms that having the character to communicate with our colleagues at the more difficult times is the key to learning and to improved patient care.

VDA Membership Task Force Summary Report:

An Assessment of Factors Related to Non-renewal of VDA Membership: Part I

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

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ABSTRACT

BACKGROUND

A declining trend of ADA/VDA membership renewals is a critical issue in ADA/VDA's sustainability. Multiple factors related to membership renewals are best assessed using a multiple regression analysis to consider all factors together.

METHODS

The VDA Membership Task Force analyzed 2010 Virginia Dental Association (VDA) membership data to identify predominant factors to VDA membership renewals. Variables included demographic characteristics, practice characteristics, relationship with ADA/VDA, and whether they renewed their VDA membership.

RESULTS

While gender, race, and practice type were not related to membership renewal, the following characteristics were related to renewal: age, specialty, geographic location/local component, ADA years, VDA years, and dues payment percentage. Non-renewals occur predominantly in the beginning years of membership: those with ADA membership years <5 years, 6-10 years, and 11-15 years renew 81%, 94%,and 98% of the time, respectively (P = 0.0004). Sixty-nine percent of all attrition occurs before 15 years of ADA membership contrasting to the attrition rate of 1.5% after 14 years.

CONCLUSIONS

The multiple regression analysis revealed that newer members were much less likely to renew their membership and should be the target segment in relationship building. Further studies are needed to evaluate core services performance related to membership renewals especially for the vulnerable groups. This will help ADA/VDA enhance services with high impacts on retaining its members.

Over the past twenty years, VDA membership market share has been declining and non-renewal rates have been increasing (Figure 1). In 2010, Virginia Dental Association (VDA) had 2,891 members representing 67.7% of active licensed dentists in Virginia, a decline from 72.8% in 2005. (1) Representing all dentists in the constituent as one voice can become more difficult and decreased revenues from dues affect financial management of the VDA. To improve membership market share, VDA's leadership made membership renewal a priority followed by recruitment and has very actively pursued a number of membership initiatives.(2),(3) Specifically, VDA membership growth workshop 2009 stated "VDA can track and understand buyer behavior among those who join and those who renew, the better able the organization can position itself as the clear choice among dentists" recognizing that joining ADA/VDA is a deliberate "choice"(2) and ADA/VDA need to actively pursue retaining its members. ADA Survey of 2011 Nonrenews summarized responses of 292 former ADA members regarding reasons for not renewing and concluded that this was a deliberate choice with "cost of membership" and "benefits as they relate to costs" being major reasons.(4) Forty one percent of the former members stated that they did not plan to re-join. The VDA Membership Task Force was created in 2011 to assess the significant factors associated with VDA membership renewals with a goal to improve membership retention.

METHODS

The membership data were obtained from VDA as of December 2010. The data included information on member characteristics, practice information, years of relationship with ADA/VDA, dues paid (0, 25%, 50%, 75%, and 100% of the normal dues) and whether or not they renewed their membership. A non-renewal in 2010 was defined as a VDA member in 2009 who did not pay 2010 dues, as of December 2010.

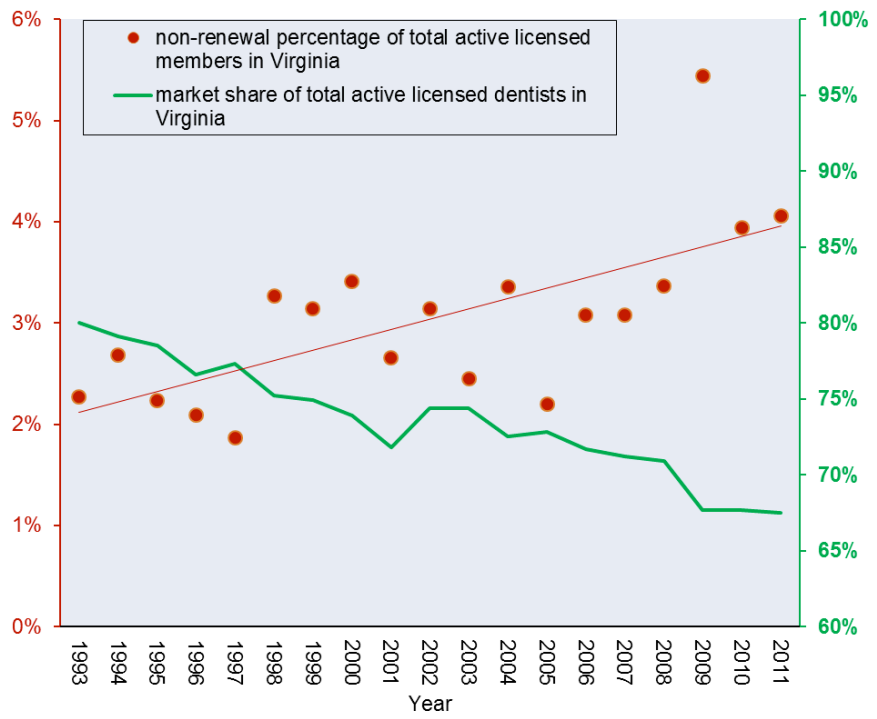
The member characteristics tested for a relationship to renewal were grouped into three sets of factors: demographic characteristics, practice characteristics, and relationship with ADA/VDA. This study was approved by VCU Institutional Review Board.

MULTIPLE REGRESSION ANALYSIS

Because many of the membership characteristics are correlated with each other, it is very important to consider all factors at the same time when

FIGURES

Figure 1. Trends in VDA Market Share and Non-renewal Rates



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TABLES

Table 1. Demographic characteristics and distribution of ADA/VDA membership non-renewals and renewals in 2010 (*N* = 3417).

DEMOGRAPHIC CHARACTERISTIC	No.[b] (%) NON-RENEW	No.[b] (%) RENEW	*P* VALUE[a]
Gender			
Female	43 (6.6)	611 (93.4)	0.273
Male	65 (2.4)	2689 (97.6)	
Race[c]			
[not reported]	31 (6.0)	484 (94.0)	
Black	14 (11.1)	112 (88.9)	
Hispanic	3 (5.5)	52 (94.5)	0.576
American Indian	0 (0.0)	4 (100.0)	
Asian, Pacific Islander	7 (3.5)	195 (96.5)	
White	58 (2.3)	2457 (97.7)	
Age decade[c]			
20s	2 (5.0)	38 (95.0)	
30s	39 (8.1)	445 (91.9)	
40s	22 (4.0)	522 (96.0)	
50s	18 (2.3)	757 (97.7)	<.0001
60s	15 (1.8)	803 (98.2)	
70s	6 (1.6)	359 (98.4)	
80s	3 (1.5)	198 (98.5)	
90s	0 (0.0)	39 (100.0)	

[a] Multiple logistic regression results from a model including the following factors: gender, race, age, practice type, specialty, VDA component, ADA total years, VDA total years, and the payment percentage.
[b] Number of members who either did not renew or did renew their membership in 2010.
[c] For the purposes of multiple regression analysis, race was collapsed into 4 categories: not reported, Black, Hispanic, and all others combined. Age was entered as a continuous covariate in the logistic regression model.
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Table 2. Practice characteristics and distribution of ADA/VDA membership non-renewals and renewals in 2010 (N = 3417).

PRACTICE CHARACTERISTIC	No.[b] (%) NON-RENEW	No.[b] (%) RENEW	*P* VALUE[a]
Practice Type			
<None>	29 (5.9)	462 (94.1)	
Associate	15 (10.4)	129 (89.6)	0.883
Non Owner	11 (4.2)	252 (95.8)	
Owner	58 (2.3)	2461 (97.7)	
Specialty[c]			
<None>	4 (0.7)	552 (99.3)	
Dental Public Health	0 (0.0)	11 (100.0)	
Oral and Maxillofacial Pathology	0 (0.0)	7 (100.0)	
Periodontics	1 (1.0)	103 (99.0)	
Prosthodontics	1 (1.8)	56 (98.2)	0.022
Oral and Maxillofacial Surgery	3 (2.0)	145 (98.0)	
Orthodontics and Dentofacial Orthopedics	5 (2.4)	205 (97.6)	
Endodontics	3 (3.0)	97 (97.0)	
Pediatric Dentistry	4 (3.7)	103 (96.3)	
General Practice	92 (4.3)	2025 (95.7)	
Geographic component			
Southside	2 (1.7)	116 (98.3)	
Southwest	5 (2.8)	175 (97.2)	
Peninsula	4 (1.8)	220 (98.2)	
Shenandoah	5 (1.9)	260 (98.1)	0.0095
Piedmont	3 (1.0)	303 (99.0)	
Tidewater	21 (4.9)	407 (95.1)	
Richmond	26 (4.2)	588 (95.8)	
Northern VA	47 (3.7)	1235 (96.3)	

[a] Multiple logistic regression results from a model including the following factors: gender, race, age, practice type, specialty, VDA component, ADA total years, VDA total years, and the payment percentage.
[b] Number of members who either did not renew or did renew their membership in 2010.
[C] For the purposes of multiple regression analysis, the specialties were collapsed into three groups: High renewing specialties = <none>, dental public health, pathology, and periodontics; Low renewing specialties = endodontics, pediatric dentistry and general practice; Middle renewing specialties = all others.
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examining what factors are strongly associated with the outcome of interest: renew or no renew of the membership. A multiple regression analysis is a statistical method that enables identifying significant factors associated with the outcome of interest while considering multiple factors at the same time. This is in contrast to a bivariate analysis (simple linear regression or a chi-square test) which examines a relationship between the outcome of interest and only one factor at one time. Although simple and convenient, a bivariate analysis could result in misleading findings as some factors could be labeled as significant but indeed are not significant, after other factors are considered.

For our purpose, a multiple regression analysis was used and it included the following factors: gender, race, age, practice type, specialty, VDA component, ADA total years, VDA total years, and the dues payment percentage. Analyses were performed using SAS software (SAS version 9.3 and JMP pro version 10, SAS Institute, Inc., Cary NC). Statistical significance was identified using alpha<0.05.

RESULTS

There were 3417 individuals who were members in 2009 and 113 did not renew their membership by the end of 2010 resulting in the renewal rate of 96.7%.

DEMOGRAPHIC CHARACTERISTICS

Our multiple regression analysis revealed gender not to be significantly related to renewal (Table 1, P = 0.273). This is in contrast to the bivariate finding, where a chi-square test indicated gender to be significantly related to renewal (P < .0001) — female members renew less often. Using a chi-square test, age also appears to be significantly related to renewal—younger individuals renew less often. But gender and age are correlated (female dentists are more likely to be younger) and when gender, age, and all other factors considered together, gender is not a significant factor.

The multivariable regression analysis indicated that factors other than race contribute to the apparent difference of renewal. There is no evidence for renewal rates being different depending upon race/ethnicity (P > 0.57). Again, this is in contrast to the results when considering only race. In a bivariate analysis, race mistakenly appeared to be associated with renewal: whites renew at about 98% and blacks renew at the lowest renewal rate (89%).

Age appeared be related to membership renewal significantly in the multivariable regression model (P < .0001) as well as in the chi-square test.

PRACTICE CHARACTERISTICS

Table 2 shows the relationship between three practice factors and membership renewal. In the multivariable regression analysis, practice type becomes not significant (P > 0.8) while it would appear that Associates renew less often than Owners (89.6% vs. 97.7%, chi-square P <.0001) in chi-square test.

Specialty-related differences remain significant in the multivariable regression analysis (P = 0.022) as well as bivariate analysis. The highest renewal rate occurs in those not specifying a specialty, DPH, OMFP, and Periodontics (≥ 99%). Those with a more typical renewal rate (approximately 97.8%) include: Prosthodontics, OMFS, and Orthodontics. The lowest renewals occur in Endodontics, Pediatric Dentistry, and GP (95.7%).

The VDA's eight local components vary in membership size ranging from 118 members to 1282 members. Both the chi-square (P < 0.02) and the multiple regression analysis show that there is a difference in renewal depending upon component (P = 0.0095). The three largest components represent 68% of all members and accounted for 84% of all non-renews.

RELATIONSHIP WITH ADA/VDA

The effect of membership history is shown in Table 3. Those with fewer than five ADA membership years renew at a substantially lower rate than those with 6-10 years (81% versus 94%). And those with 11-15 ADA years renew 98% of the time. This trend toward ADA total years being positively related to renewal is significant (P = 0.0004). Similarly, those with five or fewer VDA years renew at a substantially lower rate than even those with 5-10 years of VDA membership (88% vs 98%). This trend toward VDA total years being positively related to renewal is significant (P < 0.03) after adjusting other factors.

To further explore what seems to be going on with VDA years and ADA years, the scatterplot in Figure 2 shows dots for individuals with each combination. The grey dots are for individuals who DO renew and the orange/red dots indicate the number of non-renewals. It is apparent that most orange/red dots show within earlier stage of membership. To zoom in on the problem we see those with 15 years or fewer in each membership (Figure 3). There are 1101 people in this category (32% of all) and they account for 68% of the non-renewals. Of the 1101 people in this figure, 7% fail to renew. This is compared to the 2342 other people who fail to renew at 1.5%.

The dues payment percentage clearly makes a difference in the non-renewal rate (Figure 4). However, discounted membership does not always seem to result in a higher renewal rate. Those who pay zero-percent essentially always renew (<1% non-renewal) and those who pay 100% did not renew at a higher rate (3%). Those who pay between 25% and 75% have higher non-renewal rate than those who pay 100%. In fact, the highest non-renewal occurs in those who pay only 25%.

DISCUSSION - IMPORTANCE OF MULTIPLE REGRESSION ANALYSIS

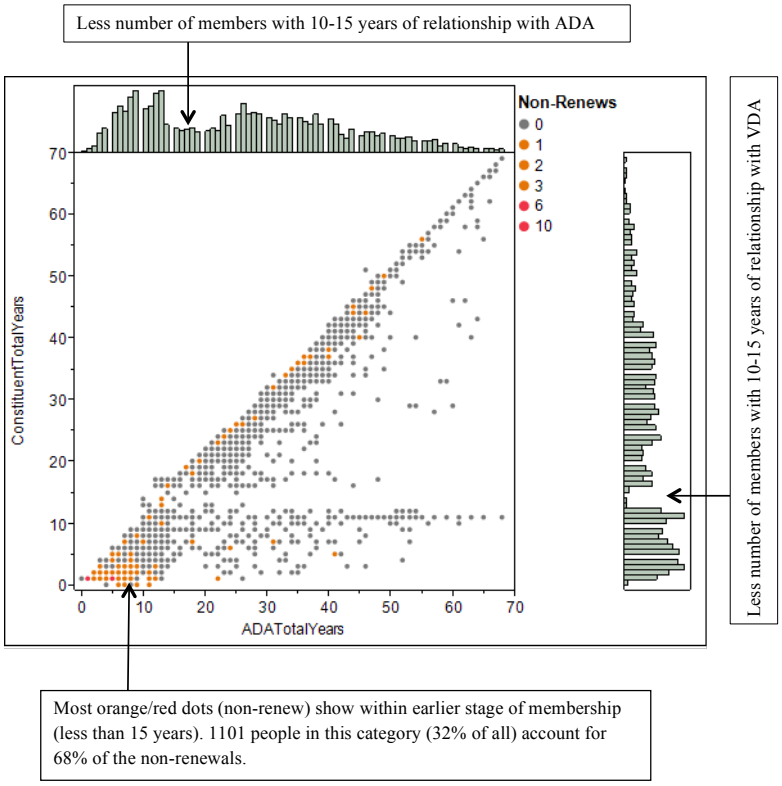
Since the multiple factors affecting the renewal are correlated with each other, all factors should be considered together. Our multiple regression analysis revealed that member age, specialty, ADA

Table 3. Relationship with ADA/VDA and distribution of ADA/VDA membership non-renewals and renewals in 2010 (N = 3417).

MEMBERSHIP HISTORY	No.[b] (%) NON-RENEW	No.[b] (%) RENEW	*P* VALUE[a]
ADA years[c]			
1 to 5	35 (19.2)	147 (80.8)	
6 to 10	33 (6.4)	485 (93.6)	
11 to 15	10 (2.2)	448 (97.8)	
16 to 20	4 (1.8)	219 (98.2)	0.0004
21 to 30	11 (1.5)	703 (98.5)	
31 to 40	12 (1.8)	665 (98.2)	
41 to 50	7 (1.8)	375 (98.2)	
51+	1 (0.4)	262 (99.6)	
VDA years[c]			
1 to 5	70 (12.1)	510 (87.9)	
6 to 10	9 (1.9)	469 (98.1)	
11 to 15	3 (1.2)	245 (98.8)	
16 to 20	4 (1.5)	266 (98.5)	0.027
21 to 30	9 (1.4)	646 (98.6)	
31 to 40	12 (1.8)	654 (98.2)	
41 to 50	5 (1.8)	273 (98.2)	
51+	1 (0.4)	241 (99.6)	
Payment percentage			
0	5 (0.8)	630 (99.2)	
25	18 (13.2)	118 (86.8)	<.0001
50	19 (5.0)	362 (95.0)	
75	7 (10.1)	62 (89.9)	
100	64 (2.9)	2132 (97.1)	

[a] Multiple logistic regression results from a model including the following factors: gender, race, age, practice type, specialty, VDA component, ADA total years, VDA total years, and the payment percentage.
[b] Number of members who either did not renew or did renew their membership in 2010.
[c] For the purposes of analysis, both ADA total years and VDA total years were entered as a continuous covariate in the logistic regression model. Both ADA and VDA totals years have a positive effect on renewal, after adjusting for other factors.
(reprinted with permission, Coe J., Best A. Moneyball: The Art of Winning the ADA Membership Renewal Game. J of Relationship Marketing. 2014)

Figure 2. VDA Total Years by ADA Total Years and Non-Renews

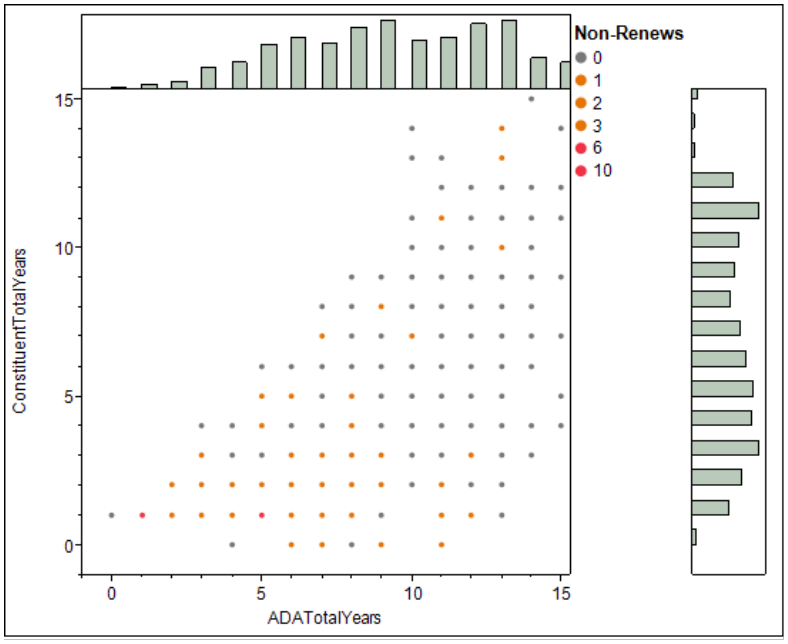


total membership years, VDA total membership years, VDA local component, and dues payment percentage are the significant factors to membership renewal after adjusting all other factors. Factors such as gender and race were found not to be significant after adjusting other factors whereas common anecdotal perception is that women and ethnic minorities are less likely to renew and should be the target group to improve retention.

