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Virginia Dental Journal

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On The Cover

Dr. Ted Sherwin,
VDA President 2013-2014

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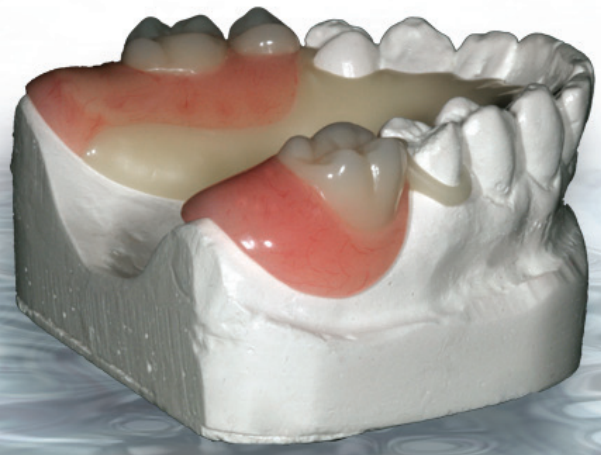

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MESSAGE FROM THE EDITOR

Dr. Richard F. Roadcap

Answer the following multiple choice question:
The dental profession today has reached

a) A watershed
b) A defining moment
c) The tipping point
d) A fork in the road (with apologies to former Yankees catcher and homespun philosopher Yogi Berra)
e) All of the above

Seasoned test-takers know the safe answer is "e", all of the above. Universal health insurance, also known as the Affordable Care Act (ACA), Obamacare, and plethora of other names, looms on the horizon, and its effect on the practice of dentistry is the subject of much speculation. The ADA has hired a private consulting firm, Leavitt Partners[1], to help decode the inscrutable language of healthcare reform, and shed light on what may be a sea change (which could have been one of the answers above) in the way dental care is delivered.

Anyone who's practiced for the last ten years knows that dental benefits have eroded. The ADA's research confirms this, with adult coverage declining over five percent in the last decade. Young adults are most likely to go without, with older adults more likely to retain benefits. Two questions yet to be answered: 1) will employers jettison dental plans, girding their loins to meet yet unknown mandates of the ACA? and 2) will employees purchase insurance on their own? Also, a new model for benefits is emerging. Employers will provide a fixed sum for employees to purchase insurance online from so-called private exchanges.[2] Their experience, and the ADA concurs, is for employees to buy less expensive plans with fewer benefits and less choice of providers. Dental plans have always been a non-taxable benefit employers use to attract and retain good employees. Will dental benefits become a casualty of healthcare reform? The ACA provided no new adult benefits, and largely left dental care unmentioned.

The ACA intends that all children in the US be enrolled in a dental plan. Hosannas rang out when this benefit was announced, with the belief that every child would now have access to dental care. So, will every child have dental insurance? Well, not exactly. It seems that the IRS interpretation of the law exempts stand-alone dental plans for children from tax credits, meaning that parents may have to fork over hundreds of dollars a year, if their child is to be enrolled. To be certain, enrollment of children will rise (as it has for the past decade, countering the trend for adults), but we'll still have kids coming to the office with no insurance. The nirvana predicted by so many has yet to arrive. Veteran healthcare journalist Mary Otto writes that in California, the state exchange offers no plans that include children's dental insurance, and neither bundled nor stand-alone plans offer a subsidy for the purchase of these plans.[3]

A little-noticed, but sinister, side effect of ACA, could be the effect on our staff. How's that, you say? Doesn't the law exempt businesses with fewer than fifty employees? Why, I'm nowhere near that number! Consider this: suppose a staff member elects to pay the penalty associated with the Supreme Court endorsed individual mandate. They're uninsured. Also, many dental staff now have healthcare coverage provided by a spouse. Package delivery giant United Parcel Service fired a shot across the bow of other industries recently when it decided to drop health insurance for spouses of employees.[4] Will other employers follow suit? Analysts say there's no evidence that this approach will gain a following, although the headlines were unmistakable: big company drops spouses' health insurance. Imagine if our staff members were to join the ranks of the uninsured. It could hurt office morale. Some dental offices offer health plans, some don't, but all could be disrupted by this new approach to purchasing healthcare.

The 800-pound gorillas could be the Accountable Care Organizations (ACO), which are groups of health care providers (such as physicians and hospitals) formed to deliver care to a defined population for a predetermined, fixed payment. It's not known whether they will attempt to deliver dental services beneath their umbrella. The ADA reports that few of the nearly 500 ACOs have any dental component, but Leavitt's troubling analysis predicts a "shift away from fee-for-service care". This portends a return to the much-maligned DMOs of the '80s, which failed to capture any significant market share then. Oregon, with the Obama administration's blessing, is proceeding with its Coordinated Care Organization (CCO) for Oregon Health Plan participants. It includes dental benefits, and payment is described for these services as "capitated" with the following comment: "CCOs are expected to move beyond fee-for-service payment mechanisms for compensating health care providers."[5]

One final test question:
Which of the following predictions about dentistry have proven true?

a) Most dentists will practice in retail settings
b) Franchises will dominate the delivery of dental care, as in other service industries
c) Fluoride will eliminate dental decay (in our lifetime)
d) There will be a shortage of dentists after the year 2000
e) None of the above

Instructors often use multiple choice answers not only to test students' grasp of the subject, but also to impart knowledge. Once again, the brightest pupils will left-click on "e", none of the above, knowing the teacher wants them to learn from the test-taking experience, as well as recite from the syllabus.

1 http://www.ada.org/news/8991.aspx

2 Anna Wilde Mathews. More employers overhaul health benefits. *The Wall Street Journal.* September 4, 2013.

3 http://healthjournalism.org/blog/2013/07/childrens-dental-care-an-essential-benefit-left-out-of-calif-exchanges/

4 http://www.washingtonpost.com/blogs/on-leadership/wp/2013/08/26/ups-to-cut-employees-working-spouses-from-its-health-plans/

5 http://www.nashp.org/aco.oregon

Trustee's Corner

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

The August Board of Trustees meeting began with a presentation by the Chair of the Strategic Planning Committee, Dr. Hilton Israelson. He led us through some very important data from the environmental scan that will be used to help shape the new Strategic Plan. Discussed were the forces that are leading to change and the impact that these forces will have on the Association and our members. I will touch on just a few of the points that were gleaned from the scan:

- In 2007, 20% of dentists reported a business problem
- In 2011, 39% reported a business problem
- Decrease in utilization began in 2003, and continues or is flat to this day
- Adult care is decreasing while child care increases
- 19 to 34 year old group has doubled in ER use
- Dental spending is declining
- Patients are more consumer conscious
- Payment reform is shifting to more accountability and outcome based
- We must learn to do more with less

The goal of the new Strategic Plan is to ***Help All Dentists Succeed***. With this in mind the Board decided to ask the Strategic Planning Steering Committee to host an informational hearing at this year's House of Delegates. This hearing will provide House members with an important opportunity for input into the next Strategic Plan. Please plan to attend what promises to be a very informative hearing.

Much time was spent reviewing material that has already been forwarded to the HOD and can be found on ADA Connect. Board Report 2 has been finalized as well as a proposal for new delegate allocation. There are several resolutions resulting from the Student Debt Task Force that have financial implications. This task force was formed after the HOD passed a Resolution authorizing it; and, I believe it is important the House makes the decision on how to proceed with these resolutions- in particular, **Res. 56** calls for **A Comprehensive Study of the Current Education Model**.

The Council on Dental Education asked for our comments on the future governance structure of the Continuing Education Recognition Program (CERP). The proposal calls for the creation of a new commission for continuing education, which would have an "arm's length" relationship with the ADA. After significant discussion, the Board voted to communicate to the Council on Dental Education and Licensure (CDEL) that the Board endorses CDEL's concept regarding a change in the governance of CERP, and establishes a Commission on Continuing Dental Education Accreditation in the ADA Bylaws. The BOT communication to CDEL will express the diversity of opinions and concerns within the Board.

The task force on resolution 97 regarding authority for budget approval was forwarded to the Board at this meeting. This is a very complex topic and the Board discussed the benefits and problems associated with the task force's proposal. The Board did not agree with the final approach advocated by the task force and has moved a Board substitute (Res.64B) based on the original resolution 97 proposed by the Board last year. This resolution was based on considerable study and the advice of our expert consultants. The Board did agree with the sentiment of the task force that the House should have a greater role in the Strategic Plan but did not agree with Resolution 66, as proposed by the task force. Instead, as I mentioned above, the Board decided to ask the Strategic Plan Steering Committee to host an informational hearing at this year's House meeting. It is the Board's hope that because the Strategic Plan should drive the ADA budget process (and the fact that the House will have input into the new Strategic Plan), the HOD will be more inclined to vote favorably on Res. 64B. Last year Res.97RC-2012 was supported by a majority of the House with 56%. Our hope this year is that Res.64B will garner the necessary two-thirds vote.

The ADA is unveiling a six-prong strategy in collaboration with the states and the component societies to reverse the current negative member market share trend, with a goal of turning around this trend in 2014. These strategies are:

- creating a culture for change among the tripartite,
- focusing on member value and make it tangible for a member,
- aligning the membership infrastructure to remove barriers for members,
- fostering tripartite accountability through data sharing and agreed upon goals for growth,
- driving member engagement through consistently high levels of member service at all levels, and
- investing more resources in the recruitment, conversion and retention of students and members

The previous focus for membership growth has been to Recruit, Retain and Convert.
The new focus will be on **Membership Value**. The primary focus will be **The Power of Three**:

An ADA membership enhances your

- Security
- Earning Power and
- Reputation

while building excellence as a dental healthcare professional.

Dr. Jane Grover briefed us on plans for the November Prevention Summit hosted by the ADA. If you have any questions or would like additional information, please let us know. This summit will be held in Chicago (in November) and I, along with Dr. Rocky Napier, our 16th District member on CAPIR will be in attendance. Dr. Grover also offered us a brief presentation on CDHCs. She and CAPIR staff are available to us as a resource on this topic.

And finally, we continued an ongoing dialogue on the DQA (Dental Quality Alliance). This is an important topic and one often misunderstood by our membership. I must admit that it still confusing to me at times. That being said, my plans are to attend a DQA meeting to become better acquainted with their mission. We will need to continue to clear up confusion and fully vet the issues inherent in the concepts embodied in DQA. Our work on this will certainly continue and it is important that the ADA leads this effort.

As always, if you have any questions or concerns please call or email me: fairjh@bellsouth.net

MESSAGE FROM THE PRESIDENT

Dr. Ted Sherwin

It is an honor to serve as VDA President. I thank you for your support and look forward to what we can accomplish this year. Also, I want to thank our immediate past President, Dr. Kirk Norbo, for his outstanding leadership, and helping the VDA think about new ways of providing value to members, particularly in the area of helping dentists be successful in the business side of our lives.

I hope that some of you may recognize the famous structure behind me (on the front cover) as the home of James Madison's Montpelier. I arrived in Orange County about the time this landmark was turned over from the duPont family to the National Trust for Historic Preservation upon the death of Mrs. Marion duPont Scott. Aside from Mrs. Scott's world-class stables where national and international steeplechase winners were kept, her marriages and life were the stuff that filled the magazines and celebrity lists of her day. In the early days of the Trust, money was scarce, so it was an honor for me to do some photography for Montpelier on numerous occasions as a volunteer.

I had free reign to wander Montpelier photographing the mansion, grounds, and even Madison's temple that also served as an ice house. The entire estate reminds me of James Madison's importance as a historical figure. As you may recall, after the war of American independence there was a period, 1776-1789, where the colonies operated under the Articles of Confederation. These 13 years were marked by a weak and ineffective national government. Though quiet in nature, James Madison was the youngest participant in the Continental Congress. He argued effectively for a new direction with his "Virginia Plan" and ultimately became known as the "Father of the Constitution," and the primary author of the Bill of Rights. His success in helping the passage of the Constitution allowed our loosely knit colonies to transform themselves into a legitimate nation. Madison's invaluable leadership during times of challenge and transition propelled him to the highest office in the young nation's life as our fourth President.

I find Madison's approach to challenge, transition, and his personal leadership transformation a fascinating study. In some ways our nation's history parallel that of membership issues found in associations today. Like Madison, we face a host of new challenges knowing the old ways no longer work. For instance, membership declines are a challenge that requires us to transform ourselves. We have to operate differently. We know that what brought members and kept them members in the past, no longer works. What we need is a new direction, a new value proposition for membership. Thanks to the vision and hard work under my two predecessors, Drs. Roger Wood and Kirk Norbo, and the PR Campaign Chair, Dr. Mike Link, we have laid the first corner stone in a new value proposition, a well-placed PR Campaign.

In addition to the PR Campaign, studies of other states strongly support the need for a robust web-based resource center. For instance, in California a web-based resource is used by over 60% of the members and surveys show users value it as a top membership benefit. I believe that this can be our second corner stone in building a new value proposition.

This year, I will work hard with the Board and staff to investigate, and hopefully launch a new dynamic resource center online. We will get much needed help from the ADA through its Center for Professional Success. My hope is to integrate information that VDA members need that is state specific into the larger non-state specific information that the ADA provides through CPS into a seamless experience. It will include management information and decision support tools that can be easily accessed, impactful, and relevant to the everyday business challenges of members. Our goal will be simple: to provide one-of-a-kind resources for members to ensure their success.

The PR Campaign and a web-based resource center are two examples of our new thinking and direction. They are a great start toward a new value proposition. Success will come slowly but that is the nature of transformation in our Association. These are times of challenge and transition that even Madison might fine intriguing!

Today you can get the sense of incredible beauty of James Madison's home, circa 1764, set in the rolling hills with amazing views of the Blue Ridge Mountains. I invite each of you to visit one of the Virginia's foremost historic homes here in Orange County.

VDA Foundation Welcomes New Staff Member

Jessica Park is the new Program Manager for the VDA Foundation's Donated Dental Services (DDS) and Give Kids a Smile (GKAS) programs. She began her career in human services as an AmeriCorps member in Las Vegas, where she served as a case manager for veterans experiencing homelessness. After moving to Williamsburg in 2009, she was able to continue her work on addressing homelessness in a broader capacity by coordinating the Greater Virginia Peninsula Homeless Continuum of Care. Jess solidified her commitment to helping others by recently completing her Master's in Social Work (MSW) at Virginia Commonwealth University. As a passionate and strong social justice advocate, Jess looks forward to strengthening and growing these vital programs at VDAF and working with other dental safety net providers to improve the lives of many Virginians!

An Interview With:
Dr. Ted Sherwin

VDA Journal: Why do you want to be VDA President?

Dr. Ted Sherwin: I think it's human nature that when you been given opportunities, achieved some success, you want to give back to something that's meaningful. Dentistry gives each of us a platform in life to achieve financial success, time with our families and hobbies, as well as opportunities to serve and help others in a way that few careers can. I got involved in leadership at the SVDA, because I believe that this profession needs an Association to both look after its best interests and better enable us to provide care for others who are not otherwise able to receive care. I found that I enjoyed the challenges of leadership, the camaraderie of other dentists who had a passion for service, and what we could accomplish working together. I consider myself very fortunate to be able to serve as President, and look forward to the upcoming year of service to the Association.

Journal: If you could change one thing about organized dentistry, what would it be?

Dr. Sherwin: I do get frustrated from time to time with the segmentation of the tripartite system within our Association and wish there was better communication and smoother efforts at each level to work together to solve common issues. Having served at the Component, State, and ADA levels, I can better see how each of these tends to get a bit compartmentalized, leading to disconnects up and down the tripartite. So while the tripartite system is a real strength to our members I feel that it, sometimes, can be a weakness that we leaders need to develop appropriate solutions for.

Journal: How do you expect the Affordable Care Act, also known as Healthcare Reform, to impact the practice of dentistry?

Dr. Sherwin: At the time of this interview, we still don't know a lot of specifics relating to the impact on dentistry, but within the next few months we will begin to gain a better understanding. In a broad sense, what we do know is that ACA has the potential to significantly reform health care in throughout America and including Virginia. These changes will likely involve expansion of medical insurance, integration of our delivery systems, and financing of health care. The dental profession will see a move to expand Medicaid coverage for adults with low income. In Virginia, we are still not sure how this will play out. The VDA will be continue to stay on top of ACA and as things become more clear here in Virginia we will inform our members through VDA publications.

Journal: Your policy proposals on access-to-care have provided a framework for delivering care to the underserved. Where do we go from here?

Dr. Sherwin: Virginia's legacy of service to the public, and leadership and collaboration to improve the availability and care of children is recognized as best-in- class at the ADA in access to care arena. Most of the credit goes to Dr. Terry Dickinson and then recently the work of the members of the Access to Care Taskforce. From here, we must continue to work on our leadership and collaboration in our work on access for children, and in addition, we need to look at emerging issues of poor oral health in the growing population of nursing homes and problems both financial and treatment of those who are seeking care in the ERs around the state for dental related problems. My expectations are that the VDA plays a leading role in understanding these issues and bringing all the needed partners together to help find programmatic solutions.

Journal: More than one study has predicted that (indemnity) dental insurance will cover fewer adults in the future. How should organized dentistry respond?

Dr. Sherwin: Great question. This is one of the big shifts we have seen in American society, particularly among 20-30 year olds without dental insurance. There are three ways that organized dentistry should respond. First, we should help with those who suffer now. This can happen at numerous free dental clinics around the state (most of which were started by dentists), at MOM projects, at dentist offices through the DDS program and by dentist helping those who walk in, in pain. But, as we all know charity is not the answer to such a pervasive problem. Therefore, we must advocate for some type of safety net that can, with governmental funding, take care of the most basic oral health issues. Finally, we must be the leaders in providing messages in oral health education and the importance of prevention. If we do these three things well, I believe, we have provide the best response to this significant and growing health problem.

Journal: What would you do to reverse the decline in VDA membership?

Dr. Sherwin: I will continue the leadership in transforming our value proposition for all members and particularly for younger dentist. Our history of declining full dues paying members and percentage of dentists who belong to the VDA has been a top priority for years. It's just that all our efforts, as focused and intense as they have been, have not made the desired needed changes. We now know, we must look at this problem in a different way. We need, what we are calling, a new value proposition. What used to attract and keep members doesn't work anymore. I believe we need develop several major propositions to make a convincing case for value in membership of the VDA. The first cornerstone is already in place, our PR campaign. This was a big commitment of our current members to the future of our profession. The second major proposition is based on providing what VDA members need to be successful throughout their careers. In our search, we found some best practices in several states in the form of a web-based resource center. Data from those states strongly supports that a rich resource that members can quickly access for all the common questions relating to being successful as a dentist is highly valued by members. There are many sources where

our members can gain clinical related information. But there are few places we can go without having to hire and retain expensive advisors to learn the basics of how to successfully navigate the day to day business issues each of face. These are examples I believe we need to pursue, in order to transform our value proposition such that we can stem the tide of declining membership. We shouldn't expect there will be dramatic changes in membership numbers as we continue to develop our new value proposition. My hope is that, over time, we will see a shift that we recognize as success. I will ask the Board to develop plans and actions for this next year, that will guide us as we move forward in these uncharted waters.

Journal: Does the VDA do a good job of communicating with its members? Where do we need to improve?

Dr. Sherwin: The VDA publications are fantastic source of information which is valued by our members. There may be little we need to change other than as leaders we need to be better at communicating the successes that our organization has and messages that our members can use to help them feel more comfortable and informed as they talk to new and potential members.

Journal: It appears a new dental school will open in Tazewell County, near Bluefield. How should the VDA respond to this event?

Dr. Sherwin: I believe we have reason to be concerned about this new school as there seems to be an inappropriate emphasis on the economic boost a dental school will provide this rural area of Virginia. Also, I think the VDA Board has not been convinced that there will be the significant improvement to access to care in this area, as suggested by Bluefield proponents. But with that said, there are several hurdles a school in Bluefield has in front of them in the next 1-2 years, like accreditation. If and when those hurdles are met then I think it would be in the best interest of the Association to see how we can mentor the students and help them transition to valued members.

Journal: What legislative issues will arise in the 2014 General Assembly?

Dr. Sherwin: If the VDA House approves Deferred Compensation then we will put this forward at the 2014 General Assembly. Thanks to the volunteer work of Dr. Cindy Southern of the Taskforce on Access, who did the original research on Deferred Compensation, and Dr. Roger Palmer of the Legislative Committee, along with staff coordinator Elise Rupinski, we have been able to clear all the necessary checkpoints to bring a workable plan to the House. Deferred Compensation simply allows dentists who participate in Medicaid to take their reimbursement (up to specified amounts) and assign it to the Virginia Retirement System. The goal for the VDA and the Taskforce on Access is to encourage existing providers to increase the number of Medicaid patients they see as well as to increase the number of Medicaid providers.

Journal: Who are your mentors? Who has shaped your life and your career?

Dr. Sherwin: This is a really difficult question since there are so many people. Those who shaped my life have to be my mother, father, Lois, my first wife, who is deceased, and my wife of nearly 30 years, Suzanne, and Dr. Terry Dickinson. In terms of a career, educators like Drs. Peter Dawson and L.D. Pankey.

Journal: Where do you picture the VDA in five years, 2018? And what would you like to be doing in five years?

Dr. Sherwin: My hope is that membership in the VDA has a strong value to each of our members. And as an Association, we build the capacity to be successful in all the challenges we face. I would wish that we maintain our leadership as the voice of oral health care in Virginia and that we are held in high regard by the public and legislators. Finally, it is my hope that young dentists have the sense that there is a bright and fulfilling future ahead for them, that they want to be members in the VDA, and they have the equal opportunity for either small or corporate practice. For me, I would hope to practice with the same level of satisfaction I have now. I would like to continue to find ways to be involved and contributing to organized dentistry, and improving the oral health of the public. On the more personal note, spending more time with Suzanne, family and friends, traveling, photography, and scuba diving would be great.

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LETTERS TO THE EDITOR

Dear Mr. Jordan,

I want to compliment you on the most recent column you wrote for the *Journal*. I am very sad to report there are many dentists that have decided their income is more important than their patient's health and welfare. It has become a common occurrence for me to examine a new patient that has had a diagnosis and treatment plan that is wildly fabricated. "Deep scaling", unnecessary and destructive endodontia and crowns, ripping into healthy enamel and dentin to satisfy greed have become all too common. One explanation is young dentists going to work for big corporate dental practices that put pressure on them to "produce". And these same dentists are deep in debt for their education, have a life style they feel is their right, and dump their moral compass for the cash.

The good news is that because of fluoridated water and preventive treatment promoted by ethical dentists, the incidence of caries and periodontal disease has decreased dramatically. It was common for me to see children with many carious lesions forty years ago. Now that is rare. I don't understand what happened to the honesty and care my colleagues displayed for the most part (yes, there were crooks 40 years ago too but a small minority) that has sunk. I lived in a one-bedroom apartment when I went into practice, had a used car, and just counted on slowly building my practice to where I could afford better. It never occurred to me to lie to patients. You can blame my parents and the super teachers I had at the University of Maryland School of Dentistry. Please keep you ideals and encourage your fellow students to keep their standards high.

