Virginia Dental Journal

Volume 90, Number 2 • April, May & June 2013

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Old Dominion Dental Society annual conference photo. May 1, 1961 Alexandria, VA. Photo courtesy of Dr. Lori Wilson.

on the cover

VDA
Virginia Dental Association

AADE
Member Publication
American Association of Dental Editors

Virginia Dental Journal

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

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MESSAGE FROM THE EDITOR

Dr. Richard F. Roadcap

The mandarins of personal finance tell us there are two kinds of borrowing: one bad, the other good. The former includes debt assumed to purchase goods and assets of declining value, such as carrying a balance on plastic, or a loan to buy a twenty-three foot center console Grady-White™. Good debt is used to acquire assets that appreciate in value, such as a single-family home, or to pay for education needed for a profession or a career. Both methods of financing may be unavoidable, to meet the demands of life and career, but one builds net worth and the other destroys it.

Almost every discussion of dental education and career opportunities revolves around the subject of burgeoning dental student indebtedness. It colors almost every decision on postgraduate education, practice setting, and career goals. There are two figures to keep in mind: $200,000 and $300,000.
The first is the average debt of in-state students at state-supported dental schools. The second is the debt incurred by out-of-state students. As reported in this publication by then-VCU dental student Richard Carlile[1], a survey of his fellow students in 2010 revealed numbers approaching these, even if we don't adjust for inflation. The problem has been with us for a while, and shows no signs of abating. (Please read in this issue a student's perspective by Associate Editor Jeremy Jordan.)

It may be easy to rationalize these numbers by assuming these debts can be repaid by a lifetime of earnings. The same experts mentioned above will advise young adults to get out of debt as soon as possible and start building savings. Dr. Stuart Broth of Hermitage Wealth Management tells me the (nominal) interest rate on student loans today is seven and a half percent. With real interest rates[2] today hovering near zero, and the return on most investments barely above that, the difference will insure that borrowers will be many years reducing the principal below some popular benchmark, such as the price of a home.

Consider also retiring doctors hoping to sell their practice. A recent graduate with $300,000 in debt is not looking to take on additional debt to acquire a practice. I expect bankers to counter that they have money to lend, and brokers will say practices are being sold every day. To these arguments I will reply that they are correct. But there'll be a shortage of qualified purchasers, and practices will remain for sale a much longer period. Many transition specialists are now advising senior doctors hoping to retire to practice an additional one and a half to two years, and then close the office, as a way of offsetting the lack of qualified buyers.[3] Shuttered dental offices create their own access to care dilemma.

And, what becomes of today's graduating seniors? My generation moonlighted to pay the bills. Dental students today don't have that option. They'll have to seek employment with a salary that will support debt repayment. Starting a new practice, or "building" a practice acquired from a retiring doctor is out of the question. They can't endure a few years of reduced income because of the demands of debt repayment. In the past, franchises, DMSOs, and other non-traditional forms of practice ownership made few inroads into the business of dentistry. The rise of corporate dentistry has been fueled in large measure by a growing labor pool of debt-encumbered graduates in need of a salaried position.

Is there any remedy for a process that produces dental couples who graduate with $600,000 in debt?
It's unlikely that the cost of educating students will decline. Technology and the demand for better-trained and more versatile dentists will continue to raise costs. Already there are fewer applicants to dental schools nationwide, and the cost of an education plays a role in this. Perhaps organized dentistry, dental schools, the banking industry, and government policy mavens could convene a summit to investigate the debt crisis. The testimony of students and recent graduates needs also to be heard.

Once a year I visit the local middle school to encourage seventh and eighth graders to consider dentistry as a career. I've reported previously on my encounters. My sales pitch is bolstered by an early 2000s video[4] of real-life dentists talking about their careers. One theme remains constant in the video: dentists have a lot of options in their life. Teaching, research, private practice, and public service are just some of the career paths available. Meanwhile, they're earning a good income to support a lifestyle the envy of most. I'm frequently asked by the students "How much money do you make?" So far, they've never asked how much money a dental student has to borrow. I hope they don't.

1 Carlile R. The Financial Truths of Dental School. Virginia Dent J 2010; 87(1): 17

2 http://www.investopedia.com/terms/r/realinterestrate.asp#axzz2NdUNl2ju

3 Giroux TG. Hire an associate? Long transition? Partnership? Retire? I'm confused! Dent Econ 2013; 103(2)

4 "Something to Smile About", DVD. Chicago: American Dental Association. 2005. DVD

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EQUAL HOUSING LENDER

MESSAGE FROM THE PRESIDENT

Dr. Kirk Norbo

Branding the VDA

At a recent visit to the General Assembly as part of the VDA "Day on the Hill" group, I was reminded why our association found it necessary to adopt a public relations campaign. The intent of this project is not only to direct the public to seek care from VDA dentists, but also give name recognition to the Virginia Dental Association and its member dentists.

I checked in with a legislator's receptionist and let her know that I was there representing the VDA. She looked at me in puzzlement, having no knowledge of whom I was representing. After I explained that I was with the Virginia Dental Association she asked "So, what does your organization do?" I gave her as much information as I felt would answer the question and waited for my appointment along with the VCU students who were accompanying me. The legislator knew exactly why we were there and knew all about the VDA reputation (the importance of VADPAC and knowing your legislator). The reason I mention this interaction is to reinforce the direction the leadership of the Association has chosen to follow regarding the upcoming public relations campaign. While some know who we are, there are still many who need to know.

All of us are aware of how much time and effort has been put into the MOM projects, the Donated Dental Services Program and Give Kids a Smile®, yet the VDA still has much work to do to achieve the desired name recognition. This statement is not meant to be critical of our efforts to provide care for the underserved in our state but rather to encourage our efforts to earn more respect for the VDA and its members. Some of you may ask, "Why does it matter?"

Apathy and mediocrity are two major obstacles that hinder our quest for excellence. We all desire to be part of an organization that is not only held in high esteem but also has name recognition. The Rubin Communications Group will paint the VDA as an extraordinary group of dentists. My hope is that the public will come to expect a high level of expertise from VDA members. This expertise should include both clinical skills and ethical behavior. To attain the expertise necessary for each of us to be labeled "VDA Member", there must be a constant search to improve professionally. Wouldn't it be great to be part of a group that has a reputation of being exceptional? This wouldn't be a hard goal to achieve if we all had this common vision. Apathy often stands in the way of achieving this goal. Members are continually asking the question, "What is the VDA doing for me?" when the real question should be, "What can I do for the VDA that will help me and my profession?" Look for those opportunities to get involved. Each of you have talents and qualities that could benefit the group and raise us all to that exceptional level.

Even though the topic of ethics seems boring and irrelevant to many of us, it is essential to the core of our existence. Could it be true that those of us with high ethical standards are happier and sleep well at night? If Dr. Oz or Dr. Phil had research that supported this premise, how many of us would change our lifestyles to be more content? While this is only speculation and membership in the VDA is entirely voluntary, how would our image change if the public could be assured that none of our members would be accused of Medicaid indiscretions, insurance fraud, overtreatment or misleading advertising? Our job as members will be to make good decisions that will in turn make our PR campaign successful. Dr. Larry Cook, a dental ethicist, spoke to VCU faculty, students and their families on February 22 and 23. The dental school has incorporated the Mirmelstein lecture series, focused on ethics, into the educational experience of its students. It is imperative that we continue this throughout our professional journey if we intend to gain the respect of our communities.

We are at a crossroads in dentistry, where the decisions we make now may dictate the future success of the VDA as well as our profession. Our culture has adopted the "what's in it for me" mentality. Dentistry must focus on "what's in it for us and our patients", our dental family, if our chosen profession is to continue to survive and flourish. Please join me in making the VDA and our upcoming PR campaign a resounding success. Help the VDA and maximize your professional potential while developing a superior brand for our association.

vdaf
Virginia Dental Association Foundation

VDAF Names Executive Director

The Virginia Dental Association Foundation, after a nationwide search, is pleased to announce that Beth Vann-Turnbull has been hired as Executive Director. She began work April 1, 2013, and will oversee the Foundation's outreach projects, including the Missions of Mercy, Donated Dental Services, and Give Kids A Smile!®. Her responsibilities include fundraising, personnel management, grant proposals, and coordination with the VDA and other nonprofit organizations.

Ms. Vann-Turnbull brings a extensive background in non-profit management. Most recently she served as Executive Director of Decatur Cooperative Ministry, in Decatur, Georgia. Its mission is to alleviate and prevent homelessness in the city of Decatur and DeKalb County, Georgia. She's a graduate of the University of Richmond, and has studied at Harvard Business School and Georgia State University.

She plans to live in the Charlottesville area. Please extend a warm Virginia welcome to Beth at your first opportunity.

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

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

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Trustee's Corner

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

Member Value, Engagement, and Purpose

Other than the financial stability of an organization, nothing is more important to its sustainability than membership retention and growth. Financial stability and membership growth are inseparable and the ADA acknowledges that membership growth will not occur without growing membership value. Your Board of Trustees and Executive Director have made this subject one of our top priorities. This issue has also been a major topic on Dr. Charles Norman's President-Elect's Conference Agenda.

Years ago, when Dr. Greg Chadwick was President of the ADA, he set a 75% membership share as a goal and the House of Delegates gave its approval. We made some progress toward that goal, but never quite reached it. Unfortunately, over the last six years, we have seen a steady decline in our market share. In 2008, our market share was 70%. In the years that have followed, we have seen approximately a 1% decline each year, leaving us with a 66.2% market share at the end of 2012. Obviously, the ADA - the Voice of Dentistry - cannot sustain itself as a viable organization if we allow this trend to continue.

Reversing this trend is a main discussion topic for the BOT and, hopefully, will be a main topic at all levels of the tripartite. Our tripartite system makes this topic a challenge because each component throughout the country faces different dynamics, problems, and challenges such that there is not a one-size-fits-all solution. How do we get members more engaged and excited about membership in the ADA so that they eagerly renew their membership and work to attract new members? Membership value varies among members and between regions. Some members value networking and camaraderie which can lead to volunteerism. Others value continuing education and all that goes along with attending those functions, and others value publications, group insurance or credit card benefits. Many members will tell you that being part of the ADA is all about advocacy and what the ADA can do to protect and maintain this profession as we know it. Still, others join out of a sense of duty and loyalty. The problem with advocacy as a membership value, however, is that while many members appreciate what the ADA accomplishes through its programs, there are many non-members who are perfectly content to ride the back of the ADA and enjoy the benefits without ever joining or supporting that which supports and protects and defines who they are as dental professionals.

Understanding the reality that dentists choose to join for many different reasons necessitates our engagement with both current members who may be lukewarm and non-members content to enjoy their free ride. Past-President Dr. Ron Tankersley once said we must tell our story better because we have an incredible story to tell. In order to tell our story, we must engage in one-on-one conversations throughout our tripartite.

Dr. Norman's story of his first visit as President-Elect to a component society can help us with first steps. He asked their leadership to take him to an office of a non-member so that he could have a one-on-one conversation. The meeting was very cordial. At the end, Dr. Norman asked him why he wasn't a member of the ADA. The answer was a simple one. No one had ever asked him to join.

Taking this story to heart is easy, dealing with ever-changing rules in our fast-paced world is not. We are in competition with many organizations and associations that offer value and some of the same benefits as the ADA. This is our challenge: growing membership one-on-one through engagement because of a conviction of purpose for our profession. At the President-Elects Conference in January, Dr. Norman said, "The platform we stand on allows us to network with others and form collaborations that make our voice stronger than ever." Dr. O'Loughlin told the group, "Now's the time for action for membership growth…. We have to make joining easy for dentists, and we need to be great at innovating value together as components, constituents and ADA. We've got to be in the same boat and row together. By all of us aligning to serve member needs, we can knock this out of the park." Let's not take anything for granted. Let's help grow our association today.

Member Awards & Recognition

Dr. Terry Dickinson
Humanitarian Award

Acedemy of General Dentistry

Dr. Leroy Howell
2013 First Citizen

Suffolk/North Suffolk Rotary Clubs

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

LETTERS TO THE EDITOR

Bluefield College Dental School

February 18, 2013

Letter to the Editor:

Dr. Kirk Norbo, a Northern Virginia dentist and president of the Virginia Dental Association, expressed his concerns in an open letter to the public about his reservations regarding the dental school project being developed by Tazewell County and Bluefield College. We regret Dr. Norbo was unable to attend our information meeting held at the College on January 28 because had he done so he would have heard many of his questions answered. Notwithstanding, we appreciate Dr. Norbo's interest in this project and wish to respond to his comments and concerns in this forum, the one that he chose.

Dr. Norbo stated, "I have a personal experience that makes me either qualified or biased in evaluating the Tazewell project as I was a student at Oral Roberts University School of Dentistry from 1979-1983." The school opened in 1978 and closed after eight years of operation. Dr. Norbo is concerned that the proposed new dental school will have a similar demise.

Whether Dr. Norbo is aware or not, many issues contributed to the closing of Oral Roberts School of Dentistry. That dental school significantly missed its enrollment targets. The school's enrollment target was 50 students in each class, but the first class held only 25 students. The subsequent years apparently were not better, as the school had just graduated approximately 100 students before it closed. Additionally, Oral Roberts University was staggering under tremendous debt. Along with the dental school, the University had opened a law school and a medical school, having constructed a new hospital. The University closed the medical school and hospital as part of a plan to eliminate a $25 million debt. Not only did Oral Roberts close the medical school, the University closed its law school and dental school, too. The Bluefield College School of Dental Medicine will not be encumbered with debt as was the Oral Roberts school. Also, based on the national dental school applicant-per-enrollee ratio of 2.8 to 1.0 (as of 2010-11, reported by the ADEA), Bluefield College's diligence in recruiting should be successful to achieve a positive launch of our dental school.

The first question posed by Dr. Norbo was whether a dental school should be a driver for economic development. He contends, "[W]hen the focus of any dental school revolves around income production, the profession and ultimately patient care is in big trouble." As the planners of this new dental school have said from the beginning, this project – first and foremost – will enhance the oral health of children and families, addressing a longstanding problem in our rural communities. In addition, we acknowledge that this school, like many higher education institutions, will be an economic driver in creating new, high-paying jobs, stimulating new and existing businesses, and serving as a catalyst as the first entity to open in the new Bluestone Business & Technology Center. Finally, the dental school will provide greater access to dental education, especially for those throughout Central Appalachia who even now must leave home to acquire this education and, for various reasons, often do not return. And, perhaps young people in our area who would have never thought about the dental profession will give the profession consideration.

The next question posed was whether student indebtedness arising from borrowing to attend our dental school would drive graduates to suburban areas. Certainly, a dental degree is one of the most expensive graduate degrees a student may choose to pursue, and dental students historically have graduated with considerable debt. The 2010 survey by the American Dental Education Association indicated the average amount of outstanding educational loans reported by graduating dental students for their dental education was $200,111. The average debt upon graduation was lower at public dental schools ($177,040) than at private dental schools ($236,224), mainly because of the tremendous financial state subsidies received by public schools.

The School of Dental Medicine plans to prepare dentists for a primary care dental practice in rural or otherwise underserved communities and will not have a focus on graduating dentists to enter careers in bench research or dental subspecialties. While we expect some graduates will stay and serve in our rural areas scattered throughout Southside and Southwest Virginia, certainly not all graduates will. Graduates who have a heart for the people in our part of Appalachia will either purchase existing practices from retiring dentists, seek employment in any one of several community health centers that have been unsuccessful in recruiting dentists, or open new practices in areas underserved.

Without question, a tremendous need exists. The vast majority of the Commonwealth has 65 licensed dentists per 100,000 residents, but in Southwest Virginia that ratio is only 33 dentists per 100,000 – one-half the statewide norm. In addition to attracting students who have a heart for service, we will be seeking partners to offer scholarships or loan forgiveness, such as Tazewell County's scholarship commitment to graduates who choose to serve in rural communities. Other scholarship programs exist to help dental students, including the National Health Service Corps Scholarship program, a program that pays tuition, fees, other education costs, and a living stipend, in exchange for at least two years of service at an approved facility in a high-need Health Professional Shortage Area.