Importance of building relationship with existing members (especially members less than 15 years of membership)

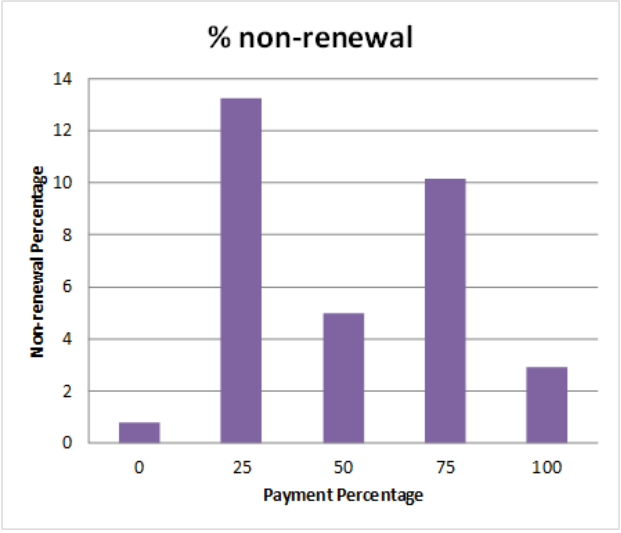
Our study found that the less time a member has been with ADA/VDA, the less likely he or she will renew his or her membership. Apparently relationship building should be actively pursued between individual members and the association on an on-going basis: identify what benefits or services members value the most and actively help them to realize and experience the membership's value. Existing individual members can help with this effort. This will lead to increased retention especially for the most vulnerable group of newer members (less than 15 years of relationship with ADA/VDA).

Figure 3. VDA Total Years by ADA Total Years and Non-Renews (zoomed-in: 15 years or fewer in each membership)



(Among the 1101 people within 15 years of fewer in the membership, 7% fail to renew contrast to 1.5% for those who have more than 15 years of relationship with ADA/VDA.)

Figure 4. Non-renewal and Dues Payment Percentage



(Discounted membership does not always result in a higher renewal rate.
Those who pay between 25% and 75% have higher non-renewal rate than those who pay 100%.)

Importance of identifying membership segments and designing value according to the segments

Our study showed that not all members are the same in terms of the likelihood of renewing their membership. Likewise, membership benefits that influence renewals in one membership segment may be different from those for other segments. Customizing the membership value and benefits to different membership segments should help member satisfaction and renewals.

CONCLUSIONS

Our analysis of 2010 VDA membership identified factors associated with membership renewals after adjusting all other factors and found that member age, ADA total membership years, and VDA total membership years were the most significant factors related to the membership retention. Newer members were much less likely to renew their membership and should be the association leadership and individual existing members' target group in building relationships which will eventually lead into an increase of member retention.

ACKNOWLEDGMENT

Sincere gratitude is expressed to the Virginia Dental Association, especially to Ms. Leslie Pinkston, Dr. Roger Wood, and Dr. Terry Dickinson.

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Direct correspondence to Dr. Julie M. Coe, Department of General Practice VCU School of Dentistry, Lyons Dental Building, 520 North 12th Street, P.O. Box 980566, Richmond, VA 23298; 804-828-2977 phone; 804-828-3159 fax; jmcoe@vcu.edu email.

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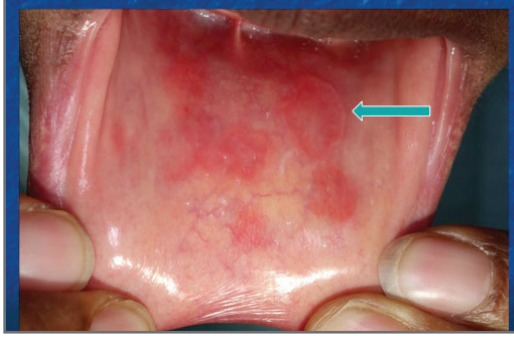
PathologyPuzzler

with Dr. John Svirsky

Figure 1 Presentation



A forty year old African-American female presented to the Virginia Commonwealth University School of Dentistry for a six-month recall appointment. Her medical history included management of high blood pressure with hydrochlorothiazide, type II diabetes with diet control and vitamin D and iron supplements. Past surgeries include gallbladder removal 2007 and lipoma removal from right arm in 2013. During the head and neck examination lesions were found on the lower lip mucosa (Figure 1). The patient had no symptoms and no idea that the lesions existed. There was no change in the medical history or oral hygiene products in the past six months. The patient was instructed to stop flavored oral hygiene products and return to the clinic in two weeks.

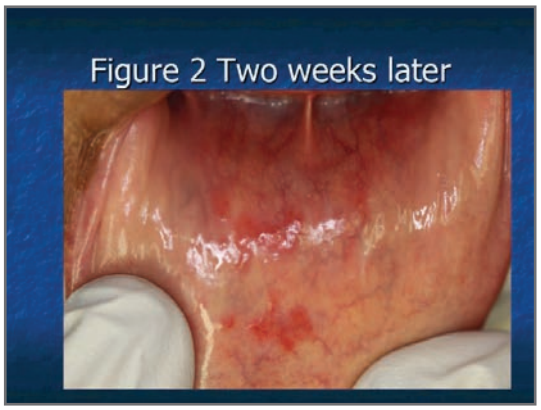
Which of the following should be included in your differential diagnosis?

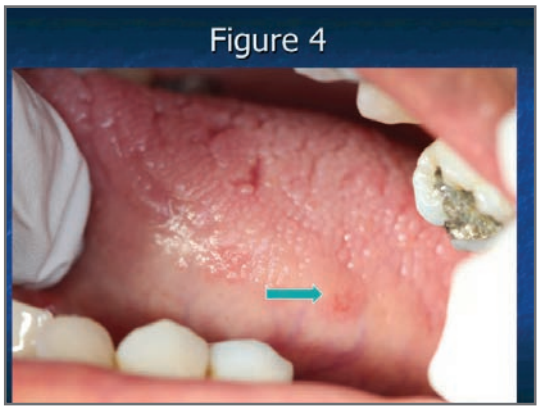
1. Erythema migrans
2. Erythema multiforme
3. Erythroplakia
4. Leukoplakia
5. Lichen planus
6. Mucositis
7. Oral lupus lesions
8. Pemphigoid
9. Pemphigus
10. Squamous cell carcinoma

Continued on page 23

PathologyPuzzler
with Dr. John Svirsky

Continued from page 21



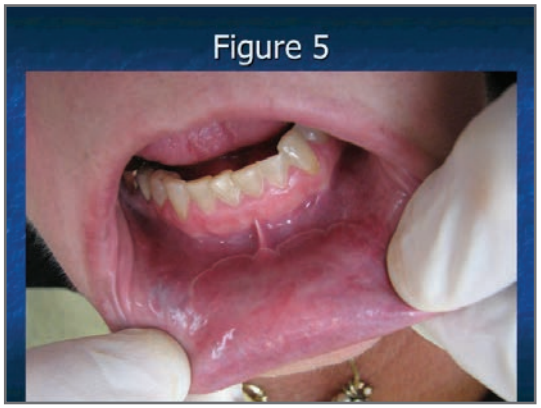


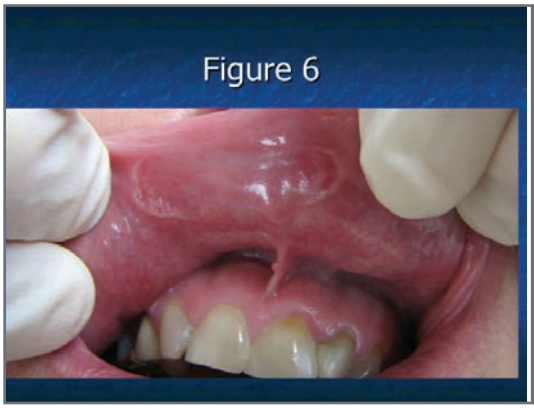
I would include erythema migrans, erythroplakia, lichen planus and mucositis in my preliminary diagnosis.

1. Erythema migrans, also known as geographic tongue, characteristically occurs as multiple well demarcated lesions of the anterior dorsal tongue and lateral borders. On the tongue proper, it shows loss/atrophy of the filiform papillae surrounded by a yellow/white serpentine border. It has a strong association with fissured tongue. Erythema migrans may occur on other sites besides the tongue (ectopic). In these instances the tongue is usually affected (but not always). The lesions off the tongue are typically asymptomatic and identified by a yellow-white serpentine zone that surrounds an erythematous zone. This was seen in one area of figure 1.
2. Erythema multiforme presents with an explosive onset and is extremely painful. In 50% of the cases of minor erythema multiforme a drug or food is involved. It typically would not be localized to the lower lip and it would show erosions, bullae and ulcerations. The patient would know the lesion were in their mouth.
3. Erythroplakic lesions are non-painful and typically occur in older individuals. The location is unusual for erythroplakia but still possible. Erythroplakic lesions would not show a serpentine border as noted in this case. Almost 90% of erythroplakic lesions are pre-malignant. In the original clinical picture there were areas that did not show the serpentine border. However with this being said, if the lesion does not regress in two weeks it should be biopsied.
4. Leukoplakia does not show the clinical presentation seen in this case and no white areas besides the white serpentine border were noted.
5. Lichen planus can take on numerous appearances but it would be unusual to have it only in this location without areas that have a lacy appearance. Typically red lesions of lichen planus would have symptoms. If the lesions were symptomatic, I would use topical steroids and re-evaluate in two weeks. If lesions do not regress or respond to therapy in two weeks, a biopsy is indicated.
6. An oral mucositis could have this appearance but the location is unusual. Typically oral mucositis would have some symptoms, such as burning.
7. Oral lupus lesions would have lichenoid features and would also be secondary to the patient having lupus. Oral lupus lesions typically have an oral erosion/ulceration surrounded by a lichenoid/lacy periphery. The location is not typical.
8. Pemphigoid lesions usually involve the gingiva and the patient typically complains of bleeding on brushing. The patient's tissue is easily separated by blowing air or rubbing with a tongue blade. There would also be minimal symptoms of discomfort. This location alone would be unlikely.
9. Oral lesions of pemphigus are usually "the first to show and the last to go" and would be bullae that quickly ulcerate. The lesions are also painful and would be in multiple areas.
10. Squamous cell carcinoma of the lower lip mucosa is quite unusual and would be elevated, granular and indurated. This was a flat lesion that was asymptomatic.

With all this being said, the serpentine appearance suggests erythema migrans. When the patient returned in two weeks the lesion were almost gone (figure 2) and when I examined the patient there were subtle changes of erythema migrans on the tongue (figures 3-4). I had not examined the patient on the presentation appointment and based my initial impression only on figure 1.
Figures 5-7 are additional pictures of erythema migrans off the tongue.

This case was submitted by Khalifa Alhaddad, a fourth-year dental student at Virginia Commonwealth University School of Dentistry.





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AEGD Abstracts of Interest

Zuffetti F, Testori T, Capelli M, Rossi MC, Del Fabbro M. The Topical Administration of Bisphosphonates in Implant Surgery: A Randomized Split-Mouth Prospective Study with a Follow-up Up to 5 Years. Clin Implant Dent Related Res. 2013 Sep 20. doi: 10.1111/cid.12151.

Problem: A beneficial goal in implant therapy involves the enhancement of bone healing and osseointegration. Bisphosphonates have been used in many clinical situations to inhibit osteoclast resorption activity and improve bone density and are potentially beneficial to enhance implant osseointegration.

Purpose: This split-mouth prospective study was designed to evaluate the clinical effects of the application of topical bisphosphonates to the implant surface and site as related to implant survival up to 5 years of functional loading.

Methods and Materials: A total of 39 patients were selected for the split mouth study with the following inclusion criteria: patient must be older than 18 years of age with the presence of bilateral or total edentulism and the ability to tolerate conventional implant procedures. There were 22 patients either fully or partially edentulous in both upper and lower jaws and 17 patients were bilaterally partially edentulous in one arch (9 in the mandible, 8 in the maxilla). Ten patients smoked less than 10 cigarettes per day. On the test side, 155 tapered, external connection tapered implants [Osseotite NT, 3i Biomet] were placed in a 1-stage surgical procedure using an aqueous solution of clodronate 3% mixed with a surfactant (Tween 20) in a 1:3 ratio. The implant site was irrigated and the implants were submerged in this solution for 5 minutes before implant insertion. On the control side, the implants were placed using a 1-stage conventional approach. The provisional prostheses were placed 10 days after insertion and final crowns were inserted 3 months later. Implants were evaluated at 6 months, 12 months and yearly for 5 years. Periapical radiographs and marginal bone level measurements were used in the evaluation, along with specific success criteria.

Results:

- The test and control groups included 75 and 80 implants respectively.
- Seven (7) implants failed in the control group and no implants failed in the test group.
    - Two maxillary implants failed before loading in 2 non-smoking fully edentulous patients.
    - One mandibular implant failed before loading in a smoking fully edentulous patient
    - One mandibular implant failed one year after loading in a smoking fully edentulous patient.
    - One maxillary implant failed before loading in a non-smoking partially edentulous patient.
    - Two mandibular implants failed before provisional delivery in non-smoking partially edentulous patients.
- Implant survival in the control group was 91.3% as compared to 100% in the test group.
- Radiographic analysis of marginal bone loss was 0.85 +/- 0.71mm for the test group and 1.12 +/- 0.85mm for the control group at the 1 year follow up.
    - Marginal bone loss was stable and not statistically significant at the 5 year follow up.
- Previously published scientific data have demonstrated that topical use of bisphosphonates has shown histological evidence of improved bone quality around implants.

Clinical Usefulness: The use of bisphosphonates has been controversial due to safety concerns relating to reports of IV administered bisphosphonate as connected with osteonecrosis of the jaw. Although this study deals with the single administration of low-dose nonamino bisphosphonates, more studies with long term follow-ups and and larger sample sizes will help to evaluate the safety and efficacy of this potentially beneficial technique for improving implant osseointegration and success.

Dr. Shelli Boucher, Resident, Advanced Education in General Dentistry, Virginia Commonwealth University

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Meyle J, Gersok G , Boedeker RH, Gonzales JR. Long-term analysis of osseointegrated implants in non-smoker patients with a previous history of periodontitis. Doi: J Clin Periodontol, 2014 Jan 29, doi: 10.1111/jcpe. 12237 [Epub ahead of print]

Problem: Peri-implantitis is defined as the loss of radiographic bone after 5 or 10 years compared to baseline, combined with bleeding on probing/suppuration in at least one implant site. It has become an area of question if peri-implantitis is more prevalent in those patients who have been treated for or who have chronic periodontitis. Purpose: The goal of this article is to evaluate the long-term results of two-staged screw retained implants with an internal hex in patients with a previous history of periodontitis at 5 and 10 year intervals.

Methods and Materials:

1. Patient selection:
    a. Included 20 patients (9 males and 11 females) with diagnosed chronic periodontitis. Inclusion criteria: 1) > 18 yrs of age, 2) absence of systemic conditions, 3) 4-6months of healing after tooth extraction, 4) sufficient alveolar bone volume for achieving primary implant stability. All patients were partially edentulous and presented with missing single or multiple teeth. Smokers were excluded from this study due to a higher risk of peri-implantitis.
2. Periodontal treatment:
    a. Treatment consisted of a hygiene phase aimed at achieving full mouth plaque and bleeding scores less than 30% prior to implant placement.
    b. Scaling and root planning was performed on all teeth with probing depths ³ 4mm and bleeding on probing (BOP) using hand and mechanical instruments by an experienced dental hygienist.
    c. Evaluated at intervals of 3-4 months during the first year, and 6 month recalls afterwards.
3. Implant placement
    a. Fifty-four Frialit-2 [Dentsply] dental implants were placed.
    b. The Frialit implants incorporate a roughened surface with a grit-blasted and thermal etched microstructure, except the most cervical portion which has a smooth collar.
    c. Implants were placed following the classic two-stage surgical approach.
    d. Implant locations: 43.9% - posterior mandible, 33.6% - posterior maxilla, 14.6% -anterior maxilla, and 7.8% - anterior mandible.
    e. Implant diameter: 51.8% - 4.5mm, 33.6% - 3.8mm, and 14.5% - 5.5mm.
    f. Implant length: 54.5% - 13mm, 40.2% - 15mm, 2.7% - 11mm, and 2.6% - 10mm.
    g. The implants were restored with single cemented crowns after 4-6 months by the same two specialists who placed the implants.
    h. The same type of abutments was used in all patients.
4. Clinical evaluation
    a. A complete documentation of periodontal and peri-implant conditions were recorded after 5 and 10 years and included pocket probing depth (PPD), clinical attachment level (CAL), and BOP.
    b. O'Leary simplified plaque index and papillary bleeding index were the oral hygiene indices used.
    c. The remaining teeth were matched to the implants according to their position.
    d. Clinical attachment level in implants was defined as the distance from the crown margin to the deepest point reached by the pocket probing depth.
5. Radiographic examination
    a. Patients were screening by Panorex radiographs after the implant surgery and at every 24months after.
    b. Periapical radiographs were taken at the time of the crown cementation and at the 5 and 10 year follow-ups.

Continued on page 25

c. The location of the marginal bone level in relation to the implant shoulder was assessed at the mesial and distal sites of the implants with the use of a magnifying loupe and an x-ray viewer.
d. Two distances measured: 1) the distance from the implant shoulder to the deepest contact of the marginal bone with the implant surface (bone to implant level)and 2) the distance from the implant shoulder to the highest point of the crestal marginal bone in the interdental space (crestal peri-implant level)

6. Prevalence of peri-implantitis and Data Analysis
a. The percentages of implants and subjects presenting with loss of radiographic bone combined with BOP/suppuration were calculated.
b. 3 time points were analyzed: 1) the baseline (time implants were loaded), 2) 5 years, and 3)10 years.
c. Primary outcome variable was the change in clinical attachment levels at implants and reference teeth between the baseline and the 5 and 10 year marks.
d. The cumulative survival rate (CSD) was calculated using the Kaplan-Meier analysis.

Results and Conclusions:

- The mean PPD and CAL of all teeth showed a slight increase after 5 years and after 10 years demonstrated an increase in comparison to the baseline values.
- The percentage of sites with pocket probing depths of 4-5mm and > 5mm increased after 10 years.
- There was a radiographic mean bone loss of < 1mm in all implants after 5 and 10 years.
- BOP was evident upon probing in sites showing bone loss
- Prevalence of peri-implantitis on the implant level was 8.9% after 5 years and 23.8% after 10 years. On the patient side it was 18.2% after 5 years and 30% after 10 years.
- No circumferential peri-implant loss of bone was determined, only horizontal or angular loss.
- Recorded 89.9% success for implants after 5 years and 74.9% success for implants after 10 years.
- Overall it was found that patients treated for chronic periodontitis and treated with screw retained implants with an internal hex showed stable peri-implant variables survival rates, and stable radiographic bone levels after 5 and 10 years as long as the patients were engaged in a regular periodontal maintenance program.

Dr. Casey Currey, Resident, Advanced Education in General Dentistry, Virginia Commonwealth University

Moghaddam AS, Radafshar G, Taramsari M, Darabi F. Long-term survival rate of teeth receiving multidisciplinary endodontic, periodontal and prosthodontic treatments. J Oral Rehab 2013; doi: 10.1111/joor.12136 [In Press; e Publication]

Problem:
As the practice of implant dentistry is growing, the decision to preserve a tooth that is compromised or to extract the tooth and restore with an implant-supported prosthesis has become a common dilemma in dentistry.