Mitchell J. Bukzin, DDS
4391 Ridgewood Center Drive, Ste C
Woodbridge, VA 22192

To the Editor of the VDA *Journal*:

Dear VDA Colleagues,

Twice in recent months I have read articles in your publications addressing the ADA library situation. Neither article has placed the ADA's handling of this matter in a very positive light. The most recent letter in "Etch" was addressed to the 2013 ADA House of Delegates from the American Association of Dental Editors. The Library Transition Task Force, of which I am a member, felt it important to respond to this letter. Below you can read the letter that was sent in response from the Chair of the Task Force.

Preceding this letter I have listed a summary of just a few of the benefits that will be realized if the HOD approves the recommendations of the Task Force.

- Expansion of ADA member access to electronic journals and research database
- Maintenance of the ADA leadership role as the source for EBD
- New links to on-demand, clinical dentistry tools that can be accessed daily to enhance the treatment of patients
- Digitization of the ADA archives, allowing for direct member access of materials through the ADA website
- Redesign and simplified navigation to library and archives page from the ADA main page
- ADA library print book collection supplemented and enhanced by the UIC Medical Center Library print book collection, with increased access to the print collection on evenings and weekends at the UIC Medical Center Library.
- Access to the print medical literature and journal collection at the UIC Medical Center Library.
- Operational policies and procedures in place to assure that library resources are evaluated and up-graded on a regular basis.
- Library staff development and cross-training to ensure continued excellent service to the ADA member. ADA library staff will be able to provide services in a more effective and efficient manner.
- Efficient use of space within the ADA Headquarters Building.

I hope this information enlightens both the delegation and the membership as to the work of the task force and the progress of the Library Transition.

Until next time,

Julian H. (Hal) Fair, III, DDS; Sixteenth District Trustee, ADA
August 23, 2013

Dear Drs. Orr and Cohlmia:

I am writing to you as Chair of the Taskforce on the ADA Library Transition Plan, in response to several of what I believe to be misleading statements in a recent AADE newsletter regarding the future of the ADA Library. At the direction of the 2012 House of Delegates, the Taskforce spent over six months gathering information on library usage from ADA members; consulting with numerous national library experts; making "site visits" to other dental libraries (UIC and LSU); hiring a highly experienced and knowledgeable project manager; and fully engaging the current ADA library staff. The Taskforce believes that the transition plan that has been developed and submitted for action to the 2013 House of Delegates not only maintains the ADA library's role as the evidence-based dentistry and archival resource for the profession, but also will provide an expanded access for ADA members to digital resources and databases.

I would like to address specifically several statements in the newsletter which I found to be misleading. First, the ADA Library is not being given "…to a medical school to maintain." The implication of the newsletter statement is that all aspects of ADA Library services will be transferred to an outside entity. This is simply not correct. If approved by the House of Delegates, a Memorandum of Understanding (MOU) will be developed between the ADA and the University of Illinois at Chicago (UIC) Medical Center Library regarding the print book collection. ADA library staff has cross-indexed the ADA collection and the UIC collection, and while the ADA collection is stronger in older editions of classic texts and practice management texts, the UIC collection is stronger in offering an increased quantity of the latest print texts. Approximately 2,500 texts would be transferred to UIC in order to complement and complete the UIC collection. The ADA would retain ownership of its texts and would be able to retrieve the collection intact. ADA members would have both on-site access to the collection at UIC, or could obtain print texts through inter-library loan that ADA Library staff would then send to non-local users (as is the current practice).

Second, the Transition Plan does not propose to "…injudiciously bequeath our 'sacred' written dental endowment to non-dental parties…" The archives, including all the original dental texts cited in the newsletter, will remain housed at the ADA Library. ADA members will still be able to view the original tomes of Pierre Fauchard, Chapin A. Harris, Horace Wells, G.V. Black, and other 20th century icons. The ADA archives are in dire need of modernization. The catalogue is only in print form, and does not correspond with any commonly accepted cataloguing system. Enhanced resources are needed in order for the archives to align with best practices for archival function and management. In addition, with the development of a digital database, ADA members would gain online access to these important historic resources that make it easy for users to search within and across collections and to access both descriptions and relevant digital files.

Third, the newsletter implies "credible and original sources" of scientific information will be lost if not available in print form. This is simply not the

case. The migration to digital forms of knowledge storage and retrieval does not change the validity of the science. Digital sources of peer-reviewed journals and articles still must meet the same rigorous criteria for acceptability. The enhanced availability of digital databases for dental and medical literature, along with a significantly increased number of available peer-reviewed online journals will give ADA members greater access to evidence-based dental literature than available previously.

Finally, I wish to dispel the notion that the ADA does not "truly value" the ADA library. The ADA has in the past, and continues to make, a significant financial commitment to the library. However, the ADA must also, in these times of constrained finances, make the most efficient use of available funds. I might add though, that contingency funding was provided by the Board of Trustees for 2013 to provide additional resources to enhance library services, with further resources proposed for 2014 budget. This includes maintaining the five full-time library and archives professional staff.

The "…argument against maintaining the library in its current structure…" is not about costing each ADA member $8.00 in dues per year. It is about the fundamental changes taking place in how information is delivered. All libraries are going through the process of maximizing resources through expanded use of electronic and digital means of conveying information. The ADA library is not immune to these changes; indeed, the ADA Library must make the same changes in order to stay relevant for ADA members and the profession. The future lies in the efficient searching for knowledge through electronic databases, where the library serves as a knowledge resource center. The ADA Library Transition Plan makes a commitment to maintain and develop a comprehensive collection of information resources for ADA members in various formats and makes a commitment to remain the focal point in support of evidence-based dentistry. To keep things with the ADA Library exactly as they were and not do anything, would have been a breach of our responsibility to make the ADA the best it can be. To not do anything would have endangered the ADA position as the leader in evidence-based dentistry. Indeed, to not do anything would have doomed the ADA Library to irrelevance.

Sincerely,
Joseph F. Hagenbruch, D.M.D.
ADA 8th District Trustee
ADA Library Transition Plan Taskforce Chair

To the editor:

After reading the editorials in Volume 90, Number 2, of the *Virginia Dental Journal* by the Editor-in-Chief, and dental student Jeremy Jordan (also an Editor of the American Student Dental Association District 4 Newsletter), I suddenly realized what could cause a disaster in a very serious and significant health profession. The problem simply stated is the overwhelming cost of a dental education.

Most students upon graduation from dental school are now in debt about $250,000 as in-state students, closer to $300,000 for out-of-state students. Does this imply that only wealthy and upper middle class income families should consider their children as future dentists and physicians? (Incidentally, medical school graduates also end up with $250,000 debt.)

To make dental education affordable for average families who have children who sincerely wish to be dentists and who have the mental capacity there are changes in the education program which can reduce the financial burden and still produce competent practitioners of dentistry.

These changes may sound distasteful to recent graduates, dental educators, and other dentists because they may think that the dental profession is on a downward trend. I suggest you explore the consequences if we leave things as they are; such as less applicants in US dental schools, less teachers, less family dentists, less education in dental schools or possibly closing some dental schools and more untreated dental and oral disease.

Here are some suggestions to decrease the debt of dental education:

1. The pre-dental program should require two years of community college which should include chemistry, biology, physics, and English for minimum total of 60 hours. The scholastic achievements, with DAT exam and a dental school interview should the character, capability, and competence of the future dental student and future dental professional.
2. Accelerate the 4-year dental school curriculum to a 3-year program. This is now in progress in many medical schools.
3. I would encourage the medical model of a team approach to dental care. This means the use of a dental therapist, dental hygienist, and dental assistant. These individuals would treat the emergency toothache, extract mobile teeth, do cleanings, radiographs, and minor periodontics, all under the supervision of a dentist. The dentist should spend his or her time treating the more complex dentistry such as impacted teeth, implants, alveoloplasty, endodontics, biopsies, routine orthodontics, and difficult patients with serious systemic diseases or severe anxiety. Where will the 3-year dental graduate get the education and skills to perform the complex dentistry which is necessary to maintain the team dental practice? This basic knowledge should be provided in dental schools and, upon graduation, followed by an AEGD (Advanced Education in General Dentistry) which is frequently in a hospital. This is the one year to master complex aspects of dental care without cost to the dentist; in fact, they receive a salary of $30,500. In 2011 there were 84 programs in the US. In 2011 there were 286 one- and two-year general practice residencies, mostly hospital oriented, with resident's salary approximately $48,000 per year. These residents worked frequently with dental specialists in the clinical dental specialists, frequently on a one-to-one basis with patients.
4. For other recent dental graduates, who are married and have children, they may be comfortable going to a branch of the military. With some convincing you may get a commitment from the military to provide you with training in a dental specialty. You would of course, have to pay back by serving more time in the military. With a good assignment, practicing your specialty, you will serve more time, receive promotions in rank with increasing salary. After your payback time, you may have the option to complete 20 years in the military, enjoy its benefits, or retire sooner and enjoy your specialty as a civilian.

These options are coming from a former dental specialist (60+ years) who had a private practice, who served in the military, who taught physiology in Universities, and my dental specialty at my alma mater dental school (VCU).

I hope I have not offended those who are young, middle-aged, and seniors who are practicing now. I lived an practiced in a different generation and so will the generations that follow us. May they feel fortunate to practice in an outstanding health profession, as I have these many years. The present cost of dental education can be significantly reduced without loss of integrity or competence.

Marvin E. Pizer, DDS, MS, MA, FACOMS (hon.)
Formerly: Clinical Professor of Oral and Maxillofacial Surgery, VCU School of Dentistry, Richmond; Adjunct Professor of Medical Physiology, The American University, Washington, DC

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Managing neurological disorders in the dental practice: Schizophrenia

Busch EC, BSDH, RDH; Callahan LK, BSDH, RDH; Jones CJ, BSPH, BSDH, RDH; Pellegrini, JM, RDH, PhD.

Introduction

Schizophrenia is a complex, chronic disorder of the brain causing the affected individuals to endure a lifelong, distorted interpretation of reality. Schizophrenia, which translates to "split mind," is categorized not by split personality nor multiple personality behaviors, but instead, a disarray of unbalanced thoughts and emotions.[1]

Although a small percentage of the United States' citizens suffer with the disorder, those who are affected are not alone. This condition affects the individual, family members, and the entire community. Treatment is available to alleviate some of the symptoms. However, most individuals cope with symptoms throughout life, leaving family, friends, and caregivers to assist them in satisfactorily achieving activities of daily living.[2]

Due to the complexity of this life-long disorder, including a multitude of unrealistic thoughts and feelings, oral health is generally an area of neglect for the person affected with schizophrenia and his/her caregivers. The purpose of this report is to enable the dental care provider to better manage individuals affected by this disorder who present for care in their practice.

Who Does It Affect and What Are Its Symptoms?

Schizophrenia demonstrates no predilection for race, ethnicity, or gender. The age of onset usually occurs between sixteen and thirty, when individuals begin to experience symptoms. The reported prevalence of individuals diagnosed with a schizophrenic disorder account for 0.3% to 0.7% of the population. There are slightly more males diagnosed with the disorder than females.[3] The classic symptoms of schizophrenia fall into three categories. The first is labeled as positive symptoms. They include delusions, movement disorders, hallucinations, and thinking disorders.[2] Positive symptoms range from sporadically mild to persistently severe and are not exhibited by the mentally healthy. The second category of symptoms is the difficult to recognize negative symptoms which involve disturbed emotions and behaviors. Examples include speaking in a monotone, difficulty enjoying life's pleasures, failure to commit to activities, and withdrawn speaking in social settings. Individuals who possess both positive and negative symptoms are important to a dental professional because they often neglect personal hygiene habits. This population may seem extremely unmotivated and lackadaisical, when they may be manifesting signs of schizophrenia.[2]

The third group of symptoms is cognitive. Similar to negative symptoms, the cognitive indicators are found in many other disorders and are difficult to recognize. The inability to make informed decisions, pay attention, and use information shortly after learning it could all be symptomatic of schizophrenia as well as attention-deficit disorder.

Medications to Treat Schizophrenia

Medications for this disorder can include dopamine receptor blockers, which address symptoms such as delusions, catatonia, bizarre behavior, and hallucinations. Examples of this category of drugs are Thorazine™, Haldol™, and Navane™. Other categories of drugs used to treat this condition have greater effect on the patient's lack of voluntary action, lack of speech, and inability to perform goal-oriented tasks. These include Clozaril™, Risperdal™, and Olanzapine™.[4]

Drugs used to treat schizophrenia can precipitate new concerns. Often certain antipsychotic medications can trigger facial grimacing, bradykinesia and resting tremors. Tardive dyskinesia, which is characterized by involuntary mouth and jaw movement, can be another side effect of these patients' medication. The schizophrenic patient may experience medication-induced restlessness, often having an urge to pace. Frequently, psychotropic drugs can produce blurred vision, postural hypotension and palpitations. Additionally, medications used to treat schizophrenia can predispose a patient to developing agranulocytosis. Potential for oral candidiasis and a reduced leukocyte count can lead to an increased risk of infection.[4]

Oral Conditions

Common side effects accompanying the long term use of anti-psychotic drugs and anti-depressants are xerostomia and oral pigmentation.[5] More severe side effects include oral dystonias or dyskinesias which may result in damage to the dentition or other oral traumas.[6,7] Adverse effects of xerostomia include halitosis and taste perversion. The consequences of untreated xerostomia may include oral infections such as gingivitis, glossitis, stomatitis, parotiditis, candidiasis, periodontal diseases, and an increase in caries incidence.[4,8] Additionally, research has shown xerostomia as being a contributing factor to other dental disorders such as burning mouth, fissured tongue, tongue atrophy, dysphagia, enamel erosion, and oral ulcers.[5] Consequently, these factors may increase the individual's social stigmatization thus negatively impacting one's motivation and self-esteem. These factors should accentuate the importance of regular dental treatment for the subjects with this psychotic disorder.

Oral Hygiene

Two of the most prevalent health conditions impacting social interaction are psychiatric and dental diseases.[9] Risk factors of dental diseases are influenced by side effects caused by psychotropic medications, inadequate diet, avoidance of oral hygiene behaviors, and tobacco use. Barriers to dental care and treatment may be attributed to the individual's lack of motivation, education, ability to communicate, and degenerating physical state.[10] Additional contributing factors may include one's inability to adjust to new prostheses, physical mobility complications, apprehension of treatment, and financial resources. These factors hinder the patient's ability to carry out proper oral hygiene practices, further impacting the individual's health both orally and systemically. Previous published studies showed a minority of institutionalized schizophrenic males had habitual tooth brushing habits, and concluded that the majority of schizophrenic patients' daily activities did not incorporate oral hygiene practices.[11] Another finding revealed patients with schizophrenia visited the dentist less frequently than those in the general population.

Association of TMD

There is evidence that patients with schizophrenia are at an increased risk of developing temporomandibular disorder. This is accredited to emotional distress and the side effects of psychotropic medications. Prolonged use of the medications can increase the risk of parafunctional activities such as bruxism or clenching, oral dyskinesias, and oromandibular dystonia. Oral dyskinesia may contribute to muscle stiffness, degenerative changes in the temporomandibular joints, and mucosal lesions. Oromandibular dystonia may result in the involuntary and excessive contractions of the tongue, lip, and orofacial muscles. These parafunctional activities associated with temporomandibular disorder often result in pain. Damage and wear to teeth and prostheses may occur as well.[6]

Oral Trauma

Self-mutilation is a behavior frequently observed in individuals affected by schizophrenia. These injuries can be due to hallucinations where the individual hears voices, instructing the dismemberment of their body parts, while other injuries may not involve hallucinations.[8]

According to current literature, a strong causal association exists between schizophrenia and self-mutilation.[12] Appliances have been designed to help prevent individuals from inflicting injuries on oral structures. An alternative preventive strategy for lip injury is injection of toxins into the peribuccal musculature; however, this treatment poses a risk of dysphagia and pharyngeal muscle paralysis. In some cases, neither appliances nor toxin therapy

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can successfully prevent injury to the affected individual. Collaboration between medical and dental care providers can offer successful outcomes, thus reducing self-mutilation.[8]

Dental Appointment Management

Meticulous monitoring of the schizophrenic patient by the clinician during the dental appointment is imperative. Understanding of the potential side effects of medications taken by the patient is crucial as well, due to ramifications of these drugs. Difficulty with patient positioning and instrument adaptation as well as retraction of soft tissue is a consequence of uncontrolled grimacing inherent in tardive dyskinesia. This sequela could rule out the inclusion of removable prostheses in a treatment plan. A mouth prop used during instrumentation may be helpful to reduce with muscle fatigue.

The schizophrenic patient may experience medication-induced restlessness, often having an urge to pace. If the patient exhibits agitation and restlessness, the appointment should be kept short in duration. Intake of an antipsychotic drug may result in postural hypotension and palpitations. Schizophrenic patients should be monitored closely and encouraged to proceed slowly when returning from a supine position. When a patient is experiencing uncontrolled physical and psychological symptoms, elective restorative and preventive dental hygiene therapy should be postponed. Immediate referral is indicated when a schizophrenic patient "breaks down" or decompensates during a dental appointment.

In the event psychotropic drugs have caused blurred vision, effective use of visual aids could be minimized. This provides a challenge in demonstrating proper oral health care instructions. Techniques involving tactile sensation (touch) and pressure should be considered as an alternative to using visual stimuli alone when instructing for an oral health self-care regimen. Taking an antipsychotic drug often results in xerostomia. Saliva contains beneficial antibodies, acts as a buffer, and acts as a natural cleanser as well as aiding in the remineralization process. When it is diminished or absent, there is a substantial increased caries risk necessitating therapies including use of high-potency fluoride supplements and saliva substitutes as agents in a preventive oral health program.[13]

Comorbidities

Attention deficit hyperactivity disorder (ADHD) and seizure disorders (epilepsy) have been identified as comorbid factors of schizophrenia. Both ADHD and schizophrenia can claim dopaminergic neurotransmitter system biological changes. Evidence in the literature suggests schizophrenia and epilepsy share an etiologic factor of "neuronal migration deficits and dysregulation of common neurotransmitter systems, particularly of the dopamine and glutamate systems."[14] Epileptic subjects were found to have an 8.5-fold increase in their risk of developing schizophrenia.[14] Most of the studies supporting these findings are limited by small sample sizes and selection bias. Even though the study findings cannot be generalized, they do provide information on comorbidities and a potential link that can be the basis of future research endeavors.

Sixteen percent of individuals diagnosed with schizophrenia were concurrently diagnosed with diabetes mellitus. Type II (non-insulin dependent) diabetes is 2 to 4 times more prevalent in schizophrenics than that of the population at large. Researchers hypothesize that neuroleptic drugs used to treat schizophrenia increase the risk of developing diabetes.[15] Second generation antipsychotic agents can precipitate weight gain of varying degrees due to their interference with lipid and glucose metabolism. Study results indicate oral health professionals should be cognizant of the relationship between BMI and a potential for increase in caries risk.[16]

Study conclusions suggest the side effects of the pharmacotherapeutics may provoke or exacerbate Parkinson's disease-like conditions. These conditions may hinder oral hygiene routine, resulting in xerostomia and/or hyposalivation leading to an increase in caries progression.

Conclusion

Persons with schizophrenia are often misinterpreted and misunderstood. Coping with the symptoms of this disorder on a daily basis is a priority for the affected individual as well as those who help care for them. Add the common comorbidities to the symptoms, and the situation is exacerbated. Often personal hygiene and oral wellness are not a priority and are neglected by the schizophrenic and their care providers. Dental professionals need the knowledge and skills to deal with this disorder and its manifestations. Increasing awareness of this disease for oral health care providers and personal caregivers is paramount to improving the oral and systemic wellness, and the quality of life for individuals diagnosed with schizophrenia.

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Elisabeth Busch, RDH, BSDH
11086 Hemlock Lane
Doswell, VA 23047
elisabethbusch@hotmail.com

Laurie K. Callahan, BSDH, RDH
callahanslpc@gmail.com

Courtney Jones, RDH, BSDH
6100 Lincolnia Road, Apt 805
Alexandria, VA 22312
Courtneyjanjones@gmail.com
Employed by Reston Center for Dentistry

Joan M. Pellegrini, RDH, BSDH, MS, PhD
Associate Professor, Department of Oral Health Promotion and Community Outreach
VCU School of Dentistry
Perkinson Building, Suite 3100-A
1101 E Leigh Street
Richmond, VA 23298-0566
jmpelleg@vcu.edu
Phone: 804-828-9096 Fax: 804-827-0969

Oral Surgery Abstracts

Bedoya M, Park JH. A review of the diagnosis and management of impacted maxillary canines. JADA 2009; 140(12): 1485-1493

Purpose: A review of the literature to identify the successful diagnosis and treatments for impacted maxillary canines so that they can be allowed to erupt and be guided to an appropriate location in the dental arch.

Materials & methods: A search of the literature from 1959 to 2009 was conducted using several databases, including PubMed and Cochrane Library, as well as bibliographies from identified reviews relevant to the study. This included clinical and radiographic studies involving impacted maxillary canines, literature reviews and case reports containing information about the prevalence, etiology, and diagnoses of impacted canines. Also included were reviews and case reports from the past ten years that addressed the surgical and orthodontic techniques used for the proper management of impacted maxillary canines.

Results: Early impacted canines detection is possible, and members of the dental team might be able to prevent them from occurring altogether if a sound diagnostic and radiographic evaluation is performed in a timely fashion. From a surgery standpoint various treatments exist depending whether the canines are impacted palatally or labially. Orthodontic treatment on the other hand might vary depending on the clinical judgment and experience of the practitioner.

Conclusion: With early detection, timely interception, well managed surgical and orthodontic treatment, impacted maxillary canines can be allowed to erupt and be guided to an appropriate location in the dental arch. However it is only with the interdisciplinary care of general dentists and specialists that impacted maxillary canines can be treated successfully.