So even though the debt is significant, and while the school is committed to seeking opportunities to assist students in minimizing debt, the average annual salary of dentists in the U.S. exceeds that of U.S. pediatricians, family practitioners and general internists. We recognize, however, that a dental practice in rural Southside or Southwest Virginia will not place a dentist in the upper earning brackets. But just as hundreds of other health professionals who work in these rural areas repay their education loans, we believe that the dental students in successful practices will find that the career and profession are worth the investment.

Equally as important, if not more so, will be the dental school's third- and fourth-year students, who will work with dental faculty to render oral care in underserved areas and to those who are on Medicaid. Our dental school's clinical experiences that are a part of all dental students' education will not be in a centralized location, as is the case in most dental educational programs. Rather, they will be located in several "built out" clinics located in rural and underserved regions in Southside and Southwest Virginia, and perhaps extending into neighboring Appalachian states and communities. Our dental school is designed to have a public health research focus and rely on a dispersed clinical experience that benefits residents in rural communities, not just once a year but on an ongoing basis.

Another question raised by Dr. Norbo was, "Will a brand new school in a beautiful, but rural area, be able to compete as competition is fierce and getting fiercer?" While, anecdotally speaking, this competition may be the impression,

the data speaks otherwise. The American Dental Education Association notes that, while national dental school enrollment has increased over the past 10-year period 2001-02 to 2010-11, the number of applicants has increased even more. Enrollment at dental schools has risen from 4,407 to 5,170 (a 17 percent increase), but the number of applicants has risen, as well, from 7,412 to 12,001 (a 62 percent increase). Based on DAT scores and GPA, the applicants appear to be qualified and have the credentials to be successful. Thus, the supply and demand is quite evident and demonstrates room for a new dental program such as the one being developed. With more dentists projected to retire and leave the profession than those entering it in the next 10 years (ADEA), our dental school will be meeting a great national need in preparing the next generation of dental professionals. And further, more people desire to preserve their dentition, finding extractions and dentures a less appealing option than in the past. Therefore, the demand for routine dental services is anticipated to grow.

Dr. Norbo further asked, "How financially sustainable is the model over the mid-long term?" He bases his skepticism about the financial plan of the new dental school (one which he has not yet seen) on a study he refers to as the UVA-Wise study. In fact, there are two studies that have been conducted in recent years. One study was by UVA-Wise to investigate developing a dental school, and the other was a study by VCU investigating the creation of a dental clinic in Wise County. Dr. Norbo refers to the clinic and asks why it wasn't developed when offered "free money" by the Commonwealth. The VCU study projected start-up costs of $2,643,400, which included construction of the facilities and the installation of dental equipment and office furniture. The study further projected ongoing annual operational costs of $1,041,650, but deemed the clinic would generate revenue of only approximately $150,000 per year. Thus, the study projected that, in order to break even, the clinic would require a minimal subsidy from the state or private funding of $900,000 annually.

The model proposed in the UVA-Wise study is not our model. The County is not building a traditional dental school similar to VCU, as the UVA-Wise study proposed and almost every existing dental school across the country provides. Unlike those models, our plan calls for the use of existing dental resources in the regions served instead of trying to replicate resources that already exist. Our financial model is sustainable and one that has been employed by at least two other successful dental schools in the U.S., as well as having been reviewed by dental experts, including the College's consultant, Dr. Karen P. West, dean of the UNLV School of Dental Medicine.

While touching somewhat on previous questions, Dr. Norbo's final question was, "What in the University of Virginia study should be considered?" He then enumerated aspects of concern raised in the UVA-Wise study, specifically:

1. "Demand for dental services is low due to lack of funds to pay providers." We agree with Dr. Norbo, and we invite him and members of the Virginia Dental Association to advocate along with us on this public health issue. Virginia's investment in dental services for those of lower economic means is one of the lowest in the country. That's why third graders in Southwest Virginia are 107 percent more likely to have untreated cavities than is typical for third graders at the statewide level. Let's work to change policies so that we can improve access to dental care for young and vulnerable other populations.

2. "The recently implemented dental hygiene protocol is working well." While that dental hygiene protocol is working well to the extent that hygiene services have been expanded in Southwest Virginia, the data details that a significant number of children in our region still lack access to dentists and professional preventive and treatment care.

3. "Graduates settle down where they can make a living." Again, we don't disagree. But, does everyone in Southwest Virginia need to move to Northern Virginia or other areas where one can "make a living?" Dr. Norbo now actually is suggesting why a dental school is needed here from an economic development perspective. Secondly, prospective dental students who are solely focused on how much money they will make need not apply at our new dental school. We seek students who see beyond themselves to a world which needs their service.

4. "Recruitment of faculty would be a major challenge." Yes, and that is why we will pay competitive salaries. This same argument was made as the Appalachian School of Law and Appalachian College of Pharmacy were being envisioned. Faculty who desire to live in large areas with low crime, great outdoor activity options and low cost of living have been successfully recruited and retained by both of these successful institutions of higher education. Secondly, similar to the previous statement, prospective faculty who are solely focused on the money need not apply. Faculty who do come teach at this school will feel, in part, called to serve and live out the mission of the school.

5. "Southwest, VA is an attractive place for all kinds of businesses but is a dental school on of those?" Yes. We invite Dr. Norbo to come visit and see why. In fact, a letter was sent last week to Dr. Norbo inviting him to visit the site of our future facility and review our plan.

We are excited that our dental school will address a significant need not only in Southwest and Southside Virginia, but in other similarly situated underserved communities. We are confident that the business plan is sound for the model developed. And, we are committed to seeing this new school become a reality. We are deeply appreciative of Dr. Norbo's closing statement – "I know the Virginia Dental Association and the dedicated, loyal dental practitioners stand ready to help and provide any help necessary to make the best decision possible" – and we look forward to partnering with him and members of the VDA in launching this new dental school.

Sincerely

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David W. Olive
President
Bluefield College
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Passing Up the Chance to Prevent Oral Cancer

What in the world is the matter with some parents? What in the world is the matter with some physicians and dentists? There is a vaccine out there (Gardasil) that will prevent 70% of the oropharyngeal, anal, penile, and cervical cancers stemming from the Human Papilloma Virus, (plus it prevents genital warts). But, only 23% of girls in this country, ages 11 to 17, have been given the vaccine. In Australia the vaccination rate for girls is 70%.

And what about boys? About 8000 boys and men develop cancers caused by HPV each year, and 6000 of them are oropharyngeal cancers. And yet, only 1% of boys have received vaccinations.

There is a terrible disconnect here. Are Australian parents smarter than those in the USA? Are Australian physicians and dentists more concerned about their patients than their counterparts here? Are American doctors afraid to say the word "sex"? Have some ignorant American politicians so scared the population that thousands of people will be getting cancer that could have been saved from this dreaded disease? What have YOU done to counter this ignorance? Yes, ***DOCTOR***, oral cancer is in your domain.

Doing an oral cancer screening is an important service, but an even greater service is telling parents how to prevent those cancers from occurring in their children in the first place.

Henry Botuck, DDS
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LETTERS TO THE EDITOR

Starting and Building a Dental Specialty Practice

If you have just completed formal training in a dental specialty and have decided on the community you wish to live and practice in, there are approaches that lead to a successful practice.

- **The location**: find an office that is convenient for general dentists as well as dental specialists to refer patients to you. (If possible, be the only dental specialist in your specialty.) The office should be easily accessible to the community by car or civic transporation.

- **Announcements:** theses should clearly state your specialty, phone number, address and especially free and available space for car parking. If an article in the local newspaper can be accomplished, designate your education and exactly the nature of your professional services.

- **Visits:** visit as many general dentists as possible and invite them to lunch. I would also visit with the other dental specialists and invite them as well to lunch with you.

- **Professional Society:** become an active member of the local dental society as well as the state dental association. If the local dental society publishes a newsletter, ask if your name and dental specialty might be in it. Once a member, attend as many dental programs that are available. If there is a guest speaker, do not hesitate to ask any questions and gently make a short comment how the subject relates to your specialty. Thank the guest speaker for his or her contributions to dentistry. As you become active you may be asked to become an officer in the dental society or even give a small lecture on your specialty. This is good exposure!

- **New patients:** when you have a new patient referred by another dentist, call his office and thank him for the referral and explain what you feel is the correct diagnosis and your proposed treatment. After the patient has obtained the results you desire, I would suggest this kind of letter to the referring dentist: "Your patient, Mr./Ms. --- has been treated successfully and I am referring your patient back to your office for your continued excellent care." I would use the same approach when there is a physician referral.

- **Other affiliations:** it is nice to become a member with your family of a religious (church, temple, mosque) organization. This gives you even additional exposure to fellow congregants. Affiliating with a civic organization that engages in charitable deeds also has many advantages. The members of these organizations will question what kind of doctor are you. This means more exposure to the community. As a warning, be aware of any organization that discriminates against other religions, races, gender, or national origin. Stay far away!!

- **Other professional personnel:** if possible join the local medical society. If accepted as an associate member, that's fine. Go to the medical society meetings as often as possible. Family physicians are a good source of referral if they understand your specialty. Almost all hospitals will accept dentists to their staff. Go to the meeting of the Medical Department (not the Surgical Department) and you will be surprised how many physicians will refer patients to your office. Most important, many of the physicians have their lunch in the hospital dining room. Sit with them after introducing yourself and if the opportunity arises explain your training and specialty and how it relates to the general health of the patient. Do not get involved when they engage in medical debates or medical issues.

- **Family participation:** if your spouse cares to be social, this can be a definite advantage to you. He or she can join either a dental (or even medical) auxiliary and be a subtle advocate for you.

- **Your discovery:** if you should find a different technique or a "short cut" for dentistry, publish it in a local newsletter or state dental journal. Make reprints and send them to your referring doctors.

- **Office staff:** this is vital. The individual who answers the phone can make or break a practice. This person must have a pleasant voice, he or she must be intelligent and understand what encompasses your practice. She or he must reveal concern for the patient's anxiety and professional needs, and make the appointment that compatible for you and the patient. Everyone on your staff should treat patients with intelligence, kindness and compassion.

I could go on but now you have an overwhelming practice and are seeking an associate!! Good luck!

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

Formerly: Clinical Professor of Oral and Maxillofacial Surgery, VCU School of Dentistry: Adjunct Professor of Medical Physiology, The American University, Washington, DC

Correction:

Virginia Dental Journal
Volume 90 Number 1
January-March 2013

Page: 9

Title: An Unusual Complication From Oral Surgery...

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

Paragraph two should read as follows: He was chairman of Oral Surgery at ~~Howard~~ **Harvard** Dental School;...

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ODDS held its 1917 annual meeting in Buchroe Beach (Hampton), Virginia. Photo courtesy of Dr. Lori Wilson.

Old Dominion Dental Society Celebrates 100 Years

Dr. Randy Adams, a local Pediatric Dentist in Richmond, assumed the role as President of the Old Dominion Dental Society (ODDS) in December 2012. The past President is Dr. Jim Watkins of Hampton. Dr. Adams begins his presidency as the ODDS is preparing to celebrate its 100-year anniversary. Plans are to honor the early ODDS pioneers by focusing on a continuous model to raise the quality of the dental profession. Dr. Adams states that one of his goals as president is to work with dental organizations, especially the National Dental Association (NDA) and the Virginia Dental Association (VDA) through these current and challenging economic times. Another one of his goals is to increase the ODDS membership and to make membership more relevant to young members.

Dr. Adams also supports mentoring to others and inspiring a sense of service to pull interested people into this great profession of dentistry.

The Centennial Celebration of The Old Dominion Dental Society was held in Newport News, Virginia, April 13th – 14th, 2013. This meeting celebrated a century of rich history, continued learning and fellowship. The conference met at the Newport News Marriott at City Center, 740 Town Center Drive, in Newport News.

An all-day seminar on esthetic restorations was taught by Dr. Ron Jackson of Jackson Professional Services, Ltd. He is the Director of the Advanced Adhesive Aesthetic Dentistry and Composite Artistry Programs at the Las Vegas Institute for Advanced Dental Studies. This is a recognized post-graduate learning center, where the latest techniques in dental science and technology are taught.

In the evening, a formal banquet celebrated the 100-year milestone. Also recognized were members who have made significant contributions to The Old Dominion Dental Society and to the dental profession. The special guest banquet speaker was Dr. Raymond Gist, the first African-American president of the American Dental Association.

Please logon to www.OldDominionDentalSociety.org for more information.

Missions of Mercy
Virginia Dental Association Foundation

Looking ahead:

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

Join the MOM Team!

Upcoming MOM Projects

NORTHERN VIRGINIA MOM March 15-16
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SPECIAL OLYMPICS MOM - Richmond June 8
VSU CARES PETERSBURG MOM June 15
WISE MOM July 19-21
ROANOKE MOM September 13-14
GRUNDY MOM October 5-6
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* Delta Dental Plans Association, May 2012

Civil rights participants remember Danville's Night of Infamy

By: Katherine Calos, *Richmond Times-Dispatch*

Reprinted with permission from the Richmond Times-Dispatch

Dr. Randy Adams

Randy Adams remembers the Danville jail as metal and concrete, nothing as soft as a mattress in the summer that turned the tide on civil rights 50 years ago.

As a 17-year-old, he was among an estimated 600 people charged with 1,200 offenses during the Danville Movement, the only time that national attention found Virginia authorities using the brutal tactics of the Deep South.

On the night of June 10, 1963, Danville police corralled 50 demonstrators in a blind alley beside City Hall and attacked with nightsticks and fire hoses. Forty-seven people went to the hospital for treatment.

That was the year that:

- authorities in Birmingham, Ala., used police dogs and fire hoses against nonviolent black protesters in May;
- civil rights activist Medgar Evers was killed in Mississippi in June;
- the Rev. Martin Luther King Jr. gave his "I Have a Dream" speech at the March on Washington in August, with support from hundreds from Richmond and even Danville;
- four black girls were killed in a Sunday morning church bombing in Birmingham in September; and
- President John F. Kennedy's proposed civil rights legislation was strengthened in response to the summer's violence and reported out of committee two days before his assassination in November. It became the Civil Rights Act of 1964.

"There was so much violence, and so much of the violence was directed against young children," said Lauranett Lee, curator of African-American history at the Virginia Historical Society. "And so much was seen on television. It woke America up to what was happening.

"Much like our recent Newtown experience, when children are involved it really brings things home," she said, referring to the recent school massacre in Connecticut. "It really makes you stop and think, 'What are we doing?'"

Raymond Hylton, a history professor at Virginia Union University, said the brutality and senselessness of events "may well have turned Kennedy from being on the sidelines and not wanting to take huge steps to avoid offending Southern Democrats to submitting the civil rights bill."

In Danville that summer, Adams -- now a pediatric dentist in Richmond -- joined a family effort. His uncle, Julius Adams, helped create the Danville unit of the Southern Christian Leadership Conference to take a more active approach to desegregation.

"I just remember walking down the street," Adams said. "We sat down in a group. They called the police cars or trucks and put us in and took us to jail. I also remember it was nonviolent. Our principle at the time was we were not to respond back to anything anybody did to us. If they hit you or did anything else, you were supposed to turn the other cheek. It took a lot of willpower and self-control."

Adams wasn't there the day that marchers were beaten with nightsticks and blasted with fire hoses, but he heard about it.

Ruth Harvey Charity, a Danville lawyer, recalled what happened in a 1982 interview for *Southern Exposure* magazine, in which she estimated that 600 people were charged with offenses over the course of the protest. The Library of Virginia has case files of more than 250 people in its Danville civil rights collection. Nationally known lawyers -- including Arthur Kinoy, William Kunstler and Len Holt -- joined the local group to push for federal court rulings on constitutional rights.

On June 10, following up on a May 31 march, a student group went to City Hall. Leaders were arrested and police turned fire hoses on members of the group, who ran frantically for protection, Kinoy said in the article.

That night, Charity said, "Reverend (H.G.) McGhee led a group down to the jail 'to pray for our brothers and sisters.' As he stood up, the order was given to 'let them have it.' And the 'Night of Infamy' happened.

"You see, there was an alley between the jail and the Municipal Building. ... The state troopers had been called in, and they lined up to block the alley so there was no exit. The firetrucks and hoses were pulled up to the entrance, thus trapping the persons who were there for the prayer service.