Purpose:
The purpose of this article is to investigate the 3-year to more than 10-year survival rates of teeth that have undergone endodontic, periodontic and prosthodontic treatments.

Methods and Materials:
A retrospective study was completed of clinical records and radiographs of 245 teeth in 87 patients. Teeth examined underwent primary or retreatment of endodontic therapy, crown lengthening procedures, and a prosthetic restoration between 1996 and 2009. Bleeding points index (BPI), position of restoration margin relative to gingival margin (RM-GM), pocket depth (PD), mobility, crown- root ratio (C/R), and intra-canal posts were evaluated for each tooth. Using one-way ANOVA, clinical parameters comparisons were made between teeth in four survival groups (<3 yrs, 3-5 yrs, 5-10 yrs, and >10 yrs). Teeth were deemed hopeless if they developed at least two of the following conditions as molars or at least one as anteriors and premolars; 1) secondary caries requiring a second crown lengthening surgery, 2) root fracture/ periapical lesion, 3) grade 2 mobility or greater, 4) pocketing of more than 7mm, 5) grade 2 or greater furcation involvement, 6) need for endodontic retreatment, or 7) C/R >2:1. The Kaplan- Meier estimator was used to evaluate survival rates and the Tarone-Ware test was used to compared quality of survival distributions relative to sex, age, jaw, smoking, and presence of intra-canal post. The Cox regression model was used to determine predictors for success/ failure.

Results:
Survival distributions of examined teeth showed the following: 1) patient mean age of 51 yr, 2) 81.2% women, and 3) 3.27% smokers. There were 149 maxillary teeth and 127 mandibular teeth. A total of 18 teeth were deemed hopeless. Survival rate analysis revealed 3-, 5- and 10- year survival rates were 93.3 ± 1%, 96 ± 1.6%, and 83.1 ± 4.5%. Kaplan- Meier estimator predicted 51.9 ± 14.5% for 13+ years. The highest PD seen was in >10year survival group, highest BPI was observed in 3-5 year survival rate group. No significant difference of RM-GM between groups. C/R was significantly highest in >10 year survival group. Cox regression model revealed C/R on distal surfaces and subgingival extension of restoration margin on MB and lingual surfaces are predictors for tooth failure.

Conclusions:
Performing multidisciplinary therapeutic procedures increases risk of tooth overall failure. In treatment planning whether a tooth should be restored using interdisciplinary approach or replacement with an implant it is important to consider 1)patient age, 2)whether the tooth belongs to the maxilla or mandible, 3)whether the patient smokes, 4) if an intra-canal post is present, and 5)patient preference. The major determinants for survival success were C/R ratio and RM-GM position. The overall long-term survival rate of compromised teeth that underwent endodontic, periodontic and prosthodontics treatment was 83-98%.

Dr. Melissa Papio, Resident, Advanced Education in General Dentistry, Virginia Commonwealth University

Farina AP, Spazzin AO, Xediek Consani RL, Mesquita MF.Screw Joint Stability After the Application of Retorque in Implant-Supported Dentures Under Simulated Masticatory Conditions. J Prosthet Dent 2014 Jan 11. pii: S0022-3913(13)00319-3. doi: 10.1016/j.prosdent.07.024[In Press; e-published]

Problem: Static stresses are created in multi-unit implant supported dentures due to inherent misfit tendencies, which can then affect the behavior of the screw-joint stability.

Purpose: To evaluate the effectiveness of torque and retorque on joint stability of gold and titanium prosthetic screws under different levels of misfit under simulated masticatory function.

Methods and Materials: Ten implant supported mandibular prosthetic frameworks were fabricated with twenty cast models to create ten passive fit dentures and ten misfit dentures. Four protocols were created as follows: titanium screws with and without retorque and gold screws with and without retorque. In the retorque protocol, screws were tightened to 10Ncm and retightened again after ten minutes to 10Ncm. The screw joint stability was analyzed after one year of simulated clinical function with a digital torque meter. Statistical analysis was completed using a 2-way ANOVA and Tukey Honestly Significant Difference (HSD) post hoc tests (p=0.05).

Results:

- There was a statistically significant difference between the passive fit and misfit dentures
- All tightening techniques reduced the loosing torque values in misfit dentures compared to passive fit dentures.

Continued on page 26

Continued from page 25

- Retorque significantly increased the loosing torque in both titanium and gold screw regardless of the fit levels.
- Passive fit dentures showed an increase in loosening torque for both screw types after retorque.
- In passive fit dentures, titanium screws had higher loosening torque values without retorque than gold screws.
- There was no significant difference in loosening torque between the two different screw types in misfit dentures that underwent the same tightening technique.
- Higher values were found after retorque application in misfit dentures for both screw types.
- Gold screws had deep pits and furrows compared to a more homogenous surface on titanium screws after conditions were applied.

Conclusions: Multiunit prostheses having some degree of misfit demonstrated a significantly reduced loosening torque value compared to passive fit dentures. The application of retorque significantly increased the required loosening torque of both gold and titanium screw types. The implementation of the retorque technique may decrease the occurrence of connection-screw loosening or breakage for multiunit prosthesis and the results as found within the condition of this study suggest abutment screws should be routinely retorqued.

Dr. Cheyanne Warren, Resident, Advanced Education in General Dentistry, Virginia Commonwealth University

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Long H, Zhou Y, Ye N, et al. Diagnostic accuracy of CBCT for tooth fractures: A meta-analysis. J Dent 2013; dx.doi.org/10.1016/j.jdent.2013.11.024 [in press; e-published]

Problem: The diagnosis of tooth fractures can be a source of frustration for patients and practitioners. Tooth fractures can be found in teeth with and without restorations. Fractures are most frequently associated with high occlusal forces and parafunctional habits. The application of traditional radiography techniques only provide a two-dimensional representation which have low diagnostic accuracy for assessing tooth fractures.

Purpose: The authors conducted this meta-analysis to critically evaluate published studies that have examined whether in-vivo CBCT imaging could be an effective diagnostic tool for evaluating suspected fractured teeth.

Methods and Materials: The authors searched electronic databases for articles published between January 1990 and April 2013. The authors exclusively selected in-vivo studies for inclusion in the meta-analysis. Studies were included that involved at least 10 participants and that evaluated patients with suspected tooth fracture using CBCT. Studies were also selected based on whether they used surgical exploration or extraction to determine the definitive diagnosis. The selected articles had sample sizes ranging from 10 to 135 teeth and included horizontal, vertical and oblique fractures. Both vital teeth and endodontically treated teeth were included.

The authors investigated study outcomes: sensitivity, specificity, positive likelihood ratio (LR), negative LR and summary receiver operating characteristic. The authors interpreted the data in order to calculate prevalence as well as positive and negative predictive values.

Results and Conclusions: The authors found that employing CBCT imaging to affirm a clinical suspicion of tooth fracture resulted in a sensitivity of 0.92 and a specificity of 0.85. The authors found that the diagnostic accuracy of CBCT was *reduced* when used on endodontically treated teeth. This was attributed to potential artifacts caused by various root canal obturation materials. Even so the analysis indicates that there is a 97% chance of positively identifying a fracture in a non-endodontically treated tooth where as there is an 82% chance of positively identifying a fracture in an endodontically treated tooth.

The authors make a compelling case for CBCT use in diagnosis of tooth fracture. The authors suggest that patients suspected of tooth fractures be examined using periapical radiographs. If negative, then CBCT may be utilized in order to diagnose tooth fracture. Practitioners should be cautioned that the study shows that there is a risk of false negatives. With that information in mind, negative results, especially those for endodontically treated teeth, should be managed closely with appropriate patient recall.

Dr. Justin Johnson, Resident, Advanced Education in General Dentistry, Virginia Commonwealth University.

Todd J, Oesterle, L, Newman S, and Shellhart W. Dimensional changes of extend-pour alginate impression materials. Am J Orthod Dentofacial Orthop 2013;143(4):S55-63.

Problem: Many manufacturers are marketing extended pour alginate impressions as being dimensionally stable for up to 100 hours to allow transit to the dental laboratory for the accurate fabrication of a digital model. Despite the manufacturers' claims of dimensional stability, studies on extended pour alginates provide mixed results on the accuracy of these claims. In addition, temperature during transit from the dental office to the dental laboratory can have an effect on the dimensional stability of alginate impressions.

Purpose: The purpose of this investigation was to evaluate the dimensional changes of newer alginate materials after storing them at different temperatures and times. The dimensional changes of 2 traditional irreversible hydrocolloids, 2 newer extended pour irreversible hydrocolloids and a vinylpolysiloxane impression were evaluated at 10 minutes, 24 hours and 100 hours after mixing.

Methods and Materials: Two extended pour alginates (Kromopan and Triphasix), 2 traditional alginates (Jeltrate and Kromatica) and 1 vinylpolysiloxane (VP mix) were used to impress a deeply scored aluminum die. A total of 75 specimens were divided into 5 groups of 15 specimens for each impression material and further subdivided into 3 temperature subgroups of 5 specimens each, all of which were measured at 10 minutes, 24 hours and 100 hours after mixing. One subgroup for each impression material was stored at room temperature (23 degrees Celsius) and the other 2 groups were stored at either a high (46 degrees Celsius) or a low (-9 degrees Celsius) for the first 8 hours to examine the effect of temperature extremes. The distance between score marks was measured on the die and the impression surface by a measuring microscope. The measured distance on the impression was then compared to the true distance on the standard die to determine the amount of linear change in order to calculate the percentage of dimensional change.

Results: Statistical analysis of the vinylpolysiloxane samples showed no statistically significant differences between the mean measurements regardless of time or temperatures. Kromopan and Kromatica were the *most* stable and Triphasix and Jeltrate were the *least* stable. There were no significant differences between the alginates when measured at 10 minutes after the start of the impression mix. All alginate samples had significant dimensional changes from the original die when measured at 24 and 100 hours. From 10 minutes to 24 hours, there were statistically significant dimensional changes in all alginates, but there was not a significant dimensional change from 24-100 hours regardless of the storage condition. All alginates stored at freezing temperatures for the first 8 hours showed double the percentages of dimensional changes at 24 and 100 hours when compared to hot or room temperature.

Conclusion: The chemical setting reaction of alginate impression material causes syneresis which leads to a dimensionally unstable impression overtime. If impressions are being sent to digital model companies, vinyl polysiloxane impressions would be recommended over alginate impressions to minimize inaccuracies.

Dr. Kirsten Lee, Resident, Advanced Education in General Dentistry, Virginia Commonwealth University

The Virginia Meeting®
A Program of the Virginia Dental Association

Agenda

Wednesday, September 17

Board of Directors Meeting

Thursday, September 18

House of Delegates & Reference Committees

Continuing Education Courses

- The Madow Brothers – Dental Entertainment
- Dr. Charles Blair – Practice Profitability
- Dr. Ron Jackson – Anterior & Posterior Composites
- Mr. Theodore Passineau – Risk Management
- Ms. Anastasia Turchetta – Practice Communication
- Ms. Linda Cannon – OSHA
- Tidewater Center for Life Support (TCLS) – Heartsaver CPR
- Dr. Tegwyn Brickhouse & Sarah Holland – Pediatrics

Exhibit Hall Open

Social Events

- Pierre Fauchard Breakfast
- Putting Tournament
- Opening Reception (in exhibit hall)
- Ping Pong Tournament
- ACD Dinner

Friday, September 19

Continuing Education Courses

- The Madow Brothers – Practice Improvement
- Dr. Ron Jackson – Anterior Direct Composite Workshop
- Dr. John Olmsted – Advances in Endodontics
- Invisalign – Fundamentals, Intermediate, & Records Training
- TCLS – Healthcare Provider CPR
- Bank of America – Practice Finance

Exhibit Hall Open

Social Events

- AGD Breakfast
- VDA Fellows' Lunch
- 16th District Meeting
- Putting Tournament
- Closing Reception (in exhibit hall)
- New Dentists' Reception
- MCV/VCU Alumni Reception
- President's Party

Saturday, September 20

Continuing Education Courses

- Dr. Charles Blair – Coding & Administration
- Drs. James Wooddell & Joe Passaro – Worn Dentition
- Dr. Ron Jackson – Metal-Free Crowns
- Ms. Anastasia Turchetta – HPV, Malodor, & Hygiene
- Dr. John Olmsted – 35 Tips for Endodontics
- Mr. Theodore Passineau – Risk Management
- Dr. Riki Gottlieb – Mentorship Program
- TCLS– Healthcare Provider CPR & CPR Refresher
- Ms. Linda Cannon – HIPAA/ACA

Social Events

- ICD Breakfast
- Annual VDA Golf Tournament
- 2nd Annual MOM Awards Dinner

Sunday, September 21

House of Delegates

Board of Directors Meeting

September 17–21, 2014

The Virginia Meeting®
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Meeting Details

The Virginia Meeting is an opportunity for dental professionals across the commonwealth to come together for five days of top-notch continuing education, governance proceedings, fun social activities, networking opportunities, and relaxation at Virginia's premier resort. The Virginia Meeting has something for everyone! Make plans to attend!

Registration

Your Virginia Meeting registration includes the following:

- All continuing education lectures
- Endless networking opportunities
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- Opening and Closing receptions

Registration will open in early June. Additional information will be sent via email and mail in the next few months.

Accommodations

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VDA Members will be notified by email and mail when the 2014 Virginia Meeting room block is open.

Activities

The Omni Homestead Resort has an endless list of activities for you, your staff, and your family to take advantage of! When making your schedule for the meeting, don't forget to carve out some time for an activity or two! We strongly advise that you make activity reservations in advance as spaces fill quickly. You can do this while making your hotel reservations or by calling (866) 354-4653.

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THE Virginia MEETING®
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Dentists can spot deadly disorder

Dr. Michael McMunn

If you're one of the estimated 20 million Americans suffering from undiagnosed obstructive sleep apnea (OSA) — a potentially deadly condition that too many dismiss as harmless snoring — your dentist might be your new lifeline to better sleep, improved health and longer life.

Dentists are the health professionals most likely to spot physical indicators inside the mouth of OSA, a sleep disorder that does far more harm than simply triggering snoring and robbing you of restful sleep. Over time, the decrease in oxygen from frequent disruptions in breathing damages vital organs, contributing to early death through heart attack, heart rhythm irregularities, stroke and other serious health problems.

As a practicing dentist for more than 30 years, I've only recently discovered that my profession is uniquely positioned to screen for OSA. Evidence of upper airway obstruction can be revealed by a variety of signs in the mouth and throat, including an enlarged uvula, a small or recessed jaw, crowded teeth, scallops (teeth marks) on the tongue and enlarged tonsils. In obese patients, fat deposits can crowd throat tissues and hinder night breathing.

I observed these signs of airway obstruction for decades without realizing what they were trying to tell me. It reminds me of the medical dilemma described by the physician Sir William Osler, one of the founders of Johns Hopkins Hospital: "What the brain does not know, the eye cannot see."

Thankfully, my eyes were opened in 2009, when I attended a continuing education seminar on dental sleep medicine. I learned how dentists can work with physicians to identify, refer for diagnosis and treat obstructive sleep apnea, thereby improving patients' health while preventing countless highway accidents caused by the chronically sleep-deprived.

Now I'm on a mission, along with scores of other Virginia dentists and dental hygienists, to spread the word that we have a moral and ethical obligation to routinely screen for OSA. No other health professionals regularly observe more undiagnosed upper airways, and we must seize this opportunity to save lives. As we look for tooth decay and periodontal disease and oral cancer, we've been overlooking signs of OSA, which can be life-threatening.

Health improvement after treatment for OSA can be dramatic. I recently referred a patient to a sleep specialist after observing several oral signs of sleep anea. A subsequent sleep study by the specialist revealed that the patient had OSA.

The patient, who was unaware of his sleep disorder until that routine dental visit, reports that a custom-molded oral appliance he wears at night has given him a new lease on life, virtually eliminating his daytime sleepiness and greatly increasing his energy level.

Similar results reported at the sleep medicine conference four years ago inspired four equally passionate Virginia dentists — Drs. Scott Gore, Barry Kurzer, Erika Mason and James Schroeder, along with dental lab tech Mike McMunn Jr. — to join me in founding the Virginia Academy of Dental Sleep Medicine (VADSM).

The gold standard for treating severe OSA has long been the CPAP machine, an acronym for "continuous positive airway pressure."

CPAP works by pushing slightly pressurized air into nasal passages via a custom-fitted mask, which keeps the throat open throughout the night.

However, a large percentage of patients can't tolerate the discomfort of sleeping with a bulky mask strapped to their face, and either yank it off during sleep or simply stop wearing it.

Illuminating new research published in April 2013 in the American Journal of Respiratory and Critical Care Medicine shows that oral appliances and CPAP are equally effective in managing moderate to severe OSA. The study authors explained the results by noting that the greater efficacy of CPAP was offset by inferior compliance compared to oral appliances, resulting in similar effectiveness.

Either way, dentists should refer patients at risk of OSA to a physician specializing in sleep disorders who will perform a physical exam and take an in-depth medical and sleep history. An overnight sleep study can determine the severity of the apnea.

While dentists can be understandably reluctant to add one more responsibility to their practice, the benefit to public health greatly outweighs any misgivings. To my fellow dentists who are not screening for sleep-related breathing disorders, please drop by our conference to see what you're missing. To the general public, consider asking your dentist about an upper airway exam during your next checkup.

Dr. Michael O. McMunn, DDS, practices in Henrico County's West End and is an associate clinical instructor in the oral surgery emergency clinic at Virginia Commonwealth University's Medical College of Virginia, Past-President, Virginia Academy of Sleep Medicine. Contact him at info@drmcmunn.com.

Reprinted from the *Richmond Times Dispatch*, "Commentary", November 10, 2013.

Obtaining Prescriptions for Appliances for Sleep Apnea

Kathe G. Henke, Ph.D.

As most of you are now aware, a physician's prescription is required for an oral appliance for obstructive sleep apnea, especially if medical insurance coverage is expected. Most of the sleep specialists are very willing to supply these prescriptions for the appliances but there are some basic guidelines that should be followed. Most sleep specialists will not (should not) provide a medical prescription for a patient whom they have not seen in the last year or with whom they have not discussed the oral appliance as a treatment option. It is recommended that, before the patient is scheduled for an impression, the dentist contact the sleep specialist to determine what steps are needed so that the specialist can write a prescription for the appliance if he or she believes that treatment to be appropriate for a patient. In general, a physician would defer the choice of a specific type of appliance to the dental specialist. Good communication is always the key!