Ludmils Antonos, DMD, Resident, Oral & Maxillofacial Surgery, Virginia Commonwealth University

Cohen L, et al. Toothache pain: A comparison of visits to physicians, emergency departments, and dentists. JADA 2008; 139(9): 1205-1216

People with dental pain often turn to hospital emergency departments (ED) and physician offices for treatment of dental problems. This article discussed the differences in symptoms, demographics, and socioeconomics between people seeking care at a dental office, an emergency room, and a physician's office. The authors concluded that respondents ultimately sought definitive pain relief from dentists, but many relied on the ED and physician visits for temporary relief. To obtain the data they wanted, researches conducted a cross-sectional telephone survey. Participants were from different block groups including low-income whites, Hispanics, and non-Hispanic blacks. The questionnaire for the telephone survey was developed from previous focus groups. The survey revealed 80.5% of respondents that visited an ED and 82.5% of respondents that visited a physician's office subsequently contacted a dentist. Only 8.7% of respondents reported contacting the ED for toothache pain relief and this was associated with the severity of pain experienced. The more severe the pain the more likely the respondent was to visit the ED. None of the respondents received definitive treatment from EDs or physicians. Higher income people were more likely to visit a dentist first and to seek more timely care. People with household incomes over $25,000 were 2.5 times more likely to go to a dentist than individuals with household incomes under $25,000. Contacts with dentists were most associated with the duration of the toothache. Reasons people gave for delaying visits to the dentist included the belief that the physician was the best provider to visit and access-to-care issues. Access to dental services was most problematic for Hispanic respondents, and this problem was made worse by health literacy issues. Respondents in this study ultimately sought definitive care from dentists, but many used the ED and physician visits for temporary relief. This article demonstrated that access to dental services can be problematic for individuals with lower socioeconomic status and for the Hispanic population and these populations tend to seek care at emergency departments or physician offices first.

Amber Johnson Hurley, DO, DMD, Resident, Oral & Maxillofacial Surgery, Virginia Commonwealth University

Tsao C, et.al. Oral Health Risk Factors for Bisphosphonate-Associated Jaw Osteonecrosis. J Oral Maxillofacial Surg 2013; 71(8): 1360-1366

Purpose: To examine the role of oral health, especially periodontitis, as a risk factor for bisphosphonate-associated jaw osteonecrosis (ONJ).

Materials and Methods: This cross-sectional study compared cases with an ONJ history to controls. All had a history of intravenous bisphosphonate treatment for malignancy, and the cases had a history of ONJ consistent with the American Society of Bone and Mineral Research ONJ Taskforce. Participants underwent oral examination, gingival crevicular fluid (GCF) sampling, and phlebotomy. Serum was analyzed for biochemical parameters, bone markers, and immunoglobulin G titers against four periodontitis-associated bacteria. Cytokine levels were determined in GCF using a compound assay.

Results: Periodontitis was significantly associated with ONJ using the US National Center for Health Statistics periodontitis definition (P =.002), at least one site with a probing depth of at least 4mm (P=.003), and the percentage of sites per participant with a probing depth of 4 to 5 mm (P=.044). Immunoglobulin G titer against *Porphyromonas gingivalis* and GCF interleukin-1b level were also significantly associated with ONJ (P =.018 and P =.044, respectively). *P. gingivalis* may have characteristics that predispose to ONJ including promoting bone resorption more directly. Details of the mechanism underlying the association between ONJ and periodontitis are still unclear.

Conclusion: In participants with a history of bisphosphonate treatment for malignancy, periodontitis, as measured with three (3) clinical parameters, was associated with ONJ, suggesting that periodontitis and associated bacteria are potentially important in ONJ pathophysiology.

Dr. Eric Strayer, Resident, Oral & Maxillofacial Surgery, Virginia Commonwealth University

Ata-Ali J, et al. Do antibiotics decrease implant failure and postoperative infections? A systematic review and meta-analysis. Int J Oral Maxillofac Surg 2013; http://dx.doi.org/10.1016/j.ijom.2013.05.019

Introduction: The efficacy of perioperative antibiotic use in dental implant surgery has often been debated. However, no definitive consensus has been reached as to whether use of perioperative antibiotics leads to reduction in the rate of implant failures or postoperative infection. The authors of this paper attempt to answer this question via meta-analysis of the current literature on the topic.

Methods: The authors conducted a systematic literature search of PubMed, as well as a manual search of multiple peer-reviewed journals for any randomized control trials (RCTs) studying implant surgery and the use of antibiotics. Studies were included if specific definitions of implant failure were given, and if specified antibiotic regimens were defined and followed. A total of four RCTs were chosen, which included a total of 1002 implant patients receiving a total of 2063 implants. Statistical analysis included an inverse variance calculation to obtain an odds ratio as the measure of

effect. Values for the 95% confidence interval and P values were also given. Finally, the number needed to treat (NNT) to prevent 1 implant failure and 1 postoperative infection was calculated.

Results: A total of 1077 implants were placed using perioperative antibiotics. These antibiotics consisted of amoxicillin exclusively, though the dosage and duration of treatment varied among studies. 986 implants were placed without antibiotics as a control. Perioperative antibiotics were found to significantly decrease the odds of implant failure by 66.9% (P<0.003). The calculated NNT to prevent 1 implant failure was 48. Conversely, perioperative antibiotics were not found to significantly decrease postoperative infection rate (P=0.754).

Conclusion: The use of perioperative antibiotics does significantly decrease the rate of implant failure, and the NNT to prevent one implant failure is reasonably low. Thus, the recommendation of the authors is that perioperative use of antibiotics in dental implant surgery should be advocated. However, the authors point out that there remains no consensus on the duration or dose of antibiotic treatment, nor has there been significant study of alternative regimens for patients allergic to penicillins. Large multi-center RCTs are needed to further clarify the answers to these questions.

Kevin Wright, DDS, Chief Resident, Oral & Maxillofacial Surgery, Virginia Commonwealth University

Donaldson M, Touger-Decker R. Dietary supplement interactions with medications used commonly in dentistry. JADA 2013; 144(7): 787-794

Background: As the baby boomer population begins to age, its medical complexity increases. There has been a recent increase in patients who are becoming more health conscious and have turned to vitamins and dietary supplements, many of which are not discussed with clinicians thus providing an inaccurate pharmacological history. Many of these dietary supplements may have drug-drug interactions which could potentially cause adverse outcomes. The purpose of this paper was to identify frequently prescribed drugs by the dental provider which may have interactions with dietary supplements, as well as to stress the importance of obtaining a history of dietary supplements.

Methods: the authors reviewed the literature regarding popular dietary supplements with common medications and invasive dental procedures performed by the dental clinician. The authors reviewed studies which ranged from randomized controlled clinical trials or meta-analyses.

Results: Among many common dietary supplements discussed in this review, Gingko and St. John's Wort both potentially can cause adverse outcomes such as reducing effectiveness of antibiotics, as well as increase bleeding tendencies. These, among several other dietary supplements, should be reviewed prior to initiation of any pharmacological therapy or surgical therapy.

Conclusion: Dietary supplements are not benign drugs; they can have adverse interactions with medications. Stopping a dietary supplement for four half-lives will reduce most adverse effects of dietary supplements. The dental clinician should be aware of these interactions and should be able to alter their treatment plan as needed.

Roman Meyliker, DMD, Resident, Oral & Maxillofacial Surgery, Virginia Commonwealth University

Baqain Z, Moqbel W, Sawair F. Early dental implant failure: risk factors. Br J Oral Maxillofac Surg 2012; 50(3): 239-243

Introduction: Increase in research and advances in implant dentistry in the past two decades has made replacement of teeth with endosseous implants the standard of care, and an implant-supported prosthesis is the first line of treatment and long-lasting rehabilitation. Criteria for success of an implant includes the absence of mobility at the start of the prosthetic phase, the absence of continuing radiolucency around the implant, the absence of peri-implantitis with suppuration, and subjective complaints from the patient. Most implants fail early therefore recognition of factors causing the failure is important. Factors such as quality and volume of bone, site, and grafted bone as well as systemic factors such as smoking, genetic predisposition and metabolic disorders have an impact on implant failure. The aim of this study was to investigate potential risk factors that lead to early failure of endosseous implants.

Material and Methods: This was a prospective study performed in University of Jordan Hospital between March 2006 and March 2010. Patients with systemic disease were excluded. Threaded, grit-blasted, and acid etched implants were used. All patients were operated on by a single consultant surgeon. Local anaesthesia was by local infiltration (2% lignocaine with 1:100,000 adrenaline) following which a mucoperiosteal flap was raised. Prophylactic antibiotic was given orally one hour before operation, and the course continued for 5 days postoperatively. All patients were prescribed chlorhexidine digluconate rinse postoperatively twice a day for 7 days. When bone was needed to cover exposed threads, autogenous cancellous bone was used. In cases of augmentation of the horizontal or vertical ridge, corticocancellous blocks were harvested, usually from intraoral sites. For sinus lift, alloplastic or allogeneic bone was used mixed with autogenous bone. An implant was considered a failure if peri-implant radiolucency was detected on intraoral radiographs, if there were signs or symptoms of infection, or if there was the slightest movement when the implant was tested by feeling at the time that the cover screw was removed.

Predictive variables for the study were classified as patient, implant, anatomical, and operative-specific. Variables specific to patients included: age, sex, smoking habits, and general health (history of hypertension, ischemic cardiac disease, gastric problems, osteoporosis, hypothyroidism or hyperthyroidism, hypercholesterolemia, asthma, and diabetes. Anatomical variables included: site of implant, width of the keratinized gingiva), and quality of bone. Variables specific to the implant were its length and diameter. Operative variables included: timing and method of placement, use of a bone graft, internal sinus lift, type of suture used, and intraoperative complication (lack of primary stability by tactile assessment, fracture, perforation, or dehiscence of the jaw). Statistical analysis was computed. Descriptive statistics were calculated, and bivariate analyses using the chi square test and Student's *t* test for independent samples were used to assess the significance of differences between the predictive variables and outcome.

Results: The study group comprised 169 patients ranging in age from 16 to 80 years. These patients were given a total of 399 implants, with a mean of 2.4 implants/patient. Of the total number inserted, 15 (4%) in 14 patients failed to osseointegrate. Statistical analysis confirmed the importance of the width of keratinized gingiva and the type of suture material used as independent predictors of the failure of implants. Implants inserted in areas of narrowly attached gingiva had nearly five times the risk of early failure, and the use of polyglactin sutures was associated with a nearly four times higher risk of early failure.

Conclusion: Early failure of dental implants is thought to be caused by failure of bony healing around the implant and subsequent failure of osseointegration; this could be attributed to local or systemic factors. In this study narrow short implants were associated with greater risk of failure. Patients with type 2 diabetes were found to have similar implant success rate as non-diabetic patients. Smoking has an adverse effect on their survival and success however tobacco alone cannot be considered a risk factor for early failures. Higher failure rates were reported when implants were inserted next to neighboring teeth than implants in an edentulous ridge. In this study it was found that type 1 and 4 implants were more likely to fail. Lack of keratinized gingiva and the use of polyglactin sutures may be strong predictors of the early failure of implants.

Dr. Farzaneh Rostami, Chief Resident, Oral & Maxillofacial Surgery, Virginia Commonwealth University

Oral Surgery Abstracts

Mehra P, Reebye U, Nadershah M, Cottrell D. Efficacy of anti-inflammatory drugs in third molar surgery: a randomized clinical trial. Int J Oral Maxillofacial Surg 2013;42(7): 835-842

Pain, swelling, and transient loss of function of the masticatory apparatus are all normally associated with the removal of impacted mandibular third molars. Management of these post-surgical sequelae is based on the pharmacologic manipulation of a patient's local and systemic inflammatory and pain mediators. Prostoglandin E2 (PGE2) is a clinically measurable marker of inflammation in the post-surgical patient, and the reduction of circulating prostaglandin levels has previously been identified to reduce inflammation and associated pain, swelling, and functional loss.

The objective of this randomized, prospective, double-blinded clinical trial was to evaluate PGE2 concentrations in urine and saliva after mandibular third molar removal with an attempt to correlate these concentrations with clinical symptomatology. The authors also evaluated the efficacy of PGE2 concentration reduction by dividing 80 patients with bilateral full bony impacted mandibular third molars evenly into four test groups: Group 1 - placebo, Group 2 - preoperative ibuprofen (600mg), which was continued for 7 days postoperatively, Group 3 - intraoperative dexamethasone (8mg), and Group 4 - preoperative ibuprofen (600mg), which was continued for 7 days postoperatively, in addition to intraoperative dexamethasone (8mg). All patients were evaluated preoperatively (0 hours) and postoperatively at regular time intervals (24, 48, 72, and 168 hours). At each assessment, patients were evaluated subjectively for pain, loss of jaw function, swelling, diet restrictions, and general wellness and objectively for maximum inter-incisal opening, lateral excursion, masticatory muscle tenderness, and temporomandibular joint symptoms. Saliva and urine samples were taken from patients at each assessment point and evaluated for PGE2 concentration.

Results showed that PGE2 concentrations increased for the first three days postoperatively in both saliva and urine in all groups, and PGE2 levels were significantly higher in the placebo group when compared to the three test groups, which were all relatively similar. All patients receiving ibuprofen had a significant reduction in almost all subject and objective parameters when compared to the placebo group and a single dose of dexamethasone only had an additional transient beneficial effect. All test groups had a reduction in narcotic pain medication use after surgery when compared to the placebo group. The study also showed that the laboratory PGE2 values mimicked the clinical presentation of the patients and as PGE2 concentrations increased in the saliva and urine so did the signs of clinical inflammation. Based on this study it can be concluded that there is a link between systemic PGE2 concentrations and postoperative inflammatory sequelae and that anti-inflammatory drugs (NSAIDs and steroids) have a measurable reduction in systemic PGE2 levels. Combining NSAIDs and steroids in the perioperative period does show a slight improvement over either individually, but this was not statistically significant.

Nicholas J. Kain, DDS, Resident, Oral & Maxillofacial Surgery, Virginia Commonwealth University

Walker L, Morris G, Novotny P. Implant Insertional Torque Values Predict Outcomes. J Oral Maxillofac Surg 2011; 69(5):1344-1349

Introduction: Osseointegration is paramount to long-term dental implant success. Furthermore, primary implant stability has been shown to positively correlate with a greater potential for osseointegration. Factors such as bone quality and quantity as well as bone implant contact play important roles in achieving high primary stability. The purpose of this study was to investigate relationship between insertional torque values recorded at the time of implant placement and cumulative survival rates and implant healing times.

Materials and Methods: This is a retrospective study conducted from October 21, 2004 to May 10, 2007. It included 174 BIOMET Osseotite®, 6.0 mm diameter dental implants placed in 172 patients at the time of dental extraction of non restorable first or second molars. Insertional torque values were measured and characterized into 3 groups: low (15 N-cm or less), medium (15-30 N-cm), and high values (30-50 N-cm). At two weeks post-operatively sites were assessed for mobility, infection and pain. Those that remained symptomatic were removed and excluded from the study. At three months, all implants were evaluated for osseointegration by applying forward and reverse torque to healing abutments at 10 and 20 N-cm. Implants that were mobile and painful to torque tests were discharged and re-tested after a three month healing period. At subsequent follow up if pain and mobility were still present, implants were removed and excluded from the study. Patients who demonstrated stability of implants at 2 week and 3 month follow ups were discharged to restorative dentist. At 6 months periapical films were obtained and sites were assessed for bone loss. Subsequent follow up ranged from 2 to 4 years. Success rates and rates of healing time were studied using Cochran-Armitage tend tests. The Fisher exact test was utilized to determine whether or not the proportion of subjects at each implant length differed among the three insertional torque value groups.

Results: In this study 174 total implants were placed in 172 patients. Of those placed, 3% (n=50 were removed due to perceived mobility. The remaining stable implants (n=169) were divided into 3 groups based on their insertional torque values: low torque values (n=49), medium torque values (n=39), high torque values (n=81). Cumulative success rates for each of the groups were found to be 86% for the low torque value group, 90% for the medium torque value group, and 96% for the high torque value group. At the scheduled 3 month follow up appointment 33% of the implants from the low torque value group, 21% from the medium torque value group, and 5% from the high torque value group required an additional 3 month healing period prior to restoration.

Conclusion: Data collected from this retrospective study demonstrated a difference in implant healing time as well as cumulative survival rates when compared to the insertional torque values at the time of implant placement. A positive correlation does exist between torque values and cumulative success rates which indicates that insertional torque value may be a predictive tool in estimating cumulative success rates and implant healing times at the time of implant placement.

Dr. Samir Singh, Resident, Oral & Maxillofacial Surgery, Virginia Commonwealth University

PathologyPuzzler
with Dr. John Svirsky

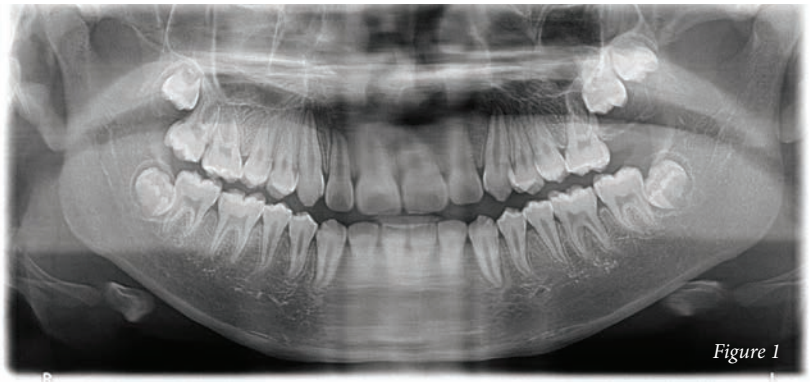

Figure 1

A 13 year old Asian-American male was referred to a local oral surgeon for evaluation and treatment of an asymptomatic , non-expansile radiolucent lesion associated with impacted teeth numbers 15 and 16 (Figure 1). The lesion measured 2.5 by 1.5 cm in greatest dimension and surrounded the crowns of teeth 15 and 16, preventing their eruption. The patient's medical history was uneventful and his only medication was for an asthma inhaler, which was used sporadically.

Based on the clinical findings, which of the following would you include in a differential diagnosis?

1. Dentigerous cyst
2. Odontogenic keratocyst
3. Ameloblastoma
4. Odontogenic myxoma
5. Central giant cell granuloma
6. Ameloblastic fibroma
7. Adenomatoid odontogenic tumor
8. Calcifying odontogenic cyst
9. Calcifying epithelial odontogenic tumor
10. Ameloblastic fibro-odontoma

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PathologyPuzzler
with Dr. John Svirsky

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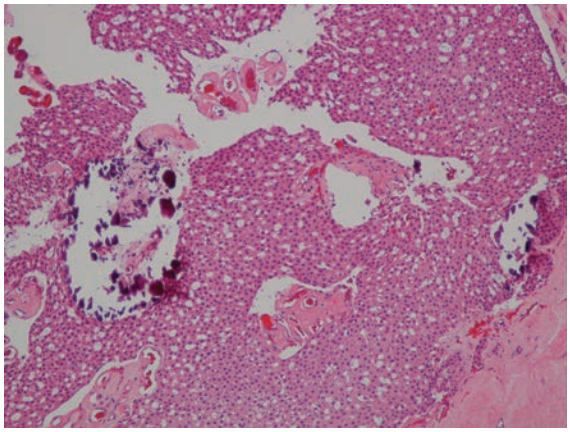

Figure 2

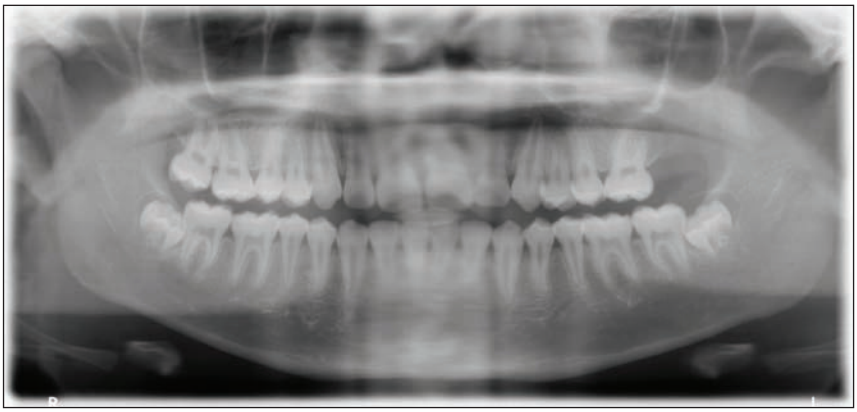

Figure 3

My differential diagnosis would include a dentigerous cyst, ameloblastic fibroma, and odontogenic keratocyst with all the other possibilities unlikely based on this radiolucent lesion surrounding the crowns of two impacted teeth. However, a number of lesions that eventually calcify begin as radiolucencies. An ameloblastic fibro-odontoma is associated with impacted teeth and is associated with patients of this age.

1. A DENTIGEROUS CYST is the most likely (my choice) since this is a radiolucent lesion associated with two impacted teeth and appears to surround the crowns. It could even be an eruption dentigerous cyst. However, involving two teeth that erupt at different times is unlikely.

2. An ODONTOGENIC KERATOCYST could have this appearance and may occur especially in an individual with the Nevoid Basal Cell Carcinoma Syndrome. This is the age where the odontogenic keratocysts start to occur in the syndrome. This is an autosomal dominant syndrome. The peak age range of odontogenic keratocysts is 10-40 with a slight male predilection. The location is typically the posterior mandible (over 60%).

3. AMELOBLASTOMAS are extremely uncommon in individuals under 20 and typically occur in the mandible (80% or more). There was no expansion in the case which is typical of an ameloblastoma. The radiographic findings appearing radiolucent cannot exclude an ameloblastoma, but with the age of 13, without symptoms, and the posterior maxilla location, it is unlikely.

4. An ODONTOGENIC MYXOMA is an uncommon odontogenic tumor with an average age of the mid-twenties. It is radiolucent and usually multilocular with "tennis racket" architecture, showing septations intersecting at ninety degrees. Clinically they are indistinguishable from ameloblastomas. The age of the patient, absence of symptoms, and location make this an unlikely diagnosis.

5. Seventy percent of CENTRAL GIANT CELL GRANULOMAS normally occur in the mandible, anterior to the molars. They present as both unilocular and multilocular radiolucent lesions and may be expansile. There is a wide age range and this case is a possibility. They are not typically associated with impacted teeth. This lesion is a possibility for this case but I still feel unlikely due to the location and association with impacted teeth.

6. The AMELOBLASTIC FIBROMA typically presents as a radiolucent lesion of the posterior mandible in the first two decades of life. It can be associated with impacted teeth and also be multilocular. I think this one is a possibility.

7. The ADENOMATOID ODONTOGENIC TUMOR typically occurs in this age group and has a strong tendency to be found in the anterior portion of the jaws. The maxilla is twice as common as the mandible and the tumor can be associated with an impacted tooth. They seldom exceed 3 cm and have a female predilection. The radiographic appearance is typically mixed radiolucent/radiopaque with snowflake calcifications. However, early lesions may appear as radiolucent. This lesion must be excluded by biopsy. The location argues against this diagnosis.

8. The CALCIFYING ODONTOGENIC CYST (Gorlin cyst), as the name implies, would normally have calcifications. This lesion is typically diagnosed in the second and third decades. A large number are associated with odontomas, especially in younger ages. Studies show that 13-30% of COCs are extraosseous and 65% are found in the incisor/canine region. Lesions typically start as a radiolucency before becoming radiopaque. This is a possibility but unlikely.