"When the order was given, city police, (including) deputized garbage collectors ...moved in against the demonstrators, beating them and turning on the hoses, washing the people down the street, like so much trash. Gloria Campbell (wife of the influential Rev. Lawrence G. Campbell) received such a high-intensity stream of water, it tore her dress off, and I'm sure she still suffers from the injuries sustained that night."

Adams said he couldn't understand why the group had been treated in such a violent fashion when the demands were simple justice -- desegregation of public facilities, equal job opportunities, and appointment of black representatives to city boards and commissions.

"At first I felt very bad because I did not understand why we as a group (were) treated that way," he said. "It didn't seem to me that it was as big a deal as they were making about the things we wanted. It seemed to me it should have been something everybody could have agreed on."

In jail, the demonstrators sang freedom songs and prayed with the black

Continued from page 17

ministers who were among the leaders, he said. "I remember us singing and hearing other people singing as well. I think it was just the point of us being together and doing something to pass the time and, especially the younger people, to make them feel comfortable and to know they were not alone."

Hylton said 15 students from Virginia Union went to Danville on July 28, continuing a civil rights activism that in Richmond had been successful and peaceful. Holt wrote in his 1965 book about the Danville Movement, "An Act of Conscience," that VUU professor Ben-Zion Wardy brought along drug-laced hamburger as a weapon against police dogs.

King, president of the Southern Christian Leadership Conference, came to Danville on July 11 to show his support.

"I have seen some brutal things on the part of policemen all across the South in our struggle, but very seldom, if ever, have I heard of a police force being as brutal and vicious as the police force here in Danville," King said in a portion of the speech recorded by a Roanoke television station and archived at the University of Virginia.

"I'm sure we will all agree that we stand today on the threshold of a most significant breakthrough in civil rights. ... You have inspired all of us through your courageous efforts, your willingness to suffer, and your willingness to stand up for a cause which you know, and which we all know, is a righteous cause, and one that will ultimately triumph."

Injustice in Danville, he said, "is a threat to justice everywhere. And as long as this community has problems, as long as the Negro is not free in Danville, Virginia, the Negro is not free anywhere in the United States of America."

Looking at progress in the 50 years since that summer, Hylton used the analogy of a 100-mile journey. "We've gotten a little beyond the 50-mile point, but we have a ways to go," he said. "There's tremendous improvement, but we can't be complacent. There is still much to be done."

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Large Office, Small Footprint

Roanoke practice is one-of-a-kind in US, world

By: Dr. William Moore, Associate Editor, Component 5

Roanoke dentists Drs. Randy Dickey, John Singleton, and Sean Lynch have recently opened a new dental practice, which may just be the greenest in the valley. The new facility was designed and built with the Passivhaus design standards for energy efficiency. It is the only dental practice in the world to meet the stringent standard and one of only a handful of buildings in Virginia to attain the certification. The new 5,500 square foot building took three years to complete. It boasts 14 operatories, 27 parking spaces, sterilization facilities, a lab, and offices for each of the doctors.

"We opened in January," said Dr Dickey. "It has been a lot of fun to finally be in our new building. We're all really excited."

The Passivhaus (or "passive house") concept originated in Germany in the late 1980s. The concept is a series of guiding principles and standards that lead a building to be ultra-efficient. Concepts such as "superinsulation" lead the building to be very thermally efficient and thus require minimal heating and cooling as compared with a conventional building. The buildings are designed and landscaped to maximize heat gain in the winter and deflect heat in the summer. This is done by carefully positioning windows to maximize afternoon sun exposure; the windows are constructed in a way as to promote net heat gain, even in the winter months. Landscaping is also used to dampen the amount of sun reaching the building in the winter. There is a focus on making the structure as air-tight as possible, as this leads to less demand for heating and cooling.

"When they built the building, they taped the frame from the inside and outside," noted Dr. Dickey. "They then used vacuum pressure to check that everything was sealed."

The dentists purchased a property down the street from their existing practice and built the new building from the ground up. Adam Cohen with Structures Design/Build, a Roanoke-based architecture and construction firm, oversaw the project. Mr. Cohen has a 25-year Green Building history and boasts Green Builder and Leadership in Energy and Environmental Design (LEED) certifications. By completing the Passive House Institute US training, Mr. Cohen became one of less than 100 United States designers to meet the certification.

While the practice is up and running at full speed, there is still a lot of unpacking to be done and the office is still sparsely decorated. Dr. Singleton is planning on using his love of photography to furnish the office with some of his best pieces. The energy savings from the Passivhaus design are expected to pay for themselves within ten years due to reduced energy costs.

Ethics: Doing What's Right, While Doing Good

By: John "Jay" Owen, IV, VCU School of Dentistry, Class of 2014

Tooth #30 (MO) has been prepped to receive a composite restoration, checked off and deemed restorable. Composite is layered into the mesial box at the perfect angle and cured to allow optimal integration between the tooth and the bonding agent, as well as to ensure perfect depth of cure and minimize leakage associated with the restoration. The pulpal floor on the occlusal aspect is filled, the marginal ridge given ideal anatomy, and care is taken to place a distinct central groove and accessory anatomy allowing perfect food deflection during mastication. After curing, the restoration is polished and sent for grading.

Next on the list - #10ML. An ideal preparation was completed with retentive features and an esthetic bevel placed so the composite will blend right in. My loupes were removed to rest my eyes and admire my work, only instead of relief, panic set in. Sitting, looking me dead in the eyes, was a test tooth – I had completed my work on my personal dentoform tooth and not the required and specially marked test tooth. My immediate thought was, "…this is ridiculous…," then, accompanied by tachycardia, came the rush of self-preservation thoughts: "I can just re-prep the test tooth and no one will know." Instead, I decided to confront the professor, admit my mistake, and take the failing grade on my mock boards. Failing was not only going to mean loss of a passing grade, but also several clinic sessions to make up the failed work. In the end, I made the correct decision: I was able to accept my mistake, free my mind of burden, and I even learned something during the process.

What would you do in this case? Have you ever prepped or extracted the wrong tooth? Damaged an adjacent tooth? Seated a crown without optimal margins because the cement will "close the space"? Started a treatment without a proper or complete diagnosis? When these ethical situations arise, it is hard to make the correct decision and tell the patient what we have done because, "…they will never really know." As dentists, or in my case, dental student, we work in a profession that has been established based on trust. Patients do not understand the complexity of the dental procedures and cannot see the results, but rely on us to do the correct thing – both ethically and professionally. It is important that we, as a profession, continue to operate in an ethical fashion and build the relationship of trust with long time and new patients. We need to remember that rapport based in trust will be far more beneficial than not redoing a restoration or providing a free fix for the damaged adjacent tooth, even in those procedures that run over into lunch or a date with the wife.

In the current state of affairs and changes in society norms, ethics has taken on a new connotation and is not based on common belief, but rather based on situational circumstances. It is our job to maintain unity in thought and practice about what is professionally ethical so future dentists, like my classmates and me, can enjoy the world of dentistry as those who came before us. Even if the proper and ethical decision comes with a loss to our financial bottom line, our personal coffers will be filled. This year is a great time to clean our slates and work as a family to better the profession we all pledged to protect.

John "Jay" Owen, IV is in the class of 2014 at the VCU School of Dentistry and is a member of the VDA Ethics Committee.

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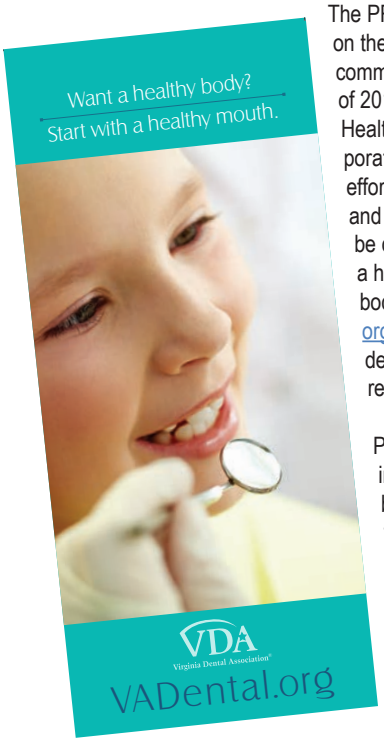
Advertising and Public Relations Campaign -- Coming Soon!

By: Dr. Mike Link, Chair, PR Task Force



The PR Task Force is continuing to work diligently on the 2013 advertising and PR campaign. The commercials will begin to air in the second quarter of 2013 and the wheels are already in motion. The Healthy Body, Healthy Mouth campaign will incorporate television advertisements, public relations efforts, a web presence, printed collateral pieces and search engine marketing. The campaign will be directed at consumers to let them know that a healthy mouth is an integral part of a healthy body. Consumers will be directed to vadental.org to find a VDA Member dentist to provide their dental care. The VDA website is currently be redesigned for this campaign.

Prior to the ads airing on television, all practicing VDA members will receive a large supply of brochures. These pieces will be reflective of the advertising campaign and will be a great way to continue the conversation with your patients and your community about the new campaign. Please be on the lookout this spring for a package from the VDA with your brochures.

As the final preparations for the campaign are completed, now is an excellent time to be sure that your practice website is up to date and ready for potential new patients who will be looking you up online. It is also a great time to check out your overall online presence. VDA Services has two endorsed vendors that are here to help!

PROSITES® Website Design and Internet Marketing

ProSites (prosites.com/vda) offers VDA members a 25% discount on website design services.

Demandforce® Growth. On Demand.

Demandforce (demandforce.com/vda) is offering to waive their set-up fee for all VDA member dentists. Demandforce can help your practice with marketing and communications with your current patients, gathering online surveys and enhancing your online presence.

Also, don't forget that as members you can download the new 'VDA Member' logo from vadental.org/logo to use on your website and to let patients know that you are a VDA member.

This is a very exciting time for the VDA as we reach out to the public about the importance of maintaining their oral health. Thank you to all members for your support of this campaign!

Dr. Michael Link, a general dentist practicing in Newport News has served on the VDA Board of Directors for the last four years. He is the chair of the PR Task Force. Dr. Link can be reached at michaellink@cox.net

Massive Changes Predicted for Dental Benefits Markets

By: Mary T. Dooley, DDS, Chairman, VDA Dental Benefits Committee

The National Association of Dental Plans is preparing for dental markets to shift dramatically from an employer-based to a direct-to-consumer model. A seminar presented last November by Careington Dental Solutions discussed many trends which are driving this change. Due to health care reform, large companies are moving employees to private exchanges. Employers are increasingly offering only voluntary dental benefits which many will not purchase, while other employers are decreasing their contributions to employer/shared funded plans. They stated that dental insurance premiums are increasing faster than medical premiums, and that the number of DPPOs is increasing as dental indemnity decreases. Retiring baby-boomers, estimated at 44 million, will lose their employer-funded dental benefits. Increasing awareness of the need for dental health is expected to lead to a demand for affordable plans.

The number of Americans without dental insurance is projected to go from 133 million to 221 million.

This seminar presented their best products for this direct-to-consumer market, and how to promote it. They offered the following solutions: Discount plans, Hybrid plans, Affordable individual products, Flexible Savings Accounts, Pre-paid debit cards, Plans for retirees and those on Medicare, Pediatric with Discount Adult plan, and Bundling Dental with other health-related products and travel and leisure/financial services.

An example model for a voluntary employer with minimum 20% enrollment, combines some insured benefits with discounts on non-covered services. An Affordable Individual product example would re-price a porcelain crown to $660 dentist fee, insurance will pay $450 and out-of-pocket will be $210. A Hybrid plan would reduce benefit to only $100 and increase patient out of pocket to $560. **Hybrid example #2 would re-price the dentist fee of $240 for an exam, 4BWX and prophy to $120, with a plan benefit of $100 and patient cost of $20.**

To seek and create positive press is the number one step in the promotion plan. Positive press is being created online where Brighter.com compares "dentist fees" and reputations with access to discount networks. DentalPlans.com and iDental.com also offer many different plans said to be specific to your zip code. If you have not heard of these plans or sites, or don't know much of what they propose, **please take a couple of minutes to review online what they have in store for your zip code.** I believe it is important to know the details of what others are planning for us.

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The Four Steps For "Done Right" Accountability

By Dr. Rhonda Savage

Every job in the dental practice is important. The dental team feels empowered and encouraged when they are given responsibility. And with responsibility comes accountability to the team, the doctor, the practice, and patients. Accountability is often viewed negatively, as if it's just a way to point a finger at someone to blame or highlight failure. But accountability done right is exactly the opposite. It is a system within the practice that gives the team members the time, tools, and training they need to succeed. There are four key steps to accountability done right:

Step #1: Sole Responsibility.

For each specific job – recare/recall, scheduling, ordering supplies, etc. – one person is put in charge and is clear on the expectations and the training needed to accomplish the task. It's a good idea to put expectations in writing so there are no miscommunications, and expectations should include both measureable goals (such as past due account balances) and desired behavior. For example, your goal could be to reduce A/R to less than 5% of production, with the behavior to make use of a patient financing company like CareCredit.

Step #2: Time.

Clearly defined time is scheduled for the team member to work on the job. If not, it's almost guaranteed the job will not get done. This means that if, for example, we want the person in charge of recall and reactivation to make calls Tuesday, Wednesday, and Thursday from two to three in the afternoon, then that person is not also trying to juggle answering in-bound phone calls or patient care.

Step #3: Due Date.

Each job should have a non-negotiable completion date. The date could be months away, later that day or an ongoing event scheduled on the calendar. For example, recare and reactivation reports on the doctor's desk the first working day of each month.

Step #4: Follow Up.

When you follow up, the doctor has the opportunity to praise and appreciate what the team member did. Daily coaching is a big part of follow-up. Creating a culture of coaching is one of the ways you can make change stick and it can be done in many different ways. In daily coaching it is about helping the team along the path of success. If something goes wrong, take a deep breath and choose the best time to discuss the situation with the team member in a way that is productive.

One great technique that can make daily coaching easier is the "feel, felt, found" technique that clearly states intention. This is how it works. Let's say you have two team members who seem to bicker, even in front of patients. The coaching might go something like this:

Alice and Linda, I feel we have a communication challenge and it's affecting the superior level of patient care we as a team are committed to providing. When you were in conflict in front of our patient today, I could tell they felt uncomfortable, and I did, too. I have found that the best way to keep our practice and team healthy is to discuss any issues between team members privately. It is my intention to always provide our patients with a comfortable, welcoming and warm environment, and both of you are an important part of that. So in the future, please do not argue in front of patients again.

Accountability done right is:

- Putting one person in charge of a task
- Giving the time and training to succeed by a specific due date
- Giving appropriate and encouraging coaching

This will ensure a positive impact on the team's morale, patient care and the practice's health.