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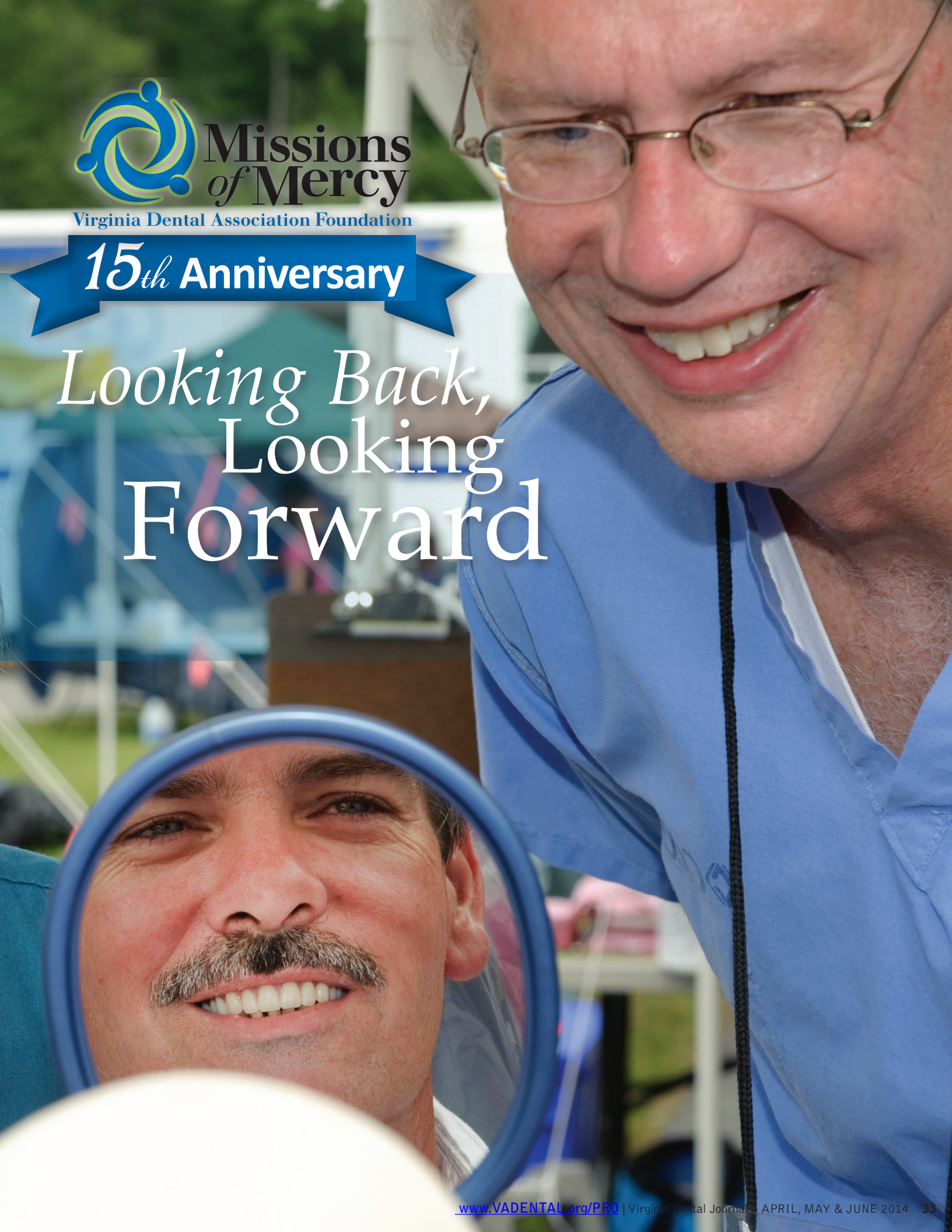
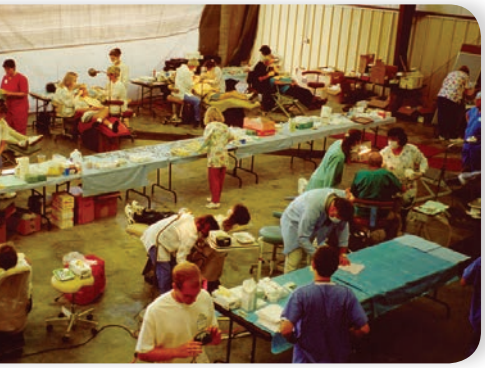


Looking Back, Looking Forward

Missions of Mercy
Virginia Dental Association Foundation

52,000 Patients and Still Growing

By: Joel Rubin, APR, Rubin Communication Group



When Dr. Terry Dickinson left private practice in Texas to become executive director of the Virginia Dental Association in 1999, he was looking for "a purpose in life." He found one, thanks to a phone call asking whether dentists from out of state could help with a volunteer health project in southwest Virginia. Because of reciprocity issues, Dr. Dickinson was inclined to say no.

But Dr. Dickinson had a thought. Would he be able to find enough VDA dentists to come to Wise County in the middle of the summer? The request went out and an amazing 30 said yes. But in March he began to worry that there wouldn't be enough patients. "There's nothing worse than having volunteers standing around with nothing to do," he recalled. But a combination of fliers, radio, church and school announcements from St. Mary's Health Wagon, the local coordinators, did the trick. The crowds came that weekend, and they continue to come.

Now 15 years later, Mission of Mercy projects, which started in Wise in 2000, are held in regions all across Virginia. Hundreds of volunteer dentists from the VDA have provided more than $20 million in donated care and seen more than 54,000 patients. By the end of this year, they will have treated thousands more from Springfield to Grundy. "I came to the realization that this is what I'm supposed to be doing," says Dr. Dickinson. "That was the key to meaning and purpose in life, and then I knew I was brought to Virginia for a reason."

This special section of the Journal looks back at a decade and a half of MOM events, through the voices and experiences of those who provided the care, and those who received it. And it looks forward, thanks to the generosity of sponsors and volunteers, to what's ahead... because the need never ends.

MOM Projects 2000–2014
Projects, Patients served, Value of Care

2000
Location: Wise
Patients Seen: 739
Value of Care: $190,000

2001
Locations: Eastern Shore and Wise
Patients Seen: 1,434
Value of Care: $475,000

2002
Locations: Eastern Shore, Wise and Northern Virginia
Patients Seen: 2,406
Value of Care: $878,000

2003
Locations: Eastern Shore, Wise, Norfolk, Martinsville and Petersburg (mini-MOM)
Patients Seen: 3,165
Value of Care: $1,344,000

2004
Locations: Eastern Shore, Northern Virginia, Wise and Grundy
Patients Seen: 3,305
Value of Care: $1,403,000

2005
Locations: Petersburg (mini-MOM), Eastern Shore, Northern Virginia, Wise and Grundy
Patients Seen: 3,397
Value of Care: $1,494,000

2006
Locations: Katrina New Orleans, Eastern Shore, Northern Virginia, Wise and Grundy
Patients Seen: 6,120
Value of Care: $3,007,000

2007
Locations: Northern Virginia, Eastern Shore, Roanoke, Wise, Grundy and Petersburg (mini-MOM)
Patients Seen: 4,290
Value of Care: $2,551,000

2008
Locations: Northern Virginia, Eastern Shore Roanoke, Wise, Grundy and Emporia
Patients Seen: 4,700
Value of Care: $3,065,000

2009
Locations: Goochland, Northern Virginia, Eastern Shore, Wise, Grundy and Emporia
Patients Seen: 4,316
Value of Care: $3,244,000

2010
Locations: Gloucester, Northern Virginia, Roanoke, Piedmont Regional, Wise and Grundy
Patients Seen: 4,695
Value of Care: $3,978,000

2011
Locations: Gloucester, Northern Virginia, Roanoke, Special Olympics, Wise Grundy, Emporia and Homeless Connect
Patients Seen: 5,004
Value of Care: $4,046,000

2012
Locations: Gloucester, Northern Virginia, Roanoke, Virginia State University, Wise, Grundy and Homeless Connect
Patients Seen: 4,699
Value of Care: $3,996,000

2013
Locations: Northern Virginia, Charlottesville Special Olympics, Virginia State University, Wise, Roanoke, Grundy and Homeless Connect
Patients Seen: 4,247
Value of Care: $3,277,000

2014
Locations: Suffolk, Northern Virginia
Patients Seen: 1,396
Value of Care: $868,000

2000-2014 Grand Totals
Patients Seen: 54,000
Value of Care: $33.8 million

My MOM Experience

"The respect that all of the volunteers give to these patients is admirable. I had one patient who was a vocalist, and he and I sang a couple of Motown songs, while my assistant Cindy gave us encouragement! What fun!"

Dr. Joe Lombard, DDS
Gloucester, VA

"The task of taking an open gymnasium or a bare fairground and transforming it into a fully functional dental practice complete with specialists and all the amenities of a continuously operating facility is a highly complex ordeal. I am humbled to be part of such a superb group of people."

David Voth
Graduate Student, Richmond, VA

"Every MOM patient that I have been blessed to treat has been so appreciative of the services provided to them. Most of them say that the only time they receive dental care is when MOM comes to their city. I look forward to volunteering for many more years to come."

Lisa Lloyd, RDH
Richmond, VA

Missions of Mercy
Virginia Dental Association Foundation

2000

1st MOM project, Wise County, Lonesome Pine Airport

2001

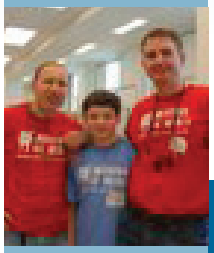
MOM used as model for other states: 1st MOM held in Texas

New MOM: Eastern Shore

2002

1st Northern Virginia MOM

MOM trailer purchased



2003

New MOM: Norfolk, Martinsville and Petersburg mini-MOM

2004

New MOM: Grundy

10,000th patient treated at Wise MOM

2005

Donated care exceeds $5 million at Wise MOM

2006

Weeklong MOM project at Audubon Zoo in New Orleans after Hurricane Katrina

20,000th patient treated at Wise MOM

25th MOM: Grundy

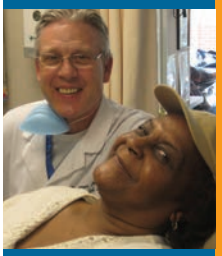
Introduced digital x-rays

2007

Donated care exceeds $10 million at Wise MOM

New MOM: Roanoke

2000-2014 Milestones



2008

25,000th patient treated at Eastern Shore project

MOM truck acquired

2009

MOM Celebrates 10th Year, $15 million in charitable dental care

New MOMs: Goochland, Emporia

2010

10,000th MOM volunteer (Roanoke)

Wise marks $20 million in free care

New MOMs: Middle Peninsula (Gloucester) and Piedmont Regional (Orange)

2011

50th MOM Project held in Gloucester

Grundy MOM marks $25 million in donated care

New Projects: Special Olympics, Homeless Connect

Addition of second MOM truck

2012

New MOM: Virginia State University in Ettrick

2013

MOM Celebrates 50,000th Patient

NOVA MOM marks $30 million in free care

New MOM: Charlottesville

2014

MOM Celebrates 15th Year of Service

Kick-off celebration in Suffolk

MOM replicated in 30 states

Credits

Jessica Bensten, Creative Director, Rubin Communications Group
Patrick Finnerty, President, Virginia Dental Association Foundation
Shannon Jacobs, Managing Editor, Virginia Dental Journal
Richard F. Roadcap, D.D.S, C.D.E., Editor-in-Chief, Virginia Dental Journal
Barbara Rollins, Director of Logistics, Mission of Mercy Program
Joel Rubin, President, Rubin Communications Group
Beth Vann-Turnbull, Executive Director, Virginia Dental Association Foundation

MOM FOUNDER DR. TERRY DICKINSON Reflects

Dr. Dickinson, pictured here with former Governor Tim Kaine.

Q. What was that initial MOM in Wise like?
TD: That first July morning of the project, traffic was gridlocked about a mile from the airport, and I thought, 'That's strange' because I really thought we wouldn't have enough people to treat. It was foggy that morning, and when we got there you could see a line that disappeared into the fog. Then Sister Bernie Kenney who was running the St. Mary's Health Wagon appeared from out of the crowd and asked, "Is that enough, Dr. Dickinson?" They turned away 1,000 that first day. We didn't have enough chairs for all the volunteer dentists.

I will tell you another story. Kansas scheduled their first MOM in February 2002. I asked them if that part of the state had much snow. They said, "Oh, yes!" Well sure enough there was a blizzard the night before it opened. The next morning there was a huge line of people standing in horizontal snow. I've never seen anything to stop patients from showing up.

Q. In what ways have the lives of the volunteers been changed?
TD: We hear dentists, uniformly, walk away from MOM and say that their lives have changed. They felt something different in their hearts. Faith is a big part of the way I am. I ask, "Is this what Christ wants me do?" We have this innate search for those moments in life that are special. It's not how many breaths we take, but what takes our breath away. I've heard more than one volunteer say a patient told them, "I've never been treated so well in my life." It also makes you sad that these (patients) reach that point in their life and never felt anyone cared about them. Over the years I've been impressed by the volunteers who want to bring their kids. The parents want to create a model for their kids.

Q. How important has the partnership with VCU been?
TD: We would struggle without their support. What we're teaching is that when you get a (dental) license you also get a responsibility to give something to your community. You have this amazing gift that allows you to provide care to people who need it. It's a great model for kids and their families to see that it's our obligation. Also, students get to see very complex patients. They don't get to see this in school. Now they're in a site where all the parts come together. We all want the patient to walk away better than they were when they arrived. Another benefit we've seen is the relationship to MDs, particularly at Wise, as we jointly try to determine what's best for the patient. I wish we saw more of this. MDs have come to realize that what is happening in the mouth is erecting a barrier to the patient getting well. Students are seeing this. It's a great learning experience and a great collaboration. One year at Grundy, Scott Syverud, who teaches the residents in the ER at UVA, asked his residents to observe. He said "We get these dental cases in the ER, and we'd like to learn more. What can we do, beyond just giving pain relievers and antibiotics?"

Q. It must be frustrating, knowing that many of the patients won't see a dentist again until you return.
TD: It is, but we're making progress. The Eastern Shore

MOM project is a good example. We got three or four dentists to move there, like Noel Root and Ed Griggs. Now we don't need to go back. Mark Crabtree did the same thing in Martinsville. Now we don't need to go back there, either. It was tough getting everybody there together, but he made it work. Look what happened in Orange – now they have a clinic. My dream is that when we leave, people will start asking the right questions. We hope that people will sit down and talk about a long-term solution.

Q. What have been MOM's contributions to clinical dentistry?
TD: Larell Dentures wouldn't be as popular as they are now. When I talked to Larry (Wallace) I thought, "This guy is onto something." So I turned him over to Scottie Miller and Steve Alouf, our prosthetic experts, and figured if he could get past them, it would work. Scottie says it allows us to see twice as many denture patients. That's had a dramatic impact. Sister Bernie called it "like winning the lottery" if a patient got picked to receive a denture. Another thing that doctors have dealt with is ethics. We have to have conversations with these patients about what they want done. We are sometimes challenged to have to remove a tooth that should stay in. I tell doctors that the patient will find somebody to do it for them. That's their view of the world. But it makes us better in dealing with our patients in our office. Our motivational techniques are improved when we're challenged. This can be difficult because their parents and grandparents lost all their teeth. We can take out the bad ones, but we have to struggle with their view of the world. The projects have allowed us to become better motivators.

Q. If you could change one thing about the Missions of Mercy, what would it be?
TD: Better follow-up. When we leave town, I worry about that. At Wise, Carole Pratt will stay a week and see follow-ups. Right now, it's not formally structured. Maybe we should put this in our requirements, to have four or five dentists who agree to do follow-ups. Our overarching theme would be that we would put ourselves out of business.

Q. The concept has been replicated in 30 other states. What predictions do you make for the future?
TD: What surprised me was how quickly other states – such as Texas – wanted to see it. Now they're doing a series of mini-MOM's across the state. Kansas and then North Carolina followed and now there's a national foundation. There are projects in Maryland and South Carolina, and Florida is starting one. It's a lot of work though and there's a lot of money to raise – about $100,000 for a 100-chair clinic. Projects like this define us as a profession. It's amazing the effect it has on legislators, if we can just get them out there and walk them through.

Q. You must be very satisfied personally.
TD: It says in the Bible to take care of "the least among us." I try to live up to that standard. That continues to drive me.

My MOM Experience

"The UVA Pre-Dental Society looks forward to MOM Projects every year. Everyone gives his or her greatest effort and comes back to campus with the treasured experience of witnessing unique procedures, networking with dental professionals, and making tangible contributions to serve the needs in our neighborhood."

Sarah Yang
UVA Student, Charlottesville, VA

"My son Andrew, who is now a pre-dental student in college, was a sophomore in high school when he convinced me to take him along as an assistant at the Wise MOM. We have volunteered every year since. Andrew said he was most impressed with how so many professionals, who many times did not even know each other, could come together and so quickly and efficiently devise a practical plan to address the immediate and sometimes complex needs of one patient."

William Horbaly, DDS, MS, MDS
Charlottesville, VA

"I started as a student attending a MOM project in 2009 and now when I know one is coming up, I rally up my hygiene girlfriends and we head to it. The MOM projects have inspired me to go back and obtain my Masters in Public Health."

Heather Herrera, RDH
Richmond, VA

Members of the VDA,

Congratulations on the 15th anniversary of your first Mission of Mercy. Through the efforts of the VDA, the underserved people of Virginia have benefited from the direct care provided, as well as the increased awareness of the need for a robust safety net to provide a dental home and regular care.

Dr. Dickinson has championed the project from its formative stage to today, and we could never thank him enough for his guidance over the years. What started as a vision by one person has spread and grown into a nationwide program. Many states have embraced this concept and offer multiple clinics that have helped millions of Americans receive free dental care. More importantly, we hope that our lobbying efforts at the state and national level will successfully provide access to all citizens so that someday we may no longer need a Mission of Mercy.

On a more personal note, those of us that have participated as volunteers have truly benefited more from the experience than those we help. I want to thank each and every member of the VDA for your commitment and leadership to this most valuable outreach program.

Dr. Charles H. Norman

President, American Dental Association

A Letter From U.S. Senator Tim Kaine

I've been a long-time fan of Dr. Terry Dickinson and the Missions of Mercy. Over the past 15 years, I've had many opportunities to help out at Missions of Mercy clinics and interact with the volunteers. Whether it's in Wise County, Northern Virginia, or Richmond, I'm always struck by their energetic altruism. But I wish the need for them wasn't so great. The program has served an astonishing 50,000 Virginians and delivered more than $32 million in services. Despite this incredible accomplishment, too many Virginians lack access to dental care. As a Commonwealth, we need to better meet the needs of our citizens. Thanks to the work of Missions of Mercy, fewer uninsured Virginians go without any care.

I'm grateful to the Virginia Dental Association for raising awareness about the unmet dental needs in Virginia, especially in rural communities and among low-income families. Parents and children who need teeth pulled or cavities filled are able to receive high-quality, free treatment thanks to Missions of Mercy clinics. Terry's leadership has been essential and the collective hours provided by Virginia dentists and hygienists represent a remarkable contribution to the health of our citizens. Here's to many more years of success!

Senator Tim Kaine

DENTAL TECH BILL HALL IS "HONORED" TO BE IN CHARGE OF EQUIPMENT FOR EVERY MOM PROJECT

Q. Bill, you've attended more MOM projects than almost any VDA member. What inspires you?
BH: I like the challenge of starting with nothing and making it something. I know that Terry has put his trust in me that everything will be set up right. That responsibility is an honor. The best part is me doing my job and then seeing the doctors go out and help the patients. Everyone here is my friend. I may only see them once a year, but they're still my friends.

Q. What's most often your biggest headache at a project?
BH: The equipment arriving damaged. That's going to happen in transportation; that's physically hard on the equipment. Terry consistently works at the VDA between projects taking care of the lights. One other headache, but extremely necessary, is hooking up the new vacuum system. It adds approximately two-and-a-half hours to the project setup.

Q. What real-world knowledge do you see students acquire?
BH: They get to see things they don't see in school, such as taking hundreds of Panorexes. I've had them learn to develop x-rays in Dixie cups. There are shortcuts and techniques to keep the practice going and they learn different ways than in school.