9. The CALCIFYING EPITHELIAL ODONTOGENIC TUMOR (Pindborg tumor) is an uncommon lesion that has a wide age range and found in many parts of the jaw. It is most often encountered between 30 and 50 in the posterior mandible. This lesion usually presents as a painless, slow growth lesion that begins as a radiolucent process (unilocular or multilocular). The tumor is frequently associated with impacted teeth and calcifications are found throughout the tumor.

10. The AMELOBLASTIC FIBRO-ODONTOMA is found in young people (average age 10) in the posterior mandible. They are asymptomatic and discovered on routine radiographs. They typically present as a radiolucent lesions with varied calcifications and are associated with unerupted teeth.

The histologic findings were a surprise with figure 2 showing sheets of polyhedral epithelial cells with prominent eosinophilic cytoplasm, intercellular bridges and a few scattered concentric calcifications. This lesion was a CALCIFYING EPITHELIAL ODONTOGENIC TUMOR (Pindborg tumor). This again teaches me that "lesions do not read textbooks" and "the patient is a case of one". Figure 3 shows a one year follow-up radiograph with normal appearance.

This case was submitted by Dr. John Truitt, an oral surgeon practicing in Richmond.

VDA Services Announces a New Endorsement:

Miles Global – The Leaders in Dental Consulting

By: Elise Rupinski, VDA Director of Marketing & Programs

VDA Services is very pleased to announce their most recent endorsement – Miles Global, a national firm dedicated to dental practice consulting, dental team training and education. After a thorough evaluation by the Virginia Dental Services Corporation Board of Directors, Miles Global was selected for endorsement based on their industry-leading consulting services and the value they can bring to VDA member dental offices. Miles Global emphasizes establishing exemplary organized business systems, team accountability, leadership at all levels, customer service, and marketing – all in the pursuit of creating profitable, efficient dental practices.

Miles Global, formerly Linda Miles & Associates, is one of the most respected dental management consulting firms in North America. Founded in 1978 by the legendary Linda Miles, with Dr. Rhonda Savage's acquisition of the company in 2007, the name of the company changed to Miles Global. Also part of the team at Miles Global is Virginia's own, Dr. Tanya Brown of the Center for Cosmetic and Restorative Dentistry in Chesapeake. Dr. Brown is a consultant with Miles Global and is part of a great team that is ready and willing to help VDA members with all aspects of practice management. With over 150 years of accumulated experience, the team at Miles Global is uniquely positioned to help dental practices through consulting services, practice analysis, team retreats and workshops, front office development, telephone coaching, staff training and online webinars. While the Miles Global home office is now located in Gig Harbor, Washington, their reach is global – if there's an industry conference or seminar, regardless of location, a Miles Global consultant will be there!

Dr. Rhonda Savage, CEO of Miles Global, recently commented on the new endorsement: "The leadership at VDA Services is focused on the success of your practice; this is our focus also. The entire team at Miles Global is honored to be a VDA Services endorsed business. Our mission is simple, yet complex: We focus on people, processes and profits. We find that dentists today want engaged team members, a higher level of customer service and a better bottom line." VDA Services is also very pleased to be able to offer the expertise of Miles Global to VDA members with a special discount only available for members. Dr. Lanny Levenson, President of VDA Services is very pleased to announce the endorsement. "The new VDA Services endorsement of Miles Global is truly a win-win situation. VDA Members are able to access exceptional consulting services with exclusive discounts and VDA Services is able to provide a non-dues revenue stream to help keep VDA member dues as low as possible. Great services, special pricing and support for the VDA all with one program!"

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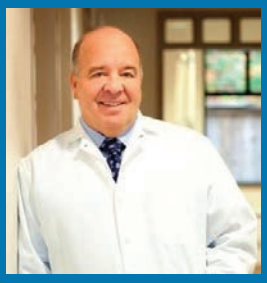
Dr. Jim Schroeder



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A 21st century dental practice cannot ignore the rapidly growing population identified as "special needs." These populations encompass physical, mental, and medical impairments that may alter our standard routines in delivery of oral health care. Embracing these varied populations can be a vibrant part of a healthy general practice. Many myths discourage the care of special populations in the private sector. Development of management skills and acquiring knowledge related to specific special needs can be rewarding for your team and a source of practice growth in the community.

COURSE OBJECTIVES:

- Overview of growing special needs populations and oral health needs
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- Remove the mental and physical barriers in your office
- Modify treatment planning and the factors to consider with special populations
- Increase awareness of the home environment and impact on care taker/family
- Overview of general dentistry in the operating room
- Learn how to network in the healthcare community to understand the unique needs of special populations
- Uncover the financial pathways for treatment

SPEAKER BIO:
Dr. Jim Schroeder has a distinguished career as a dental educator and champion for special needs dentistry. He is an adjunct faculty member in the Department of General Practice at Virginia Commonwealth University School of Dentistry, where he teaches the Treatment and Care of Special Needs Patients. Dr. Schroeder is a Fellow with the American College of Dentists and was awarded the American Dental Association (ADA) Award for Improving Access to Care for Special Needs Populations.

He currently serves as the chief consultant to lead the five-year strategic planning process for the VCU School of Dentistry and serves as President of Virginia Academy of Dental Sleep Medicine. Dr. Schroeder was in private practice for over 30 years and is now the Founder and President of Leadership by Design, a consulting firm that specializes in practice and organizational development.

Dr. Schroeder is the Chief Consultant to 5-year strategic planning process at the VCU School of Dentistry, adjunct faculty at the VCU School of Dentistry, and the Founder/President of Leadership By Design.

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An Interview With:
Dr. Frank Serio

Editor's Note: Dr. Frank Serio was recently appointed as the first Dean of the Bluefield College School of Dental Medicine. He was interviewed July 20, 2013, at the Missions of Mercy Project in Wise.

VDA Journal: Why do you want to be the dean at Bluefield College School of Dental Medicine?

Dr. Frank Serio: Several reasons. In general, it is the natural progression in my career. I've always planned to be a dean. I've completed my MBA and have had good administrative experience, especially helping to start the new dental school at East Carolina University. Primarily, it's a good fit to the mission of the school and my personal interests. My entire career has focused on teaching pre-doctoral students. Also, it fits the mission of Bluefield. Bluefield College is committed to Christian witness and committed to service. I've been involved with mission work for 32 years in the Dominican Republic and have done a lot of other volunteer work both overseas and in the US.

Journal: Name one thing that will make Bluefield unique among US dental schools.

Dr. Serio: The fact that it's here in Appalachia. Lots of schools do community service. We'll develop a network of community health centers throughout the region where our students will receive some of their clinical training. These extramural sites will be a challenge in delivering dental training. Some of the issues are: can the site provide training? Where do you have this training? What's the service mix for the patients and is it appropriate for our dental students?

Journal: How will basic sciences be taught to your students?

Dr. Serio: We're recruiting an academic dean and a chair of biomedical sciences. They will develop the details of how biomedical sciences are taught. We are trying to develop an interactive model of teaching. The SCALE UP method of teaching is used at NC State and Virginia Tech. It's an interactive model of teaching. Bluefield would be the first dental school to adopt this method of interactive teaching. We're not yet totally committed to it but will have some sort of interactive instruction. Anyway you look at it, dentistry is still a psychomotor profession so clinical skill development must be stressed. I've always been a clinician, a wet-fingered dentist so I am interested in graduating new dentists with strong clinical skills.

Journal: Much has been written about the growing indebtedness of dental students. How will your school address this issue?

Dr. Serio: We can't address the student indebtedness problem completely. In southwest Virginia, there's about three dentists per 10,000 people, or about half the national average. The question is, how do you get dentists to come here? First, we need to recruit both at the high school and college level in places where dental schools have not traditionally recruited. I recall that when ECU recruited for its students, in-state applications to Chapel Hill went up, just due to ECU's recruiting. Some of these communities here need to support their residents. We'll develop a model where communities will help pay off the loan if their students will locate a practice there. Here's what needs to be done: 1) make the community part of the effort both in identifying students interested in a dental career; 2) have them support the dental students they want to support 3) reduce student debt 4) teach the business of dentistry to students: we'd teach wealth management, that is, work backwards . How much money do I need, and how do I get there?

Journal: How will Bluefield entice its graduates to remain in Appalachia?

Dr. Serio: We will propose that local communities and foundations invest in their students. We need to get communities to step up and support their residents. If a community financially supports a dental student while in school, that student will be contractually obligated to return to that community or repay any financial support with interest. We'll recruit students who otherwise couldn't afford to go to dental school.

> *"We'll recruit students who otherwise couldn't afford to go to dental school."*

Journal: Where will the faculty live?

Dr. Serio: Part of the reason Tazewell County has supported this project is they are interested in economic development. There has to be a significant investment in infrastructure over the next three years to build housing for faculty, students, and staff. Bluestone has plans to seek developers for safe, multifamily housing to be built that will house up to 250 students. Right now there are very few places for the faculty to live. The housing supply in eastern and central Tazewell County is fairly small. We'd like for them to live here in Tazewell County, if possible as the County is providing the start- up capital for the school. To be sure, the School of Dental Medicine will repay these funds going forward. There is a meeting in Tazewell County with the Board of Supervisors next month on the subject of developing residential housing.

Journal: Let's say I have a private dental practice in Southwest Virginia. Why shouldn't I fear competition with your school for available patients?

Dr. Serio: In general, dental school patients are not private practice patients. Everybody worries about that. Dentistry is thriving in cities where the schools are located. Most of our patients are not going to be your patients. The question is, what will happen when faculty practice opens? First, look at the faculty – they're not practicing all the time, and they're not that efficient. When I was at Mississippi private practitioners were concerned about what would happen to the dentists in Jackson when the school opened. What they found was faculty practice was producing about the same amount as a busy two-doctor practice, and most communities can absorb that. What needs to happen is people need to know the facts. People will be concerned when there are unknowns, and this creates a lot of anxiety. The same thing happened at ECU when it opened.

Journal: It's been estimated it costs $100,000 per year to educate a dental student in the US. How will your cost structure compare?

Dr. Serio: It's going to be less. I can't give you a number. Let's looks at most dental schools: they have hefty administrative structures. We can't afford to be top-heavy. We'll have a lean administrative

Continued on page 38

Missions of Mercy
Virginia Dental Association Foundation

MOM Celebrates 50,000th Patient

L-R Beth Vann-Turnbull, Norma Roadcap, Dr. Richard Roadcap, Heather Heranney (50,000th patient), Joyce Estes and Barbara Rollins

The Mission of Mercy project celebrated the 14th year of service at the Wise Fairgrounds on July 19-21. A noteworthy year: Heather Heranney, resident of Southwest Virginia and mother of 5, was awarded a basket of gifts and dental products celebrating her as that 50,000th patient treated through MOM! Congratulations Ms. Heranney!!

Over 425 volunteers from Virginia and twelve other states (including California, New York and Florida) gave of their time and talents. Volunteer dentists, hygienists, dental assistants, and dental and dental hygiene students provided 1,329 area patients with dental care valued at $1.4 million. These free services included 1,329 exams, 216 cleanings, 1,724 fillings, 3,996 extractions, 1,176 x-rays, 67 root canals/pulpotomies, 57 complete dentures, 62 denture relines, 12 denture adjustments, and 216 fluoride varnishes. Through the 69 completed projects (2000-2013), 51,311 patients have received dental care valued at $32 million!

The MOM Team wishes to thank all volunteers and sponsors for their commitment to the success of the Mission of Mercy!

Dr. Robert Faiella (American Dental Association President) helps out in triage.

We wish to thank Best Western Hotel and Reno's Roadhouse (both in Wise, VA) who made generous donations in celebration of the 50,000th patient seen at Wise MOM 2013. (L-R) Quinn Bowling (General Manager) and Tiffany Adams of the Best Western, Wise accepting certificate of appreciation for their support of the MOM project.

Robbie Schureman presents certificate of appreciation to Frank Meredith (Manager) and staff of Reno's Roadhouse for support of the MOM project.

Breakfast in the Bleachers

By: Richard F. Roadcap, D.D.S., Editor

Napoleon claimed, "An army marches on its stomach." He understood the importance of well-fed troops. Since the first Missions of Mercy project in Wise (in 2000) the Lions Club has fed breakfast and lunch each day to as many as 2,000 volunteers. The breakfast line forms in the dark at 6:00 a.m. (it's far west in the Eastern time zone), but the food prep begins at 2:00 each morning: eggs, sausage, pancakes, potatoes, fruit, biscuits and gravy. Hot coffee and orange juice are the last items off the tables before the diners take a seat in the stands at the VA-KY (the locals like to abbreviate names) fairgrounds in Wise. Low calorie and low fat? Not likely! Delicious…of course!

Lion Joey McCaffrey, of Chester, Virginia, gave me a behind-the-scenes tour of the food service operation, starting with a frosty look into the refrigerated trailer. Food City®, a regional grocery retailer based in Abingdon, donates every year the use of a 53 foot trailer, designed to keep the prepared food at 34° F. Everything from salads to sandwiches to salsa is held in stacked containers, awaiting the next onslaught of hungry volunteers. Mr. McCaffrey is grateful for Food City's support and recounted how, several years back, a trailer that broke down was immediately replaced. He said the worst event he remembered was the overnight shutdown of a trailer, requiring over 250 pounds of barbecue to be tossed out.

Friday morning 635 were served breakfast, and the Lions expected to serve 3,800 meals during the weekend. This includes hundreds of box lunches prepped for dental volunteers, allowing them to remain at their work stations without having to spend time in the inevitable long lunch lines. I asked if there was a budget, of sorts. "Less than $2 a meal" said Mr. McCaffrey, estimating overhead. What about donations? "No, we don't ask for them," explaining 25% of the food was donated, and the Lions were busy with food prep and there was no time to solicit. He said the local prison farm and other community groups were eager to give, and all donated food was put to good use. He said the servers found if there were fewer choices, but better quality, the lines moved quickly and everyone was fed on time. Menu favorites included breakfast potatoes and pancakes. Especially the spicy potatoes: "We always run out of them!"

Backstage at the stadium, volunteers Ken Isaac, Pat Isaac, Penny Sharpe (head cook and menu wizard), Kay Almarode, Joe Angsten, and Marge Angsten worked feverishly at 9:30 a.m. to ready salads for an 11:30 lunch. Ethel Daniels, Tammie Brightwell, Phil Sharpe and Jim Newman prepared bag lunches to be delivered to doctors and volunteers. Approximately 150 Lions Club volunteers come from all parts of Virginia to serve here each year, and like many dental staff, it's an annual event they look forward to. Mr. McCaffrey arrives Monday, four days ahead of Friday's opening day of the MOM Project, and leaves the following Monday to head home. I asked, what was his greatest satisfaction? He said, "I have so much fun, meeting all these people, joking and talking with them. I just like coming here – I schedule my vacation around this." I also asked, "Be honest – are the doctors hard to please?" He laughed, "Oh, no, they're happy with what we give them!"

Wise volunteers know they'll always leave tired, sometimes overheated, but they'll never go hungry, thanks to the tireless Lions Club volunteers. Dental volunteer Arlene Dunkum said she appreciated not having to leave for something to eat while working. Lions Club International, the largest service organization in the world, states its mission is to "empower volunteers to serve their communities". Their service to the MOM projects allows dental (and non-dental) volunteers to carry out their mission without worry about meals. Napoleon's dictum later proved prophetic: the French army was unable to defeat the Russians in 1812 due, in part, to the destruction of food supplies ahead of their advance. Hunger dogged their retreat from the outskirts of Moscow. Volunteers at the Wise MOM Project head home well-fed, with fond memories of camaraderie and service to others in need of basic dental care.

Chain Reaction Supports Meeting Dental Care Need

By: Patricia Brown Bonwell, RDH, BSDH, MSG, PhD, Dental Clinic Coordinator, Lucy Corr Village, Adjunct Instructor, VCU School of Dentistry, Dental Hygiene Program

Webster's Dictionary defines "chain reaction" as a series of events each of which is initiated by the preceding one. This term describes the progress made in providing dental care at the Lucy Corr Village Dental Clinic. Stemming from a chain reaction, the Lucy Corr Village Dental Clinic (LCVDC) has experienced wonderful progress in helping to meet the oral health care needs not only of its geriatric residents, but also of members of the geriatric population in surrounding communities. The chain reaction progress began with the much-needed modernization of the dental clinic that was completed in July 2012. A celebration recognized all volunteers, contributors and donors recognized at the ribbon cutting held in November 2012.

The modernization supported an increase in volunteer dentists who offer their talents to treat patients in the dental clinic free of charge. This increase in volunteer dentists supported the expansion of off-site oral screenings. I am fortunate to have the opportunity to collaborate with geriatric programs in surrounding communities, such as the Shepherd Center, Hopewell Respite Program, Chesterfield Lifelong Learning Institute, Lucy Corr Adult Day Care Services, Dominion Place and South Richmond Adult Day Center. This effort has enabled dentists who volunteer at the LCVDC to provide oral screenings and referrals for participants of these programs. Dr. Michael Hanley, Hanley Family Dentistry in Chester, and Dr. Gordon Witcher, Chief, Dental Services Chesterfield Health District, have been kind enough to let me schedule them to travel to off-site locations to perform exams on interested program participants. Based upon findings, these participants can come to the LCVDC to receive most of the dental services they need. Transportation to the LCVDC is coordinated by me with the assistance of a program site representative.

At the LCVDC, we have continued our relationship with the VDA's Donated Dental Services Program. Barbara Rollins has assisted us with coordinating the provision of dentures and partials as well as extractions for patients seen in the LCVDC. We are also thankful for the continued partnership with Southside Oral and Facial Surgery, which has allowed us to send patients directly to their offices for dental services including evaluations, extractions and biopsies.

Modernization and more dentists allow us to rotate dental students through the LCVDC as a preceptor site for senior dental and dental hygiene students. For the past two academic years, senior VCU dental hygiene students have rotated in pairs through the LCVDC. As a Registered Dental Hygienist, a Gerontologist, an adjunct faculty member at the VCU School of Dentistry's Dental Hygiene Program, and the Dental Coordinator at LCVDC, I am delighted to supervise senior dental hygiene students at this preceptor site. Dental hygiene treatment rendered by these students aids in maintaining periodontal health, improving overall health and quality of life for geriatric patients. This rotation will continue every Wednesday and Thursday during the 2013/2014 academic school year.

I am also excited about securing and coordinating the rotation of two VCU dental students per scheduled rotation date through the LCVDC on the 1st Wednesday and 1st, 2nd, and 3rd Fridays of each month under the supervision of the following volunteer dentists and honorary faculty members: Drs. Tyson Anderson, Peter Appleby, David Beam, Michael Hanley, and Edward Jordan. The rotation of VCU Dental Students in a nursing home facility is groundbreaking for the School of Dentistry. This rotation addresses the high level of restorative needs presented by nursing home residents. These rotations provide the dental and dental hygiene students an opportunity to increase their knowledge and improve their skills in the provision of care to members of the geriatric population. The collaboration increases access to care for a population that may not be able to obtain timely and necessary treatment otherwise. This action demonstrates the forward thinking of all involved. I extend a sincere thank you to Kim Isringhausen, Chair of the Department of Oral Health Promotion and Community Outreach at the VCU School of Dentistry and to Dr. David Sarrett, Dean of the VCU School of Dentistry, for their continued support in using students to provide much needed dental care to an underserved population.

Acting as a free dental clinic can be quite challenging when it comes to purchasing supplies. The modernization also served as an incentive for the award of grant funding from the John Randolph Foundation Fund, and the Altria Companies Employee Community Fund. This funding will assist with the purchase of supplies for the dental clinic. Funding for the LCVDC has also been raised through different events such as the 5K Run for the Future held in 2012 on the grounds of Lucy Corr Village, and the annual Lucy Corr Rock 'N Roll Dance, as well as gifts from various donors and contributors. Funding received will also assist with the purchase of the Larell Denture System for chairside fabrication and delivery of dentures to anxiously awaiting patients. Dr. Hanley completed special training for use of this system and he will share his knowledge with the students that rotate through the LCVDC.

I am very grateful to be able to work with dedicated people such as Debra Marlow, Executive Director Lucy Corr Foundation, and Tammy Shackelford, Lucy Corr Foundation Development Assistant, because our efforts have enabled submission of successful grant proposals allowing us to continue to provide dental care at LCVDC. A "thank you" is also extended to Bonnie Meyers, Assistant to the Executive Director at Lucy Corr Village and Jim Musgrave, CEO of Lucy Corr Village, for their enthusiastic support of the dental clinic. I also want to commend CNA Stacey Akrie on a job well done assisting with the transport of Lucy Corr Village residents to the dental clinic.

Also stemming from the chain reaction, the Lucy Corr Foundation received grant funding two years in a row from the Virginia Center on Aging's Geriatric Training Initiative. This funding enabled the training of direct health care providers working at Lucy Corr Village and in the surrounding community on the importance of oral health in the geriatric population. Significant findings indicate that both the interdisciplinary educational and peer educational approaches used in this training improve geriatric workforce development.

With the expansion of collaborative efforts accompanied by the continued support of the Chair, David Saunders, and all Lucy Corr Foundation Board members, the chain reaction should continue and assist with addressing the issue of meeting the dental and oral health care needs of members of the geriatric population. Working together, we can achieve the common goal of improving the quality of life for members of the geriatric population, not only those who reside in our facility but also those who reside in surrounding communities.

A Day for Special Smiles: Mission of Mercy and Healthy Athletes United

Matthew Cooke, DDS, MD, MPH: Clinical Director, Healthy Athletes, Special Smiles Program, Special Olympics of Virginia

Special Olympics
Special Smiles®

You're Not Healthy without Good Oral Health. For the millions of people worldwide with intellectual and developmental disabilities, dental care is not often a top priority and unfortunately takes a back seat to more pressing medical issues. However, maintaining good oral health should be a priority for everyone.1 In the words of former United States Surgeon General C. Everett Koop, "You are not a healthy person unless you have good oral health."[2]

It is well documented that oral diseases affect quality of life.[3] The impact of oral diseases in pain, suffering, impaired function and reduced quality of life, is both extensive and expensive.[4] Dental treatment has been identified as the most unmet health care need.[3] It is estimated to account for between 5-10% of health costs in industrialized countries, and is beyond the resources of many developing countries.[4]

Unlike other diseases that resolve without treatment, oral disease can lead to complications that can be difficult and expensive to cure. Over the past few decades, dentistry has made great strides in research, which proves that proper oral hygiene and regular visits to the dentist can prevent many dental diseases.[1] However, barriers to care still exist for many populations.[3] Children younger than 6, patients with special health care needs, and patients from lower socioeconomic backgrounds are disproportionately at higher risk.[3]

Special Olympics Inc. quickly identified that individuals with developmental and intellectual disabilities have many barriers to receiving care. It's mission is to provide year-round events for children and adults with intellectual disabilities, giving them opportunities to develop physical fitness, demonstrate courage, experience joy and participate in a sharing of gifts, skills and friendship with their families, other Special Olympics athletes and the community.[5] Health is also a vital part of their mission. Special Olympics Healthy Athletes programs have offered health services and information to athletes in approximately 1.2 million clinics in more than 100 countries. Throughout this process, Special Olympics has become the largest global public health organization dedicated to serving people with intellectual disabilities.[5]

Locally, the Healthy Athletes program started in 2001 with dentistry being the first venue represented. The 2001 Summer Virginia Special Olympics Games hosted the first official Special Smiles program. The original program consisted of a dental screening, topical fluoride application, oral hygiene instruction, a mouth guard, and a referral to a local dentist. In 2011, Special Smiles partnered with the Virginia Dental Association's Mission of Mercy (MOM) Project to provide a full range of services to the athletes. Virginia was the first state ever to offer comprehensive care to Special Olympics Athletes at a state game, making Virginia a leader in providing oral health care to persons with intellectual and developmental disorders.