Dr. Savage started her career in dentistry in 1976 as a dental assistant. After graduating Cum Laude from Seattle University and then with honors from the University of Washington School of Dentistry, Dr. Savage spent almost two decades in private practice and also as an active duty dental officer in the U.S. Navy during Desert Shield/Desert Storm. Today, Dr. Savage is CEO for Miles Global, an internationally known and well-respected practice management and consulting firm exclusively serving dentists. Dr. Savage can be reached at Rhonda@milesglobal.net

A Solid Foundation of Prevention for Improved Oral Health Care

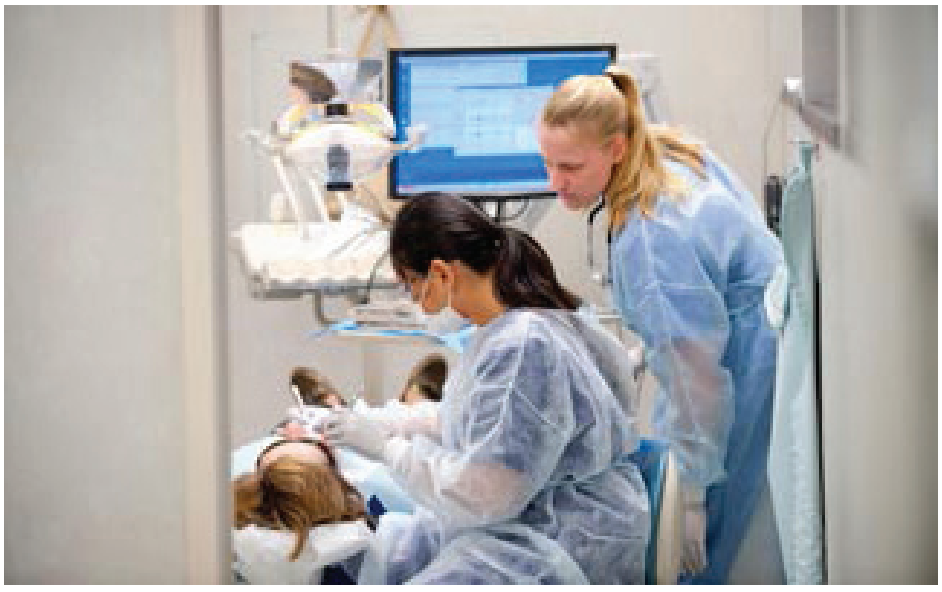
By: Michelle McGregor, R.D.H., B.S., M.Ed., Assistant Professor and Director of Dental Hygiene Program, VCU School of Dentistry

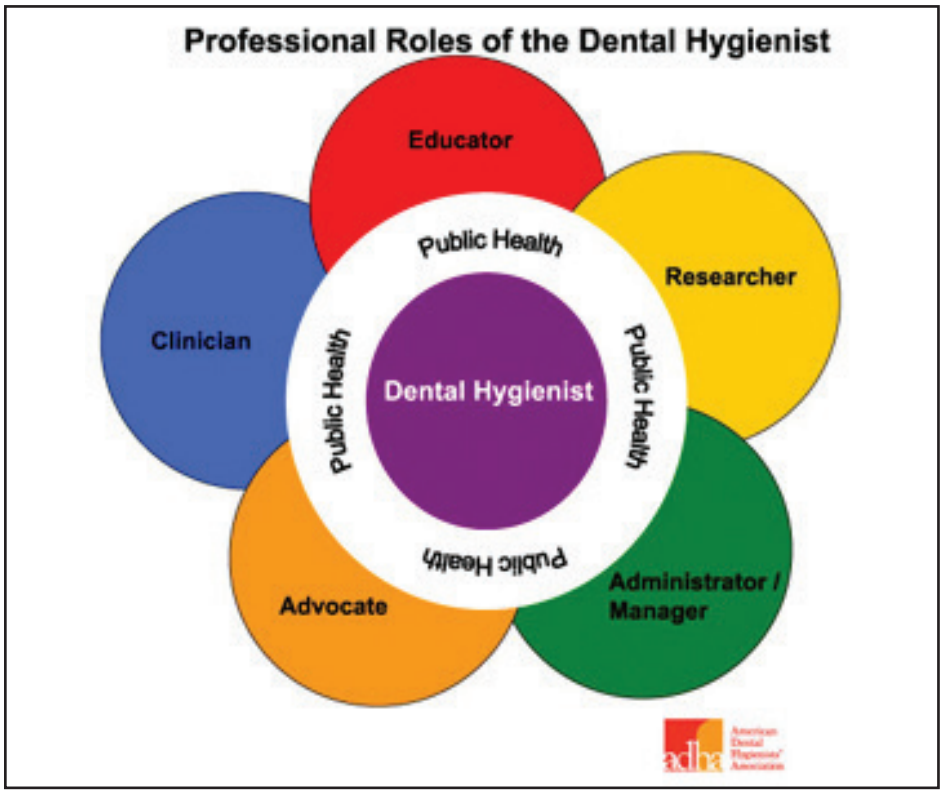
Dental hygiene is one of the few health care professions based exclusively on preventive care. The profession was cultivated in the early 1900s by a visionary dentist, Dr. Alfred C. Fones, who grasped the significance of prevention to avert or decrease the severity of dental disease. At a time when extracting teeth was the common practice of dentistry, Dr. Fones hypothesized that removing the "sticky film and bacteria" from the oral cavity would reduce dental disease. He went against the grain and in 1906 trained his assistant, Irene Newman, as the first auxiliary to scale and polish teeth and coined the term "dental hygienist."[1]

The scope of dental hygiene care and delivery of preventive oral health care services continues to evolve. Since Dr. Fones's time, a greater understanding of the cause and effect of oral bacteria in relation to oral and systemic health has been realized, resulting in improvements in prevention methods. Oral health is linked to cardiovascular disease, premature birth, poor birth outcomes and diabetes. Additionally, there is an increased risk for developing gingivitis and periodontal disease among older adults who may be diabetic and/or taking certain anti-hypertension drugs.[2] Periodontal disease can lead to osteoporosis, renal dysfunction, immunodeficiency diseases, environmental immunosuppression and diabetes.[3] Improved oral health through prevention methods can reduce disease and lessen the economic burden of treatment by providing essential dental care with the potential of decreasing other health risks or systemic conditions. As the country faces health care reforms and disparities in access to oral health care continue to rise, the delivery of oral health care must evolve to meet the needs of the public.

"2001 Oral Health in America: A Report of the Surgeon General" outlines challenges to improving oral health and recommends a focus on prevention and producing health rather than restoring health. It found that the current workforce is not meeting the needs of all populations. Ten years later, "2011 Oral Health in America: A Report of the Surgeon General" continues to emphasize prevention, improvement of public knowledge and behaviors and policy to improve oral health outcomes.[4]

Rooted in prevention and education of patients, dental hygienists are poised to be on the front lines serving the oral health needs of our communities in response to the Surgeon General's report. To meet these needs, models of oral health care delivery must evolve. The emerging trend in dental hygiene care is direct access to the patient resulting in the hygienist providing preventive services directly for patients without seeing the dentist first. Direct access to dental hygiene services can be accomplished through expanded levels of supervision or emerging workforce models within a specific scope of practice.
Currently, 35 states have legislative policies that allow direct access services by dental hygienists.[5] The direct access model allows patients to access services provided by dental hygienists without a prior visit to or authorization from a dentist. The framework for these new models of supervision expanding permissible oral hygiene services is individual to each state. In Virginia, a pilot program began in 2009 to address oral health care in underserved areas. The General Assembly passed legislation for the pilot program that allowed dental hygien-





This year the American Dental Hygienists Association (ADHA) celebrates its 100th anniversary as a professional organization. Dental hygienists serve many roles including advocate, educator, researcher and clinician, but the focus since the early 1900s has remained on promotion of good oral health through prevention.

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ists employed by the Virginia Department of Health (VDH) to provide preventive care in specified dentally underserved areas in Southwest Virginia. The pilot has had impact and demonstrates improvement in oral health care services across the Commonwealth. In 2012, "remote supervision" was adopted by the General Assembly as the standard of care and extended to the entire Commonwealth of Virginia. As many as 20 states, excluding Virginia, may be considering or already have implemented or piloted new oral health workforce models. The American Dental Hygienists' Association (ADHA), the American Dental Association (ADA) and the federal government (e.g. Indian Health Service) all have supported new forms of oral health professional workforce models. Such models include the advanced dental hygiene practitioner (ADHP), the community dental health coordinator (CDHC), dental health aide therapists and a range of dental therapist models similar to those in New Zealand, Canada, Great Britain and, most recently, Minnesota.

Currently, there is no protocol for mid-level providers in Virginia. As this trend continues and oral health care delivery transforms, educational institutions will need to prepare future practitioners with the appropriate knowledge, skills and attitudes for safe and successful patient outcomes. The educational quality must align with the scope of preventive services required for these new roles.

The Dental Hygiene Program at Virginia Commonwealth University (VCU) was initiated in 1969 as an integral component of the VCU School of Dentistry. Today, dental and dental hygiene programs work collaboratively to meet the developing needs of oral health care delivery and patients. The Dental Hygiene Program at VCU resides in the Department of Oral Health Promotion and Community Outreach. This department is responsible for the coordination of prevention activities and services for the public. As the only dental hygiene education program in the Commonwealth of Virginia located within a dental school, VCU's program offers students a state-of-the-art learning facility and exposure to innovative faculty and cutting-edge technology in a professional networking environment. The Dental Hygiene Program and Dental Program at VCU provide a University-designated service-learning course to students. Service-learning as a course combines classroom instruction, reflection and community service, promoting civic responsibly and commitment. Students experience the importance of collaboration with other healthcare professionals and participate in interdisciplinary care. These experiences prepare dental hygiene students to collaborate with other oral health care providers and augment relationships with other health care members.

Michelle McGregor, RDH is an Assistant Professor and Director of the Dental Hygiene Program at the VCU School of Dentistry. For more information on the Dental Hygiene Program at VCU, please contact Michelle McGregor at mrmcgregor@vcu.edu

Dr. Desai (L) and Dr. Abubaker consult with patient in Oral Medicine clinic.

New Oral Medicine and Oro-Facial Pain Clinic at VCU School of Dentistry

By: Bhavik Desai, DMD, PhD; A. Omar Abubaker DMD, PhD; and John A Svirsky, DDS, MEd

The incidence of oral mucosal lesions in the general population ranges between 12% and 85% across different parts of the world (1-3). Early detection of oral mucosal diseases is associated with increased patient comfort and, in some instances such as head and neck cancers, early detection can result in decreased morbidity and mortality (4). Patient knowledge about oral cancer has been found to be lacking, but they have been found to be receptive to the idea of periodic oral cancer screening as a preventive measure (5). Similarly, chronic oro-facial pain is associated with significant compromises in the quality of life as well as with psychological co-morbidities (6). There is a significant population of patients locally and in the Commonwealth who suffer from various types of oro-facial pain, TMD symptoms, and oral mucosal and mucocutaneous lesions, as well as exhibit oral manifestations of systemic diseases.

The Department of Oral and Maxillofacial Surgery at Virginia Commonwealth University (VCU) School of Dentistry, in collaboration with the Department of Oral Pathology, has recently established an Oral Medicine Clinic within the Dental Faculty Private Practice at the VCU School of Dentistry (Dentistry@VCU). Faculty from both departments will serve as attending practitioners for this clinic. The Oral Medicine Clinic was established after identifying unmet oral health needs in the greater Richmond area and across the Commonwealth of Virginia and to establish the Virginia Commonwealth University School of Dentistry as a venue for provision of comprehensive dental and oral healthcare.

The American Association of Oral Medicine defines Oral Medicine as "the discipline of dentistry concerned with the oral health care of medically compromised patients and with the diagnosis and non-surgical management of medically-related disorders or conditions affecting the oral and maxillofacial region." Oral medicine exists as a distinct discipline in several dental schools across the USA and internationally, offering both patient care and educational training in this discipline. Oral Medicine is also offered as a CODA-certified residency training program in eight universities and hospitals in the United States.

Within the scope of an oral medicine practice, patients with oral mucosal and mucocutaneous diseases and oral manifestations of systemic disease are evaluated and managed. Some of the common conditions treated by an oral medicine provider include, but are not limited to, oral lichen planus, oral candidiasis, leukoplakia, melanotic and pigmented oral lesions, and burning mouth syndrome. Patients suffering from chronic oro-facial pain conditions such as temporomandibular joint disorders, disc derangements and myofascial pain, as well as neuropathic pain disorders including trigeminal neuropathies and atypical facial pain are also managed in oral medicine.

Patients with any of the above conditions will be seen in the newly established VCU Oral Medicine Clinic. Patients who may need a biopsy of their oral lesions after a tentative diagnosis has been made can be promptly referred to their outside oral surgeons or to the Oral and Maxillofacial Surgery Practice at the VCU School of Dentistry for such a biopsy. Patients who have had prior biopsies and need re-evaluation and follow-up care or periodic assessment of their condition (precancerous and non-precancerous conditions) can also be seen at the oral medicine practice, as well as patients with problems related to radiation therapy and chemotherapy. . Detailed evaluation and non-surgical management of temporomandibular joint disorders are also performed in this clinic. Patients who do not respond to conservative therapy can be referred for surgical intervention, if deemed necessary.

In addition to providing patient care in the Oral Medicine Clinic, the faculty also contributes towards an important educational component of healthcare needs that is not otherwise identified in the dental curriculum. Dental students and post-doctorate residents at the VCU School of Dentistry will rotate through the clinic for exposure to patients with oral medicine problems and orofacial pain. The integration of dentistry and medicine within the scope of oral medicine equips graduating dental students with the knowledge to face diagnostic challenges in an ageing and increasingly medically complex patient pool. It involves recognition, diagnosis and management of oral mucosal disease, oro-facial pain and dental management of medically complex patients. Oral medicine training of graduating dentists can help the graduates learn how to manage at least some of those patients with chronic oro-facial pain, including temporomandibular joint disorders, and identify those patients in need of referral, when necessary. Future plans to enhance the educational potential of the clinic comprise intramural and extramural education activities to booster the knowledge of clinicians from various specialties in oral medicine. The clinic is proposed to

Continued on page 27

Student Debt as a Barrier to Care

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

It's no secret that the cost of a dental education is on the rise; however, the ramifications of this steep price are currently unknown. According to the American Dental Education Association, the cost of attending dental school has nearly tripled over the past twenty years and most current dental students will begin their career with almost a quarter of a million dollars in debt. Although some students will pursue programs that offer loan repayment options, others see the accumulating debt and interest as a distant burden to be dealt with upon graduation. In either instance, student debt is undoubtedly affecting a number of decisions about when, where, and how these students will practice dentistry.

In the current economic climate, the issue of student debt is an obvious topic of discussion, need of reform, and advocacy. All the same, it is important that students and dentists, alike, recognize that access to dental care is an ever pressing issue. Several years ago, the American Student Dental Association (ASDA) resolved to utilize the phrase 'barriers to care' rather than 'access to care.' The use of 'barriers to care' allows the recognition of a number or potential barriers, including those geographic, financial, personal, and those involving government policy. Although advocates and politicians continue to search for solutions to each of these barriers, it is necessary to consider the potential effect of the student debt load on dental care.

Dental students don't have the answers either – students are just as concerned with how their debt will affect their practice, with the threat of competing with mid-level providers, and with the access to care issue. As an organization, ASDA is opposed to dental therapists and mid-level providers of any kind. Students are concerned that these programs will create confusion among patients, and diminish the quality of oral health care provided. Students feel that no patient, regardless of barriers to care, deserves to receive second-rate dentistry. Furthermore, because of the debt associated with a dental education, educating more dentists, or creating mid-level provider programs, is unlikely to improve access to care.

As more debt is amassed, students are deliberating more options for repayment. For many students, the guaranteed salaries of corporate dentistry seem to be the most suitable solution. In some cases, it doesn't take long for students to regret that decision, as they're forced to compromise their ethical integrity to meet strict quotas and production requirements. For others, practicing in an underserved area is a speculative risk, and they worry that small patient pools and other factors may contribute to loan default. Because of concern with decreasing reimbursement rates, student debt has the potential to impact which insurance and government health care plans graduates will accept. Although it might seem that by making these decisions students are absent in their role of improving access to care, the choices being made have as much to do with necessity to meet loan payments as they do the students' preferences.

Weighing each factor proves that the best areas for improvement are in patient education, improving health programs, and providing incentives for graduates to practice in underserved areas. In many instances, patients avoid seeing dentists unless they are in pain. Emphasis on the importance of oral health, and its link to systemic health, will help patients, and others, to make dentistry a priority and allow dentists to stress prevention. Through education, improvements can be made to health programs so dentists are likely to participate, affordability is increased for patients, and patients are encouraged to see their dentist. Focusing on education and improvements to health care programs are idealized solutions to address access to care; however, if more patients are motivated to see the dentist, either by priority or by increased affordability, a significant impact could be made on current oral health disparities. At the same time, incentives, such as loan repayment programs, for graduates to practice in underserved areas, will help meet the potential need for more practitioners.

Access to care is a multifactorial issue. Each barrier to care, including geographic, financial, personal, and government policy factors, must be considered in finding an appropriate solution. While the issue of student debt won't disappear overnight, acknowledging its impact as a barrier to care aides in determining a solution. Fortunately, the leaders of organized dentistry are hard at work in solving access to care, advocating for students, and in protecting the profession. It's because of these leaders that the strength of dentistry as a profession is so well recognized. Earlier this year, *US News* reported dentistry as the nation's best career. Despite what seems to be an uncertain future, the example of dentists provides students with continued inspiration and supports our enthusiasm to join the profession.

Jeremy Jordan is in the Class of 2015 at the VCU School of Dentistry. He is also the editor of the American Student Dental Association (ASDA) District 4 newsletter.