Q. Do you have a favorite MOM project story?
BH: My wife Donna's first MOM project. There was a 21 year-old girl, maybe 20 feet from where she was working, who was getting a full mouth extraction. Donna's crying watching all this, and I told her, "You can't let this get to you." When she left, the patient said, "I guess I can find a young guy in his twenties with no teeth."

Q. What changes have you seen in the past 15 years?
BH: One of the biggest advances has been central suction, and we now have endodontists at each MOM event, when we didn't before. I'd like to thank the VDA and the doctors for the opportunity they have given me and my family to participate.

My MOM Experience

"It always seems that at least once a year we encounter an individual who can move us to tears. The child who says, 'even if I cry, please don't stop because I know my teeth will feel better when you are finished.' The young mother who looks at her anterior restorations and cries because she sees herself as beautiful again. The man who says, 'thank you, now I can get a job because my teeth look so much better.'"

Heidi M. Hessler-Allen
Dental Assistant, Midlothian, VA

"I will never forget my first experience. We were at the Eastern Shore and we used lawn chairs for the patients to lie in. I had never seen the needs that these people had. We used only hand instruments and poured water in their mouths from a cup to rinse and then they spit in a bucket. It was very primitive but the patients were so very receptive to us. There was peacefulness in the aching backs and sore feet as we finished our long day. May we continue for many more years."

Bonnie B. Leffingwell, RDH
Sandston, VA

Dr. Carol Brooks Has Made MOM a Priority for VCU Students

By: Dr. Katie Lee; Associate Editor, Virginia Dental Journal

Dr. Carol Brooks still vividly remembers the wet, foggy morning she came to the Lonesome Pine Airport Hangar in Wise County, Virginia for the very first Mission of Mercy Project in July 2000. So many patients had come seeking dental treatment that traffic was backed up all around the tiny airport, and Dr. Brooks and her residents could not even reach the hangar. Dr. Terry Dickinson ended up driving them down the tarmac in his SUV, and as they pulled up she could see a long line of patients winding up the mountain into the fog. They quickly unloaded and got to work seeing those patients.

That first afternoon, Dr. Brooks noticed a young man named Michael milling around the hangar hours after the work had been completed on his front teeth. "You're all done," she told him. "There's no need to stay here in the hangar." He replied that he couldn't bring himself to leave yet. There was only one mirror at the whole health fair, he explained, and it was in the hangar bathroom. "I just have to keep going back in there to look at myself and my new teeth," he said. Dr. Brooks had agreed to assist with the new, idealistic project to provide dental care to underserved, uninsured Virginians "for the greater good," but she hadn't realized what that really meant until that moment.

Anyone who has spent time at a Virginia Mission of Mercy Project since it began that summer in 2000 can tell you that the MOM projects would not be what they are today without Dr. Carol Brooks. She served as clinical director of the Virginia MOM projects for 12 years, starting with that very first one in Wise County, and she organized the VCU dental students to participate. Today, the VCU dental students are integral to the well-organized, highly successful MOM projects in Virginia, which are now a nationally recognized model for providing quality dental care to underserved populations.

Dr. Brooks graduated from VCU/MCV in 1975 with a BS in Dental Hygiene, going on to work in private practice while also teaching in VCU's Dental Hygiene

Department. She became Coordinator for Clinical Trials in the Department of Periodontics at VCU in 1983, and her organizational skills were honed while she helped to orchestrate clinical trials for major pharmaceutical companies that wanted to conduct research at the dental school. She returned to school at VCU in 1991, graduating with her DDS in 1994, and she is glad she did. "If I hadn't been a dentist," she said, "I would never have had the opportunity to run the MOM project all those years." She completed her Advanced Education in General Dentistry Residency at VCU in 1995, and began to serve as an Associate Professor in the Department of General Practice at VCU. She still holds the position today.

According to Dr. Brooks, plans for a Virginia Missions of Mercy Project began in 1999. Dr. Brooks was the director of the AEGD program at VCU at the time, and Dr. Dickinson approached her after a CE course to gauge her interest in a dental mission project in Wise County. He hoped she might agree to bring her residents to help with the project. She was hesitant, and she asked him why she should shut down the whole Advanced Education Department to take her residents six hours from Richmond. "For the greater good," he replied. She didn't really know what that answer meant, but she agreed.

Several months later, she and her residents traveled to Wise County for that first MOM project. They worked with dentists as well as hygienists from the VDA, treating patients the whole weekend. They didn't have a lot of the equipment used at MOM projects today, such as portable lights. Instead, they made do with flashlights. Patients received cleanings in folding beach "chaise longue" chairs, with providers perched next to them on cinderblocks. It wasn't an ideal set up, but what Dr. Brooks made sure they did have, even at that very first project, was an emphasis on organization and protocol. Her experience as a volunteer with VCU's Jamaica Project had taught her how important it is to be as organized as possible when planning a makeshift clinic. The ready-to-use instrument tables, for example, needed to be set up so the patients did not walk by them and risk compromising sterilization. She also knew the importance of maintaining a strict protocol for seeing patients. If patients were simply lined up and treated one by one as quickly as possible, important factors like high blood pressure or low blood sugar could slip through the cracks. Dr. Brooks insisted that stations be set up in the hangar to ensure that all patients were triaged appropriately, including a thorough medical history, a blood pressure reading, and necessary radiographs, before being seen. This rigid protocol allowed the standard of care to be maintained even in difficult conditions.

By the end of that first day, Dr. Brooks had seen the greater good. Patients came because their teeth hurt, or because they didn't like how their smile looked. Every single one left with at least one problem fixed, and many left with much more. A new smile can give a patient hope, a new lease on life, a better chance of getting hired for a job. In Dr. Brooks's opinion, providing patients with that smile is incredibly rewarding, and a big part of what inspired her to get so involved.

In the years that followed, Dr. Brooks began to bring VCU dental students along with the residents. With increased funding from the VDA components, locations were added and the MOM projects grew larger. Dental students became an essential part of these projects. "We could never have done the MOM projects without the dental students," Dr. Brooks said. The students set up and broke down equipment, sterilized instruments, cleaned spit buckets, assisted dentists, and, depending on how far along they were in their training, provided dental care to the patients. Student coordinators were initially appointed simply to help load and drive the equipment trucks, but their role quickly evolved into a much larger one. They helped to troubleshoot when equipment malfunctioned, bad weather intervened, or other unforeseen problems arose. They became responsible for organizing hotel room assignments and transportation, keeping supply records, creating rotation schedules, and making sure that dental students rotated through their three-hour anesthesia, sterilization, extraction, assisting and other blocks correctly.

The student coordinators essentially owned the MOM projects, becoming the leaders the project needed to be successful. Dr. Brooks helped them learn true leadership skills, like giving up their own opportunities to help keep everything running smoothly. They would willingly pass up the chance to do exciting clinical procedures like extractions, if help was needed taking radiographs or sterilizing instruments instead. Several student coordinators with the project have gone on to use those leadership skills to start MOM projects in their own home states. Dr. Brooks is extremely proud of those former students as well as all those who graduated and now volunteer at the Virginia MOM projects as dentists.

BROOKS *(Continued on page 45)*

Our Favorite MOM MOMENTS

BROOKS *(Continued from page 42)*

But she is quick to point out that it was not simply the students who benefited from the chance to take on leadership roles at the projects. Her work with the MOM projects taught her a lot about leadership as well. When the MOM projects first started, she felt as though it was her responsibility to make sure that everyone knew what their job was, stayed on task and completed everything exactly as assigned. She credits Dr. Dickinson with helping to remind her that while an organized, rigid schedule is important and helps everything go smoothly, the students came to learn, which meant she couldn't always expect perfection from them. Things might not always go exactly as planned, but as long as the students were respecting the patients and guarding their safety and dignity above all else, then she had done her job. "Also, the students learned to be on time," Dr. Brooks laughed. "Don't be late. Never be late!"

As for the most important clinical lesson that students learn at a MOM project? Dr. Brooks hopes that all MOM project student participants come away understanding the importance of a good medical history, and how to obtain one. "Don't treat a patient that you don't know well," Dr. Brooks tells her students. "Take the time to ask your patient all the important medical questions. Watch your patient. If they're limping, ask them why. Did they just have a joint replacement? If they're not feeling great, why is that? Could they have uncontrolled hypertension or diabetes?" Dr. Brooks's students know that no matter how busy you are, or how healthy the patient seems, a thorough medical history is an essential part of providing standard of care dental treatment, whether it's in your office, at the school or at a MOM project.

Asked if there is anything she would change about the MOM projects, Dr. Brooks said that she can't think of anything. When Dr. Dickinson told her that these projects would be for the greater good, she didn't expect them to change her own life. But they have. "I am so grateful to have had the opportunity to be a part of it all," Dr. Brooks said. "The MOM projects have been one of the best things in my life."

"The level of enthusiasm I've seen from our students about this part of their education is refreshing," says Kim Isringhausen (B.S. '95, M.P.H. '04), who chairs the VCU Department of Oral Health Promotion and Community Outreach. "Through service to others, we are encouraging our students – future practitioners – to do the right thing, the right way."

My MOM Experience

"I don't have any insurance and it's been years since I've had my teeth cleaned. I also had a chipped tooth and they're going to do a crown on it, so I'm kind of going home a new man."

Levon Saddlefield
MOM Patient

"I began volunteering at the MOM projects in Wise and the Eastern Shore as a dental student. The lines were as long as my eye could see and we were all up before the sun rose. As a dentist further into my career, I have continued to volunteer in Martinsville, Petersburg, Emporia, Roanoke, Gloucester, Annandale, and Norfolk, to name a few. I am proud to have the opportunity to be part of such an amazing project."

Marci S. Morris, DDS
Richmond, VA

"Throughout the years, all four of my kids have volunteered for the MOM so I give this project the credit for jump-starting their feeling to give back. Now as adults, I see them continuing this pattern, volunteering for not only the MOM Project, but also for Special Olympics, Free Clinics, Cystic Fibrosis Foundation, the school system and so much more."

Dr. Diana Marchibroda
Greenwood, VA

Suffolk MOM was Well Coordinated Kick-off to Program's 15th Year

By: Joel Rubin, APR, Rubin Communication Group

For Dr. Ralph Howell, years of wishing, hoping and planning for a free dental clinic in his hometown of Suffolk nearly came to a screeching halt just after noon on March 8.

A 185 PSI compressor, on loan from a local agency, suddenly stopped, killing all power to air and vacuum lines and effectively silencing handpieces and air syringes that Dr. Howell and his fellow dentists were using to clean molars, fill cavities and suction body fluids. "They could continue doing extractions and examinations, but that was about it," said veteran dental technician Bill Hall, who was in charge of setting up all the equipment on the floor of Kings Fork Middle School that day. "I've been doing this for 15 years, and this is the first time we've ever had a compressor go down."

Fortunately Dr. Howell, a highly-respected dentist in the community, had connections and a calm disposition. "I made a couple calls and was able to rent a compressor within an hour," he said. The day was saved.

Good thing for patients like house painter Julie Price of Suffolk, who had not been to the dentist in 20 years, and daycare worker Deloris Boone of Franklin, who hadn't seen one in 13. "I don't have insurance and I couldn't afford to even pay for x-rays," said Price, who was preparing to have two cavities filled. "Thank goodness they have this."

"This" was the first Mission of Mercy or MOM project ever held in Suffolk. What is now the Virginia Dental Association Foundation began these outreach efforts in 1999 in rural Wise County and has funded and staffed, with VDA dentists, over 70 of these one or two day events since. For Dr. Howell, whose father, Dr. Leroy Howell, and daughter Dani, a VCU dental student, were also among the volunteers on the floor treating the 500 men and women who streamed into the all day makeshift clinic, it was the culmination of months of preparation.

"We knew there was a need in this part of the state, but did not know how urgent it was until recently," said Miriam Beiler, who runs the Western Tidewater

Free Health Clinic, which had a key role in the run-up to the event. "We had planned to take registrations up until 11 o'clock in the morning but had to cut them off at 7:30 a.m. That means there are a number of people who will now have to go another year without care."

The City of Suffolk, whose mayor Linda Johnson participated in a celebratory "milk toast" to kick off the MOM, was a partner in the effort, along with the school system, police department, Obici Health Care Foundation, Virginia Health Care Foundation, Suffolk Partnership for a Healthy Community and local physicians.

Only minimal advertising was needed to raise awareness of the opportunity to receive the services that more than 60 VDA dentists and their support teams from across the state were willing to provide at no charge. Many arrived a day early to triage patients in the school auditorium and put bands around their wrists to assure they would be treated the next day.

The dentists could hardly do it alone. Supporting them at makeshift dental stations, furnished with patient lights, portable chairs and ample amounts of gloves, gauze, syringe tips, cotton balls, masks, mouthwash and lidocaine, were several dozen students from Virginia Commonwealth University in Richmond, and not just from its dental school. "This was invaluable training for us to be able to talk directly with the patients about their medications, " said Lauren Grecheck, a VCU pharmacy student. Her professor, Dr. Evan Sisson, watched proudly as his charges interacted with each other as well as VCU nursing students and the dentists. "You can only learn so much by studying cases on paper. You need to have real world experience, and they get it at these MOM projects."

For patients like Levon Satterfield, who was last treated by a dentist a decade ago, MOM gave him back his smile. "I have had a real bad tooth for quite a while but was able to get a crown today," he said. "I am very blessed and also very impressed by the work these people are doing." That included the man who fashioned his crown, Dr. Michael Fernandez, who was creating them at a steady clip, and glad to do it. "We haven't had a MOM event in eastern Virginia in a long time so I'm happy they staged this one in Suffolk so I could be part of it."

At other chairs were dentists from Portsmouth (including Dr. Steven Carroll, assisted by his 20-year-old daughter Jessalin, who is

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My MOM Experience

"It's during the process of providing care to those who need it that you realize why you entered the profession of dentistry in the first place. It is truly a gift that you as a participant have the ability to change the life of someone by sharing your skills."

Dr. Ralph Howell
Lead Dentist for Suffolk MOM Project
Suffolk, VA

"I work in a fairly affluent community, and hear complaints from my patients on a daily basis ('that light is too bright, you're making my gums bleed,' or 'could you make this quick, I need to get to a meeting'). When I came back from Wise, I asked my DDS, 'do you know how many complaints I had in Wise? ZERO!' I've been practicing for 15 years, and there are days that feel monotonous, and that I'm not making a difference. My experience at MOM changed that."

Maria K. Leibowitz, RDH
Alexandria, VA

"The MOM project was a beautiful experience for me. I've never seen so many people looking for dental work. I worked as a dentist in Peru for many years and the Mom project gave me the opportunity to enjoy what I love the most."

Dr. Lily Salazar
Ashburn, VA

SUFFOLK *(Continued from page 48)*

considering a dental career) and Fairfax, and from Richmond and Chester, where Dr. Sam Galstan runs a family and cosmetics practice. "I try to come to as many MOM events as I can," said Dr. Galstan. "It's what professionals in healthcare should be doing, and I'm proud that the VDA is a leader in providing treatment to those who so desperately need it but cannot afford it." Rasheka Smith, an ODU psychology graduate with a three year old at home, never thought she would be one of Dr. Galstan's patients this day. "My child is covered under Medicaid, but I don't have insurance, so this was a godsend."

This was the first MOM in Suffolk, but it may not be the last because of how many turned out to see their dentists. "I had no idea it was like this," said VCU pharmacy student and Suffolk native Melissa Ellis. "I volunteered at the Wise County MOM last year and thought this was only a problem in rural areas. I was wrong."

2014 Northern Virginia MOM

Governor Terry McAuliffe came to the Springfield campus of Northern Virginia Community College for a milk toast to kick off the MOM project conducted by the Northern Virginia Dental Society (NVDS). Hoisting a glass with the Governor were VDA dentists Dr. James Willis and Dr. Peter Cocolis, local member of the Virginia House of Delegates Eileen Filler-Corn and Cathy Griffanti of the NVDS. At the two-day clinic (March 14-15), 142 dentists and specialists, supported by 58 hygienists, 97 dental assistants and 268 community volunteers, treated 932 patients, providing nearly $400,000 in free care.

2014 Suffolk MOM Stats

On March 8, 2014 at Kings Fork Middle School, 464 patients received $475,711 in dental treatment from 65 dentists, 62 dental hygiene students and hundreds more volunteers.

The care included:

- 464 exams
- 494 fillings
- 1,302 extractions
- 68 cleanings
- 68 fluoride varnishes
- 19 gum disease treatments
- 473 x-rays
- 32 full dentures
- 16 root canals
- 9 crowns

Of the 464 patients, 253 were from Suffolk and 50 from Chesapeake.

IS THIS KIND OF SUFFERING *acceptable* IN OUR SOCIETY?

DC Writer Reports from Wise County MOM

By: Louise Levathes

Wise is a small community in southwest Virginia, a stone's throw from the Kentucky border and 411 miles from my home near Dupont Circle in Washington, DC. It might as well be a world away. Where the roads have been carved out of the mountains, the black rock, rich in coal that's the backbone of the economy, is clearly visible. The 8,000 or so people who live here are mostly white and desperately poor. "Coal is everything," they will say. "It's the only thing."If they have jobs, the jobs are unlikely to offer health insurance. Regular dental care or getting fitted for eyeglasses, outside most health insurance policies anyway, are luxuries very few people here can afford.

I came to volunteer as a dental assistant at the three-day Mission of Mercy/Remote Area Medical health fair recently, largely funded by the Virginia Dental Association Foundation. I'm not a trained dental assistant, but I was inspired by my DC dentist who is a regular volunteer at these free Mission of Mercy clinics held eight times a year at various locations around Virginia. General volunteers such as myself assist with treatment forms, move patients from one area to another, and comfort and talk to them during their long periods of waiting for treatment.

By 5 a.m. on the Friday morning when I arrived at the fairgrounds just outside of Wise, 1500 tickets had already been given out to people who came days earlier to get in line for the free treatment. Many had slept in their cars. It was still dark, and, as I walked through the huge parking lot, I saw license plates not only from Virginia and neighboring Kentucky and Tennessee but also from Florida, Georgia, Mississippi, Indiana, and Michigan. Later in the weekend, I would meet a man with a mouthful of decayed teeth who had walked 12 miles with a cane to the clinic.

Inside the fairgrounds, there were several large tents for dental care – one for restorative care, such as fillings; one for oral surgery, which meant mostly tooth extractions and root canals; and one for hygiene, where people were given a tooth brush with a small tube of toothpaste and taught how to use it. Another area behind the tents had mobile trailers for fitting dentures. Patients were triaged when the come into the fairgrounds and assigned to one of these dental care areas based on their most pressing need – though they might have needed many services. The clinic also offered free prescription eyeglasses and other medical screening.

In the oral surgery tent, I teamed up with Dr. Frank Serio, dean of a new school of dentistry to be established at Bluefield College, about an hour and a half north east of Wise. Dr. Serio, an energetic former New Yorker, hopes not only to provide low-cost dental care at the dental school clinic at Bluefield, but also to help meet the dental needs of underserved people

SOCIETY *(Continued on page 50)*

SOCIETY *(Continued from page 49)*

across the region in community health centers. His immediately task, however, was pulling more than 20 teeth from a 46-year-old man with a scraggly beard who said he was on disability. He was in so much pain, he told me, that he had lost 30 pounds in the last few months because he couldn't eat. His teeth were black from decay and many were worn down to the gum line. When Dr. Serio finished, the man had no teeth left at all.

"Could some of these teeth have been saved?" I asked the dentist.