On June 8, 2013 at the Virginia Summer Special Olympics Games, Special Smiles and Mission of Mercy teamed up for their second annual event. The event was held at The Robins Center, University of Richmond. The project was a huge success thanks in part to the 100 plus volunteers who staffed the event. Showcasing the ideals of team spirit, Special Smiles and Missions of Mercy offered comprehensive free dental treatment to both visitors and athletes allowing them to see around 250 patients over the course of the day.

It was evident from seeing the smiles on the athletes' faces that they appreciate all that was done. In the words of a Special Olympics volunteer, "To those who are given much, much is the responsibility!" This is an incredible opportunity to serve a special population, who may otherwise not have access to oral health care. The Virginia Chapter of Special Smiles is continually seeking volunteers to help with its program. If you are interested please contact Matthew Cooke, DDS, MD, MPH, Clinical Coordinator for the Virginia Special Smiles Program at mrc99@pitt.edu.

On behalf of the Special Olympics Virginia, thanks to all who made our 2013 event a success! We look forward to working with you next year. Until then, keep smiling!

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Virginia's Dental Safety Net: Striving to Meet the Needs of the Uninsured and Underserved

By Tracey A. Van Marcke, Dental Opportunities Champion, Virginia Health Care Foundation

The percentage of Americans who lack dental insurance from a private or public source is a staggering 47%, according to the National Association of Dental Plans (2012). This far exceeds the number of medically uninsured, yet is discussed much less frequently in the press. The sweeping reform of the Patient Protection and Affordable Care Act did little to expand dental insurance for the uninsured.

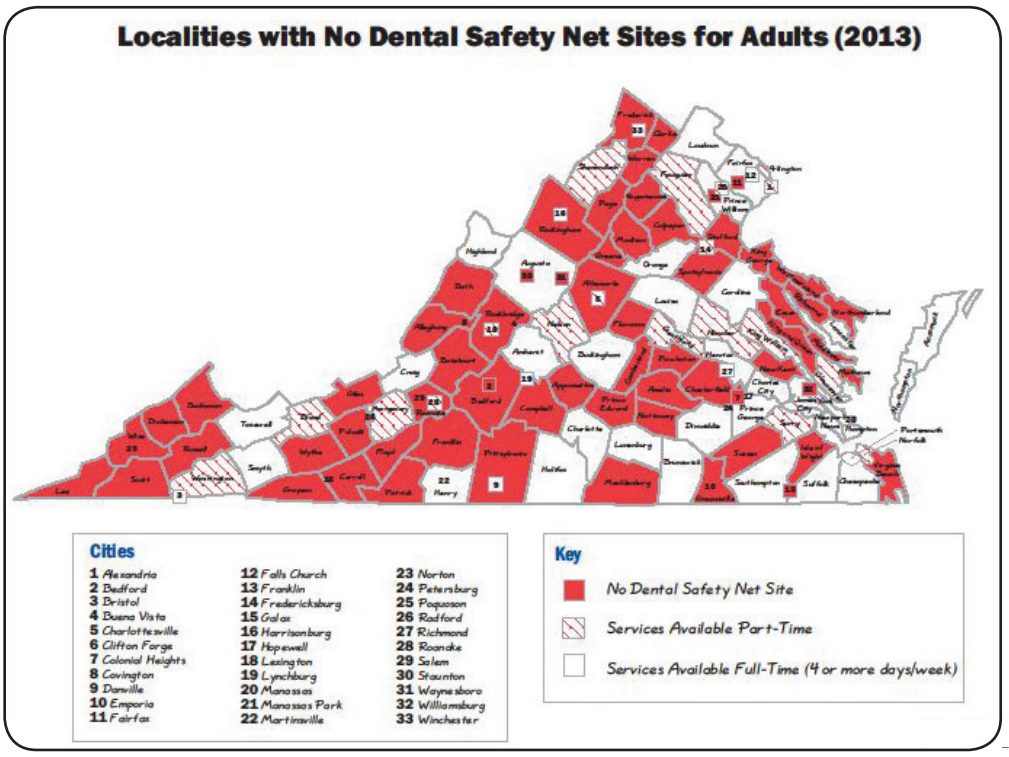
Despite this overwhelming need, 70 localities in Virginia do not have a dental safety net (DSN) facility. It is no wonder that access to dental care has become the top priority in many local community needs assessments.

Dr. David Crouse, one of the more than 500 dentists that volunteered in free clinics last year, shows a patient her new smile.

Funding the Dental Safety Net

The Virginia Health Care Foundation *(VHCF)* has worked for many years in collaboration with the Virginia Dental Association *(VDA)*, the VCU School of Dentistry, and a host of community organizations to increase the size and capacity of the Commonwealth's DSN. Over the last 15 years, VHCF has devoted more than $9.5 million to this endeavor, making it the largest funder of the dental safety net in Virginia.

Early grants supported the VCU School of Dentistry's mobile outreach program and school-based services in underserved Accomack County. Since then, VHCF has partnered with the VDA to fund operatories and seed money for its Missions of Mercy (MOM). It has also stimulated the development or growth of 43 DSN sites with financial assistance for start-up and expansion costs.



VHCF will have the ability to fund a significant expansion of the DSN over the next several years, thanks to a recent $1 million challenge grant from the Delta Dental of Virginia Foundation *(DDVF)*, and the corresponding match to be raised. VHCF was one of 36 organizations across the Commonwealth to receive one of DDVF's inaugural oral health grants.

A Snapshot of the DSN

Currently, Virginia's DSN is comprised of 76 community-based dental clinics, located in 63 localities. This includes 27 sites at community health centers providing services to children and adults, 35 free and charitable clinics serving adults only, and 14 additional clinics that are freestanding or affiliated with other organizations. Many of these treat patients of all ages.

Some DSN clinics, particularly free clinics, provide care entirely with volunteers. These volunteers include local dentists, dental students working under the supervision of community dentists, dental hygienists, and dental assistants. Services are rendered either at the clinic, or in the volunteer's private office.

Adult and pediatric patients are appreciative of the care they receive in DSN clinics.

Other DSN clinics provide dental services by employing a full or part-time dentist. This structure is often used in rural areas, where fewer dentists are available to volunteer. The dentist's salary is typically supported through a combination of patient revenue (per visit fee), insurance revenue (Medicaid), and grants from organizations like VHCF.

Providing Support to the Dental Safety Net

Operating a DSN clinic under any model is

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challenging. That is why VHCF provides far more to Virginia's DSN than money. It also makes a range of technical assistance, resources, and tools that reduce costs available.

A series of VHCF guidebooks called, "Models that Made It," provide assistance to clinics based on successful programs within Virginia's own DSN. One example is the "70/30" model first developed at Augusta Regional Dental Clinic. This approach is based on the concept that in order to provide care to uninsured adults in a financially sustainable manner, 70% of the appointment mix must be reimbursed by Medicaid or FAMIS to support the remaining 30% of appointments.

DSN dentists and administrators are empowered to network and share best practices through VHCF's *Tooth Talk Roundtable*, and its corresponding online forum. These gatherings also provide an opportunity for experts like the Virginia Oral Health Coalition to present up-to-date information on a host of issues relevant to the DSN.

Interactions with DSN providers enable VHCF staff to identify further opportunities for education and support. As needs are identified, VHCF's Dental Opportunities Champion, a position generously funded by the Delta Dental of Virginia Foundation, works to address them through various initiatives and programs.

For example, to help DSN clinics lower costs, VHCF negotiated a special discount with the Patterson Dental Company. This extends Patterson's maximum discount to all Virginia DSN clinics, regardless of size, and covers supplies, equipment, software, and service calls. Through this program, over $1.16 million in expenses has been saved by Virginia's DSN since 2007.

VHCF's Larell OneStep Denture Initiative is aimed at providing high quality, lower cost dentures to Virginia's DSN patients. Safety net dentists are provided with training and startup supplies, underwritten by VHCF. This enables them to provide dentures to a greater number of patients, and has even allowed some DSN clinics to offer dentures for the first time.

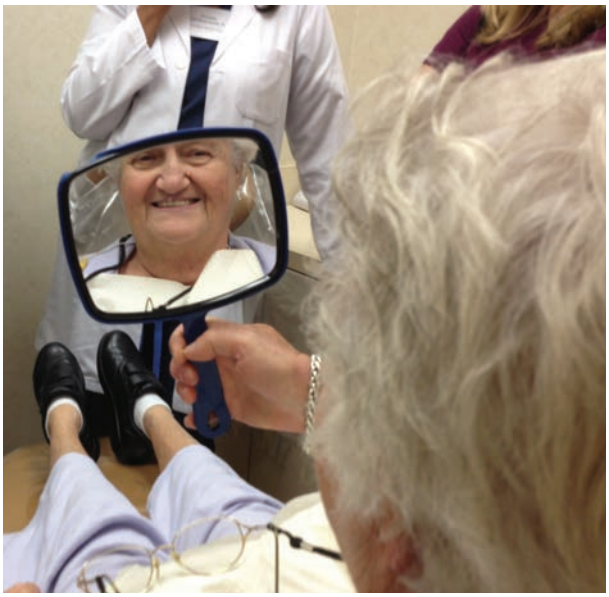
A comprehensive listing of DSN services is maintained by VHCF, (www.vhcf.org), and accessed by Virginians in need every day. Despite the wonderful work happening in Virginia's 76 existing DSN clinics, they are only scratching the surface of the overwhelming need that exists for the many low income Virginians without dental insurance.

How You Can Help

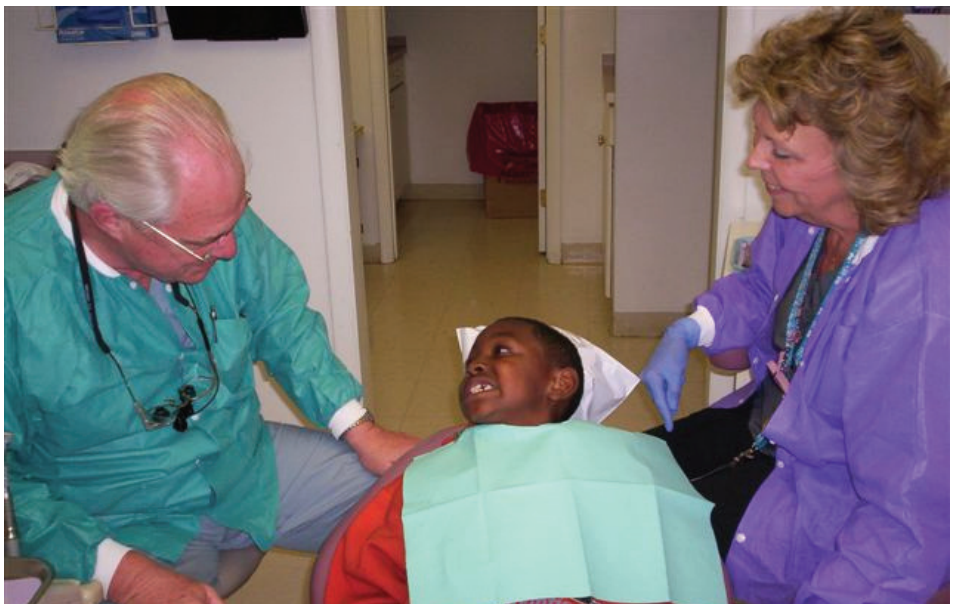
VDA members are integral to the success of the Commonwealth's DSN, and most have found involvement to be very rewarding. Please consider engaging in one of the following ways:

1. Contact your local free clinic to volunteer on-site, or to see DSN patients in your own office.
2. If you don't have a local clinic, why don't you convene some local dentists and start one? Or, contact community leaders and offer support if they are interested in starting one.
3. Volunteer as a preceptor for dental students providing care in DSN clinics.
4. Contribute your time to a MOM project, or help organize one in your community.
5. Consider donating supplies or desirable equipment to a clinic, when you replace items in your office.
6. If you do not have the time to engage personally, consider supporting the DSN financially through the Virginia Health Care Foundation, the Virginia Dental Association Foundation, your local DSN clinic, or all of the above.

Tracey van Marcke is the Dental Opportunities Champion at the Virginia Health Care Foundation. This position has been generously underwritten by Delta Dental of Virginia since 2006.



Safety net dentists are being trained to use Larell OneStep dentures, and the patient is pleased with the results.



VSU Cares Addresses Dental Disparities

Karen Faison, APRN, PhD, CNE, VSU Cares Leadership Team

On June 14-15, 2013, Virginia State University (VSU) once again joined with the Virginia Dental Association Foundation, Southside Dental Society, Old Dominion Dental Society, VCU Health System, and the Lions Club, along with numerous community partners and volunteers to host the 2nd annual VSU Cares mobile dental and health fair, a Missions of Mercy Project.

More than 350 volunteers, including 33 dentists, hygienists, dental assistants, dental and dental hygiene students, other health professionals, and general volunteers came together on Father's Day weekend to provide dental services to 400 patients. Services offered include minor dental surgery, extractions, fillings and cleanings. Services were expanded from last year to include 97 vision and hearing screenings and 50 breast exams. Prescriptions were filled, and referrals were made for assistance with eye glasses, hearing aids and mammograms where needed. The total estimated value of donated care was $334,076.00.

The mobile dental and health fair was held in Daniel Gymnasium on the campus of Virginia State University in Ettrick, Virginia. VSU is a historically black college and university (HBCU) offering degrees ranging from the associate degree to the doctorate degree. The university is located in south Chesterfield County and the Tri-Cities area of Hopewell, Petersburg, and Colonial Heights. This area has a high incidence of uninsured/underinsured residents with health disparities. Dental health is very important to the overall health and wellness of individuals and the community. The university identified a need and the community came together to offer this much needed service on the VSU campus.

On August 28, 2013 the VSU Cares leadership team and representatives from the community partnerships were honored with a resolution from the Chesterfield Board of Supervisors. VSU Cares is looking forward to continued health services and community engagement.

L to R: Sam Galstan, DDS, lead dentist; Honorable Steve Elswick, Matoaca District BOS; Dr. Sheryl Bailey, Deputy County Administrator; Dr. Edgar Wallin, Planning Commissioner for Matoaca, Chesterfield County.

Chesterfield County Board of Supervisors (BOS) acknowledges VSU Cares partners with Resolution on August 28, 2013.

Missions of Mercy
Virginia Dental Association Foundation

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Upcoming MOM Projects

HOMELESS CONNECT November 14, 2013
SUFFOLK MOM March 8, 2014 NEW SITE!
NOVA MOM March 14-15, 2014
SPECIAL OLYMPICS MOM June 7, 2014
WISE MOM July 20, 2014

Volunteers are invited to register online at www.vdaf.org

We wish to thank you for your continued support and look forward to seeing you at an upcoming project.

Looking ahead:

NEW MOM Site for 2014 - Suffolk, VA (March 8, 2014)!
Watch for more information on the VDA Foundation website.
www.vdaf.org

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Donated Dental Services (D.D.S.) Continues to Change Lives!

L-R Dr. Sam Galstan, Susan Mawyer, Dr. C. Sharone Ward taken in our reception area

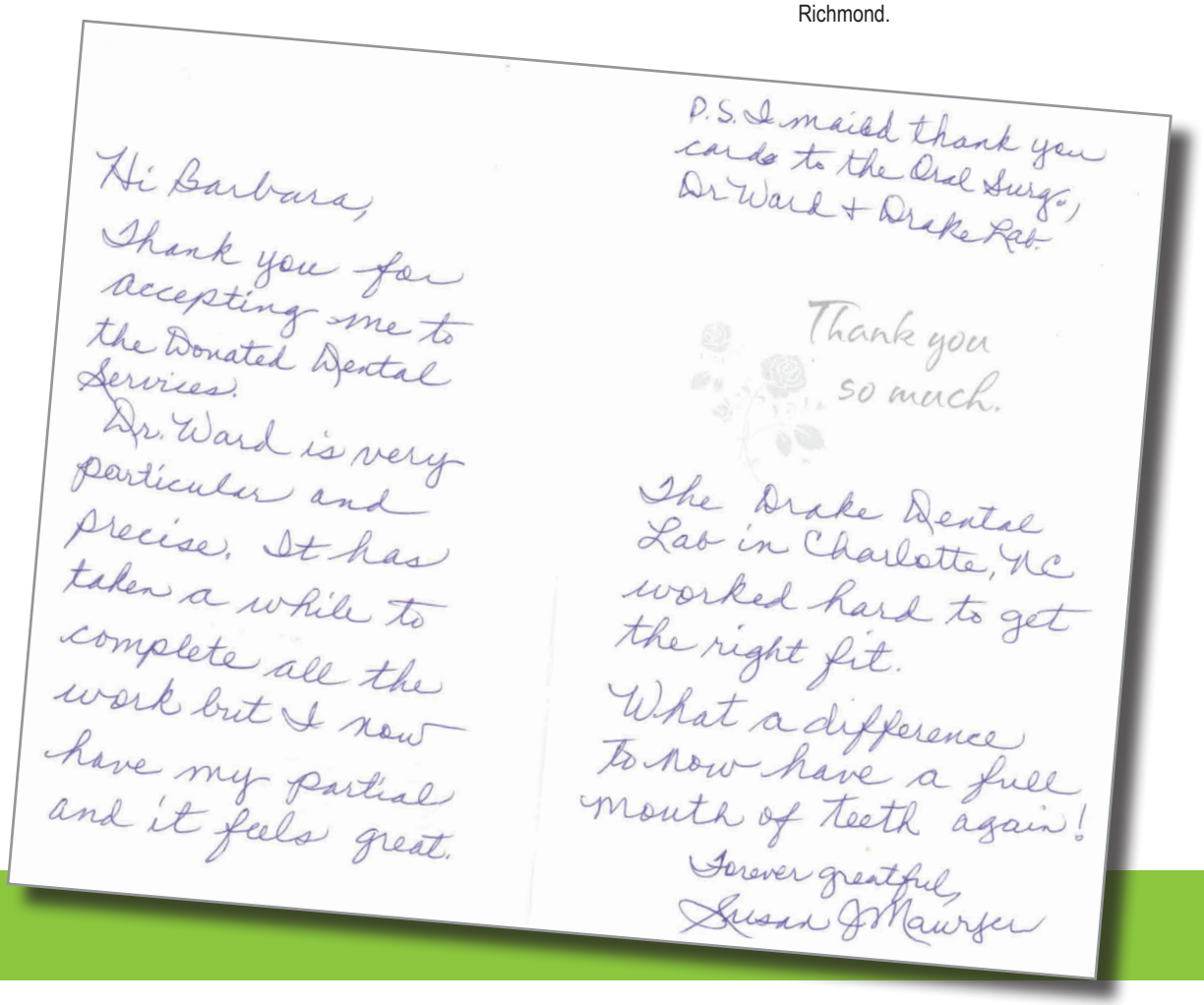
Dr. C. Sharone Ward's Donated Dental patient, Susan Mawyer

Pictured is DDS patient, Susan Mawyer, who Dr. Ward and I finished up today. She received several restorations, a crown on #27 and a lower cast partial denture. Ms. Mawyer is 68 years old. She was a super nice lady and very, very appreciative. A real blessing- she made our day!! (Dr. Ward did all the work, I just consulted!!).

We feel so very fortunate to have you at the VDA and for all the great work that you do for us and for those in need. We also feel blessed to be a part of dentistry which allows us to give back to people. Thank you!

Dr. Sam Galstan
Chester, Virginia

The cast partial denture and crown work were generous donations made by Goodwin Dental Lab, Richmond.


Hi Barbara,
Thank you for accepting me to the Donated Dental Services.
Dr. Ward is very particular and precise. It has taken a while to complete all the work but I now have my partial and it feels great.

P.S. I mailed thank you cards to the Oral Surg., Dr Ward + Drake Lab.

Thank you so much.

The Drake Dental Lab in Charlotte, NC worked hard to get the right fit.
What a difference to now have a full mouth of teeth again!
Forever grateful,
Susan J Mawyer

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Challenges facing Virginia dental ethics today

By: William J. Bennett, DDS, Chairman, Ethics & Judicial Affairs Committee

Professional conduct is a major area of discussion and concern nationally as well as here in Virginia. The subject contains numerous variables for consideration. As members of the American Dental Association we have pledged to uphold the *ADA's Principles of Ethics and Code of Professional Conduct*. It is essential to note what might be viewed as legally acceptable may not be ethical behavior. Proper ethical behavior is on an elevated level of putting patient welfare first.

What is considered ethical behavior by a healthcare professional as a whole has changed over time and locale. However, the basic premises have remained stable: Patient Autonomy, Beneficence, Compassion, Competence, Integrity, Professionalism, Justice, Tolerance, and Veracity. Doing no harm and not misleading a patient for personal reward is the basic foundation.

A shrinking world with different cultures, differing state laws, local norms, the economy, educational costs, treatment advances, social media, practice management companies, promotional companies, the internet, office costs, treatment advances, family responsibilities, dental personnel, state and federal regulations, insurance company influence, corporate practice ownerships and more shape and make ethical decision making increasingly more difficult and complex. It is essential then to have and maintain a solid base of clear information on which to base our decisions. A solid foundation should be the focus of all institutions and agencies that are involved in ethical and legal professional behavior. The ADA Code is considered the foremost reference. Many states use it as the foundation for their dental practice laws. Dental specialty organizations and other ethically based dental groups also utilize the Code in their organizational documents. Due to the vast utilization and information available on the Code, the VDA has been suggesting increased utilization of the ADA Code by the Virginia Board of Dentistry.

The Code and many guidance documents can be found by accessing the ADA website or calling the ADA directly for information. A new ethics line has been established to assist in ethics communication.

Another excellent source on professional behavior is material obtained on the website of the American College of Dentists. Information on Virginia Dental laws can be found on the Board website. Thus, there is available information that can be obtained regarding proper ethical and legal behavior. Knowing the current laws and the ADA Code is a personal obligation that should not be overlooked.