Oral Medicine, Continued from page 26

serve as a site of educational training in oral medicine for dental and medical providers who are keen to gain expertise in the diagnosis and management of oral mucosal conditions and oro-facial pain. This goal will be implemented by means of hands-on continuing education courses or certificate programs. The oral medicine clinic will also be used as a resource for community service and outreach activities such as annual oral cancer screenings.

The Clinic is located in room 101 of the Lyons building of the VCU School of Dentistry. The providers in the clinic participate with most medical and dental insurance providers. If there are any patients who may benefit from the clinic services, the scheduling staff can be reached at (804) 628-0310.

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THE Virginia MEETING

A program of the Virginia Dental Association

September 18–22, 2013

Photo courtesy of The Homestead Resort, Hot Springs, VA

The Homestead Resort

Hot Springs, Virginia

Pre-Registration: June 10—August 30

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Mr. Bruce Christopher

Bambi vs. Godzilla

Difficult people are everywhere! They can be patients, staff, doctors, almost anyone. This program humorously reveals the six basic difficult personality styles that are out to drain you and your practice of vital energy. You will learn what they do, why they do it, and what you can do about it!

Dr. Barry Musikant

Common Sense Endodontics: Where Sophistication and Simplicity Meet

In this course, Dr. Musikant will detail the different systems that are available to dentists today and help you understand why engine-driven reciprocation results in clinical excellence. You will take away common-sense, money-saving solutions to endodontics that are easy to incorporate into your practice.

Ms. Susan Richardson

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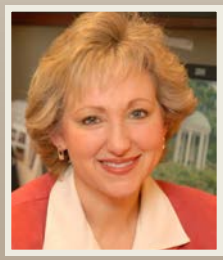
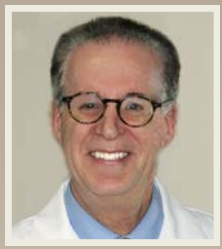


Ms. Rebecca Wilder

Systemic Disease and Oral Health: News You Can Put Into Practice

Dental hygienists need to stay current with information that is vital to a patient's health and be proactive in their approach to treatment! This course reviews current evidence on oral systemic connections discusses treatment strategies to incorporate into everyday practice, as well as providing information for best treatment strategies for patients at risk for disease and product recommendations for periodontal patients.



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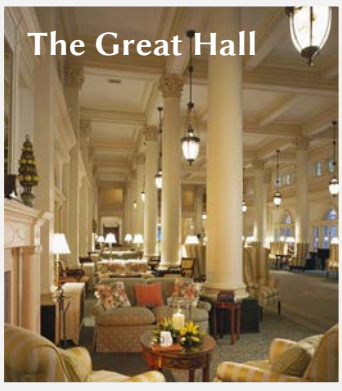
Guest Suite


Dining Room


The Great Hall


Sam Snead's Tavern

Photos courtesy of The Homestead Resort, Hot Springs, VA

Reservation Request

Virginia Dental Association

September 18-22, 2013

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Please circle preferred rate:

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Arrival date:_____/Time:_____ Departure date:_____/Time:_____

Name (please print) _____**No. of adults** _____

Room mate (if applicable) _____

Address _____

City_____ State_____ Zip Code_____

Daytime Telephone _____ ____FAX _____

Email Address: _____Have you been a previous overnight guest at The Homestead? _____

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An advance deposit equal to one night's room rate plus resort charge and tax is required to guarantee your reservation. **Early mailing of reservations is highly recommended.** Confirmed reservations are based on room availability. Reservations must be received by August 19, 2013 or until the room block has been filled. Deposit may be made with Visa, MasterCard, American Express, Diner's Club, and Discover, **which will be charged when reservation request is received.** If deposit is by check payment must be received with this reservation request. **Deposit is refundable if notice of cancellation is received at least 7 days prior to the scheduled arrival date.**

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Photos courtesy of The Homestead Resort, Hot Springs, VA

WAR ZONE DENTISTRY

By: Elizabeth Taylor Nance, DDS, MSHA

I had the distinct honor of recent deployment to Kandahar Air Field (KAF), Afghanistan. Last summer, I served as a Virginia National Guard dental officer assigned to the NATO ISAF (International Security Assistance Force) Role 3 MMU (Multinational Medical Unit) hospital in Kandahar Air Field, Afghanistan. I supported Operation Enduring Freedom in the KAF Combat or Trauma Hospital.

KAF is located near Kandahar City, a civilian town. The base is a no-salute zone due to security considerations.

My tour included both the Fourth of July and Ramadan during the troop drawdown, with the US active military exiting by 2014. Working during Ramadan often required covering my arms during clinic and covering my legs and arms walking to the gym. Indigenous native patients in the hospital and workers on the military base could take offense at by exposure of uncovered female arms and legs.

Kandahar Air Field is widely known for noise, unique shopping, blimps, and foul smells. Pairs of roaring jets, frequent helicopters, transport airplanes, buzzing drones plus armored transport and personnel vehicles made sleeping a challenge. Continuous gas-powered generators were humming everywhere on KAF. Staccato outgoing artillery often punctuated the night. The most jarring noise was the rocket attack alert. One day, we had seven alerts. Sometimes the alerts were accompanied by a KAF wide power outage.

The Boardwalk and inside-the-wire Bazaar offered price haggling opportunities with the local businessmen.

The elegant blimps hovering over a nearby mountain were a reminder of wartime use of technology. They were in clear view unless the occasional sand and dust storms hid them. For nasal stimulation, I had the continuous stale odor of burning trash in conjunction with the ever present offensive Pooh Pond.

The public health environment was vastly different from the US. Active cases of polio and malaria exist in Afghanistan. The life expectancy for both sexes is around 44 years. My pre-deployment activities included firearms certification, multiple military and cultural competency courses plus Afghanistan-specific vaccinations including Anthrax and smallpox. Taking anti-malaria medication was a fact of daily life.

Our water supply was treated with numerous concentrated chemicals. Thus, bottled water was supplied free everywhere, to everyone on KAF. Staying hydrated in the desert climate was a daily challenge. The customary breezes at KAF helped mitigate the triple- digit summertime temperatures and the many dust storms of southern Afghanistan. The dust penetrated everything, even the nose and ears.

Although KAF Role 3 MMU was a NATO hospital, the US Navy operated the facility. Most of the US doctors and medical staff were Navy, with the US Army staffing the dental clinic. The NATO Role 3 hospital was a tall fortified building. Just like all buildings on KAF, the building had generators enabling services even during power outages.

The military hospital in KAF sent staff to the Kandahar City civilian hospital for support. As you have read, many of the US military responsibilities are being transferred to Afghan control. The Role 3 NATO hospital duties might remain with the US.

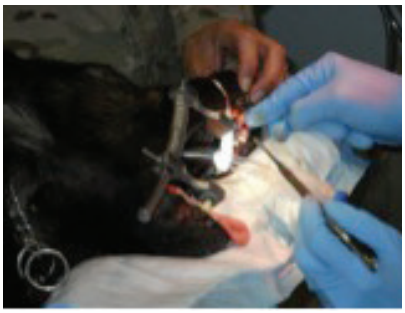
As a NATO Role 3 hospital, in addition to US military, the providers and staff included Australians, British, and Belgians. The hospital sign included the Red Cross and the Red Crescent since we worked in the Islamic Republic of Afghanistan.

Outside of workplace

The Role 3 hospital was a fortified, bunker structure made to withstand rocket attacks and other explosions. Since the hospital was adjacent to the airfield, patients were transported from the field to KAF via ground or air transport. Hospital staff was paged when litter transportation was required to carry the patients to the hospital emergency or operating room.

My military mission was to delivery emergency dental care to American and NATO coalition forces, select contractors and nationals in the war zone. Since military dogs played an integral role with the US forces, their dental needs were also met in the dental clinic: endodontic treatment, extractions and treatment of infections. The dental excursions to nearby Afghanistan villages had ceased before my deployment.

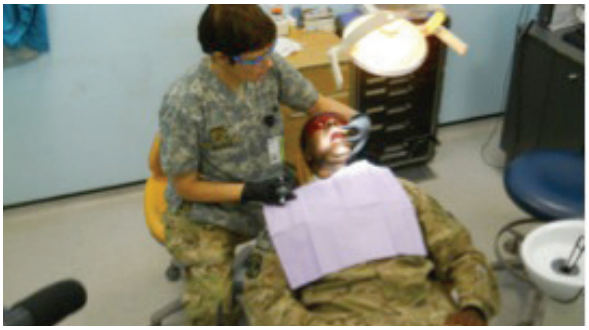
Dr. Nance with military dogs



Military dog receiving treatment

The Role 3 dental clinic had four teams of dentists and assistants, rotating through three operatories. We worked 8:00 - 6:00, seven days a week. When the British team was present, the three Army teams worked different rotations. One dental team was always on call to evaluate and treat dental emergencies.

A Navy OMFS was assigned to the operating room for traumatic surgical cases. The Role 3 dental clinic consisted of three general dentists and one endodontist.



Treating patients in Role 3 Dental Clinic

The hospital dental department looked similar to many dental offices. We had a reception desk, a staff lounge, a Panorex® room, a sterilization room and a storage room. A wide hall with a high narrow window (for security) ran down the center of the suite.

Each operatory was equipped with hand pieces, suction, and a porcelain spittoon. We used digital records and photography. After entering patient records and notes digitally, the paper records from the patient's sign-in were burned.

Obtaining supplies and equipment was a challenge at times due to the Pakistan transportation embargo. But routine and emergency supplies arrived via alternative routes.

I saw many interesting emergency cases. All dental cases were evaluated then treated after considering the patient's mission, military priorities and other factors such as the patient's R&R plans and their date for redeployment (returning stateside). Depending on the patient needs, most cases were completed that day so service members could return to duty immediately. Dental treatment beyond the scope of our clinic in Afghanistan was provided in Germany.

Many times salvageable teeth were treated surgically or with antibiotics so to enable endodontic treatment. In addition to extracting many infected third molars, I performed multiple I&Ds, extracted failed implants plus non-restorable fractured teeth and hopeless periodontally involved teeth.

Of special interest was the treatment of a dehydrated soldier's parotiditis. He was placed on clindamycin and lemon drops then confined to quarters on KAF for two days. After re-evaluation, he was returned to full duty with instructions to stay hydrated.

In theater, TMJ and traumatic issues were prevalent. A tooth fractured and beyond endodontic therapy or restorability, was extracted. Replacement of extracted teeth was a challenge since dental laboratories were not readily available in Afghanistan.

Most American military members' dentistry was provided stateside before deployment. The foreign military members' dentistry often had not been addressed before they were "in theater".

Each day, I walked to the hospital from my modular housing over paved and unpaved roads in full US Army desert camouflaged combat uniform with my M9 sidearm. At work, I changed to a military scrub for patient care and placed my sidearm in a nearby locked cabinet.

Even during war time, I couldn't resist going through my 1600+ digital photos and presenting a CE to my unit: "In Theater Dentistry".
Day to day differences between working in a war zone and working stateside included:

- Dressing in full military uniform with boots and M9 side arm and magazine.
- Taking anti-malarial prescription medicine
- Maintaining constant awareness about life threatening factors such as suicide bombers, rocket attacks and disease
- Locating bunkers which could provide safety during a rocket attack
- Knowing that both the internet and cell phones were owned and monitored by non-friendly countries
- Maintaining hydration levels
- Actively protecting critical military and personnel information

A war zone is stressful but since basic needs like water, food, shelter, electricity and running toilets were provided, I was able to focus on my mission.

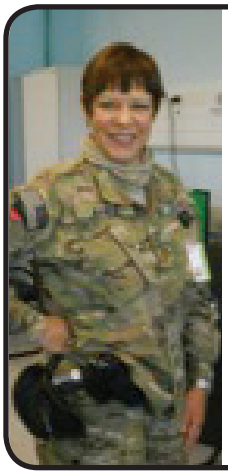
Presenting CE "In Theater Dentistry" at KAF

MAJ Elizabeth Nance (VA Army National Guard) and CAPT Wilsom Nance (US Marine Corps)

A special adventure was donating platelets. Donation required prescreening and testing of my blood by a stateside lab, then receipt of clearance weeks later. The donation took about three hours. During mass casualties serviced by the KAF hospital, calls went out to the staff for donations of blood.

Another adventure was seeing my oldest son, a Marine intelligence officer, at KAF. We were interviewed for the Armed Forces Network and for a Richmond Times- Dispatch article.

Serving my country on this deployment was a highlight of my life. I have a new appreciation of the opportunities and freedoms that we often take for granted in America.



Dr. Nance serves in the Virginia (Army) National Guard and is Dental Director for the Virginia Department of Health, Peninsula Health District, in Newport News. She was deployed to Afghanistan in 2012. Previously she was in private practice and on the faculty of the VCU School of Dentistry. She can be reached at elizabeth.nance@vdh.virginia.gov

Dental Care in Pregnancy

Oral Health Coalition educates physicians, other providers

By: Sarah Bedard Holland, Executive Director, Virginia Oral Health Coalition

Virginia's dental community is doing amazing things to increase access to oral health services throughout the Commonwealth. Dental professionals across the state are teaching fellow providers and patients about the importance of optimal oral health care at every age and phase of life, including stressing the importance of oral health care during pregnancy. Because dental disease in pregnant women is linked with pre-term birth, treatment and education during pregnancy can lower a patient's risk for premature birth and help to lay a foundation for a lifetime of good oral health for the patient and her child.

As you know, preventive, diagnostic and restorative treatments are safe and effective throughout pregnancy to improve and maintain oral health. The Virginia Oral Health Coalition has been working with area obstetricians as part of its medical and dental collaboration initiative to educate them about the safety of oral health care during pregnancy and encourage them to refer their patients to a dentist, if they do not have one. Referrals from OB-GYN providers can help grow a dental practice and establish ongoing relationships with physician practices and new parents.

On the national scale, the National Maternal and Child Oral Health Resource Center (OHRC) recently released a consensus statement intended to improve the overall standard of oral health care for pregnant women. "Oral Health Care During Pregnancy: A National Consensus Statement" was developed with input from organizations like the ADA, ADHA, AAPD, Association of State and Territorial Dental Directors and others to serve as a guideline for stakeholders who wish to improve the provision of oral health care and services during pregnancy.

To view more oral health resources for providers, pregnant women and caregivers, visit the OHRC website. To learn more about the Coalition's medical and dental collaboration initiative, please contact Katherine Libby, program manager, at 804.269.8723 or klibby@vaoralhealth.org, or visit the Coalition's website at www.vaoralhealth.org.

Seventh Free Dental Day held in Chester

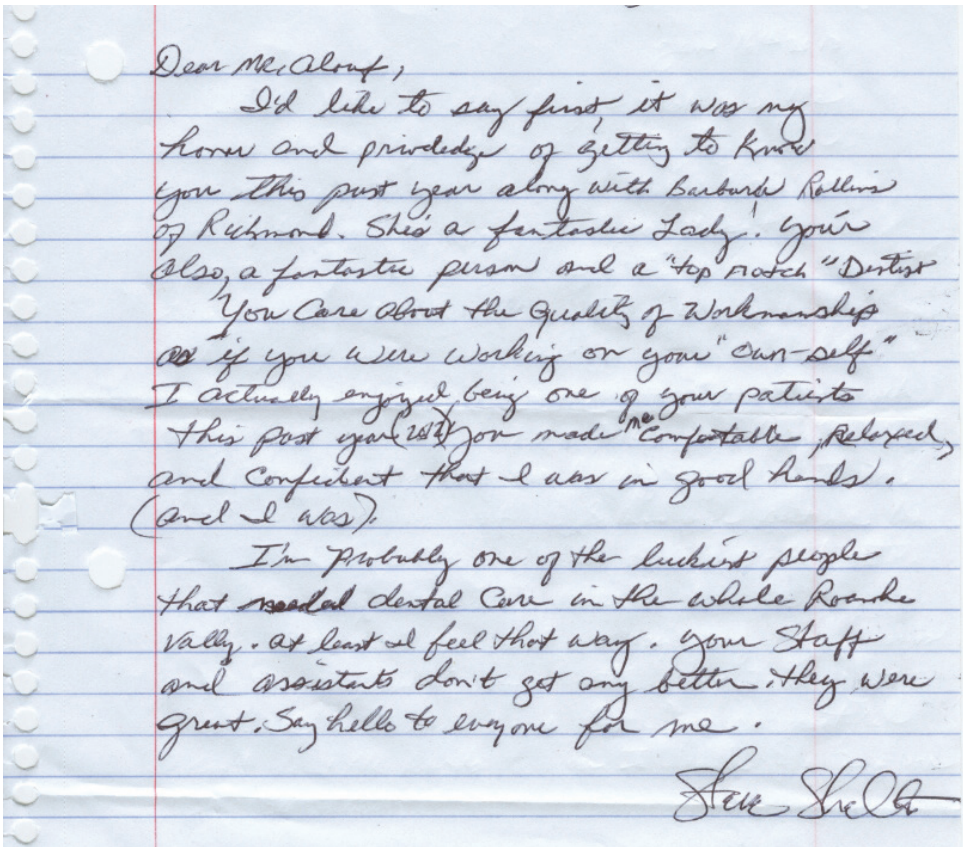
By Dr. Tony Agapis and Dr. John Agapis

Free Dental Day was a huge success! This was our seventh annual event which helps the underserved in our community with basic dental services for free. It was held in our dental office in Chester on February 22. There was no screening process and each was treated on a first come, first served basis. Patients began forming a line at 10:00 p.m. the night before. Shelters were provided by volunteers to help protect patients from the cold. Twelve dentists, four hygienists, and thirty assistants were able to treat 178 people with extractions, prophys, and fillings. I am always amazed by the generosity and hard work of all those that help deliver the care to these good people. If anyone would like to volunteer for next year's event, please contact us at: dragapis@comcast.net.