"Yes, probably," he said. "With root canals and caps, but it is expensive, $4,000 to $5,000 to save some teeth. Almost half of the people in this corner of the state don't go to a dentist on a regular basis. They are probably making $35,000 a year and given the choice between fixing a tooth – at $200 just for a filling – or pulling it out for about $175, most patients will choose to lose the tooth and not have any more trouble with it." At the weekend clinic, only about 60 root canals were performed compared to almost almost 4,000 tooth extractions, though all patients were given the option of to save their teeth, if it was possible.

Our next patient was an 18-year-old boy who could barely grow a beard. He looked 15. Dr. Serio pulled the boy's four upper front teeth, which were badly eaten away with decay. Afterward, he encouraged him to have "an intimate relationship" with a toothbrush and to cut out smoking, drinking Mountain Dew and chewing tobacco. "If your boss gave you $3,000, you would think that was good thing, right?" Dr. Serio asked. "Well, why don't you give that to yourself by cutting out the $5 a day cost of cigarettes? You'd have $3,000 at the end of a year…" The boy nodded politely. Later I saw him leave the fairground with a buddy, each of them holding a can of Mountain Dew.

Later in the day, Dr. Serio removed all of the remaining teeth, about a dozen, of a pretty, 43-year-old woman who was already a grandmother of two. She wore tight cut-off jeans, which showed off her shapely (and tattooed) legs to maximum effect. Her hair was dyed black and her eyebrows carefully plucked. She told us she was a heavy smoker and carried a lighter on a retractable chain on her belt. With her mouth full of gauze to stop the bleeding after the extractions she scribbled a note to me: Can I have my dentures fitted on Monday? I passed the note to a surgical resident who said "yes," but that the gums and bones would change in the next few months so that her new dentures would probably have to be re-fitted. "It will take 3-4 months for the gums to heal completely," he cautioned her. She was barely listening, delighted to have all her teeth gone and impatient for her dentures. But she will probably have a long wait. Dr. Scott Miller, a local dentist who was working at the clinic, told me that 300 atients in and around Wise are waiting for dentures. Seventy more were added to the list after the weekend. He and his team fitted about 40 pairs of dentures during the three-day clinic. "The ones we use cost us $280 a pair, just for the materials, and we just didn't have the money to buy more for our patients this weekend," he said.

I asked him how old the youngest patient he had fitted for a set of dentures was.

"Eighteen," he replied.

I didn't sense any remorse from the people we saw about losing their teeth. They were all relieved. They were relieved because they were no longer in pain. And there was a disconnect between their lifestyle choices and the loss of their teeth. They say, "I have soft teeth just like my Mama…" Losing teeth was an expected part of growing older, that's all. And they accepted that. I asked one young man with a mouthful of decaying teeth if he ever brushed his teeth and he said, "No, It hurts too much." The most he was able to do was to put

a little toothpaste on his finger and gently rub his teeth. Serio told me that if any inroads are going to be made on the preventive side here, grammar school kids need to be targeted and told to brush their teeth – no matter what their patients do.

By the end of the long day, we had seen eight patients and removed, Serio estimated, more than 50 teeth. "In private practice," he said, "this would be a $12,000 day."

By the end of the weekend, the clinic with more than a thousand volunteer dentists, doctors, nurses, medical students and general volunteers had served 1323 patients – and turned away an estimated 400-500 more. Since Mission of Mercy clinics started in Virginia in 2000, they have treated more than 50,000 patients with an estimated $32 million in free dental care.

Dr. Miller, who is the son of a coal miner and has a dental practice in Bristol, Virginia, shook his head. "It is hard to tell if we are making progress, " he said. "We are treating more and more patients each year. Ultimately, we have got to teach people in our schools or churches to take care of their bodies and their teeth – or this is never going to end. If you loose all your teeth, what are you going to eat? You can't eat carrots; you are going to eat cake. And a poor diet eventually leads to a host of other health problems like diabetes and cardiovascular and lung disease." He told me that a lot of miners believe that if they chew tobacco it will somehow catch the coal dust and help prevent black lung disease. "It's not true, of course," he said. "That's what we're dealing with."

It was at the end of my second day that I became angry. I was escorting a Mexican- American man in his '60s, who had had all teeth pulled, to the pharmacy for pain medication. He was trembling and the back of his shirt was wet from perspiration after his one-hour ordeal. The gauze that the resident had put in his mouth could not contain the blood from his gums that had been split open from multiple extractions and it was now dripping from his lips onto his shirt. As I rushed to get more gauze, his wife asked me, "Where do we go to get help if we need it now?" The truth is that follow up with patients after the clinic is spotty because many live so far away. I advised her to ask the nurses at the pharmacy for resources near where they lived. As I watched her walk away, cradling her husband with one arm, I wondered who was it was that decided that dental care and eye health and even mental health were optional add-ons to health insurance. Is this kind of suffering is acceptable in our society?

Later, I had a chat with Dr. Terry Dickinson, executive director of the Virginia Dental Association, who echoed my feelings. "How politicians can separate dental health from a patient's general well-being bewilders me," he said, "The inflammatory process in the mouth of course affects general health and if you have pain in your teeth you can't be a functioning member of society. All you can think about is the pain."

As I drove home from Wise, 411 miles, back to Washington, D.C., I thought that's not very far at all. Wise is on our watch.

(c) Louise Levathes writes about science and society and is a senior editor at The Berkshire Review and New York Arts.

My MOM Experience

"My daughter, Michelle, who graduates from dental school this May, went to her first MOM as a sophomore in high school. I watched her endure the heat of July in a horse trailer to develop dental x-rays. When she accepted the task of cleaning dental instruments without complaint, I realized she was serious about becoming a dentist."

Deborah Stelmach
Mother of a VCU Dental Student

"One of the best parts about volunteering at MOM is that it doesn't even feel like work. I know now, that I can make a change in this world, thanks to these amazing, caring, helpful, and smart people that I volunteered with."

Isra Hamdi
Student

"I remember at MOM fixing a chipped tooth for a lady. I borrowed a mirror from a friendly hygienist and showed her the filling. She began to cry. I thought she was upset until she told me that that tooth had been chipped for about five years, and she had always wanted it fixed. Well, it turns out that she was to be married a week after. She said, 'Now I can smile for my wedding picture.' That made my day."

Dr. DJ Bickers
Charlottesville, VA

"Eventually, We Want to Eliminate the Need for Missions of Mercy"

By: Patrick Finnerty, President of the Virginia Dental Association Foundation

Like so many others, I have been transformed by my experiences volunteering at Missions of Mercy (MOM) projects over the past 14 years. MOM has come a long way from its humble beginnings in an airplane hangar, and I am thrilled to not only celebrate the 15th anniversary of the program, but also complete our 75th project this year. We could not have offered health and hope to so many people without an ever-growing network of donors, volunteers, and partners. To everyone who has contributed to the success of MOM, I say "thank you."

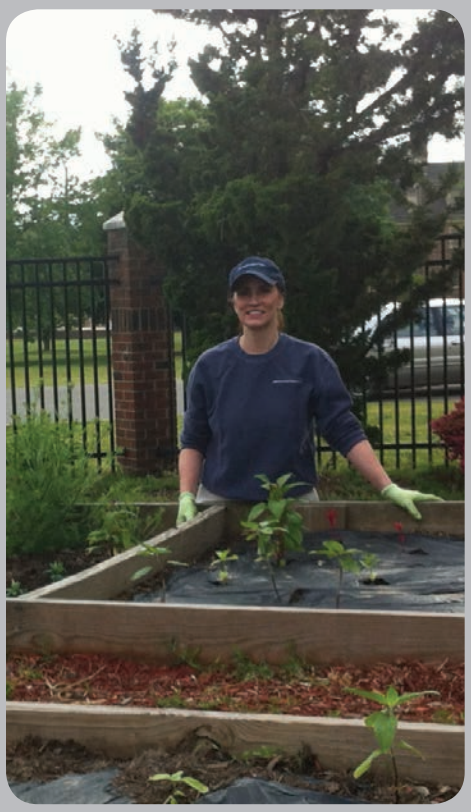
What's next? Where do we go from here? Eventually, we want to eliminate the need for the Missions of Mercy program. MOM is not the answer. To quote founder Dr. Terry Dickinson, "MOM projects are not intended to be the solution for providing dental care to the uninsured. Our long-term goal is to leverage the MOM projects to create sustainable solutions so that in the richest country in the world, Virginians do not stand in line to receive dental care."

Until we reach the day when it is no longer needed, MOM will continue to play a vitally important role in Virginia's dental safety net. The Board of the Virginia Dental Association Foundation (VDAF), in conjunction with the VDA, is making a strategic transition to ensure that MOM and our other nationally-recognized outreach programs are successful and sustainable. Strategies for the next one to two years include:

- Identifying and engaging the next generation of MOM volunteers and leaders. Our current volunteers are amazingly dedicated and hard-working. However, as they eventually retire or relocate, we want to have a group of talented and diverse leaders in the pipeline.
- Diversifying income so that we are less reliant on VDA funding. VDA members volunteer thousands of hours each year through MOM and other programs to improve the oral health of underserved Virginians. The VDA also provides significant funding to the Foundation, as well as connections to numerous donors. While we will always be the charitable and outreach arm of the VDA, our desire is to bring other contributors, sponsors and foundations into the fold.
- Exploring additional preventive and educational services for patients at MOM projects. While limited access to affordable dental care is clearly a barrier to good oral health for many residents of the Commonwealth, so, too, is the limited understanding of the importance of good dental hygiene. We have an excellent opportunity to interact with patients waiting in line at projects to offer education on preventative care.
- Utilizing experiences and data from MOM projects to raise awareness of critical issues and influence policy. We want MOM to motivate people at every level to create broader access to care through an appropriate mix of coordinated public and private efforts. By sharing stories and statistics gathered at projects, we can get the attention of legislators and community leaders and propose viable, long-term solutions for dental care access.

Implementing these strategies will be no small feat. But, together, we can make great strides in improving the oral and overall health of Virginians through MOM. I look forward to working with you on these strategic initiatives in the year ahead.

An Introduction to the 2013-2014 Component Presidents



Dr. Kit Sullivan
Richmond Dental Society

My three main passions are spending time with my family (4 children and 5 grandchildren), travel (my goal is to go to at least 2 new countries a year) and gardening. I plant, maintain and give flower arranging classes as a volunteer at the United Methodist Family Services. UMFS is a residential home for children in need. My specialty is cut flower growing. I'm also a member of two garden clubs in Richmond, Boxwood and Windsor Farms.

My goals as President of the Richmond Dental Society this year are to build our membership, engage our new dentists and rekindle enthusiasm. Early engagement is critical as dentists' membership decisions appear to be fixed early in their careers. I'll also be working to increase our sponsorship income so we can provide more services to our members and the community.

We've actually increased our attendance at our meetings by over 50%! Some of the things we've instituted to create enthusiasm include:

- Changed our membership meeting format to heavy hors d'oeuvres to allow more socializing with speaker in a separate room
- Inviting 20 dental students to each meeting (member dentists cover their costs).
- A raffle for each new dentist attending for free attendance at an all-day CE course
- A raffle for all members at each meeting
- A New Member Series of events including an evening at the Virginia Museum followed by cocktails, VCU basketball game, course on Risk Management, and a Social at the home of a member dentist. We've had great response!!
- Started a new article in our newsletter-"New Member Spotlight" (selected at membership meetings from new dentists attending)
- Our Membership Committee and New Dentist Committee personally called and invited all new member dentists to attend our November meeting
- At each membership meeting we've spotlighted a different population of our membership. First was New Members, second was retired members and our next one is non members. We've sent invitations to non members to attend the next meeting at no charge to see what all the excitement is about!!

The composition of our organization has changed dramatically over the past few years so we'd like for them to give us a try!!!!

Dr. Russell Taylor
Peninsula Dental Society

Being in a leadership position I hope that I›m able to encourage our members to act fraternally towards one another resulting in lasting friendships and a thriving membership. I hope to encourage our members to reach out and be great mentors for the legacy to come, subsequently guiding the future generation with sound ethics that have instilled such great trust and prestige for our profession.

Dr. Mike Webb
Southside Dental Society

My goals this year are to increase communication by reducing our dependency on paper and mail, and using electronic communication, such as e-mail. It's more timely and saves money. Also, we plan to increase our membership through greater recruitment efforts. We're working on a standardized template for welcoming new members as well. We hope also to expand our participation in Give Kids A Smile!® and the Missions of Mercy projects.

An Introduction to the 2013-2014 Component Presidents

Dr. Kevin P. Snow

Piedmont Dental Society

I am excited about my upcoming year as your president. I hope to see many positive changes in the VDA this year. As for our component, I believe we can make a few positive changes to insure the health of the VDA for many years to come. I hope to visit the local dental societies in our component to discuss "the storm" that has been identified by the VDA that is occurring as we speak in dentistry. Hopefully if we are educated about what is happening in dentistry, we can each make the appropriate changes in our practices to sustain a bright future. I also want to emphasize the importance of each member making their VADPAC contributions. I want to stress how important it is that organized dentistry in Virginia not allow what has recently happened in medicine happen to us. I hope to persuade more component members to come to this year's VDA meeting at the Homestead in September. The more members we have participating in the decisions of the VDA, the stronger we will become in the future. The VDA has also asked each component to delegate members in each locale as ambassadors for the VDA. These ambassadors will be informed when new dentists move into their respective locales, and they will approach these new dentists to inform them of the importance of joining the VDA. Anyone interested in becoming an ambassador should please contact me and we will be sure to register you with the VDA. Lastly, I would like to encourage all members to try and make our Spring Piedmont meeting at the Holiday Inn Tanglewood in Roanoke. This meeting will be Friday, April 11 and the program is "The Alternative Denture" presented by Dr. Stephen Alouf and Dr. Scott Miller. In closing, please feel free to contact me about anything, and if I don't know how to help you, I will try to find someone who can. ksnow@riverviewdental-va.com

Dr. Anthony Meares

Tidewater Dental Association

I would like to help facilitate communication with our membership about changes that are being seen in the profession of dentistry. I would also like to encourage member dentists to submit their office photographs to be published on the VDA website as part of our ongoing public relations campaign.

Inspiring an engaged membership

By: Jeremy Jordan, Class of 2015, VCU School of Dentistry

In early February, members of our chapter of the American Student Dental Association attended our annual District 4 Meeting in Raleigh, NC, held in conjunction with the North Carolina Academy of General Dentistry Meeting. During this meeting, students had the opportunity to network, learn more about organized dentistry and the issues facing dentistry, earn continuing education credit, and collaborate on ways to strengthen our ASDA chapters. Student leadership from chapters at East Carolina, Georgia, Meharry, North Carolina, South Carolina, Tennessee, and Virginia had an opportunity to give an overview of their chapter, including the chapter's most successful events, new ideas, and strengths and weaknesses. Despite their differences, each chapter reported the same major struggle: creating an engaged membership that understands the important of their involvement in organized dentistry.

ASDA is the largest student run organization in the nation, representing over 20,000 members and almost ninety percent of the market share. We're so proud of our growing organization, and the opportunity it provides for students to engage in organized dentistry and learn to advocate for our profession early on in their careers. At the same time, our local chapter leadership is beginning to realize that 100% membership doesn't equate active member participation and desire to learn more. In fact, since our chapter is auto-enroll, one of our greatest struggles is helping students realize the benefit of their membership. For some of our students, there's no mental buy-in, and they receive the benefits of membership without recognizing the importance of the organization and how their participation can make an impact. We know that studies show a correlation between membership in ASDA and conversion to the ADA after graduation, and because of this, we're ever adamant about getting our student body more engaged. Our question is the same as that of the VDA in recruiting new members: how?

More often than not, classmates approach me with questions about ASDA prefaced with the question, "you're in ASDA, right?" While I'm more than happy to field questions about taking advantage of membership benefits, and about how to get more involved, I'm often discouraged that these classmates fail to recognize that their membership is the same as mine and that the difference is what you choose to do with it. In the next year, our local chapter is following the lead of the VDA and creating a strategic plan that will help us address our concerns by the development, implementation, and evaluation of goals specifically directed at our members, and their thoughts on our organization. Much like the VDA, we've started this process by creating a membership and communication benefits survey, to evaluate where our membership stands and how we can best meet their needs. For us, understanding where our members are is the first step in realizing where we can meet them.

...start now, take action, and figure out 'why' for yourself.

In a TEDTalk titled "How great leaders inspire action," speaker Simon Sinek, author of "Start With Why" and "Leaders Eat Last," discusses how leaders can inspire cooperation, trust, and change. As Sinek points out, we often start out discussions aimed at persuasion with 'what,' then explain 'how,' and end with 'why.' Sinek states that great leaders do exactly the inverse—they start by explaining 'why,' before discussing 'how,' and close with an explain of 'what.' Sinek uses examples from leaders like Martin Luther King, Jr., and innovative companies like Apple, to show the effect of starting with 'why.' Sinek suggests that providing insight into what you believe helps others fundamentally understand 'why.' As he explains, "the goal is not to sell people who need what you have, it's to sell to people that believe what you believe." Sharing our core values shows others why we do what we do, and helps them buy-in to those values—in short, starting with why inspires others to do what inspires them.

As I take a look back on my dental school career thus far, I realize that it would be entirely different if not for my involvement in organized dentistry. Over the past three years, I've had the opportunity to strengthen my leadership abilities, learn more about dentistry outside of the classroom, learn how to advocate on behalf of my future profession, and see the impact my active participation can make. While I'm glad to have had these opportunities, the truth is that it isn't enough. Now I'm challenging myself to reach out and share 'why' with my classmates and to encourage them to become engaged in their membership. Our past successes make it evident that there's strength in numbers and that active participation can keep the decisions affecting our profession in our hands. For dentists, you're uniquely positioned to inspire students to become better leaders, better clinicians, and better advocates—all of which can be accomplished through an engaged membership in organized dentistry. For students, you don't have to wait until after graduation to take advantage of the resources, benefits, and opportunities organized dentistry provides for you—start now, take action, and figure out 'why' for yourself.

First chair to support program, honor mentor

By: Development Office, VCU School of Dentistry

Dr. A. Omar Abubaker will be the first Bear Chair and the first chair within the VCU School of Dentistry.

An endowed chair is one of the highest forms of recognition provided by a university to an individual, and the VCU School of Dentistry is proud to officially announce its first endowed chair – the S. Elmer Bear Chair. At its September meeting, the VCU Board of Visitors approved the chair, established with funds totaling $1.1 million.

Previously, the Bear Chair was an endowed professorship within the Department of Oral and Maxillofacial Surgery. On the thirtieth anniversary of Dr. S. Elmer Bear's passing, with the leadership of Dr. A. Omar Abubaker, professor and chairman of the Department of Oral and Maxillofacial Surgery, and the guidance of the VCU School of Dentistry Development Office, several alumni renewed the commitment to honor and preserve the memory of a revered practitioner, educator and mentor. To aid the fundraising effort, Andrea Bear, Dr. Bear's daughter, produced a video tracing his life, his work at VCU and his impact on his chosen profession, which introduced him to a whole new generation of oral surgeons and VCU alumni. The chair will support the residency program's continued development through recruitment and retention of the best and brightest faculty and residents.

Dr. Bear served from 1960 to 1981 as the first chairman and founder of the OMFS residency program. He made a name for himself nationally and internationally and devoted himself to his profession, his fellow oral surgeons and his residents, whom he affectionately thought of as his family.