It is hoped that VDA efforts to promote the ideals of the membership and our ethical standards have been noticed. Public opinion of our profession has been decreasing from past high levels of trust. Maintaining that trust is up to each of us and how we act as individuals and a group. Being apathetic or not making a comment to others that are acting unethically is not a solution. Members of the VDA ethics committee are finding that most individuals contacted do not even know what they are doing is unethical. If you are not comfortable talking to a friend or colleague ask your local ethics committee representative for assistance. Our ethics committee efforts are to first educate and not regulate. These efforts are having positive results.
The VDA has been at work with the dental school as well. For the last two years the first-year class has been engaged with faculty and VDA members in a half-day discussion on professional ethics. In the second year the White Coat Ceremony instills professionalism as they begin to treat patients. From comments these efforts are appreciated and making a difference for our collective professional futures. The challenges being faced by these new young dentists after graduation are considerable.

The dental association has also been making attempts to present issues of concern to the Virginia Board of Dentistry. The laws that regulate dental practice should be clear and easily understood by practicing dentists and Board of Dentistry personnel. Presently guidelines are not clear or do not exist. The result is confusion when addressing legal as well as ethical decisions. Effective, clear and timely regulation is being requested of the Board. Dentists do not have to belong to ethical professional organizations but to practice they must have a current state dental license. Few questions should exist as to what is the law and the process for resolving issues.

A VDA petition for rulemaking has been recently filed in an attempt to obtain clarification on the Board's position on the unprofessional activity of fee splitting. It is one of the past areas of concern that have been presented to the Board. It is hoped concerns will be taken more seriously in the future.

Addressing this issue is felt to be of mutual benefit in protection of the public and maintaining patient respect for our profession.

There are ethical challenges that require resolutions. We are all a part of preserving and elevating good professional behavior. The VDA has been making increased efforts. The results are making a positive difference. You can also make a difference.

Words from Another Satisfied NPT Client...

"Beyond Belief!" is the best phrase I can honestly use to sum up my experience with Amanda Christy and National Practice Transitions (NPT) during the sale of my dental practice!! Anyone involved in this practice transition will honestly tell you it was a very unique transition from day one. To sum it up, my 2-1/2 year old practice was only being sold because I got married to an active-duty US Army Soldier who was unexpectedly transferred out of state.

I started out with another, "very reputable" company; however, I never felt that my practice sale was a priority. My assumption was that they were too busy for my practice and me since we were not in the multi-millionaire category. I felt as if we got pushed to the back burner. I located NPT from their newsletters they mail out, and was assigned to my local broker, Amanda Christy. Thank God for what I feel was Divine intervention!!

NPT literally did acrobatics to get this transition completed, without complaint or murmur. We hit some very unheard of obstacles and they stepped up to the plate and hit home runs each and every time!! I am forever grateful for the long days, weeks and months that Amanda sacrificed sleepless nights with numerous text messages and phone calls to make this transaction a success for both the buyer and myself.

They should be awarded the "Broker of the Year" Award. NPT's professionalism and knowledge is priceless. I am beyond blessed to have them as my broker. I pray many, many years of success and may this be the hardest transition they ever have to endure!! Amanda, you are loved and respected! Trust me when I say...Amanda & NPT surpass ALL of the rest!!!!

~Joy N McDaniel (Graves), DMD

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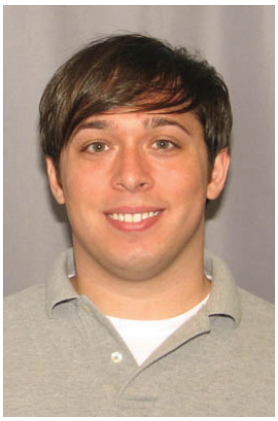
Licensure raises concerns among students

By: Jeremy Jordan, Associate Editor; Class of 2015, VCU School of Dentistry



As a third-year dental student, the reality of beginning a career in dentistry is setting in. Along with that reality comes the realization that the next two years of my dental education will be spent preparing for the licensure process. For most students, licensure is the last hurdle before graduation – months of preparation go into studying for board exams and into selecting the perfect patient for the clinical exam. Students understand that the licensure system is set in place to protect both the dentist and the patient; however, students across the nation are increasingly concerned with the process in which dental licenses are earned. According to the American Dental Education Association, "ethical and practical questions about the use of human subjects, regional variations in examinations and results, and the reliability and validity of the exams have been some of the sources of concern." VCU student Reem Alhussain, D2015, Chair of the American Student Dental Association's Council on Education and Licensure, states, "our concerns are not only that a competent student dentist might have one bad day, but that an incompetent student dentist could have a good day."

"our concerns are not only that a competent student dentist might have one bad day, but that an incompetent student dentist could have a good day."

Students' foremost concerns are the ethics of the clinical exam. In many instances, patients are recruited specifically for the clinical exam and may not be patients of record at the dental school. Although licensure exams can vary by region, and by state, most have some restorative and periodontal components. For patients that satisfy the strict criteria, free dental work and cash are often exchanged to ensure that these patients show up for the day of the clinical exam. While most schools do offer post-operative care for patients as needed, there's an overall lack of continuity of care and patients may not receive the rest of the care needed. Ethical concerns are also raised for patients of record. For these patients, treatment for carious lesions or calculus that meets the requirements may be delayed for up to several months until the board exam. In short, the rights of these patients are not being fully respected.

In addition to the ethical questions raised during the licensure process, students have a number of other concerns. As any dental student will tell you, it's a challenge to make sure patients come to every appointment. Making sure that recruited patients are present for the clinical exam compounds that challenge. If these patients do not show up the day of the exam, students may fail, even after investing thousands of dollars into the process. Currently, there is no universal licensure exam. This means that students must take board exams based on where they plan to practice--this also means that there are no universal requirements for dental licensure. While the ADA's Commission on Dental Accreditation ensures that all dental schools meet certain requirements, the current licensure process does not ensure that all practicing dentists meet the same requirements for licensure. According to ASDA Immediate Past President Colleen Greene, another concern for live patient-based exams is that these exams "[do not] necessarily monitor your actual proficiency in the full scope of dentistry. We know it's not an accurate representation of your general competency." Students must absolutely strive for clinical excellence and consistency. However, even small mistakes during the clinical exam can require them to retake the exam, and find new patients.

As the voice of dental students across the nation, ASDA's policy on licensure (L-1) supports non-patient based clinical licensing examinations, emphasizing the diagnosis, treatment planning, and simulated treatment of disease. ASDA's policy also supports the opportunity of remediation at the dental school, guaranteed anonymity of candidates and examiners, and the acceptance of a universal exam. This policy also states that ASDA believes a clinical licensing exam should not include a written exam that duplicates the content of the NBDE part I or II, and that this clinical exam should be offered to students at the lowest possible price. Alhussain states, "the challenge for the future will be to create an assessment approach that creates less potential risk to patients, if they are used at all, and that reliably measures the competence of the candidates. It must encourage freedom in geographic mobility, elimination of those barriers that restrict access to care, and high reliability [...] in process and content, as well as predictive validity. " ASDA understands that finding a suitable alternative to live patient exams is a huge challenge. Despite the need for continual improvement of all licensing methods, ASDA supports a number of alternatives in lieu of traditional live patient based exams, some of which include: a case-based portfolio type clinical exam; initial licensure upon graduation from a CODA accredited dental school; a non-traditional, ethical live patient based exam; and the completion of a one-year post graduate residency.

Dental students understand the challenges with the creation of a new, non-patient based clinical exam. At the same time, students believe that the current licensure system leaves room for improvement in both ethical and practical aspects. As stated in the ADA Code of Ethics, our primary responsibility as oral health care providers is to do no harm. It's certain that the clinical licensure exam has the interests of students and patients in mind, yet the ethical dilemmas raised are of definite concern. With these ideals in mind, students are joining together, through organizations like ASDA and ADEA, to make known their concerns and to advocate for improving the process. Our hope is that licensure issues are made a priority, and that future examination processes are improved for both patients and candidates.

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Continued from page 23

An Interview with: Dr. Frank Serio

structure. We'll be more like the staffing at Creighton, or Mississippi than some other schools with larger administrations. Also, the salary structure in Bluefield is relatively low, with lower personnel costs. There'll be things we can't control, like fixed costs and utilities. I see us as complementary to VCU, not competitive. VCU is comprehensive, in that it has a number of residency and postgrad programs. We are focused on pre-dental education. There's other areas where we can save: some companies want $150,000 a year to provide malpractice coverage. My sources tell me that we should be able to purchase our malpractice coverage for 20% of that number. I will say that the initial tentative budget underestimated building and operational costs. Until you actually design a building, you don't know how big or expensive it's going to be. We are currently in the design phase of our new building.

Journal: How much travel will be required of your students for didactic and clinical training?

Dr. Serio: There'll be no travel for didactic courses – everything will be taught at The Bluestone Corporate and Technology Park in Tazewell County where the dental school will be built. Senior students will have to drive to the community health center remote sites for their clinical training.

Journal: If the first dental students at Bluefield enroll in 2016, what is your vision for the school in 2021?

Dr. Serio: In order, it would be 1) we will have graduated two classes; 2) at least some of the students will have gone to underserved areas. We may have to give an allowance for the graduates to complete a GPR; 3) we'll begin to elevate the dental IQ of southwest Virginia; 4) we'll know that we are economically sustainable; 5) I still have a job; and 6) we are beginning to make an impact on dental problems and systemic health in southwest Virginia. Our research focus will be on dental public health.

VISION AND STRATEGIC PLAN LEAD THE WAY TO THE FUTURE

By: Dr. David Sarrett, Dean, Virginia Commonwealth University School of Dentistry
James R. Schroeder, DDS, MS, Leadership by Design


Dr. Sarrett


Dr. Schroeder

Leading organizations are distinguished by their resiliency and ability to adapt to their changing environments. Pursuit of our vision will be no different. The external forces of change impacting our profession, higher education, and our university provide a compelling reason to unite around a shared vision. **Declining support for public education, student debt in the U.S. that now exceeds credit card debt, the opening of new dental schools, reduced or elimination of public support for adult dental care, and the increasing complexity of required educational accreditation standards are impacting the dental education system in our country.** U.S. dental schools will undergo significant change whether they want to or not. Financial gaps alone will force change. It is important to remember that when schools face financial gaps, future graduates will be impacted. Our profession needs schools that are engaged with the university community, the professional community, and are performing cutting-edge research. Did we mention educating the future oral health care workforce? That is the primary job of a dental school but it is not the only mission expected by its stakeholders.

The operating budget of the Virginia Commonwealth University (VCU) School of Dentistry has three major funding sources. Student tuition and fee revenue, the vast majority of which comes from DDS students, accounts for 41% of the budget. Patient care revenue provides 38%, and 11% is provided by the state and university. Any worthy CEO would pay close attention to major sources of revenue. More than ever, the concept of making deliberate choices about the utilization of resources for priorities that align with the most important goals is on the minds of politicians, university leaders, and students. Academia has entered the era of increased scrutiny and accountability.

We believe the new vision will put our school and our university on the cutting edge of innovation. This vision calls for national and international recognition as a dental school of excellence. This will require alignment of all stakeholder groups and our resources. We are confident we have the people in place to move us forward. Please share our excitement at what the future holds for the VCU School of Dentistry. It must prioritize for the moment but recognize that priorities must be revisited from time to time and redefined based on changes in the environment. We must travel together on this journey. The new **School of Dentistry Strategic Plan** includes three visions or themes that focus on the future direction of the school. These themes are in alignment with *The Quest for Distinction* set forth by President Rao and the VCU leadership.

The School of Dentistry engaged in a year-long planning process headed by Dr. James R. Schroeder and his associates with *Leadership by Design, LLC* (*www.drjimschroeder.com).* The rigorous planning process of engaging stakeholders, considering the future, and identifying key priorities for the school going forward is outlined by below. The setting of priorities was accomplished by the work of dedicated individuals who served on the broadly representative strategic planning committee. We wish to recognize and thank the committee members for their service.

- Former Delegate Franklin Hall and member of the School of Dentistry Advisory Board
- Dr. Michael Healy, Senior Associate Dean for Student Services and Institutional Effectiveness
- Dr. Michael McMunn, Private practitioner and member of the School of Dentistry Advisory Board
- Dr. Terry Dickinson, Executive Director of the Virginia Dental Association
- Dr. Kirk Norbo, Past President of the Virginia Dental Association
- Ms. Kim Isringhausen, Chair of the Department of Oral Health Promotion & Community Outreach
- Ms. Margaret Poland, Academic Staff Member, Office or Research
- Dr. Todd Kitten, Associate Professor, Department of Oral & Craniofacial Molecular Biology
- Ms. Freda Pickle, Clinical Staff Member, Patient Advocate
- Dr. Thomas Waldrop, Program Director Advanced Dental Education in Periodontics and Member Board of Directors of Dentistry@ VCU
- Ms. Mary Catherine McGinn, Vice President, DDS Class of 2014
- Dr. Peter Antinopoulos, Assistant Professor in the Department of General Dentistry and General Practice Group Leader
- Ms. Meredith Baines, Director of Curriculum Advancement
- Mr. John White, DDS Class of 2015

THE CREATION OF A VISION AND STRATEGIC PLAN

In response to a challenge from President Rao, VCU President, the VCU School of Dentistry was looking to the future when they engaged the services of *Leadership by Design and Associates* in August 2012. The charge was to develop a vision and strategic plan that embraces the future, aligns with the university's direction, and is supported by our many partners. This is a healthy exercise that every dental and medical practice will need to experience as external forces increasingly impact the delivery of health care in general and oral health care in particular.

The process began by seeking the perspectives of various stakeholder groups in our profession, both within the school and the University and throughout the state. Meetings were held with individuals and groups of faculty, administration, research, staff, patients and students along with leadership of the VDA. These stakeholders were asked **"What needs to change in order for the school to be on the cutting edge of meeting emerging needs in oral health care?"** Their feedback suggested that innovation in research, in preparing our students to successfully enter the changing world of our profession, and in serving our community needed to be prominent in any successful future for the school. They also recognized that **the nature and rate of changes affecting our profession and the University will not allow us to succeed with business as usual**.

In addition, a focus group of general dentists with less than ten years of experience in private practice was asked specifically "What needs to change in dental education to better equip the student upon graduation?" It was felt that these professionals would have both a recent experience with their education and recent professional experiences putting that education into practice. They were asked "What are the challenges we face and **where do we need to be in five years?"** Use of emerging technology, more advanced clinical experience and preparation, student debt, school funding and the changing face or teaching and learning are a few of the issues that were raised by these important stakeholders.

All of this valuable stakeholder feedback was provided to the strategic planning committee created to do the heavy lifting of planning and representing

their stakeholder groups. For any strategic plan to be successful, a culture of learning and change must be woven into the fabric of the organization from the leadership to the "boots on the ground". **There is a genuine excitement generated when people are engaged in proactively planning their future towards excellence**. Participation in planning for the future also builds a culture where people are valued for their opinion and expertise. It has been said that people support what they help create and every planning process must reflect this reality in a meaningful way.

After reviewing stakeholder perspectives, the planning committee completed a study of significant current and emerging trends. Only with such knowledge can a group effectively create a desired future state - a vision - that will have meaning for the organization's success going forward. The group also reviewed carefully the direction for the University as a whole established in the recently adopted *Quest for Distinction* (http://www.quest.vcu.edu/).

The entire faculty was engaged in the planning process on two occasions, spending a day in retreat examining and discussing improvements to the clinical practice experience of faculty, students and patients, and later in reviewing and commenting on a draft of the entire plan. Planning committee members helped to facilitate these discussions and faculty input from them was incorporated into the committee's work.

The strategic planning committee met twice each month for nine months, breaking down and synthesizing information, establishing priorities among many competing issues, and creating a direction for the school in three major areas. These three themes and their attendant goals are included in this article and were recently presented to the faculty steering committee for review and critique. Its modification and approval has moved this plan one step closer to implementation and execution. During this entire process, the school's leadership remained engaged to ensure feasibility of the plan and its priorities.

Finally, Peter Drucker states "What gets measured gets done." Metrics are being developed around the various goals to enable the school to monitor the progress of this journey and the plan's effectiveness for achieving the vision it describes. Ownership, clarity and alignment are coming into place as the partners of Virginia Commonwealth University School of Dentistry prepare to bring their collective talents and energy to bear in making the vision and strategic plan a reality!

Theme 1 In an atmosphere of rigor, respect and support, the VCU School of Dentistry is recognized nationally and internationally for graduating excellent dental professionals prepared to collaborate with other health care professionals in a climate of rapid and dramatic changes and possibilities affecting the future of the dental profession.

Goal 1.1 Provide its students an academic and clinical education that reflects the knowledge, skills and values needed for future success.

Goal 1.2 Promote a collaborative, humanistic and ethical culture that benefits faculty, staff, students and patients

Goal 1.3 Recruit and graduate highly qualified and diverse students

Goal 1.4 Recruit, develop and retain faculty who are inspired and qualified to meet the emerging needs of dental education

Goal 1.5 Be financially positioned to be a premier educational institution and employer in an increasingly competitive health care field.

Theme 2 Through collaboration, rigorous investigation and publication, the VCU School of Dentistry is known for its contributions in research and scholarship that advance dental practice and oral health.

Goal 2.1 Offer single and dual degree research-intensive Masters and Doctoral level programs

Goal 2.2 Clearly expect and support research-intensive faculty to conduct and disseminate research that makes significant contributions to the field.

Goal 2.3 Provide appropriate support to all faculty members and students interested in research

Goal 2.4 Continuously explore and identify additional resources to support faculty and students in research pursuits.

Theme 3 Through excellence in patient care and leadership in service and outreach, the VCU School of Dentistry is a premier resource for oral health care in the community, region and state.

Goal 3.1 Be known for the high quality and value of its patient services, including undergraduate, graduate and faculty practices.

Goal 3.2 Identify dentistry-related opportunities for community service by faculty, staff and students and encourage their involvement.

Goal 3.3 Provide leadership in the Commonwealth on changes in the field of dentistry

You are welcome to visit our Strategic Planning website and provide comments at http://vision.dentistry.vcu.edu. You will find resource articles used during the planning process as well as other valuable information there.

With highest regards and appreciation for your support,

Dr. David Sarrett, Dean VCU School of Dentistry
James R. Schroeder, DDS, MS, Leadership by Design

Dr. Jim Schroeder of Leadership by Design, Inc. may be contacted at jim@drjimschroeder.com or 804-307-5108 for information on organizational visioning and bringing it to reality for your organization, partnership, or practice. Learn more at www.drjimschroeder.com

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Dentists	438	431	323	394	365
Students	19	98	117	71	26
Guests	233	137	108	121	222
Dental Staff	471	415	383	491	293
Lab Technicians	4	0	2	3	1
Exhibitors	302	315	305	257	298
Scouts	2	0	0	0	0
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And The Winner Is....

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The Virginia Dental Association is grateful for the support of all of our vendors who go out of their way to make our meeting a success. However, in our contest judged by secret shoppers who circulated the exhibit hall during the entire meeting, Dentsply Caulk stood out! Criteria included vendor engagement, offering of a meeting special, product knowledge, booth set up for duration of meeting, and booth presentation. We salute them for their efforts!

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$2000+ Northern Virginia Dental Society, Patterson Dental

$750–$1000+ William J. Vigilone DDS, 3M ESPE, Gardner & Jones Orthodontics, Virginia Academy of Endodontists

$500 Appolonia Dental Study Club, Associated Printing, Bivins Orthodontics, Capital West Dental Arts, Inc., Creative Dental Ceramics, Dr. Cheryl Billingsley, Drs. Brown, Reynolds, & Snow, Drs. Kaugars and Miller, Endodontic Partners, Fitz Vital Dental Lab, Hancock, Daniel, Johnson, & Nagle, Harris, Hardy, & Johnstone, PC, Heraeus Kulzer, HNGRI Labs, Atkins, Maestrello, Miller & Associates Pediatric Dentistry, McKee/Dominion Study Club, Richardson, DMD - Overstreet, DDS, Ltd., Saunders Dental Lab, Team Placement Service, Virginia Academy of General Dentistry

$300 Goodwin Dental Lab, New England Handpiece Repair, The Guardian Life Insurance Company of America

Golf Tournament ($425—$1500)

Henry Schein Dental, Dr. Jeffrey Kenney, Component 6 (In Memory of Dr. Don Martin), Delta Dental of Virginia, Blue Ridge Endodontics, Carl P Roy, DDS, MS, PLC, Commonwealth Endodontics, Commonwealth Oral and Facial Surgery, Dentistry for Children & Patients with Special Needs (Dr. Randy Adams), Doctors Morris & Taylor, LTD., Dr. Brian Midgette, Dr. Frank Iuorno, Dr. Michael Abbott, Eastern Dentists Insurance Company, Goodwin Dental Lab, Gus C. Vlahos, DDS, Stephanie N. Vlahos, DDS, Hutchison & Gorman, DDS, PLLC, Patrick D. King, DDS, Suntrust Bank, Virginia Dental Lab, WorldPay, Yorktown Periodontics

Donations ($200+)

Colgate, Dr. Anthony Peluso, Dr. Andrew Zimmer, Hilton Virginia Beach Oceanfront, Paddle Palace Tennis Company, Patterson Dental, Phillips/Sonicare, PinCrafters, Premier Dental, Norfolk Waterside Marriott Hotel and Convention Center, The Greenbrier,

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Is All of Your Electronic Patient Information Secure? Use This Basic IT Audit to Find Out.

By: Samuel T. Bernier, Esq.

Have you ever wondered what happens to a computer file after you delete it or drag it to the trash bin? If that file contains patient health information, you should. Deleting a file, placing it in the trash bin, or even emptying the trash bin isn't enough to "scrub" the file from the computer's memory. Rather, these actions merely authorize the computer to overwrite the file if and when it needs more space. If your hard drive is not 100% full at all times a savvy programmer can access these "deleted" files, which the computer has not yet overwritten. One non-profit HIPAA covered entity learned this lesson in a very expensive way—a $1,215,780 penalty for failing to "scrub" the memory of a rented copy machine before returning it, leading to the disclosure of the patient health information of 344,579 individuals.

Generally, the HIPAA Security Rule requires covered entities to (1) ensure the confidentiality of patient health information that they create, receive, maintain, or transmit, (2) protect against reasonably anticipated security threats to such information, (3) protect against reasonably anticipated impermissible uses or disclosures of such information, and (4) ensure compliance with the HIPAA by their workforce. Having a simple IT audit plan in place, and executing that plan regularly, is a helpful way to comply with the HIPAA Security Rule while gaining some useful knowledge about the systems and platforms your practice uses. Here are six steps to developing a basic IT audit plan of your own.

1. Identify every physical drive where electronic health information is stored.

The first step in conducting any audit is knowing where to look. The unfortunate non-profit HIPAA covered entity mentioned above almost certainly had no idea that its rented copier was storing images on a hard drive. To avoid such a mistake, you must identify all of the devices in your office that store data. The obvious culprits are the hard drives in your computers and their backup drives, but you should also check with the manufacturers of other devices (especially rented devices) about whether and how they store information. Does your copier or scanner store images? Fax machine? X-ray machine? How many and for how long?