Donated Dental Services
Virginia Dental Association Foundation

A TEAM Effort

Missions of Mercy
Virginia Dental Association Foundation



Dear Mr. Alouf,

I'd like to say first, it was my honor and privelage of getting to know you this past year along with Barbara Rollins of Richmond. She's a fantastic Lady. You're also a fantastic person and a "top notch" Dentist. You Care about the Quality of Workmanship as if you were working on your "own self". I actually enjoyed being one of your patients this past year as you made me Comfortable, Relaxed, and Confident that I was in good hands. (and I was).

I'm probably one of the luckiest people that needed dental Care in the whole Roanoke Valley. At least I feel that way. Your Staff and assistants don't get any better. They were great. Say hello to everyone for me.

Steve Shelton

Before

After

Steve Shelton is a veteran who had his teeth extracted through the 2012 Roanoke Missions of Mercy. He was then referred to the DDS program where Dr. Stephen Alouf provided him with full upper and lower dentures. The dentures were donated by Lewis Bowles with Service Dental Lab in Lynchburg.

Thank you Dr. Alouf and Lewis Bowles!!

The Cleft and Craniofacial Team at St. Mary's Hospital

Dentistry and oral health care play a critical role in the diagnosis and treatment of patients with cleft lip and/or palate, craniofacial syndromes and anomalies, and congenital and acquired defects of the head and neck. In an effort to provide unified care for these patients and their families, the Cleft and Craniofacial Team at St. Mary's Hospital was recently formed in Richmond, Virginia. Serving greater Richmond, the State of Virginia and the Eastern United States, our team utilizes the most comprehensive and current technologies coupled with unequaled care, compassion and skill. This unique private practice team combines the talents of plastic surgery, ENT, neurosurgery, dentistry, oral surgery, orthodontics, speech pathology and social work to provide comprehensive treatment unparalleled in the community. This select group serves as a model for other teams throughout the country.

Nationally recognized by the American Cleft Palate-Craniofacial Association, the team represents an innovative approach to the traditional hospital-based services of the past. Each member of the team has access to information gathered by other team members via a unified charting system specifically designed for the purpose of managing patients with craniofacial anomalies. Patients are seen by members of the team individually, only when necessary, and treatment plans are discussed and formulated when the team meets on a monthly basis.

The team provides an approach to patient care that streamlines the multidisciplinary needs of the most complex patients while understanding the challenges a patient and their family may have with a prenatal diagnosis of cleft lip and/or palate, craniofacial syndromes or anomalies. The team is present every step of the way. Linda Shait, BSN, RN the team's patient care coordinator, helps identify patient needs, provides access to care and navigates the multidiscipline therapies.

Help your patients in their care from prenatal diagnosis to adulthood and optimize their quality of life through referral and treatment. Dentistry plays a vital role in the management of these patients, optimizing function and esthetics, while pairing with other treatment modalities of hearing, vision, speech, social work, genetic counseling and surgical intervention. It's never too early or too late to refer these patients to the Cleft and Craniofacial Team at St. Mary's Hospital for an evaluation that elevates quality of life and highlights the individual needs of every patient.

For more information please contact:
Linda Shait, BSN, RN
Pediatric Specialty Care Coordinator
Telephone: 804 287-7396
Fax: 804 287-7722
Linda_shait@bshsi.org
http://www.bonsecours.com/our-services-childrens-services.html

cleft & craniofacial TEAM at St. Mary's

Sharline Z. Aboutanos, MD
Plastic & Reconstructive Surgery

Alan J. Burke, MD
Otolaryngology, Plastic and Facial Surgery

Natario L. Couser, MD
Opthalmology

Jennifer B. Humberson, MD
Genetics

Frank P. Iuorno, Jr DDS,MS
Orthodontics

Wendi L. Lopez PSY D, HSPP
Clinical Psychology

Christopher L. Maestrello, DDS
Pediatric Dentistry

Karen S. McAndrew, DMD, MS
Prosthodontics

Michael E. Miller, DDS
Oral and Maxillofacial Surgery

Melissa Redfearn, MS, CCC-SLP
Speech Language Pathology

Ann M. Ritter, MD
Pediatric Neurosurgery

Linda Shait, RN, BSN
Team Coordinator

Isaac L. Wornom, III, MD
Plastic & Reconstructive Surgery

Edwin V. Wortham, MD
Opthalmology

VDA Services Vendors are Here to Help

Elise Rupinski, VDA Director of Marketing and Programs

Did you know that the VDA Services endorsed vendors are peer-reviewed and recommended by the member dentists on the VDSC Board of Directors? All vendors have been thoroughly vetted by the Board and they are recommended for use by VDA Members because of their strong product and service offerings. In addition, many of the endorsed vendors offer benefits and pricing that are exclusive to VDA Members – bringing added value to your membership!

The VDSC was started in 1995 as a subsidiary of the VDA. The purpose was to find and recommend products and services to VDA members and also to create a new source of non-dues revenue, thus enhancing member value while decreasing the cost of membership. Many of the endorsed vendors provide a source of revenue, at no extra cost to you, which helps to support your association and its programs. This revenue is used to keep dues as low as possible and in 2012 alone, the dues savings was over $80 per member! Over the past 18 years, the VDSC has provided over $2.5million in support for many programs including: the Virginia Meeting, CE courses at each component, MOM Projects, the VDA website and the VCU School of Dentistry.

Below please find an introduction to the VDA Services endorsed vendors. Complete information about these programs can be found online at vadental.org/vdas.

Insurance

Whether you are just starting out in practice, you are well established or you are retired from dentistry, the VDA Services vendors are here to help. **B&B Insurance Associates, Inc.** (877-832-9113; bb-insurance.com) can provide you with comprehensive insurance coverage at all stages of your career. B&B Insurance is a family-owned agency that has been working with VDA Members for over 12 years. With expertise in the insurance needs of dental professionals, the licensed agents at B&B are a one-stop shop for all of your insurance needs. Whether you are looking for an endorsed **Medical Protective** (medpro.com) professional liability policy or a comprehensive review of your entire insurance portfolio, B&B Insurance is here for you.

Financial Services

Bank of America Practice Solutions (bankofamerica.com./small_business/practicesolutions) is committed to working with dentists to provide a comprehensive practice and equipment financing solution. Whether you are buying a practice for the first time, purchasing equipment, expanding your practice or considering a commercial real estate purchase, Bank of America Practice Solutions has a variety of products to fit your needs. VDA Members are also invited to apply for both personal and business credit cards through **Bank of America** (bankofamerica.com).

Products and Services for the Dental Office

From website design, to gloves, to electronic claims and marketing and communications for your office, the VDA Services vendors over a wide variety of products and services with special benefits exclusively for members. **ProSites** (prosites.com/vda) offers website design services and a platform that allows your office to easily edit, update and change your practice website. Having a professional presence on the web is paramount with today's technologically savvy patients and ProSites is offering VDA members a 25% discount their set-up fee to help you improve your online presence. To complement your new practice website, you could also consider the marketing and communications tools available through **Demandforce** (dental.demandforce.com). Patient communications, surveys, appointment reminders, social media optimization and email campaigns can all be managed using Demandforce's innovative technology. VDA Members will have their set-up fee with Demandforce waived and the company guarantees a three-to-one return on your investment with them – a win-win for you and your patients!

You can also enhance your patient's experience and decrease your accounts receivable by trying out the electronic claims, real-time claim adjudication and eligibility checks through **MDE** (whymde.com). As an innovator in the field, MDE is working to revolutionize your front-office efficiency and improve your accounts receivable. With MDE, you can let patients know what they will owe your office for services on the same day as their appointment. You can make their payment process easier by offering options for payment including **CareCredit** (carecredit.com/dental) patient payment plans and accepting credit cards through endorsed processor **Worldpay** (worldpay.us). CareCredit offers VDA members a savings of $170 off of the enrollment fee and Worldpay can provide your office with a free, no obligation statement review to see how much your office can save by switching processors. For those accounts that do end up delinquent, VDA Services recommends the collections services of **Transworld Systems** (transworldsystems.com/gkurtz). The professionals at Transworld can offer your practice a number of solutions for aging receivables that can maintain your relationship with your patient and improve your practice's balance sheet.

The VDA Services vendors can also help you save money at your practice – more value for your membership in the VDA. Check out the exclusive member pricing for a full suite of gloves form seven manufacturers through the **VDA Services Glove Program** (vdaservicesgloves.com). Your office can also save 15% off of your payroll processing services through **Paychex** (paychex.com), a leader in the payroll services industry. Through **SolmeteX** (solmetex.com), VDA members are able to receive a free container ($179 value) and a $30 rebate when you purchase a SolmeteX amalgam separator from your dental dealer.

The VDA Services vendors are here to help you. Please visit vadental.org/vdas to learn about all of the endorsed vendors and the exclusive benefits they provide to VDA Members.

Peer Reviewed • Members-Only Benefits • Supporting the VDA

Dentist with Good Hands has Son with Good Feet

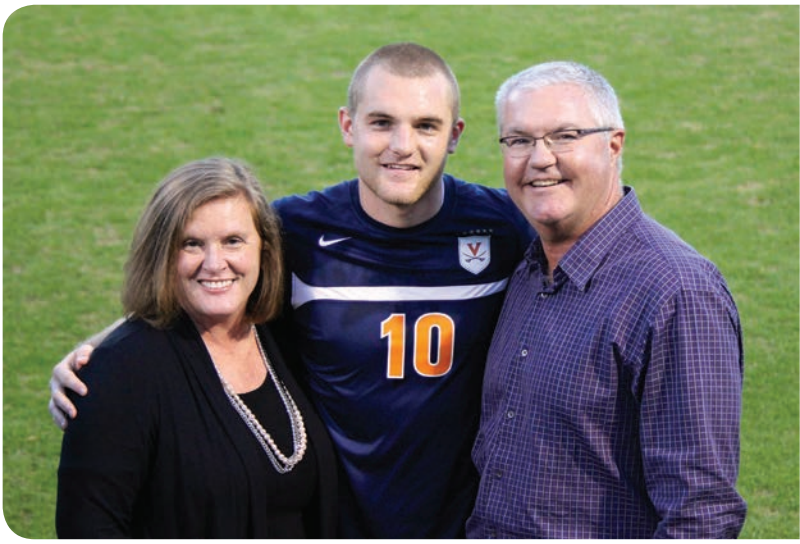
By: Dr. Michael Hanley, Associate Editor, Component 3

We have a professional athlete in our midst. No, I'm not on the Professional Bowling Tour. Will Bates, the son of our very own Dr. Rich Bates, was recently drafted by the Seattle Sounders of Major League Soccer. He was on back-to-back State Championship teams in Chester at Thomas Dale High School and then was NCAA Freshman of the year as the University of Virginia won the NCAA title. His senior year, he came back from ACL surgery to be the second leading scorer in the Atlantic Coast Conference.

Will graduated in three and a half years (Hear that, kids!) and has just moved to Seattle. He hopes to be in the starting lineup before long.

From where did this genetically superior lineage derive? Have you met Rich's wife, Sue, a star yoga and Pilates student? Rich was (or is) a good athlete himself having played linebacker at Virginia Military Institute. He is a member of Fat Boys, a men's indoor soccer league where sprinting is frowned upon. He possesses a modest skill set in golf. His drives go a long way, although mostly in wayward directions.

Rich and Sue are looking forward to seeing Will play this summer in the state of Washington. They hope there are plenty of Grand Cherokees® to rent, for it would be a shame to go Jeepless in Seattle.



L-R: Mrs. Sue Bates, Will Bates, Dr. Richard Bates

Office Culture Impacts the Bottom Line

By: Dr. James Schroeder

One of the most underdeveloped areas of any business is office culture. For the purpose of this article "culture" is defined as the behaviors, attitudes and values reflected in an organization.

Across the state, dental offices have been impacted by the economy. As I engage different offices I have discovered a wide variety of responses to the external force identified as the downturn of the economy. I have also seen creative and innovative responses that have resulted in a significant growth in office production as well as severe declines which resulted in the reduction of staff and/or poor office productivity. As dentists our creative focus is often in the clinical area of patient care. Our response to the ever changing external forces such as insurance carriers or the economy is often passive or even exhibits a victim mentality. In today's ever changing environment we cannot afford the either choice, particularly the latter one.

Although there are many ways to ramp up your office productivity factor, today I will discuss your leadership role in the intentional development of a thriving office culture. Often we do not have the eyes to see what is limiting our practice growth because it seems totally unrelated to our dental expertise. When we hire an individual for a clinical position we are very fastidious about proper training in procedures, sterilization and equipment utilization. Administrative positions receive training in the different systems such as insurance, calendar/appointment book control and the recall system.

Unfortunately, we often overlook the development of the high behavioral and attitude standards which should be expected in all patient and co-worker relationships. We allow the new employee to bring their behavior and attitude from home, off the street or from previous places of work. This is like playing Russian roulette. You may be fortunate or skilled in selecting the right individual for the position but great cultures are not developed by accident just as beautiful smiles are not created by chance. All the external marketing can be short circuited unless we have an exceptional internal culture receiving new patients. For example, the manner in which the phone is answered is an important byproduct of an office culture and requires intense scripted training.

Behaviors and attitudes are developed outside the office often are not acceptable in a culture of service to each other and to the patient. And, there is often a certain arrogance exhibited by professionals that implies, "I don't have a problem in this area," or they download it to an office manager providing little leadership or expectations. More often than not the office manager is well intentioned, but ill- equipped to carry out the critical responsibility that will ultimately be a major factor in the growth of the professional practice.

When providing an introduction to a new employee, I was explaining that our culture was built on serving both each other and our patients. Later that day an older employee came to me and shared that the newcomer had said, "What's Dr. Schroeder talking about, this serving each other stuff? I never served anybody." Fortunately, she was teachable, and we helped her develop into a great staff member. This did not happen without teaching, training and modeling over a period of time along with a few difficult conversations which held her accountable. In medical and dental offices that I work with as a consultant, I often find the doctor ignores unacceptable behaviors and attitudes and thus allowing the lowest denominator to set the office cultural standard. This pattern fuels poor behavior from all staff members. With that cycle of behavior, patients experience poor service and leave the practice, or they do not rave about you in the community. And this is an important way in which office culture impacts the bottom line. In surveying patients, the number one reason they tell other people in the community about your office is, "I experienced great and gracious service throughout the office!" I am not discounting the importance of excellent dentistry, but very few people refer friends based solely on the excellent technical service which they received.

Great office cultures attract great employees! When we take time to clearly identify appropriate attitudes and standards of behavior, and we hold employees accountable, great things happen. Clarity of expectations, alignment and equipping our people to meet our expectations, followed by execution and accountability yield amazing results.