What's so remarkable about the Bear Chair is that it was kick-started by many of the early residents that Dr. Bear trained, like Dr. Ronald L. Tankersley (D.D.S. '68, OMFS '71) and Dr. Charles L. Cuttino III (D.D.S. '66, OMFS '72), but brought to fruition by residents that came long after his tenure as chairman including recent graduates of the program. These alumni and oral surgeons share Dr. Bear's enthusiasm for the residency program and his commitment to ensuring that the program and the department continue to be among the best in the country. The Bear Chair funding to the program will enhance the educational experience of future residents, while forever keeping Bear's legacy alive.

As department chairman, Dr. Abubaker is named the inaugural Bear Chair. "I am honored and extremely privileged to be the first person to hold the honor in the department and the school," said Dr. Abubaker. "And I'm excited to share the news with alumni, friends and the entire specialty."

Dr. S. Elmer Bear, 1921-1981

To learn more about how ways to support the Bear Chair, please contact Edward G. Kardos egkardos@vcu.edu or (804) 828-0324. Check out a video about Dr. Bear at www.oralmaxillofacialsurgery.vcu.edu/giving.

Give Kids A Smile!®

By: Jessica Park, VDA Foundation

Throughout the month of February, Virginia dentists provided free oral health care services to thousands of children across the Commonwealth through Give Kids a Smile! events. A program of the American Dental Association, Give Kids a Smile! focuses on offering oral health education to all children while providing free preventive and restorative care to children who need it most. In addition to helping children, the program highlights for policymakers the ongoing challenges that underserved children and children with disabilities face in accessing dental care.

As the charitable and outreach arm of the Virginia Dental Association (VDA), the Virginia Dental Association Foundation (VDAF) functions as an umbrella for the numerous Give Kids a Smile! education, screening, prevention and treatment programs held annually across our state. There are still statistics on 2014 events to be collected, but so far, dentists and other dental professionals have reported helping more than 2,000 children at 18 different projects this year. Thanks to the many volunteers that make the Give Kids a Smile! program possible in Virginia!

"Although more and more kids have either public or private dental insurance, the number of kids being seen for a dental visit each year is only around 50%. The Give Kids a Smile! program gives an opportunity to identify children in high risk groups who have significant dental disease and at least get urgent needed care. In addition, the program provides an opportunity to increase parental dental awareness and direct them toward establishing a dental home for the children and, ideally, for the entire family."

--Dr. Frank Farrington, Professor (Emeritus) of Pediatric Dentistry at Virginia Commonwealth University, GKAS Volunteer, Midlothian, VA

Looking Around the Corner on Oral Health Care Delivery

By: David C. Sarrett, DMD, MS; Dean, VCU School of Dentistry

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I just returned from a meeting of deans of dental schools and a conference on Oral Health in Primary Care (www.adea.org/deans). The conference learning objectives were:

- Articulate national health care trends and how they are driving emerging health care models
- Describe the impact of the Affordable Care Act will have on oral health providers
- Examine existing models of interprofessional education and collaborative practice
- Explore opportunities and challenges for dentistry within the primary care model of health delivery

This was not the first time I listened to speakers on this topic; however, what I learned has now crystalized some basic concepts in my mind. At this recent conference, we heard speakers from the business world who are interested in improving the health of their employees and reducing costs, from the medical and dental insurance industry, from leaders in nursing, pharmacy, and physician assistant education engaged in collaborative practice programs, and from a chief quality officer for a major health system.

Some key take home messages were:

- Consumerism is going to drive change in health care practices.
- Patients want online access to their health information and information about providers.
- Oral health measures will become part of health-management programs.
- Providers and health-systems (including dental) will be paid based on health outcomes and to increase income, you will have to improve quality of care and patient satisfaction, improve health outcomes, and reduce errors.
- The Affordable Care Act has left many unknowns regarding its impact on oral health and dental care.
- Children will likely have much greater access to dental care while adults are seeking less care.
- Patients need to be at the center of the health care system, and will be because payment will reward this behavior by health care providers
- Economics will likely drive the number of solo practitioners to decline and the number of providers in large group and corporate dental health organizations to grow.
- Expanded reporting requirements will surface, particularly for publically supported programs.
- The actual cost to deliver specific care will be used to determine reimbursement.
- The use of electronic health records will expand and will provide data to support decisions in quality of care and cost of care.

Do you know what an Accountable Care Organization is? At CMS.gov (Centers for Medicare & Medicaid) you will find this description:

"Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors."

CMS offers a Shared Savings Program that rewards ACOs that lower the growth in health care costs and improve patient outcomes based on quality measures. For now, this is just a program under Medicare, so you may think this has nothing to do with dentistry. I feel that the ship has left the dock regarding this trend of accountability by the provider for the health care delivered and the ship will dock at Port Dentistry very soon. What if instead of being paid to restore teeth, you were paid to eliminate and control dental caries? Would this change your approach to dental and dental hygiene practice?

One of the more thought provoking speakers was from Geisinger Health System, which services areas mainly in the northeast. He reported on the transition of their care model to a patient-centered approach that rewards health outcomes. You can read about this at www.geisinger.org/about and here is a quote from their website, "Geisinger is an integrated health services organization widely recognized for its innovative use of the electronic health record, and development and implementation of innovative care models…"

Fundamental to the Geisinger approach is the use of quality of care measures and patient satisfaction data to guide continuous quality improvement. They also report these data publically on their website. For example, if you go to http://www.phc4.org/hipknee/Results.aspx?hospitals=2420 you will find a comparison of quality and cost of total hip and knee replacements at Geisinger/Danville Hospital compared to Pennsylvania statewide. What this page will tell you is how many of these procedures were performed both at Geisinger and hospitals statewide, the comparative cost, and comparative frequency of post-operative complications. You can drill down a little further on this same page and find results by surgeon. Yes, results by surgeon!

The first set of proposed dental care quality measures was released this past summer by the Dental Quality Alliance (DQA) (http://www.ada.org/5105.aspx). According to the ADA website, "The Dental Quality Alliance was established by the American Dental Association to develop performance measures for oral health care. The DQA is an organization of major stakeholders in oral health care delivery that will use a collaborative approach to develop oral health care measures."

The DQA's first set of measures (http://www.ada.org/5105.aspx) are for Dental Caries in Children: Prevention & Disease Management. The measures include utilization of services, quality of care, and evaluation of cost. This latter measure is the per member per month cost. This is a common measure in health plans and is defined as the total amount paid on direct provision of care per enrolled member within a reporting year. The calculation is straightforward. A dental insurance plan would first sum up the total amount paid for dental services over a reporting year. This is the numerator. This dollar cost is then divided by the total enrolled member months. In the example below, the plan paid out $5,000 for five plan members who were collectively enrolled in the insurance plan for 44 months. The per member per month cost is $113.64. It is easy to see how dental plans will be able compare these per monthly cost by provider or provider organization. The providers who are providing care at lower costs while maintaining quality and patient satisfaction will drive the system.

As Yogi Berra has been quoted as saying, "The future is not what is used to be." We will all be just fine in this future and the more attention we pay now to our changing environment, the finer we will be.

Total Dental Care Cost in a Year	Enrolled Members	Months Enrolled in a Year
$5,000	Member A	12
	Member B	12
	Member C	4
	Member D	10
	Member E	6
Total Member Months		44
Per Member/Month Cost of Clinical Services		$113.64

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.

NPT created the *Practice Protection Plan (PPP)*, the first of its kind in the industry, to provide you peace of mind in knowing your practice's value may be protected in the event of such an unexpected tragedy. **There is absolutely no cost to you to sign up.**

Here's how the Plan works:

- We provide you with a **LETTER OF NOTIFICATION** to sign and entrust with an individual such as your attorney or executor. This letter instructs that person to notify us immediately upon a tragic event requiring us to sell your dental practice.
- You pre-sign our standard Agreement which is then placed in your file authorizing us to sell your Dental Practice only upon receipt of the signed **LETTER OF NOTIFICATION**.
- Each year you forward us your relevant practice financials and requested data reports to be kept in your file.
- Should an unexpected tragedy occur, we will immediately appraise and market your practice. By maintaining your vital practice information, we are able to begin the sale process immediately while your practice is still maintaining its highest value.
- As a participant of the PPP, your practice will be locked in at a reduced commission rate should we have to sell as a result of a tragedy. By reducing our commission even further, we hope to provide you or your estate additional financial support during this unexpected and tragic occurrence.

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Practice Sales ◆ Practice Appraisals
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Creating Happiness as a Practice Protocol

By: Olivia McLeod Straine, Vice President, Straine Dental Consulting

There is a lot of science that demonstrates the positive effects being happy has on people, including better health and a longer life. According to Webster, happy can be defined as "being pleased or glad about a particular experience or event." So, how does being happy apply to the dental practice? Is creating happiness important and can it become a system within the practice that is implemented on daily basis? Happily, the answer is yes!

What is Happiness?

As doctors, your role is not just to cure but also to care. When people know you care, whether they are patients or team members, they tend to be happier. Logically, making patients happy should be a deliberate part of delivering effective treatment. So, let's consider what makes a happy patient. Being happy is much more dynamic that being satisfied. Dr. Martin Seligman, Director of the Positive Psychology Center at the University of Pennsylvania and founder of Positive Psychology, a branch of psychology which focuses on the empirical study of such things as positive emotions, strengths-based character and healthy institutions, defines authentic happiness as a positive emotion resulting from engagement and meaning. In dentistry, happy patients are quality patients, as demonstrated by their behavior. A quality patient commits to consistent, continuing care visits, accepts your treatment plan, agrees to your financial arrangements, keeps appointments, re-appoints for her next appointment, refers family and friends and values your practice's philosophy of preventive dentistry.

Creating a Happy Environment

Owning and operating a small business is an exciting opportunity, professionally and personally. The best part is being able to develop other people to their potential, to uncover and enhance their strengths and make their limitations irrelevant. As a leader of a dental practice, the dentist sets the example for conduct and behavior, including happiness expectations for employees and patients. In other words, they cast the vision and determine the practice philosophy, which, subsequently, determines the practice systems, including both the hard-side and soft-side systems. The hard-side systems are the structure, processes, benchmarks and feedback tools. The soft-side systems focus on creating a positive environment and the expectation for happiness, which is equally, if not more, important.

For example, dental practices understand the importance of having a daily huddle, but tend to focus on what happened yesterday, what's on the schedule today and what is coming down the road tomorrow. These are all hard-side systems. They often miss the other component, the soft-side, which is about setting the right tone for the day. At Straine, we have a huddle every morning and begin with a gratitude statement. There is science that shows gratitude exercises have the ability to change people's happiness set-point. Based on my practice philosophy, the first thing that I want to do is plant positive seeds to sprout and bloom for the rest of the day so my team will embrace opportunities to share their happiness with others.

Creating a Happy Team

Unfortunately, having a positive work environment does not automatically result in a happy team. A happy team feels they have control over the things that happen to them and they can solve the problems they encounter on a daily basis because there are clear policies, a proven management system and understanding roles and responsibilities. A happy team is created through encouragement, education and positive reinforcement. The most powerful type of reinforcement is attention, approval and appreciation and need to be given abundantly every hour of every day. But it must be authentic, which means the reinforcement is specific to the team member's behavior and an important component of that person's job responsibilities. For example, instead of being general and saying to your financial coordinator, "You're really great at handling patients," you would be more specific with "I really appreciate that you resolved the treatment plan with Mrs. Smith as effectively as you did. I appreciate the way you handled her objections."

It is critically important that the doctor is in tune with the team and is proactively encouraging and reinforcing positive behavior. Why? Because a lot depends upon it, including the team's own personal and professional growth, their openness to redirection and positive criticism and their impact on others, including patients. Ultimately, patient happiness, treatment acceptance, retention and referrals are all influenced by the dental team. Human beings are very porous. When the team is not happy, they transfer their emotional state onto the patient. There's a new discovery called mirror neurons that show we imitate the behaviors of the people we're interacting with and mimic the emotion that accompanies those behaviors. So, in other words, if the team is not happy, patients will pick up on the negativity and, more than likely, will not end up as happy, quality patients. Conversely, if your team is truly happy, their behavior will reflect that mental state and patients will, again, begin to mimic them.

Creating Happy Patients

But just like having a happy environment does not necessarily make a team happy, having a happy team does not guarantee happy patients. There's a bit more to it than that. Start by identifying if there is a problem with patient happiness. There are two ways to find out. First, measure and monitor key practice vital signs like patient retention, treatment acceptance and referrals. If they are not healthy, your patients are not happy. The second way is to simply ask a patient if there's a problem if their behavior or body language seems negative. Researchers interviewed patients at the Mayo Clinic in Scottsdale, Arizona and Rochester, Minnesota and identified seven ideal physician behaviors.1 Patients want their doctors to be confident, empathetic, humane, personal, forthright, respectful and thorough. Patients also want their health problems to be properly diagnosed and completely treated. It's about respecting the patient, listening to the patient's concerns and addressing or providing solutions to those concerns. This means that as a healthcare provider, they want and expect us to let them know the current health of their mouth, all issues and concerns and treatment solutions. So, we need to confidently, empathetically and respectfully communicate the results of the patient's examination and treatment recommendations without filtering it with our own perception of the patient's willingness or ability to accept the dentistry or invest in their oral health. If this is done consistently and with compassion, it will be difficult for patients to be unhappy with the dentist or team. Now, they may be unhappy with the extent of care they need, the limitations of their insurance benefits, the time needed to achieve oral health and the cost of care. But if happiness is a system and a goal in your practice, your team is more likely to proactively provide solutions to these patient concerns. They will work with patients to maximize their benefits, patiently explaining how insurance really works. They will try to consolidate appointments to minimize the patient's time investment. And they will proactive offer financing solutions, like CareCredit's healthcare credit card, so the patient is happy about how the cost of care fits into their monthly budget.

Creating a happy environment, happy team and happy patients must be done systematically and deliberately. The good news is, that when you create and maintain happiness in your practice, you'll end up happy, too. Authentic happiness is contagious. So, every day take advantage of the opportunity to get everyone on your team and every patient in the chair – infected!

1. Neeli M. Bendapudi, Leonard L. Berry, Keith A. Frey, Janet Turner Parish, William L. Rayburn. (2006). Patients' Perspectives on Ideal Physician Behaviors. Mayo Clinic Proceedings, Vol. 81, Issue 3, Pages 338-344, DOI: 10.4065/81.3.338

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Dr. Richard L "Rick" Taliaferro

Candidate for the office of:

President Elect

I am a general dentist and I feel blessed that I have been in practice over 30 years. I still enjoy dentistry and I look forward to more years of practice. We have been fortunate in dentistry to deliver care that we feel is best for our patients with minimal interference until recently. We are the last of the health care professions to be taken over by outside interests. I am concerned that without aggressive work on our part, dentistry and how it is delivered will change dramatically in the future. We have insurance companies forcing provider contracts at us that potentially could bankrupt us and at the least, will alter the quality of care that we deliver to our patients. We have groups such as the Pew and Kellogg foundations that are working to change the delivery of dental care as we know it. We have new dentists coming out of school with so much debt that it may not be sustainable over time. We are not as busy in our practices as we were before the "Great Recession" and long term indicators do not see a dramatic increase in dental spending over several years. Despite the downturn in spending several dental schools have opened and more are planned to open in coming years.

I see many parallels today to the time when I graduated from dental school in 1983. The economy was stagnant and we had the largest dental graduating class nationwide in history. Several private dental schools closed. Dental job openings were scarce. Fortunately for us, things turned around and we enjoyed several good years of practice.

I'm not sure things will turn out as well this time around. Outside influences are stronger. Our profession may not be as eager to fight these forces this time. Our profession has aging dentists who may not be as concerned about the future. We have young dentists that have so much debt that they have difficulty being actively involved.

I do know however, that dentists are unique. We are intense people that care about our practices and our patients. We are entrepreneurs. We are dedicated and hardworking. I still believe we can control outside interests if we are willing to do it. We will have to adapt to some changes. We will have to fight groups such as those who want to change our delivery model, by allowing poorly educated mid-level providers to deliver irreversible care to the public. We can only do that by being united.

My focus as your President-Elect and in future office will be to work with our leaders to meet our members' needs and to grow our membership and leadership, especially the younger dentists; to meet the problems they are facing and to preserve our profession as best we can for the future.

I believe my experience at the component and state levels has prepared me to serve you well. I respectfully ask for your support and I will do my best to reward your confidence in me.

Dr. David Anderson

Candidate for the office of:

ADA Delegate

It has been both an honor and a privilege to represent Virginia on the ADA level as a delegate. To do full justice to the position I have endeavored to work as hard as possible representing the VDA›s positions and concerns. To that end I have spoken before reference committees and the house to ensure our positions are heard and correctly understood. While doing that I have been appointed to a number of ADA committees in order to bring forth ideas that are pressing to the vitality of the organization.

We are in uncharted waters in organized dentistry. Membership is down, debt load is up and dentists are being pressured by a whole host of competing entities who firmly believe they know how we should practice dentistry.

I ask for your vote to continue dentistry›s position and progress and allowing me to mentor some of our younger members on the delegation to advance our profession.

Dr. Alonzo Bell

Candidate for the office of:

ADA Delegate

It has been a great honor to serve you and our profession as an ADA Delegate for the past six years. I sincerely thank you for this privilege and I now ask that you support me for election to a third term as a Delegate to the ADA House of Delegates.

The ADA and all of dentistry constantly face challenges both new and old to the dynamic profession that is dentistry. In response to these challenges, the Virginia ADA delegation must be an effective advocate for the interests of our members in Virginia. I have learned that to be effective one must understand both the issues at hand as well as how governance at the ADA level operates. During my ten years on the delegation, I have developed close relationships with many House members both within our 16th district and throughout the ADA House of Delegates. These valuable connections are instrumental in building coalitions and having our opinions heard. My varied experiences in organized dentistry as committee chair, as VDA President, as a VDA delegate, as a VDA Board Member, and as an ADA Council Member have given me the necessary perspective to fully understand the interests and needs of our members. I feel this knowledge and understanding enables me to represent Virginia dentists at the ADA level. Most important I am eager and enthusiastic to serve in this delegation. I promise to listen to your concerns and to advocate for your interests to the very best of my ability.

Dr. Alfred Certosimo

Candidate for the office of:

ADA Delegate

The Virginia Dental Association is uniquely positioned to represent the interests of thousands of dentists throughout the state. Their concerns

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regarding key issues such as: student loans, access to dental care, dental education, the dental workforce, membership and direct reimbursement must be addressed. Leadership through cooperation and a clear vision of the VDA's future are essential to our continued growth and prosperity. It has been my privilege to serve as an Alternate Delegate for the past six-years, if now elected to serve an additional three-year term as a Delegate to the ADA House, I will dedicate my years of proven leadership in the military, academics and community service to advance the goals of the VDA and our profession.

Dr. Bruce Hutchison

Candidate for the office of:

ADA Delegate

Having served on the Virginia Delegation for the past 17 years, I have developed a good relationship with dentists from around the country and the officers of the ADA. This becomes critical when debating the issues in both finding out what others are concerned with and how to get what we, in Virginia, would like to have done. I listen to my friends and colleagues throughout the state and am aware of the issues that are important to them. Knowing what is important to our members, and knowing how to get the job done make me an effective representative for Virginia dentists. It has been an honor and a pleasure to represent you these years and I hope I can count on your vote to continue my service to the VDA and the ADA.