Once you have identified all of the places where your patients' electronic information is stored, you can move on to the next step—security.

2. Securing electronic patient information that you need.

Some of the patient information that you find on your electronic devices is, of course, meant to be there and needed for the future care and treatment of your patients. Controlling access to this information is simple: passwords. Each person in your office who is authorized to view electronic patient information should have their own discrete log-on and password combination for your electronic data system. This limits access to the people who really need it, and enables your access control software to track which user accessed the system and what actions he or she took. The access control system uses this information to create an "audit trail." Checking your audit trail regularly ensures that users are not accessing records outside of their scope of responsibility. If your bookkeeper is looking at progress notes, for example, you may have a problem. Your practice should have an electronic information policy in place, requiring employees to, at minimum, (a) only log on using their discrete information, (b) never use a terminal on which another user is logged in, and (c) immediately log out the previous user if they find a terminal on which another user is logged in.

Your devices may store some information, however, that should be deleted rather than secured.

3. Permanently deleting electronic patient information you do not need.

To secure devices such as copy machines and scanners that store files, periodically delete the storage. For rented machines this is an important issue in your rental agreement. If the vendor (a business associate) has agreed to erase the hard drive, you must obtain proof that the vendor fully deleted and scrubbed the drive.

If you choose to clear a device yourself there are several ways to remove files from that a slim-to-none chance of information recovery. One option is to purchase "secure erase" software that erases files then mixes them together to form random data. A second option is a program that overwrites the "free" space on the hard drive created after you "delete" a file with random numbers. Finally, for a "scorched earth" approach, you can purchase "secure delete" software that does both. Ask your information technology consultant for a recommendation based upon the hardware that you use.

Now that your audit has identified and secured the electronic information stored at your office, you need to look at any patient health information stored off-site.

4. Identifying off-site "locations" where your patients' health information is stored.

If you use email to consult with other providers about patient care, this section is for you! Do you know where your sent emails are stored? Your deleted emails? If the answer is "on an on-site server or hard drive," then stop reading and skip to section five. The more likely answer, however, is that your emails are stored on off-site servers run by a separate "hosting" entity. If you have "corporate class" email, then you can speak to your information technology liaison to find out where the emails in your "Inbox," "Deleted Items," and "Sent Items" folders are stored, and how to permanently delete them. If you are a smaller provider using

Continued on page 46

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either your own domain name (for example, dentist@mypracticename.com) or a public domain name (for example, dentist@gmail.com), you can check with those hosts regarding storage and deletion. A more elegant solution, however, is securing the files you send.

5. Securing sent files.
Most files, even x-rays, can be converted into a portable document format (.pdf) by either a ".pdf writer" (usually free to download and simple to add to your "print" options) or by choosing the option to save the file as a .pdf. Once the file is in .pdf, you can add password protection. Password protection allows the user to send a secure file to a consulting provider without worrying about where the email itself is stored along the way. So long as the body of the email is free from patient identifying information, or the password to the document, the patient information is secure. These emails typically read something like: "Here is the document we discussed. Call me for the password."

6. Miscellaneous potential electronic security risks.
Patient Portals — If your practice's website has a patient information portal, you can and should control the level of access portal users have. Once the patient has validated access with a username and password, your access control program should audit their movements within the system, as it does with employee users. Limiting the types of documents patients can download through the portal to their own computers is another way to ensure information security.

E-prescribing and Electronic Billing — If your practices uses these tools then they are likely provided by a vendor and come equipped with their own security features. You should be familiar with the security features of these products, and ask your product representative how often the vendor "wipes" its system.

Social Media — Have you heard a lot of information about the dangers of posting patient health information to social media sites? So have we. Enough said.

Cloud Computing — Large practices with many patients may need to store patient information in a "cloud"—a virtual pool of data hosted by a third party. The safety of the patient information depends on the third party hosting the data, so choose wisely. Some concerns to be aware of are: host stability (are they going bankrupt and taking your data with them?), accessibility, and cost. You should be aware of the host's policies regarding completely deleting unused data, as well as their level of access control security.

Implementing a basic IT audit system will allow you to become familiar with your existing platforms and their features. You can execute your IT audit plan regularly to comply with the Security Rule, and provide you with peace of mind about how your patient's electronic health information is stored, who is accessing it, and whether (where necessary) you have completely destroyed it.

Sam Bernier is an associate attorney with Hancock, Daniel, Johnson & Nagle, P.C. in Richmond, Virginia. He may be reached by email at sbernier@hdjn.com or by phone at 804-967-9604.

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MONEY AND POLITICS!

By: Dr. Bruce R. Hutchison, Chair, VADPAC

Money and Politics! A very familiar coupling and often associated with "corruption and foul play." While this may be justified on occasion, it is important to note that it is only justified for a very small handful of unscrupulous players. The truth is, political giving is not only legitimate and lawful, it is essential to any advocacy effort. That is why every business, industry, and profession must participate in political giving- including dentistry. Contributing to members of Congress (on a federal level) or members of our state legislature (on a state basis), especially through a Political Action Committee, is a powerful and effective part of our political process.

Lawmakers, both state and federal, must decide what is in the best interest of the people they represent. But every lawmaker is presented with hundreds and thousands of bills- they cannot possibly be fully experienced in every area covered by those bills. They must rely heavily on the expressed views of their constituents and information provided by experts- such as YOU.

VADPAC gives Virginia dentists the opportunity to be involved in the process and thus be able to influence laws and regulations that relate to our practices and our patients. VADPAC is apolitical- we do not represent a particular party- we represent a profession. We support those who support dentistry. VADPAC allows us to influence who gets elected and then helps open doors for our lobbyists and members to speak with and educate our legislators to do the right thing for our patients and our profession.

The Wall Street Journal, on August 24, 2012, stated that "The ADA is one of the most influential trade lobbies in the country." Legislators hear us!

Our voices are heard, and our efforts have been rewarded in the past. However, as you well know, the direction of health care in America is uncertain. We will face many issues in the coming months and years, we must be ready. We must use and even increase our influence. Who knows better how to care for the dental needs of our patients? YES – dentists. We must speak with ONE VOICE and guide legislators to act correctly.

JOIN VADPAC TODAY! Your dollars, combined with those of other member dentists, will make a difference for you, your patients, and our profession.

VADPAC Fundraisers

Delegate Chris Jones Fundraiser in Suffolk

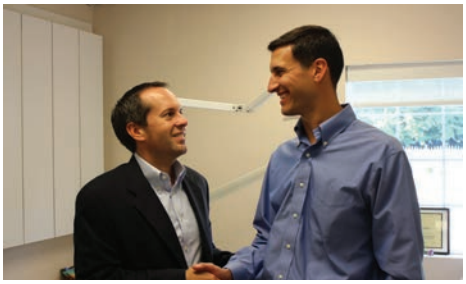
Dr. Gary and Misty Taylor hosted a VDA fundraiser for Delegate Chris Jones at their home in Suffolk on June 13th. Delegate Jones represents the 76th district, which encompasses parts of the cities of Chesapeake and Suffolk. Dentists from his district and surrounding areas attended the event to show their support for Delegate Jones, a strong supporter in the General Assembly of dentistry and the interests of dental patients.

Delegate Lee Ware in Midlothian

On August 21st, Dr. Jim and Gloria Keeton hosted a fundraising reception at their home in Midlothian. Member dentists and guests were happy to attend to support Delegate Ware and thank him, particularly for the hard work he put towards passing the bill in 2010 that prohibited insurance companies for dictating fees for services that they were not covering. His district includes Powhatan county and parts of Chesterfield, Fluvanna and Goochland counties.

VADPAC appreciates VDA member involvement in steering committees to make these fundraising events successful.

Your Support At Work!



Candidate Glenn Davis (left) was presented with a VADPAC contribution from Dr. Anthony Meares

Dr. Clay Hendricks (right) presented a VADPAC contribution to Delegate Chris Stolle

Dr. Lou Korpics and his staff presented a VADPAC contribution to Candidate Buddy Fowler

VADPAC

The Virginia Dental Political Action Committee

See Where Your Component is and What You Need to Do to Meet Your Goal

Component	% of Members Contributing to Date	2013 VADPAC Goal	Amount Contributed to Date	Per Capita Contribution	Amount Needed to Reach Goal
1 (Tidewater)	30%	$45,500	**$31,938**	$262	$13,562
2 (Peninsula)	39%	$26,500	**$24,127**	$268	$2,373
3 (Southside)	48%	$13,000	**$13,266**	$233	$0
4 (Richmond)	40%	$66,000	**$63,601**	$256	$2,399
5 (Piedmont)	33%	$31,000	**$23,057**	$242	$7,943
6 (Southwest VA)	45%	$25,250	**$22,050**	$269	$3,200
7 (Shenandoah Valley)	35%	$30,000	**$23,744**	$273	$6,256
8 (Northern VA)	33%	$135,000	**$116,924**	$280	$18,076
Other Contributions			**$500**		
TOTAL	38%	$372,250	**$319,207**	$257	**$53,043**

Total Contributions: $319,207
Goal: $372,250

WE NEED YOUR CONTRIBUTION TO RAISE $53,043

As we near the end of this year, although the goal for 2013 has not been obtained, we are so appreciative to all who made contributions. **2014 VDA Dues will be arriving in your mailboxes next month and we urge members to submit contributions when sending your dues payment.** Your contributions will again be imperative to securing the livelihood of the practice of dentistry.

Election Day is November 5th so please get out and vote for the statewide candidates and especially those folks who have been supportive of the profession of dentistry in the House of Delegates. If you have questions about voting, you can visit www.sbe.virginia.gov for information.

VDA members throughout the state met with their Delegates and several individuals who are running for office to present them with financial support on behalf of VADPAC. We would like to thank all of those member dentists for their efforts in arranging those important meetings.

Actions in Brief of the Board of Directors

June 21, 2013

The following Bylaw and Policy amendments were approved:

1. **Background:** The VDA Governance Task Force was appointed to examine ways and means to streamline the VDA governance system. It is essential to our ongoing viability as an organization that our governance system be as nimble, flexible, and proactive as possible and that it has the agility to respond quickly to ongoing challenges. Our charge included an evaluation of the committee structure to determine the most effective means of addressing VDA member needs and VDA functions. Analysis of committee structure and function was made keeping in mind the four VDA Priorities:
    1. The VDA will remain the leading authority for Virginia's dental professional for education, information, networking, wellbeing, support, and services.
    2. The VDA will develop a climate which produces innovative, diverse, and creative leaders with passion and vision for the future.
    3. The VDA will be viewed as the trusted and primary service of oral healthcare information and delivery; and be the authority on access to dental care for the profession and all Virginia citizens.
    4. The VDA will encourage recruitment and retention of members.

Input from committee chairs was obtained from a written survey sent to each chair. After reviewing responses from committee chairs and analyzing committee activity, the Governance Task Force recommends making the following adjustments to our committee structure: **Please note** that a recommendation to sunset a committee does not mean that the duties and responsibilities of the committee are not valuable to the VDA. Rather, it is the consensus of the task force that these duties and responsibilities can be done more efficiently and effectively in the manner recommended. In the case of Membership and of Communication and Information Technology, the purposes of these committees is so critical to our organization that they need more resources, agility, and speed than our present committee structure can by description provide. Task forces with specific direction and time frames for action can provide the flexibility and speed needed for these critical areas.

Resolution: Approve the Governance Review Task Force's recommended committee changes and corresponding Bylaw changes.

Standing Committees

1. Communication and Information Technology – sunset committee. Allow staff to continue to oversee this committee's activities on a daily basis. An interim task force for strategic planning/updating with involvement from VDA staff would also be feasible. This task force would provide regular reports to the VDA Board of Directors and to the HOD (no less than once a year).
2. Constitution and Bylaws – The Speaker of the House will serve as chair of the committee, there will be two members at-large and the committee will meet at the call of the chair.
3. Dental Health and Public Information – sunset committee as work falls under the VDAF. Distribution of VDA funds for Dental Fair awards will continue under the VDA with the VDA Talent Fair Scholarship Coordinator continuing to work with the VDA Director of Finance.
4. Dental Practice Regulations – Sunset the standing committee and create a Dental Practice Regulations subcommittee under the Legislative Committee. There is considerable overlap and duplication of effort of these two important committees. There will be much more coordinated and streamlined activities if Dental Practice Regulations is brought into the Legislative Committee housing.
5. Peer Review and Patient Relations – sunset the State level committee but maintain the component level committees where the activities of peer review are handled. Appeals from the local level would be referred to the Ethics and Judicial Affairs Committee.

Councils

1. Council on Finance –Add the responsibility to interview and hire the firm that will conduct the Association audit.
2. Council on Sessions –Local Arrangements Committee will be a subcommittee under this Council.

Special Committees:

1. Institutional Affairs – sunset committee
2. Local Arrangements – make a subcommittee of the Council on Sessions

New Committee:

1. Leadership Development Committee – Serve as a subcommittee to the Board of Directors. Primary function s would be ongoing leadership recognition and training so that interested VDA members would be better trained to serve on various committees, councils, task forces and on the Board.

Changes to the VDA Bylaws Resulting from Governance Review Task Force Recommendations

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P. The President will appoint a subcommittee of the Board each year as a Leadership Development Committee.

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ARTICLE VII

Section 1. Standing Committees: There shall be the following Standing Committees. They shall be formed and perform duties as set forth in these BYLAWS and shall be named and numbered as follows:

~~1. Communication and Information Technology Committee~~
~~2.~~ 1. Constitution and Bylaws Committee
~~3.~~ 2. Dental Benefits Programs Committee
~~4. Dental Health and Public Information Committee~~
~~5. Dental Practice Regulations Committee~~
~~6.~~ 3. Ethics and Judicial Affairs Committee
~~7.~~ 4. Infection Control and Environmental Safety Committee
~~8.~~ 5. Legislative Committee
~~9.~~ 6. Membership Committee
~~10. Mentoring Committee~~
~~11.~~ 7. New Dentist Committee
~~12. Peer Review and Patient Relations Committee~~

Section 2. Standing Councils: There shall be the following Standing Councils answerable to and under the direction of the Board of Directors.

1. Council on Finance
2. Council on Sessions

Section 3. Special Committees:

1. Caring Dentists Committee
2. ~~Institutional Affairs Committee~~
3. ~~Local Arrangements Committee~~

Section 4.

B. Unless otherwise stated each Standing Committee or Council shall elect a chair. Committee Chairs shall not serve more than three successive years. After a break in service, any chair may return. The ~~two~~ exception~~s~~ to the three-year limitation rule ~~are~~ is the Caring Dentists Committee

Chair ~~and the Institutional Affairs Committee Chair.~~

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O. Component societies maintain a Peer Review and Patient Relations Committee, under the auspices of the Virginia Dental Association, to review and mediate complaints arising within the component society area. Patients may appeal the decision of the local Peer Review and Patient Relations Committee to the VDA Ethics and Judicial Affairs Committee.

Section 5.

A. The representative from each component society shall serve no more than two full successive terms, with the exception of the Caring Dentists Committee. ~~and the Institutional Affairs Committee~~.

Section 6. Names and Duties of Standing Committees:

STANDING COMMITTEES

~~1. Communication and Information Technology Committee~~

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~~a. Membership: This Committee shall consist of one representative from each component society, the Editor of the Virginia Dental Journal and one VCU Dental Student. The Executive Director of the Association, who shall act as Business Manager of the Journal, will be an advisory member of the Committee.~~

~~b. Duties: It shall be the duty of this Committee: (1) to enhance the effectiveness of current communication and public awareness; (2) to explore areas of non-dues revenue as it relates to the VDA web site, to explore new technologies and advise the Board of Directors and membership on these advances and issues; (3) to supervise the editing of the publication of a minimum of four issues of the Virginia Dental Journal each year; and (4) to supervise the editorial and advertising policies of the Journal when needed. The Committee shall meet at least two times a year and additional meetings scheduled at the call of the chair.~~

~~2.~~ 1. Constitution and Bylaws Committee

a. Membership: This Committee shall consist of the Immediate Past President, the Speaker of the House, the Parliamentarian, and ~~four (4)~~ two (2) members-at-large of the Association to be appointed by the President. The ~~four (4)~~ two (2) members-at-large shall serve two (2) year staggered terms, not to exceed four (4) consecutive years. The Speaker of the House shall serve as chair.

b. Duties: It shall be the duty of this Committee: (1) to keep The BYLAWS of this Association in a consistent and accurate condition by proposing new and appropriate amendments to the Board of Directors and the House of Delegates when deemed necessary; (2) to review all CONSTITUTION or BYLAWS amendments proposed by the Board of Directors; (3) to review all CONSTITUTION or BYLAWS amendments proposed in reports of Reference Committees of the House of Delegates before action by the House; and (4) to review any CONSTITUTION or BYLAWS change after passage by the House. Review shall be for the purpose of assuring clarity and appropriateness of language, consistency with other parts of the CONSTITUTION and BYLAWS, and correctness of numbering. In such review, the Committee is authorized to make necessary changes in wording or in numbering which will in no way alter the sense of the intent of the amendment as proposed by the Reference Committee and passed by the House. The Committee shall also revise the *House of Delegates Manual of Standing Rules for the Annual Session* as necessary to insure conformity with the CONSTITUTION and BYLAWS. The Committee shall meet ~~at least two times a year and additional meetings scheduled~~ as needed at the call of the chair.

~~3.~~ 2. Dental Benefits Programs Committee

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~~4. Dental Health and Public Information Committee~~

~~a. Membership: This Committee shall consist of one representative from each component society and four members-at-large, appointed to serve for four-year terms on a rotating basis by the President of the Association. A dentist from the Dental Division of the State Department of Health and the Editor of the *Virginia Dental Journal* shall serve as advisory members to this Committee.~~

~~b. Duties: It shall be the duty of this Committee: (1) to establish and assist component societies in promotion of a dental health education program; (2) to disseminate information on dental practice, preventive dentistry and dental public health to the public, press, radio, television and other news media; (3) to interpret the dental profession and its dental health goals to the public; (4) to initiate public information programs, with the approval of the Board of Directors; (5) to cooperate with and assist school boards and interested public service organizations in establishment of preventive dental education programs; (6) to coordinate the annual National Children's Dental Health Month Program; (7) to promote the ethics and professionalism of the dental profession to the public; and (8) to recommend to the Virginia Dental Association, methods of providing dental care for the special needs patient, both now and in the future; (9) to disseminate information regarding oral cancer detection and treatment, promote lay education regarding oral cancer, encourage appropriate research, cooperate with the American Cancer Society and other national state and local programs or cancer prevention and (10) to evaluate hospital dental sections and/or departments within the Commonwealth, promoting the establishment and improvement of dental sections in hospitals, cooperating with the ADA Council on Access, Prevention and Interprofessional Affairs. The Committee shall meet at least two times a year and additional meetings scheduled at the call of the chair.~~

~~5. Dental Practice Regulations~~ Committee

~~a. Membership: This Committee shall consist of one representative from each component society who shall be a general practitioner of dentistry, and one representative from each of the ADA recognized specialties of dentistry. Advisory members may be appointed as necessary.~~

~~b. Duties: It shall be the duty of this Committee: (1) to review the statutory provisions as well as the rules and regulations which govern the practice of dentistry. The Committee shall make recommendations to the Board of Directors, with~~

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~~referral to the appropriate agency or associations, as well as serve as a resource to VDA members. The Committee shall meet at least two times a year and additional meetings scheduled at the call of the chair.~~

~~6.~~ 3. Ethics and Judicial Affairs Committee

~~7.~~ 4. Infection Control and Environmental Safety Committee

~~8.~~ 5. Legislative Committee

a. Membership: This Committee shall consist of one representative from each component society, four members-at-large appointed by the President to serve four-year terms on a rotating basis, and one member of the faculty of the VCU School of Dentistry.

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b. Duties: It shall be the duty of this Committee: (1) to protect the interests of the dental profession and the public in all matters relating to dentistry in the state and federal legislatures; (2) to maintain liaison with

elected officials; (3) to secure new legislation of benefit to the public and the dental profession; and (4) to keep members of the Association informed with pertinent information on all legislative matters. The Committee shall meet at least two times a year and additional meetings scheduled at the call of the chair.

c. A Dental Practice Regulations Subcommittee will be appointed to review the statutory provisions as well as the rules and regulations which govern the practice of dentistry and serve as a resource to VDA members. The Subcommittee will report directly to the Legislative Committee.

~~10. Mentoring Committee~~

~~a. Membership: The Committee shall consist of one (1) member from each VDA component, one (1) voting student member from each class of the VCU School of Dentistry, two (2) faculty members of the VCU School of Dentistry to serve as liaison members, one (1) liaison member from the Membership Committee, one (1) liaison member from the New Dentist Committee, and two (2) at-large members, representing dental specialties not represented by the other serving Committee members.~~

~~b. Duties: It shall be the duty of this Committee: (1) to serve as an introduction to organized dentistry; (2) to share practice experience; (3) to support the continuance of the dental profession by helping our colleagues.~~

~~11.~~ 7. New Dentist Committee

a. Membership: The Committee shall be composed of one member from each component society who shall have received a D.D.S. /D.M.D. degree less than ten years before the time of selection. An additional member shall be a voting student member of the American Student Dental Association at the VCU School of Dentistry who shall be appointed by the President of the Association, in consultation with the Dean of the VCU Dental School. The term of membership shall be two years.

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b. Duties: It shall be the duty of this Committee: (1) to assist in design and implementation of recruitment and retention programs directed to new practitioners; (2) to study and determine the current needs and concerns of new practitioners; (3) to promote and develop policies and programs that respond to new practitioners' needs; and (4) to promote the involvement of new practitioners in organized dentistry. The Committee shall meet at least two times a year and additional meetings scheduled at the call of the chair.

c. A Mentoring Subcommittee will be appointed to plan lunch and learn functions at the dental school focused on practice transitions and to carry out other duties as directed by the New Dentist Committee. The Subcommittee will report directly to the New Dentist Committee.

~~12. Peer Review and Patient Relations Committee~~

~~a. Membership: This Committee shall consist of one practicing dentist representative from each component society who shall be a member of the component society Peer Review and Patient Relations Committee. One non-dentist representative may be appointed by the President of the Virginia Dental Association and approved by the Board of Directors.~~

~~b. Duties: It shall be the duty of this Committee: (1) to maintain liaison with component peer review and patient relations committees; (2) to hear and act on appeals resulting from actions of component society peer review committees; (3) to exchange information concerning effective ways of handling patient grievances and peer review; and (4) to keep the peer review manual current by proposing new and appropriate changes to the Board of Directors. In all original hearings, actions on appeal, and other matters brought to the Committee, the Committee shall conform to the provisions of the peer review manual. The Committee shall meet at least one time a year and additional meetings scheduled at the call of the chair.~~

~~c. General Consideration: Component societies may stablish a peer review committee and a patient relations committee, under the auspices of the Virginia Dental Association, to deal with complaints arising within the component society area, one member of which shall be his component's representative on the Peer Review and Patient Relations Committee of the Virginia Dental Association.~~

Section 7. Names and Duties of Councils:

1. Council on Finance

b. Duties: This Council shall serve in an advisory capacity to the Board of Directors and the Secretary-Treasurer to: (1) evaluate the proposed expenses and revenue resources from the Board of Directors budget report and recommend the dues necessary to fund Association expenses and programs for the following year; (2) maintain up-to-date information on financial data; (3) make recommendations to the

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Board regarding the investment of reserve funds of the Association; (4) promote and to award appropriate funds for the support of dental auxiliary students and (5) finalize the budget for review by the Board of Directors; and (6) interview and hire the firm that will carry out the Association audit.