In all the different businesses I consult with, I always interview the employees. The top employees often express the desire to me, "Please help him/her be a leader and address the difficult/low performing people that are preventing the business from reaching its full potential." Often the people I work with have many years of education and letters after their name but they have never acquired the skills and confidence to execute this part of their business.

Another area of culture development which is often not addressed is the differences encountered between generational gaps. Upbringing, work ethic, values, communication styles all impact teamwork. Co-workers will either clash or they will become a well-oiled machine (with respect for their differences) largely depending on the strength of the investment in teamwork and in the modeling that you provide.

Behaviors and attitudes play an important part in the growth of your practice and consequently in your bottom line. The culture of your office also plays a critical role in the enjoyment of your day. It cannot be measured on a spreadsheet, but it is woven throughout the areas of productivity, new patients and profitability. There is not much you can do about changes of the economy, but there is a tremendous amount you can do in the development of your office culture. It is the platform upon which everything is delivered. Whether your office is thriving or struggling in this area can greatly affect the return on your investment.

When was the last time you made an investment of time, fresh energy or had a conversation on growth and development of your office culture? Is the time now?

Dr. James Schroeder practiced in Richmond. Please email him your experiences and questions to be addressed in future columns.
drjimschroeder@gmail.com
He may be contacted at (804) 307-5108.

Scientific PEDIATRIC ABSTRACTS

Casamassimo PS, Thikkurissy S, Edelstein BL, Maiorini E. Beyond the dmft: The human and economic cost of early childhood caries. JADA 2009; 140(6): 650-657

Background: Early childhood caries (ECC) is the most common chronic disease of all childhood illnesses. ECC can cause suffering, pain, diminished quantity of life, and even death. Most often those educated, insured, and employed are not aware of the consequences of untreated ECC that are experienced by a majority of the 4.5 million children who develop the condition each year. Death and serious morbidity as a result of ECC is not a new phenomenon; however, the recent death of a 12 year-old boy in 2007 from untreated dental caries gave new light to the problems with access to dental care. Extreme events such as these are highly publicized in the news; however, effects of ECC on families, community, and society are often unnoticed. Moreover, traditional surveillance measures have not portrayed the full range of ECC's impact on affected children and their families.

Purpose: The purpose of this report was to review evidence from a variety of perspectives to argue that the consequences of symptomatic ECC are multiple and significant and that broader surveillance of the disease's impact is necessary.

Methods: A traditional method to describe a disease impact is the morbidity and mortality (M&M) pyramid, a visual model where increasingly severe consequences are layered on top one another. The authors reviewed the literature for descriptions and quantification of morbidity associated with ECC and organized the studies into the morbidity and mortality pyramid in an attempt to explain the depth of ECC's penetration. The ECC M&M pyramid is attached below.

Results: ECC has a low rate of associated fatality and a high rate of dysfunction and so takes on the classical pyramid shape. An M&M pyramid provides observation of both the measure of consequence and the ability to relate that to other consequences. For instance, for each death from ECC or treatment, there will be certain number of hospital admissions, missed school days, or episode of pain-induced difficulty in eating or sleeping. The study of M&M can highlight the magnitude of a disease's effects on society. Through this analysis, health care professionals can better direct resource allocation and utilization of services to maximize prevention and treatment. An M&M analysis will represent dimensions of a disease in a range of patients, from low risk to high risk, and thus will provide insight into associated expenditures and loss of human capital.

Hospital costs are placed towards the top of the pyramid. In many hospitals' emergency departments (ED), dental pain is a main cause of pediatric admission. Families seek ED dental care for many reasons such as lack of a primary dentist, inability to pay a dentist, the perception that their child is in serious danger or pain, or the convenience of the ED. Often the ED dental intervention is limited to management of pain and infection, and not addressing the source of infection. As a result, that leaves significant cost to the patient, the hospital, and society. Numerous ED admissions become prolonged hospitalizations for management of facial cellulitis. Treatment under general anesthesia for extensive dental repair is another costly and risky consequence of ECC. It is estimated that tens of thousands of young children in the United States undergo dental rehabilitation under general anesthesia. The costs of these services to families and the public are extensive, especially when considering that dental caries is largely a preventable disease. Adverse events in sedation and general anesthesia place pediatric patients at the highest risk.

ECC is also related to children's ability to play, to attend school, eat, and sleep and has been shown to have negative effects on a child's growth. ECC also can affect at the level of the family. One study concluded that a dysfunctional family can lead to a recurrence of ECC. Unfortunately, the impact of ECC on communities is just beginning to be realized. Recently adopted policies concerning ECC will allow children to come into dental offices far earlier in order to prevent dental caries. These early interventions have been shown to be cost effective and cost saving but will require an increase in workforce and health costs.

Figure 3. A proposed early childhood caries morbidity and mortality pyramid.

Conclusions: ECC has a large, sometimes not apparent impact on society and the health care system. This recognition will reinforce oral health planning in the future. ECC is strongly linked with vulnerable subpopulations, children of impoverished, minorities, or immigrants. In summary, "Meaningful assessments of the effect of ECC on child development, learning, and family function and the economic burdens it places on families, communities, and the health care system are needed to describe the importance of this preventable disease adequately". The epidemic of ECC will continue to put the health and lives of children at risk until a comprehensive assessment is developed.

Dr. Jo K. Cronly is a resident in pediatric dentistry at Virginia Commonwealth University.

PEDIATRIC ABSTRACTS

Sankenshwari RM, Ankola AV, Tangade PS, Hebbal MI. Feeding Habits and Oral Hygiene Practices as Determinants of Early Childhood Caries in 3 to 5 year-old Children in Belgaum City, India. Oral Health Prev Dent 2012; 10(3): 283-290

Background: Early Childhood Caries (ECC) is a serious public concern, especially among financially disadvantaged social groups in both developed and developing countries. Early Childhood Caries has been defined in this study as "decayed, missing or filled tooth in primary dentition under 71 months of age" and Severe Early Childhood Caries (SECC) as "any smooth surface caries in less than three years of age".

It has been observed that children with SECC suffer from significantly lower height and weight when compared to children without ECC. ECC is a potential risk marker for anemia in children with iron deficiency. Pediatric dentists should recommend regular evaluation of iron levels in patients with SECC, regardless of their growth record.

Purpose: Investigate the existence of any relation between feeding habits and oral hygiene practices and the prevalence of ECC among preschool children in Belgaum City, India.

Methods: This is a cross-sectional descriptive study. The pilot was conducted in two stages. In the first stage a questionnaire was prepared in English and translated to Marathi and Kannada languages. Twenty close-ended questions were asked pertaining to sociodemographic parameters, feeding habits, diet and oral hygiene practices. In the second stage, a final questionnaire with 50 questions was given to the mother and their children were examined for ECC. Subjects were obtained from 12 pre-schools and 8 Anganwadis (Hindi for "courtyard shelter" – state-run facilities to help combat childhood hunger). The sample size was estimated to be 1,250. Children aged 3 to 5 years whose parents had consented to be part of the study. This study was completed in three months. Dental examinations were carried out in the schools under natural light using mouth mirrors and community periodontal index (CPI) probes. Dental caries was assessed using the WHO dentition status and dmft was calculated based on the same.

Results: Of 1,250 subjects, approximately 1,086 were breastfed. In regards to the duration of breastfeeding and ECC prevalence: (0-3 months) 52.7% presented ECC, (4-6 months) 74.07%, (7-12 months) 62.34%, (13-24 months) 58.04%, (25-36 months) 75%. The prevalence of ECC was also higher in children who were fed at night (either breast fed or bottle fed), but no statistical association between the two was found.

Conclusion: Children who are breastfed are at a significantly lower risk of being affected by ECC than children who are not breastfed. Breastfeeding for less than 6 months and more than 24 months was found to be statistically associated with the prevalence of ECC. The age at which oral hygiene practices for children are started and parental assistance with oral hygiene practices were all found to be protective factors against the risk of ECC.

Dr. Marcela Mujica is a resident in pediatric dentistry at Virginia Commonwealth University.

Niji R, et. al. Maternal Age at Birth and Other Risk Factors in Early Childhood Caries. Pediatr Dent 2010; 32(7): 493-8

Background: The classical understanding of dental caries has been described as dietary carbohydrate modified bacterial infectious disease with the focus on micro-organisms, sugar consumption and oral hygiene habits. Contemporary emphasis has been on early childhood caries (ECC) and its global impact in specific high-risk groups. A new movement within pediatric dentistry believe that dental caries should be treated not simply as a infectious disease, but as a social and behavioral condition. To the point, children whose mothers have less education and lower income, and those who were deeply religious were found to have higher risks for ECC.

Purpose: The goal of this study is to identify the impact of the mother's age and other childcare practices on children's health.

Methods: There were 646 mother-child pairs who participated in the community oral health program at ages 1.5 – 3 years of age in Tokushima Prefecture, Japan. Examinations of children were conducted from 1992 – 2005. Questionnaires were completed by the accompanying mothers with answers verified by examining dentist during an interview.

Clinical examinations were performed by three calibrated pediatric dentists (Kappa scores mean =0.95) Caries scoring was based on World Health Organization (WHO) methodology. Caries activity test (CAT)

Results: There were 646 mother-and-first child pairs and the mothers' ages at birth ranged from 17-47 years old. Twelve percent of mothers were 27years old, 13% were between 17-22 years old, 82% were between 23 – 34 years old, and 5% were between 35-47 years old.

The mean caries prevalence among 3 year-olds was 41%. The caries prevalence was higher (63%) in children born from 17-22 year-old mothers vs. the mean, and comparatively lower (38%, 34%) in children of 23-34 year-old, and 35 and older mothers.

Caries activity tests values of children 1.5 years of age were not significantly different compared to other ages (P<.001).

Conclusion: There is a strong correlation between young maternal age, specifically 22 years old and younger, and ECC. Late childbearing ages were not an important factor for caries. Oral health programs that focus on young and newly expectant mothers and high-risk children are critical factors to improve children's oral health.

Dr. Brian Burke is a resident in pediatric dentistry at Virginia Commonwealth University.

Scientific PEDIATRIC ABSTRACTS

Martins-Junior PA, Oliveira M, Marques LS, Ramos-Jorge ML. Untreated Dental Caries: Impact on Quality of Life of Children of Low Socioeconomic Status. Pediatr Dent 2012; 34(3): 49-52.

Background: While the prevalence of tooth decay has decreased, the distribution of the disease remains uneven, mostly affecting individuals from poorer regions. Few studies have evaluated the oral health-related quality of life (OHRQoL) as it relates to tooth decay in children and adolescents. Children suffering from tooth decay experience pain, problems with eating, chewing, smiling, self esteem, and communication. Also impacted are the general health, daily activities, school attendance, scholastic achievement and subsequently social relationships of these children. Knowing how tooth decay affects the quality of life of children can help dentists in making clinical decisions and encourage these dentists to support oral health public policies. However, little is known about how tooth decay affects the social interactions and psychological well-being of children who do not have access to dental treatment, or how these children and families perceive their quality of life is affected by the tooth decay.
Purpose: This study's purpose was to evaluate the impact of untreated tooth decay on the oral health-related quality of life (OHRQoL) of children from families of low socioeconomic status.

Methods: This was a cross-sectional study involving randomly selected children ages eight to ten years old from public schools in shanty towns in Diamantina, Minas Gerais, Brazil. The participants were from families of low socioeconomic status. The participants were divided into two groups, those without tooth decay and those with untreated tooth decay. Data was collected through interviews with the children and a clinical examination. The Child Perception Questionnaire (CPQ) was used to determine the impact of tooth decay on the children's daily lives. This questionnaire addressed 25 items including oral symptoms, functional limitations, emotional wellbeing, and social wellbeing. The clinical examination was completed at the school and was based on the criteria of the World Health Organization. The exam was performed by 2 trained dentists and 1 trained assistant. Descriptive analysis, Mann-Whitney, chi-square test, and hierarchically adjusted Poisson regression models were used.

Results: The study recruited 112 eight to ten year olds. There was a 100% response rate. Responses showed those with untreated tooth decay had a worse perception of their oral health. The study reveals the negative impact of untreated tooth decay, regardless of gender, age, or malocclusion.
Discussion: This study shows how children from families of low socioeconomic status with untreated tooth decay have a negative perception as it pertains to their oral health status. They perceive their oral health status to be fair or poor. The environment in which these children are raised also influences their health behavior and understanding of oral health. The oral symptoms subscales of the CPQ achieved higher mean values than the emotional, social well-being, and functional limitations subscales. The results also show that while the children are concerned with the appearance of their teeth, they do not attempt to hide their smile. The findings also support previous literature that shows eight to ten year-olds are beginning to develop global judgments regarding self-perception and self-esteem.

Conclusions: Two conclusions can be made from the results of this study:

1. Tooth decay has a great impact on the functional and biopsychosocial aspects of the daily lives of 8-10 year olds.
2. Children suffering from tooth decay are at a greater risk of a decreased quality of life, regardless of age, gender, or malocclusion.

Dr. Erika Lentini is a resident in pediatric dentistry at Virginia Commonwealth University.

Plonka KA, et. al. A Randomized Controlled Clinical Trial Comparing A Remineralizing Paste with an Antibacterial Gel to Prevent Early Childhood Caries. Pediatr Dent 2013; 35(1): 8E-12E(5)

Background: Many factors contribute to Early Childhood Caries (ECC), including early colonization of *mutans* streptococci (MS), lack of good oral hygiene and frequent consumption of sugars. There are many agents that have been proven to reduce the MS count. Previous studies have found that using a low fluoride children's toothpaste results in MS removal, and there is less ECC in children who brush regularly versus those who do not. Although there are many dentifrices available with bactericidal activity and remineralizing ability, little is known or has been studied about their effectiveness in preventing ECC.
Purpose: The purpose of this study was to compare casein phospopeptide-amorphous calcium phosphate (CPP-ACP), chlorhexidine gel (CHX) and 0.304 percent fluoride toothpaste for reducing *mutans* streptococci colonization and preventing early childhood caries in a low socioeconomic community.

Methods: Mothers of healthy children who were seen at community health facilities in a low socioeconomic status district of Queensland were approached for the study, 44 days after birth. The study aimed for 600 participants (200 per group). Children were examined at their homes at 6, 12 and 18 months of age and at the community dental clinic at 24 months of age. At every visit, calibrated examiners evaluated the children for cavitations and white spot lesions and took samples from the children's tooth surfaces and spread them on agar strips containing MS and lactobacilli selective media. Participants were randomized to use either 10% CPP-ACP topical cream, 0.12% CHX gel or no product after evening tooth brushing. Oral health education was given before the visit was over as well as a questionnaire to assess compliance and the child's feeding and oral hygiene habits. The data was analyzed to determine the effect of the preventive agents on caries rates at 12, 18 and 24 months.

Results: A total of 542 patients were seen after a 24-month period. The caries incidence was 1% in the CPP-ACP group, 2% in the CHX group and 2% in the standard control group. Among those originally colonized with MS at 12 months of age, no children in the CPP-ACP group, 22% of children in the CHX group and 16% of children in the study control group continued to harbor MS after 24 months. Among those originally colonized with MS at 18 months of age, 5% of children in the CPP-ACP group, 72% in the CHX group and 50% in the study control group remained positive for MS after 24 months.

Conclusions: Children in the general community are likely to benefit from using CPP-ACP, which will boost the preventive effects of tooth brushing due to its remineralizing and antibacterial activities. Since CPP-ACP and CHX work via different mechanisms of action, a combination of the two products is likely to produce additive beneficial effects for preventing ECC. These agents are not a replacement for daily tooth brushing with fluoride toothpaste, but are adjunctive in treatment.

Although present data shows that, when applied daily from the time of tooth eruption to 24 months of age, CPP-ACP has the greater ability compared to CHX to reduce MS levels, there is insufficient evidence to justify daily use of CPP-ACP or CHX gel to control early childhood caries.

Dr. Tiffany Williams is a resident in pediatric dentistry at Virginia Commonwealth University.

PathologyPuzzler

with Dr. John Svirsky

A fifty-nine year old white female was seen initially by a local dentist in March 2012 with an uneventful oral examination. Her past medical history was reviewed and included medical management of chronic fatigue, fibromyalgia, hormone replacement therapy and a herniated disk. Her medications include Vicodin®, Flexeril®, estradiol, probiotics, Fiberpsyll®, Savella®, Zomig®, Amerge®, Vitamin D, Calcium, Dehydroepiandrosterone, Magnesium citrate and fish oil.