Dr. Kirk Norbo

Candidate for the office of:

ADA Delegate

I want to thank you again for allowing me to serve as your VDA President last year. This office provided with a unique opportunity to take a look at all of the issues presently facing our profession. We are all aware of the changing environment looming in dentistry's future and therefore must maintain strong leadership to assure our continued success. The Affordable Care Act, cuts in insurance reimbursements, workforce model changes and the continued erosion of association membership numbers are a few things that continue to threaten the practice of dentistry. However, I have no doubt that the profession we love will flourish. It is up to the VDA leadership to provide well developed plans that will help our members enjoy their professional careers. In this effort, I have made it a point to keep an optimistic outlook and forecast for future success at the heart of the discussions surrounding dentistry. This positive energy is essential for the attraction of new members into organized dentistry. I will do my best to represent your views on the national level so that we all have a voice in molding our future. For the past 12 years, I have been part of a strong ADA delegation representing Virginia. I would like to continue serving you as an ADA Delegate and would appreciate your support.

Dr. Roger Wood

Candidate for the office of:

ADA Delegate

As a teacher at the VCU School of Dentistry, as a mentor to dental students, and as an active practioner, I have been privileged to be involved on many levels of dentistry. As Past President of the VDA, it is exciting to see the eagerness of volunteers and their willingness to sacrifice their valuable time. I have been fortunate to work on many VDA committees and have especially enjoyed serving as Chairman of the Legislative and the Dental Practice Regulations Committees. I feel strongly about access to care, so if was a great privilege to be a member of the Missions of Mercy Task Force that initiated what has become so important to people in need and indeed to the volunteers themselves. I also became a member of two Wise County hospital staffs so that I could return to treat children under general anesthesia. I had the priviledge of being a member of the ADA Council on Dental Education and Licensure for four years and the honor of being elected Council Chair for 2005. In this capacity I worked with issues that face us now and will be facing us in the future. I have served as President of Virginia Dental Services Corporation and strongly urge all VDA members to use the endorsed vendors in order to keep dues low. It is with respect that I ask for your support for ADA Delegate.

Dr. Samuel Galstan

Candidate for the office of:

ADA Alternate Delegate

Dentistry is undergoing a period of great change, and if we are to keep our profession strong, then we need strong leadership. I think that dentistry can remain strong, but we must face some of the challenges that we are facing head on. I feel that I have the passion, experience and skill set necessary to help our profession at this time. I would greatly appreciate your vote for the office of ADA alternate delegate. Thank you.

Dr. Frank Iuorno

Candidate for the office of:

ADA Alternate Delegate

As an active member of Component IV for the past 15 years, I have thoroughly enjoyed making a difference at the local level. This year, as Chair of the Access to Care Task Force for the VDA, we have made great strides in improving access to children and the elderly in the state of Virginia. It was through the VDA and Access to Care that a door opened to the ADA. This direct interaction with the national association has piqued my interest in working to advance our profession by becoming an alternate delegate to the ADA. With years of experience at the local level, rounded out by leadership roles at the state level, I feel well-qualified and excited to take the next step in working with the ADA. I believe that I not only represent our profession and state proudly, but as a younger member of the organization, can provide unique insight to the Association as we move forward.

2014 VDA Elected Leadership Candidates

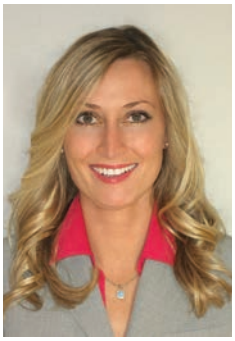
Dr. Rodney Klima

Candidate for the office of:

ADA Alternate Delegate

It is a privilege to serve the members of the Virginia Dental Association on the delegation to the ADA. These are turbulent times for dentistry. We see evidence of this with the recent cover of the VDA Journal. "The storm is here, survival is optional." We continue to deal with the outside forces, non-dentists, so called experts who purport to know what is best for our patients and how best to deliver dental care.

As practicing dentists, we need to remain the captains of the ship of dentistry. We need to be proactive at all levels, including legislative first and foremost, regulatory, public health, and evidence based scientific affairs. My interest has always been focused on the public affairs part of dentistry and the delivery of quality dental care. I appreciate the members allowing me to serve.



Dr. Danielle Ryan

Candidate for the office of:

ADA Alternate Delegate

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

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

Dr. Cynthia Southern

Candidate for the office of:

ADA Alternate Delegate

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

Dr. Richard L "Rick" Taliaferro

Candidate for the office of:

ADA Alternate Delegate

I have had the privilege of practicing general dentistry over 30 years. I truly enjoy dentistry and I look forward to every day that I practice. I am blessed with an excellent staff, partner, and a great location to practice. Those who know me will tell you I am passionate about dentistry. I am also passionate about organized dentistry. I want to see the same opportunities for future dentists that I and my patients have enjoyed. It has been organized dentistry that has preserved our great profession, allowing us to deliver the best treatment with minimal outside intervention to our patients. We are at a crossroads as we deal with several outside sources that affect us.

I believe I have the experience to serve capably as your ADA Alternate Delegate. I have served as a component president, as a VDA committee chairman, a task force chairman, and on the VDA Board of Directors. I take responsibility seriously and those who have worked with me know that I am committed to all tasks that I am given. As an alternate delegate I will work as hard as possible to understand the issues and assist the delegation in any way that I can. I promise to be ready to serve and vote intelligently if called upon.

I respectfully ask for your vote and I promise to do my best to reward your confidence in me.

Dr. Brenda Young

Candidate for the office of:

ADA Alternate Delegate

It would give me great pleasure to serve as an ADA Alternate Delegate and represent the VDA on the national level. I have been an ADA/VDA member for over 25 years, joining while I was in dental school. I have served our state and my local component in various capacities over the years including being a part of the VDA Delegation for the last 15 years. It is so important to be involved in organized dentistry and to keep our voice heard. I want to protect our ability to practice dentistry successfully and safely and I would like to further serve our association by asking for your vote for ADA Alternate Delegate. There are many changes that can and will affect our work environment - I would like to be a part of that process and represent our interests. I am extremely passionate about the access to care issue. Having organized the "Give Kids a Smile" program for the NVDS, I really see the need to continue our efforts in providing dental care to the underserved.

I respectfully ask for your vote and am grateful for your support. I would be honored to serve Virginia as your ADA Alternate Delegate.

Welcome New Members

By: Leslie Pinkston, VDA Director of Membership Information

Tidewater Dental Association

Dr. Robert Howard – Chesapeake – WVU - 1981

Dr. Elleni Kapoor – VA Beach – The Ohio State University – 2007

Dr. Peter Lanigan – VA Beach – VCU SOD - 2012

Dr. Amy Smith – VA Beach – University of Maryland – 2008

Dr. Maria Throckmorton – VA Beach – VCU SOD 2005

Peninsula Dental Association

Dr. Zane Berry – Smithfield - VCU SOD -2004

Dr. Joseph Klochak – Hampton – Temple - 1985

Dr. Trisstar Oliver – Newport News – West Virginia University

Dr. Meghan Stenvall – Williamsburg – University of Pennsylvania - 2009

Dr. Rupinder Uppal – NYU – 2013

Dr. Jasper N Watts – Hampton- University of Michigan 1976

Dr. Sang Hun Yu – VCU SOD 2012/Brookdale Hospital GPR - 2013

Southside Dental Society

Dr. Julie Hawley - Emporia – VCU SOD - 2013

Richmond Dental Society

Dr. Yuriy Abramov – Richmond – Stony Brook School of Dental Medicine - 2012

Dr. Poonum Bharal – Glen Allen – VCU SOD - 2010

Dr. Scott Culpepper – Richmond- VCU SOD – 2009

Dr. Andreen Fearon – Henrico – University of Rochester – 2011

Dr. Wanda Hall – Louisa – Medical College of VA – 1991

Dr. Audra Y Jones – Richmond – Howard University – 1999

Dr. Kyu Kim – Richmond – VCU SOD 2012

Dr. Nitesh Popat – Glen Allen – VCU SOD/GPR- 2013

Piedmont Dental Society

Dr. Christopher Allaman – Martinsville – The Ohio State University - 2008

Dr. Diane Caprio – Roanoke – UNC – 1983

Dr. Amanda Johnson – Roanoke – University of Kentucky - 2009

Southwest VA Dental Society

Dr. Steve Nauss – Norton – University of Tennessee – 1986

Shenandoah Valley Dental Association

Dr. Denise Devgon – Verona – WVU - 2013

Dr. Heather Gibson – Winchester – WVU - 1994

Dr. Vicky Hale – Orange – VCU SOD - 2007

Dr. Luke Harris – Charlottesville – Temple - 2012

Dr. Jason Karns – Warrenton – NJDS – 1999

Dr. Kelly McKown-Smallwood – Harrisonburg – West Virginia University - 2010

Dr. Brian Ott – Charlottesville – Creighton – 2010

Dr. Sam Scroggins – Fishersville – University of Mississippi/Oral and Maxillofacial – 2013

Dr. Anthony Smallwood – Harrisonburg – West Virginia University – 2008

Dr. Catherine Ventura – Lynchburg – Temple/2010 – University of Pittsburgh – Pediatric Certificate 2013

Northern VA Dental Society

Dr. Rajalakshmi Ananthasekar – NYU College of Dentistry – 2012

Dr. Alesia Apana – Arlington – Montefiore Medical Center – 2012

Dr. Nirmal Bogollagama – McLean – VCU SOD – 2002

Dr. Cliff Chen – Arlington – Columbia University Perio -2013

Dr. Fotini Chrisopoulos – Arlington – Columbia/ Prosthodontics - 2012

Dr. Christina Cowell – Reston – Tufts – 2011

Dr. Ruben Cuellar-Suarez – Arlington – Univerisad Mayor de San Simon - 2002

Dr. Erik Fox – Burke – VCU SOD -2013

Dr. Faisal Elhussein – Springfield- Nova Southeastern University – 2012

Dr. Farah Farhoumand – Vienna – VCU SOD – 1991

Dr. Foad Farhoumand – Vienna - Georgetown University - 1987

Dr. Anishka Frankenberry – Aldie – Howard University – 2005/Ortho2007

Dr. Nazila Ganji – Herndon – University of Maryland - 1996

Dr. Nagalatha Gollapalli – Fredericksburg – NYU – 2005

Dr. Techkouhie Hamalian – Arlington – Columbia - 2012

Dr. Nadder Hassan – Fairfax – VCU SOD – 2012

Dr. Hillary Hochman – Reston – Tufts - 2009

Dr. Dong-Soo Hong – Centreville – Tufts – 2013

Dr. James B Hudson – Springfield – University of Tennessee - 2006

Dr. Heta Jasani – Fairfax – Boston University - 2013

Dr. Ann Marie Leal – Annandale – Northwestern University Memorial Hospital Chicago – 1994

Dr. Sadia Mahedavi – Ashburn – VCU SOD - 2013

Dr. Courtney Marzban – Arlington – Case Western Reserve University – 2011

Dr. Mojgan Mazhari – Alexandria - University of Maryland - 1996

Dr. Ruth Molokwu – Centreville – VCU SOD 2012

Dr. Arya Namboodiri – Falls Church – VCU SOD 2012

Dr. Jung S Pak- Fairfax -University of Maryland Dental School- 2009

Dr. Monica Patel – Leesburg – University of Tennessee College of Dentistry

Dr. Pratik Patel – Alexandria-Columbia – 2012

Dr. Farshad Samadnejad – Alexandria – University of Maryland SOD

Dr. Thailong Tran – Sterling – Columbia – 2012

Dr. Malik Usman – Dumfries – NYU SOD - 2008

Dr. Mark Vagnetti – Culpeper – VCU SOD - 2003

Dr. Lauren Vaughn – Lake Ridge – Baylor College of Dentistry - 2013

Dr. Bradley Wiltbank – McLean – Oregon Health Sciences University – 2006

Dr. Bijal Shah – Vienna – Illinois University SODM – 2011

Dr. Davoud Zadehmohamadi – Arlington – Howard University – 1996

Dr. Asma Zia – Falls Church – University of Connecticut Health Center - O&M Radiology – 2012

In Memory of:

Name	Component	City	Date of Death
Dr. Patrick B. Colvard	Northern VA Dental Society	Annandale	January 2, 2014
Dr. Harold D. Dumas	Peninsula Dental Society	Gloucester	February 14, 2014
Dr. Paul E. Halla	Northern VA Dental Society	Herndon	November 30, 2013
Dr. George R. Hedrick	Shenandoah Valley Dental Assoc.	Harrisonburg	November 22, 2013
Dr. Ronald D. Jones	Southwest VA Dental Society	Forest	November 5, 2013
Dr. Leonard O. Oden	Tidewater Dental Association	Norfolk	January 15, 2014
Dr. John F. Worsley	Shenandoah Valley Dental Assoc.	Waynesboro	January 21, 2014

Robert M. Lawrence, Jr., DDS, MCV-D58. of Lexington died January 22, 2014. He conducted his practice in Lexington for over 37 years; was a VDA Fellow, and ADA and VDA Life Member and a member of the American College of Dentists.

Member Awards & Recognition

Dr. Ronald Tankersley
Distinguished Service Award

Virginia Society of Oral & Maxillofacial Surgeons (VSOMS)

Dr. Carole Pratt
Special Policy Advisor to the Commissioner

Virginia Department of Health

Dr. David Black
Daily Points of Light Award

Points of Light

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

Actions in Brief of the Board of Directors
January 16-18, 2014

The following Bylaw amendment was considered:

1. **Approved** – A resolution to allow the Virginia Meeting to be held outside the borders of Virginia by deleting Article II, Section 1.B (currently lines 296/297) from the Bylaws.

   Background: Currently the Bylaws do not allow meetings to be held out-of-state. It was determined that if, sometime in the future, an out-state-of state meeting site was a good option this resolution would allow the Council on Sessions to move forward.

The following actions are reported as information only:

1. **Approved** - the 2014 Strategic Plan.

2. **Referred** - to Council on Government Affairs to consider how to address the following issue:
   The Non-covered Services Task Force recommends to the Board of Directors that the 2010 non-covered services legislation be amended using a similar definition of "covered services" to Tennessee's legislation.

3. **Approved** - the following appointments to the VDA 16th District Delegation
   - David C. Anderson moved up to delegate to fill newly allocated position
   - Cindy Southern appointed to be an alternate delegate position to replace Dr. Anderson
   - Richard Taliaferro appointed to fill position vacated by Mike Link
   - Frank Iuorno appointed to new allocated position

4. **Appointed** to the Board Awards Subcommittee - Lanny Levenson, chair, Sam Galstan and Rick Taliaferro.

5. **Approved** – the 2014 VDAF Board members: Dr. Anne Adams, Mr. Patrick Finnerty – President, Dr. Graham Gardner – Secretary, Dr. Ralph Howell, Jr., Dr. David C. Jones, Dr. David L. Jones, Dr. Trisha Krause, Ms. Norma Roadcap, Mr. Robbie Schureman – Vice President, Mr. Robert Walker, Dr. Edward Weisberg – Treasurer, Dr. Meera Gokli, Mr. Will Harland, Jr., Mr. Barry Isringhausen, Dr. Audra Jones, Dr. Juan Rojas, Dr. Omar Watson.

6. **Approved** - Investment Committee appointments : Bob Levine, Chair, Scott Francis, Steve Forte, Les Webb, Bud Zimmer.

7. **Approved** - a resolution to give the officers the authority to find and decide the best development for a web based employment site using the initial $15,000 funding and then as unbudgeted site revenue becomes available.

8. **Approved** - If in the event that only five candidates run for ADA delegate in 2014, it is suggested that one candidate be asked to run for a one year term.

   Background: Due to the change (increase) in number of the VDA's ADA delegation and because of Bylaw guidelines (Article V, Section 3.A), the term of one delegate to be elected in 2014, for the 2015 delegation, should be limited to one year to create a more equitable rotation of 4,4,3.

9. **Approved** - With the payment of my membership dues, I acknowledge that I have read and understand the ADA Principles of Ethics and Code of Professional Conduct*. As a member of the VDA and ADA, I agree to uphold the Principles and Code and also understand that failure to do so may result in termination of my VDA and ADA membership.
   *Document on VDA website.

   Background: In continuing efforts to educate the VDA membership with ethical issues, the idea to include information about the Code of Ethics on the annual VDA Member dues statement was discussed.

10. **Approved** - A $1,500.00 sponsorship for the Virginia Oral Health Coalition 2014 Summit.

11. **Defeated** – A resolution to hold the 2016 Virginia Meeting at The Homestead Resort.

12. **Approved** – A resolution to hold the 2016 Virginia Meeting at the Norfolk Marriott Hotel.

13. **Approved** – A resolution that the VDA pay for travel, events and lodging up to $600.00 for one student from the VCU School of Dentistry to attend the 16th District Caucus in Alexandria. The student shall report to the VCU school delegation going to the ADA.

    Background: To allow student representation to the 2014 ADA 16th District Caucus.

Navigating quality assurance audits in the dental practice

By: Ann Milar, CDA Dental Benefits Analyst

Reprinted with permission from the California Dental Association.

Quality assurance audits is not an earth-shattering topic overall, but it does affect most of the dentists in our state since a large percentage of dentists are contracted with more than a dental plan or two. Essentially, if you are a contracted participating provider with any dental plan, be it HMO or PPO, you are subject to quality assurance (QA) audits by virtue of your signed participating provider agreement.

At the beginning of the year, a few hundred dentists received a letter or telephone call from a dental plan indicating that they had been selected for a quality assurance audit.

At the beginning of the year, a few hundred dentists received a letter or telephone call from a dental plan indicating that they had been selected for a quality assurance audit. Below I address common dentist questions and offer a few suggestions for navigating the audit process.

Yes, they can do this

First, take a deep breath and do not panic! All Knox-Keene licensed dental plans in California are required to audit their provider networks as part of the plans' licensure requirement with the Department of Managed Health Care. As a contracted provider with one of these plans, you have agreed to this process via your provider agreement. Failure to comply with this process could result in termination of your provider agreement with the plan.

It is a numbers game

Generally speaking, dental offices are randomly selected for quality assurance audits. Let me restate this in another way … filing a claim appeal did not result in your audit, neither did filing a provider grievance. Plans randomly select dental practices for quality assurance audits. I suggest envisioning the process as similar to the method used for pulling lotto numbers each week (it may make you feel a little better). In those instances when the audit is incident-driven, the plans will request patient records and notify you that they are auditing the practice as the result of a specific (or multiple) patient complaint(s).

Be prepared

In preparation for the audit, I recommend dentists review their provider agreement and provider manual and/or handbook to re-familiarize themselves with the criteria for which the plans hold them accountable. Plans are required to outline the audit criteria for their network in their plan documents. For dentists who went through a QA audit several years ago, the criteria may be more stringent than they remember. Plans are being held to increasingly higher standards and, in turn, must hold their providers to these standards as well.

The envelope, please.

It is important to note that the plans do not want providers to fail their audits; they want to demonstrate to the department that they have a quality network that provides excellent treatment for their plan enrollees. Dentists can expect a letter after their plan audit, which includes a summary of findings. The findings may note deficiencies or offer recommendations for improving plan compliance and may request a dentist response. Depending on the severity of the findings, the plan may re-audit the dentist in a few months, in a year, or, in those rare instances when the findings are egregious, terminate the relationship with the dentist altogether.

Just as you have required processes and procedures in your dental practice to ensure patient safety and appropriate treatment, the quality assurance audits are a tool utilized by the dental plans to ensure that their enrollees are receiving a true dental benefit with quality care and appropriate access.

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?

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