2. Council on Sessions

a. Membership: This council shall consist of five members, one appointed each year by the President to serve a five year term. The Immediate Past Chair of the Council shall serve the fifth year. The designated Local Arrangements Subcommittee Chair ~~Person~~, shall be appointed by the current President-Elect in consultation with the Council on Sessions *and* shall be an ex-officio member for one *year* prior to becoming the Local Arrangements Chair Person. No member shall serve more than two consecutive terms.

c. The Local Arrangements Committee shall serve as a subcommittee to the Council on Sessions (Local Arrangements Subcommittee) and report directly to the Council. The members of this Subcommittee shall be appointed by the President-Elect to serve as the arrangements committee for the Virginia Meeting occurring during his or her presidency. The chair shall be appointed by the President-Elect and will be an ex-officio member of the Council on Sessions. Each President's Local Arrangements Committee will serve until the end of his or her presidency.

The Local Arrangements Subcommittee shall (1) oversee exhibit operations; (2) organize social events associated with the meeting; (3) arrange transportation and housing for speakers and VIPs attending the meeting; and (4) perform any other duties necessary for the successful performance of the meeting.

Section 8. Names and Duties of Special Committees:

~~2. Institutional Affairs Committee~~

~~a. Membership: This Committee shall consist of one representative~~

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~~named by each State institution, including each mental hospital, the Dental Division of the State Department of Health, The State Department of Corrections and four members-at-large appointed by the president to serve four year terms on a rotating basis. All representatives, whether members of the Virginia Dental Association or not, shall be approved by the President of the Association.~~

~~b. Duties: It shall be the duty of this Committee: (1) to assess the need for dental services in each State custodial institution and Dental Public Health Program Facility and (2) to suggest standards for providing quality dental care at each institution and Dental Public Health Program Facility and~~

~~recommend improvements where indicated. The Committee shall meet at least one time a year with additional meetings scheduled at the call of the chair.~~

~~3. Local Arrangements Committee~~

~~a. Membership: The members of this Committee shall be appointed by the President-Elect to serve as the arrangements committee for the Virginia Meeting occurring during his or her presidency. The chair shall be appointed by the President-Elect and will be an ex-officio member of the Council on Sessions. Each President's Local Arrangements Committee will serve until the end of his or her presidency.~~

~~b. Duties: This Committee shall (1) oversee exhibit operations; (2) organize social events associated with the meeting; (3) arrange transportation and housing for speakers and VIPs attending the meeting and (4) perform any other duties necessary for the successful performance of the meeting.~~

2. **Resolution:** move committees/councils out of the VDA Bylaws (Article VII) and into VDA Policy. This will allow for greater flexibility in modifying ommittees councils as needed for better efficiency and functioning.

The following resolutions were considered and approved:

3. **Resolution:** Approve the 2014 Budget as written.

4. **Resolution:** Approve the 2013 VDA Life Members.

5. **Resolution**: Implement a 12 month installment plan. (Currently the VDA has a 10 month plan.)

The following actions are reported as information only:

6. **Approved** a petition to the Board of Dentistry for rulemaking regarding the practice of fee splitting.

7. **Approved** a resolution to support a petition to allow a dental assistant who holds a valid CDA issued by the Dental Assisting National Board (DANB) and successfully completes the CRFDA certification to take the Dental Assisting II examination without attending dental assisting school.

8. **Approved** a resolution to support the legislative initiative that physician assistants will be introducing to allow them to apply topical fluoride in physicians' offices. The initiative would add them to the current statute which allows nurses to apply topical fluoride.

9. **Approved** a resolution that the VDA's name can be used as a supporting organization by the Virginia Center for Health Innovation on their initial application for a CMS grant to fund a program to look at cutting down on fraud and waste, make a more efficient system and look at different models that would be more effective - issues that have to do with the accountability of care issue of coordinated care through MCO's. Support for the grant does not obligate the VDA in any way.

10. **Approved** a resolution to appoint a task force that will formulate a VDA position and the appropriate steps to take in response to the insurance companies that cover less than 50% for services that were once classified as "non-covered" services.

11. **Approved** a resolution to approve the responsibilities of a Board member as outlined in the document titled "VDA Board of Directors Statement of Beliefs" The document will be given to all candidates for component director to review before they are elected to serve as a director.

12. **Referred to the Membership Task Force** – research the concept of using an Ambassador Program for the recruitment and retention of members.

In Memory of:

Name	Component	City	Date of Death
Dr. Eldridge Anderson	Northern VA Dental Society	Herndon	January 1, 2008
Dr. Richard T. Bruce	Shenandoah Valley Dental Association	Harrisonburg	July 24, 2011
Dr. Clark A. Cheney	Northern VA Dental Society	Clifton	December 24, 2011
Dr. John H. Condiff	Piedmont Dental Society	Burtonsville, MD	January 28, 2008
Dr. Charles L. Halstead	Shenandoah Valley Dental Association	Charlottesville	September 6, 2012
Dr. Jesse H. Hogg, Jr.	Peninsula Dental Society	Hampton	June 19, 2013
Dr. Charles Lott	Richmond Dental Society	Richmond	August 23, 2013
Dr. Barry McNair	Northern VA Dental Society	McLean	March 8, 2013
Dr. James Midkiff	Piedmont Dental Society	Roanoke	May 7, 2013

Welcome New Members

Tidewater Dental Association
Dr. Karishma Adeshara – Hampton- Tufts University School of Dental Medicine - 2011

Dr. Rebecca P. Downs – Virginia Beach – University of Mississippi – 1995

Dr. Dina Edelbi – Fairfax – NOVA Southeastern University – 2013

Dr. Sheryle L. Hamlett – Norfolk – Virginia Commonwealth University – 1983

Dr. Ashley D. Holmes – Virginia Beach – Virginia Commonwealth University – 2009

Dr. Adrian Laxa – Virginia Beach – Virginia Commonwealth University – 2007

Dr. Eva Lopez – Chesapeake – University of Mississippi - 2002

Dr. Kallie L. Moorefield – Virginia Beach – Louisiana State University – 2012

Dr. Krystie Morrissey – Virginia Beach – University of California, San Francisco – 2008

Dr. Eric Niver – Virginia Beach – New York University – 2007

Dr. Corinne Reschenthaler – Virginia Beach – University of Pittsburgh – 2012

Dr. Amr M. Sheta – Norfolk – University of Cairo, Egypt – 1995

Dr. Sonya L. Thomas-Webb – Chesapeake – Howard University – 1986
Dr. Asha T. Wilson – Chesapeake – Virginia Commonwealth University – 2011

Peninsula Dental Society
Dr. Jacob Hartley – Williamsburg – Temple University -2011

Dr. Lina Liu – VCU School of Dentistry - 2011

Dr. Joy L. Phelps –Toano – Harvard School of Dental Medicine – 2006

Dr. Maynard P. Phelps –Toano – Harvard School of Dental Medicine – 2006
Dr. Bryan H. Wendell – Newport News – SUNY at Buffalo – 2011

Southside Dental Society
Dr. Qin Wang – Colonial Heights – Shandong University of Stomatology, China – 1987

Richmond Dental Society
Dr. Tyler E. Ball – Richmond – Virginia Commonwealth University – 2013

Dr. Emily Bowen – Richmond – Virginia Commonwealth University – 2013

Dr. Robert LeNoir – Richmond – Virginia Commonwealth University – 2012

Dr. Patrick D. Lawrence – Richmond – Virginia Commonwealth University – 2012

Dr. Parthasarathy A. Madurantakam – Henrico – Virginia Commonwealth University – 2012

Dr. Jared S. Martin – Chesterfield – University of California Los Angeles – 2008

Dr. Jodie Meredith-Smith – Richmond – Virginia Commonwealth University – 2013

Dr. Erika Mogrovejo – Arlington – Santa Maria Catholic University – 1997

Dr. Kinjal N. Patel – Glen Allen – Boston University – 2013

Dr. Sonali Rathore – Glen Allen – BVP Dental College, Pune, India – 2000

Dr. Ammar Sarraf – Richmond – Virginia Commonwealth University - 2009

Dr. Laura Tolusso – Roanoke – Virginia Commonwealth University – 2012

Dr. Irina Volkova – Richmond – Virginia Commonwealth University – 2010

Dr. Meredith C. Gray – Richmond – Virginia Commonwealth University – 2013

Dr. Jamie Yuan – Richmond – Virginia Commonwealth University – 2013

Piedmont Dental Society
David W. Stafford – Danville – Virginia Commonwealth University – 2013

Dr. Julia M. K. White – Roanoke – Virginia Commonwealth University – 2013

Dr. Samuel E. Woolwine, III – Forest – Virginia Commonwealth University – 2013

Southwest Virginia Dental Society
Dr. Eugenia M. Larrowe - Galax – Virginia Commonwealth University – 2013

Dr. Amanda Meade – Coeburn – Virginia Commonwealth University – 2012

Dr. Jeffrey B. Pettit – Wytheville – Indiana University – 2012

Dr. Anna E. Roberts - Blacksburg – Medical University of South Carolina – 2013

Dr. Francis G. Serio – Greenville, NC – University of Pennsylvania – 1980

Shenandoah Valley Dental Association
Dr. Courtney E. Ashby – Remington – Virginia Commonwealth University – 2012

Dr. Gregory A. Conner – Charlottesville – Ohio State University – 1998

Dr. Curtis G. Dean – Harrisonburg – West Virginia University – 2013

Dr. Talon E. Haynie – Charlottesville – University of the Pacific – 2013

Dr. Quay Parrott – Staunton – University of Maryland – 2002/UNC Chapel Hill 2005

Dr. John Roller – Waynesboro – VCU School of Dentistry - 2010

Dr. Aaron J. Stump – Charlottesville –Indiana University – 2010

Dr. Beulah Warf – Penn Laird – West Virginia University – 2010

Dr. James Willis – Staunton – West Virginia University - 2009

Northern Virginia Dental Society
Dr. Sooyeon C. Ahn – North Bethesda, MD – University of Pennsylvania – 2010

Dr. Ahmad Al Attar – Vienna – Virginia Commonwealth University – 2005

Dr. Irfan H. Asghar – Marlboro, NJ – Baqai Medical University – 2002

Dr. Assal Assadi-Moghadam – Dulles – Tufts University – 2013

Dr. Farima Behnami – Oakton – University of Missouri, Kansas City – 2013

Dr. James A. Bronson – Arlington – Midwestern University – 2012

Dr. Liliana Calkins – Great Falls – Howard University – 2010

Dr. Francisco T. Carlos – Hampton – University of Connecticut – 2007

Dr. Carlos Cruz Chu – Stafford – Cayetano Heredia Peruvian University – 2002

Dr. Judith T. Eugene – Woodbridge – New York University – 2011

Dr. Graham T. Forbes – Arlington – Virginia Commonwealth University – 2011

Dr. Mark P. Gerald – Oakton – Virginia Commonwealth University – 2011

Dr. Farhad Hakim – Herndon – Howard University – 1999

Dr. Sok Woong Daniel Han – Bethesda, MD – University of Pennsylvania – 2007

Dr. Youna Han – Vienna – State University of New York at Buffalo – 2012

Dr. Ariadne V. Hernandez – Richmond – Virginia Commonwealth University – 2013

Dr. Sylvie M. Ho – Annandale – University of Maryland – 2008

Dr. Mehrdad Ijadi – Falls Church – Cenrtro Escolar University, Philipines – 1987

Welcome New Members

Dr. Maria J. Javier – Springfield – Virginia Commonwealth University – 2005

Dr. April Johnson-Toyer – Springfield – University of Maryland – 2007

Dr. Kiumars Karbasi – Fairfax – Academic Centre for Dentistry Amsterdam – 2009

Dr. Shilpa Karri – Falls Church – University of the Pacific – 2013

Dr. Sana A Kazmi – Manassas – New York University -2012; GPR – Nassau University Medical Center -2013

Dr. Richard Koh – Fairfax – University of Michigan – 2007

Dr. Sloan Lanctot – Arlington – The Ohio State University – 2001

Dr. David A. Langer – Washington, DC – Georgia Regents University – 2013

Dr. Kiwon Lee – Somerville – Columbia University – 2010

Dr. Alice C. Ma – Quantico – University of North Carolina – 2011

Dr. Sheila Mazhari – McLean – Nova Southeastern University – 2012

Dr. Noelle Neill – Arlington – Tufts University - 2012

Dr. Quoc V. Nguyen – Fairfax – Virginia Commonwealth University – 2004

Dr. Hune June Park – Fairfax – Tufts University – 1999

Dr. Chirag R. Patel – North Bethesda, MD – University of Texas Houston – 2002

Dr. Carrie C. Philbin – McLean – University of Maryland – 2012

Dr. Wasim N. Qureshi – Ashburn – New York University - 2012

Dr. Sheetal Ray – Arlington – Arizona School of Dental & Oral Health – 2003

Dr. Saman Sepahi – Leesburg – Karolinska Institute – 2008

Dr. Rory Smith – Alexandria – Texas A&M Health Science Center - Baylor College of Dentistry – 2010

Dr. Bruce F. Svechota-Kingsbury – Arlington – University of Michigan – 2012

Dr. Rami Tahhan – Sterling – University of Maryland – 2013

Dr. Jennifer B. Tipograph – Washington, DC – Howard University – 2013

Dr. Amy Ton – Great Falls – University of Maryland Baltimore College of Dental Surgery

Dr. Vinh Tran – Fort Washington, MD – Howard University – 2012

Dr. David D. Tsang – Fairfax – University of Pittsburgh – 2010

Dr. Vivek Vij – New York University – 2013

Dr. Abraham Younoszai – Springfield – NOVA Southeastern University – 2010

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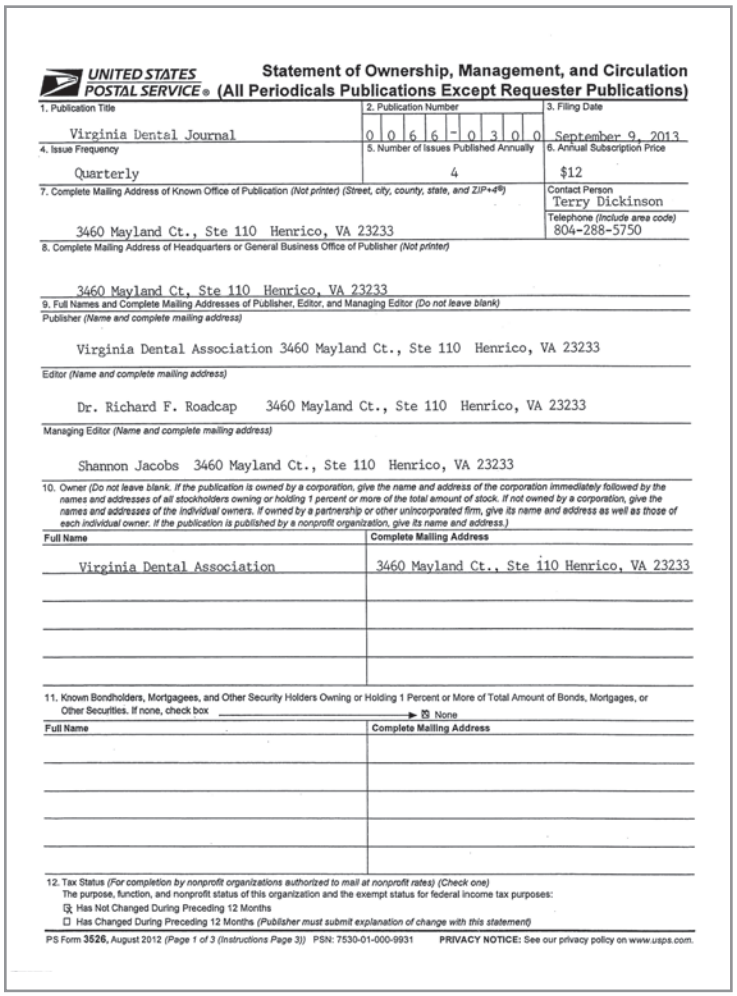

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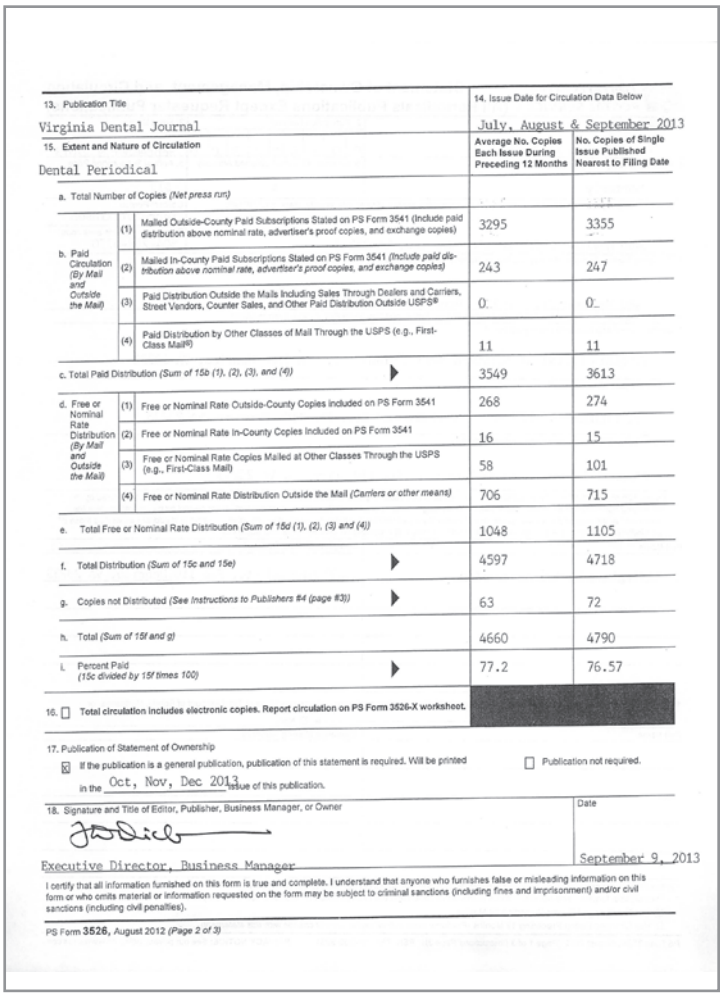

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PS Form 3526, August 2012 (Page 2 of 3)

VDA Member Spotlight: McKinley Price, DDS

Continued from back cover

The faces of dentistry have also changed from predominantly white males to many ethnicities and a large percentage of females. Dr. Price wonders if anyone believes our ADA is reflective of this. If the ADA is to be the legitimate voice of dentistry, we must have a membership that reflects and accurately represents all dentists. Change is a given. We must do our part to direct our organizations to include African-American, foreign-born and female dentists, he says. How might we incorporate the females who work part time? How do we include people of color and those within corporate dentistry?

Most of the new faces of dentistry have been born in the Information Age. Communication has drastically changed with texting becoming the preferred mode. The internet has decreased the need to attend meetings. Nevertheless, the fact remains that our organization gains new members by one-on-one mentoring and establishing relationships. If a minority is a guest or a member, Dr. Price asks you to please consider this reality: That person has stepped out of his or her comfort zone. He suggests that there is likely to be pressure to perform according to inordinately higher expectations than others are subject to. Furthermore, he says, the temptation to judge a whole race or gender based on an individual exists and must be resisted. If we can learn to be inclusive, we will benefit as a profession.

Dr. Price's advice on how to strengthen the ADA is to give young professionals the same opportunities that he was given as a young dentist. He believes that the Peninsula Dental Society is a shining example of developing leadership early. This component invites young professionals to get involved and has produced countless leaders in the VDA and ADA, including an ADA past- president, Dr. Ron Tankersley. A recent study of the VDA leadership pointed out that compared to other professions, dentists go through a more rigorous process to achieve top positions in the VDA. Until this process is streamlined across states and at the national level, the best way to cultivate excellent leaders remains to start the process early. Some may decide to lead by example, like Dr. Price. Others may be needed to lead a charge or to attract peers and delegate responsibilities. Dr. Price believes the old saying: You get out of an organization what you put into it. By giving young dentists the chance to learn the workings of organized dentistry, he says, we will be more adaptable to changing with the times and succeeding as an organization.

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VDA Member Spotlight: McKinley Price, DDS

By: Catherine Oden Fulton, DDS, Associate Editor, Peninsula Dental Society

Dr. McKinley Price is a leader who is involved and committed to excellence. It is in his blood. His great-great grandfather founded the First Church in Newport News, Virginia. Dr. Price says there are three types of leaders – those that say, "Follow me," the kind of person you want to follow into battle, those that know how to delegate and attract the right people for the task and those who lead by example, which he says is his style. He adds that leaders need flexibility, occasionally changing their style to be most effective. In 2010 he was elected to a four-year term as mayor of Newport News

Dr. McKinley Price's involvement with organized dentistry began early in his career. He was a willing and hard-working volunteer who quickly rose through the ranks. When the ADA was in the process of rewriting its vision and mission statements, Dr. Price proudly served on the strategic planning committee. Our ADA vision statement calls on our profession to be the recognized leader on oral health. Our mission statement says the ADA is the professional association of dentists that fosters the success of a diverse membership and advances the oral health of the public. Dr. Price sees a bright future for dentistry. He has witnessed the face of dentistry transition from the solo practitioner to a wide range of practice models, including commercial dentistry.

The rise of commercial dentistry, Dr. Price says, is due in part to two factors: Many graduates perceive their debt as too great for buy-in situations and more dentists who are planning an exit strategy find selling to a financial institution less stressful than negotiating with an individual. For the young graduate, there are more risks and responsibilities involved in being a small business owner compared to being an employee with the security of a steady, dependable income. However, some financial institutions are driven by profit, he says, which can place undue pressure on patients and doctors. Dr. Price believes any practice model that is motivated solely for profit is wrong. This practice model must be studied and governed accordingly. The activation of organized dentistry's ethics committees and the increased activities involving the state dental boards are evidence that this business model must have boundaries for the public's welfare. But what about the individual doctors who work for large corporations? Dr. Price believes that accepting each doctor based on his or her own merits encourages us to learn to coexist and betters our decision making as a professional organization.

Continued on page 56