On October 6, 2012, at her next appointment the patient presented with a raised lesion of the left cheek of four weeks duration, secondary to a cheek bite (according to the patient). (Figure 1) Prior to this appointment the patient saw a physician who recommended that a dentist evaluate. The dentist at this appointment did an incisional biopsy.

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

1. Fibroma
2. Lipoma
3. Papilloma
4. Peripheral giant cell granuloma
5. Pyogenic granuloma
6. Salivary gland tumor
7. Traumatic ulceration
8. Verrucous carcinoma

A Velscope® photograph (Figure 2) is attached showing the lack of fluorescence. Does this change your opinion or help diagnose the lesion? The answer is, No!

Continued on page 46

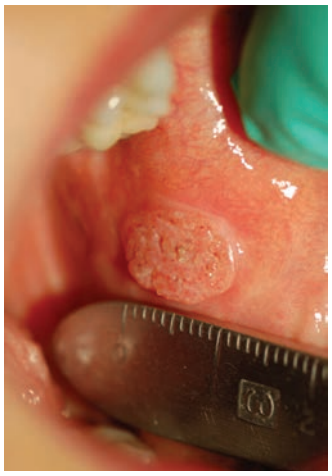


Figure 1

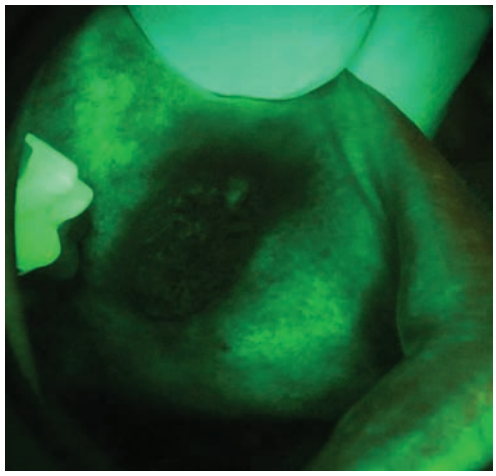


Figure 2

PathologyPuzzler

with Dr. John Svirsky

Contined from page 45

Looking at the clinical photograph, I felt that it was a 1.0 cm by 0.8 cm lesion with a verrucous/papillary appearance. Based on the clinical picture, I thought all but the papilloma and the verrucous carcinoma could be excluded.

A fibroma would have a smooth surface texture and be of normal mucosal color unless being chewed (then the surface of the fibroma may have white areas). Fibromas are normally hyperplasia secondary to trauma rather than a true tumor.

A lipoma, like the fibroma, would have a smooth surface texture and be normal mucosa color if deeper and a yellowish coloration if superficial. They are far less common orally than fibromas.

A papilloma would have this surface texture but normally do not reach this size. Now with the association of oral cancer and human papilloma virus, the "fear index " of a clinical diagnosis of papilloma has gone up. However one papilloma does not HPV make. A number of patients are undergoing HPV saliva testing, but I am not in favor of this. The percentage of the population that is HPV positive is high compared to the small number of people with HPV related oral cancers. Saliva tests give patients a reason to worry about an outcome that is impossible to predict. I feel the same way about whole body scans to find occult lesions. More unnecessary surgery will be done to find things that will never be a problem.

A peripheral giant cell granuloma (PGCG) would not be considered since this lesion only occurs on tissue that is on or near the gingiva. Also the surface of a PGCG could be ulcerated but not papillary.

A pyogenic granuloma has the same clinical appearance as a PGCG but can occur anywhere. New lesions are vascular (granulation tissue) with surface ulceration and as they mature they become the color of normal mucosa (more fibrous). They actually become a fibroma when fibrosed.

A traumatic ulceration is usually flat and at times has a hyperkeratotic "collar". They would not have a papillary surface texture. The ulceration typically has a brown, necrotic appearance.

The lesion turned out to be a verrucous carcinoma (VC) (Figures 3&4) which in reality is an exophytic squamous cell carcinoma. This lesion appears to be an early VC since it is small, well circumscribed and has a verrucous/pebbly surface appearance. Verrucous carcinomas are the lesions most closely associated with human papilloma virus type 16. This lesion is typically found in men with an average age of 65-70. A lesion of this size should have an excellent prognosis since it was diagnosed early and was only a centimeter in its greatest dimension.

This case was submitted by Dr. Stanley Kayes, a general dentist in private practice in Haymarket, Virginia.

Figure 1: A 1cm by .8cm elevated lesion with a papillary appearance of the left buccal mucosa.

Figure2: A Velscope picture showing lack of fluorescence in and around the lesion.

Figure3: Histologic picture showing parakeratin clefting

Figure 4: Histologic picture showing a broad rete ridge with dysplastic changes

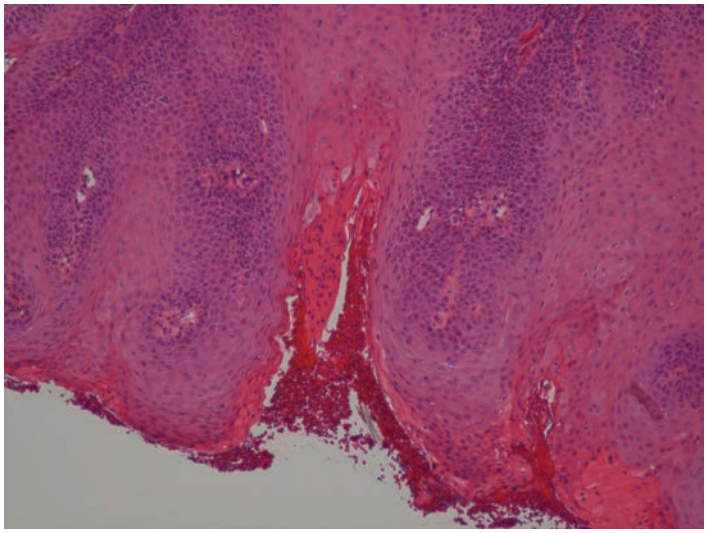


Figure 3

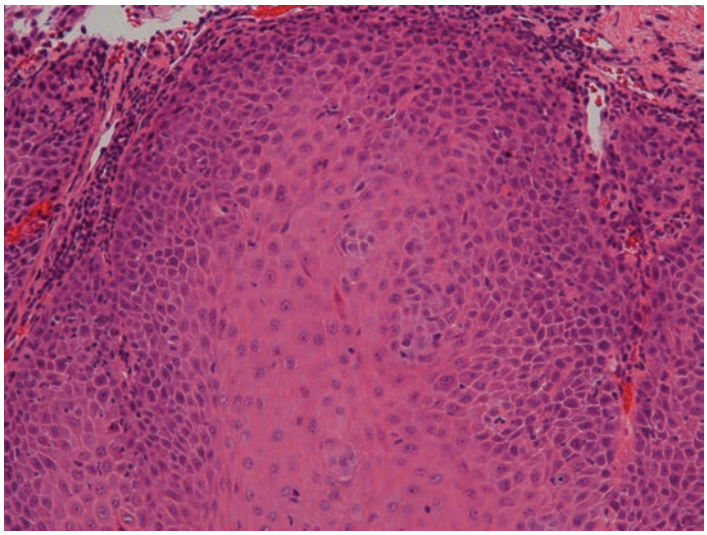


Figure 4

Prosthetic Rehabilitation of Palatal Incompetence

A Clinical Case Series

By: Dr. Lakshya Kumar MDS[1], Dr. Kaushal K. Agrawal MDS[1], Dr Saumyendra V. Singh MDS[1], and Dr. Kamleshwar Singh MDS[1]

ABSTRACT

Palatopharyngeal insufficiency is a condition that results from the cleft of the palatal region. It induces nasal regurgitation of liquids, hypernasal speech, nasal escape, disarticulations and impaired speech intelligibility. Rehabilitation of palatopharyngeal insufficiency requires an interdisciplinary approach. As a result, the patient can be socially and physically rehabilitated with the improved function. This article describes a clinical case series of a rare congenital disorder, oral submucous cleft, and soft palate cleft. A systematic diagnosis and treatment plan has been described which involves mainly a prosthodontist and a speech therapist. The patients' phonetics were considerably improved after wearing the prostheses.

INTRODUCTION

Clefts of the palate may be congenital or acquired. Partial or complete loss of the soft palate results in insufficient structure or altered function of the remaining structure to provide closure with the pharynx. The prosthetic rehabilitation of these defects presents a challenge to clinician. In such a situation, an obturator prosthesis is designed to close the opening between the residual hard palate and/or soft palate and the pharynx. The submucosal cleft is a condition which is characterized by separation of muscles in the soft palate, and by the bluish hue in posterior soft palate, displaced musculature, attenuated raphe and /or bifurcation of uvula. [1]

The speech disorder in such cases takes the form of dysarthria[2] which manifest more in resonance than articulation disturbance.

The production of speech sounds is a phenomenon of several highly integrated factors which Kantner and West divided into: (1) respiration, (2) phonation, (3) resonation, (4) articulation, and (5) neurologic integration. [3]

Prosthetic rehabilitation of the maxillofacial region has played an important role in improving the quality of life of patients with congenital maxillary defects.[4]

CLINICAL REPORT

Case 1

A 26 year-old female patient reported to the clinic with the chief complaint of a speech defect. The patient's medical history was unremarkable. Patient speech examination revealed imprecise consonant production, distorted vowels, hypernasality, harsh voice quality and slow speaking rate. A V-shaped groove was observed in the posterior median palatal region while pronouncing 'AH'. (Fig 1a)

Case 2

A 19-year-old male patient was referred to The Department of Prosthodontics from The Department of Plastic Surgery. The patient had nasal regurgitation of liquids (sometimes food) and hypernasality. Examination of the nasal resonance was done by alternating closure of the nose during repeated pronunciation of /i-a/ and /u-i/ during connected speech, and both marked hypernasality and nasal escape were observed.[1] (Fig 1b) Oral endoscopic examination showed the size and shape of a defect present on posterior part of the palate.(Fig 5a & 5b)

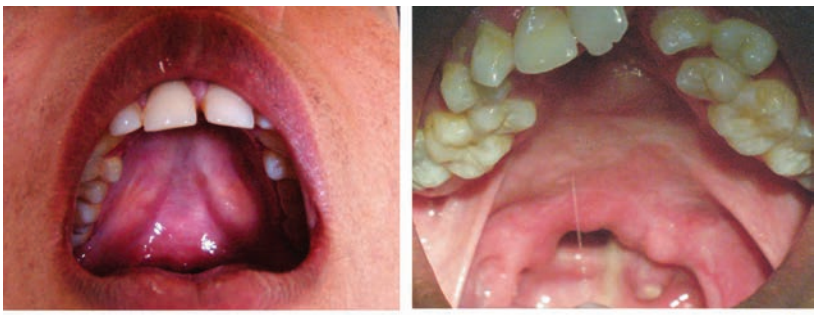


Figure 1a &1b

CLINICAL PROCEDURE

Primary alginate impressions (Zelgan; Dentsply India Pvt. Ltd., Gurgaon, India) were made for both. (Fig. 2) The impressions were poured with dental stone and a diagnostic cast was prepared. On the diagnostic cast, a special tray of self-cure acrylic was fabricated (Pyrax; Pyrax Polymer, Roorkee, India).

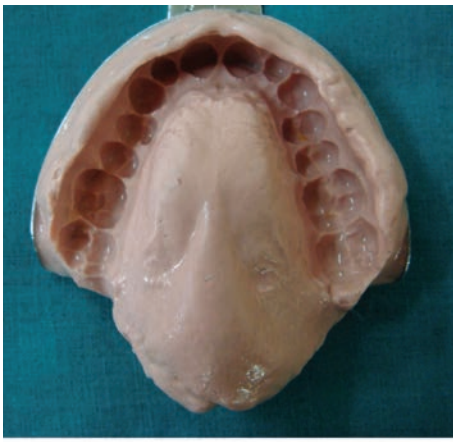


Figure 2

Case 1

A special tray was made of self cure acrylic with a wrought wire loop incorporated, vertically directed in the pharyngeal portion of tray. Softened high-fusing modeling compound (Pinnacle; DPI, Mumbai, India) was placed on the vertical extension, shaped, and flamed to create a smooth surface. After placing the hardened compound in the oral cavity the patient was allowed to wear the palatal lift for several minutes to become familiar with the sensation of the lift. Small additions were made to the compound posteriorly until the soft palate was brought into light contact with the posterior pharyngeal wall. The high-fusing modeling compound was then added laterally. Following each addition, the patient was asked to breathe through the nose and attempt speech. The patient at this stage was asked to speak 'b' and 'p'.

Once the results were satisfactory the compound was reduced by 1-2 mm. On this, zinc oxide eugenol impression material was added (ideally mouth temperature wax) and then reinserted in the patient's mouth. The patient was asked to speak, swallow water, and move the head in all directions. (Fig. 3a)

Case 2

A retentive wrought wire loop of 6mm diameter was extended posteriorly from palatal portion of maxillary record base to facilitate placement and retention of impression material into pharynx. High-fusing modeling compound was added into the defect area to the retentive loop posteriorly in order to serve as the tray for subsequent additions of low-fusing compound (Green stick; DPI, Mumbai, India).

During molding of warmed low-fusing compound on retentive loop, the tray was inserted in the patient's mouth. The patient was asked to flex the neck fully, and to rotate left and right. When border molding was completed around the entire periphery, there was no escape of liquid from the oral to nasal cavities and the articulation of plosive sounds such as "b" and "p" and nasal consonants "m", "n", and "ng" was improved.[5]

Low-fusing compound was reduced evenly (1-1.5 mm) on all peripheral surfaces of the obturator. A coating of tissue conditioner (Visco-gel; Dentsply, DeTrey GmbH, Germany) was used to take final impression of obturated portion of the prosthesis.(Fig. 3b)

After finishing and polishing, the final position and contour of obturator was determined with prosthesis positioned into the mouth.(Fig.4a & 4b)

Pressure indicating paste was used to evaluate excessive pressure areas and those areas were then relieved. The patient was instructed to wear the prosthesis continuously as long as she is comfortable. The patient was also instructed to determine the value of wearing the prosthesis during eating. The patient was instructed not to wear the lift prosthesis during night as it was not required and moreover, this will allow the mucosa of the palate to recover.

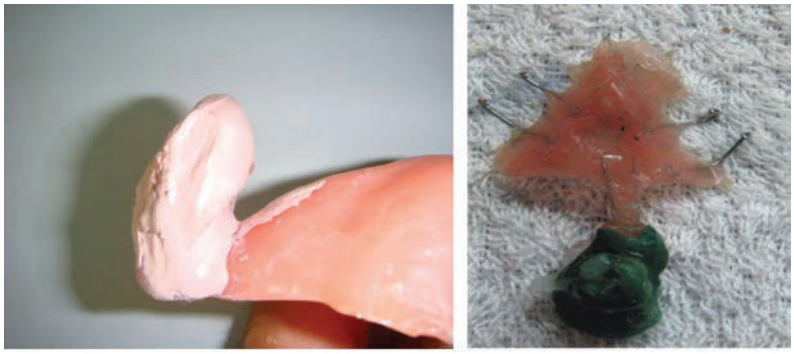


Figure 3a & 3b

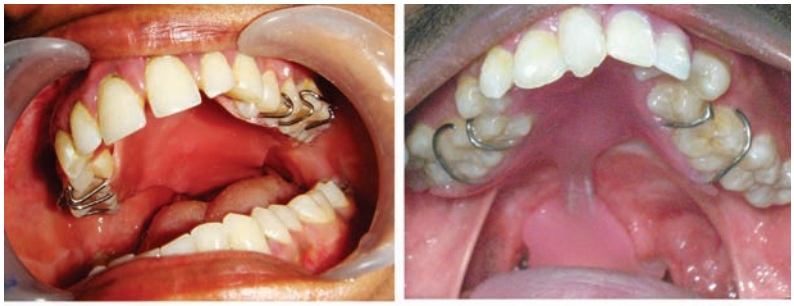


Figure 4a & 4b

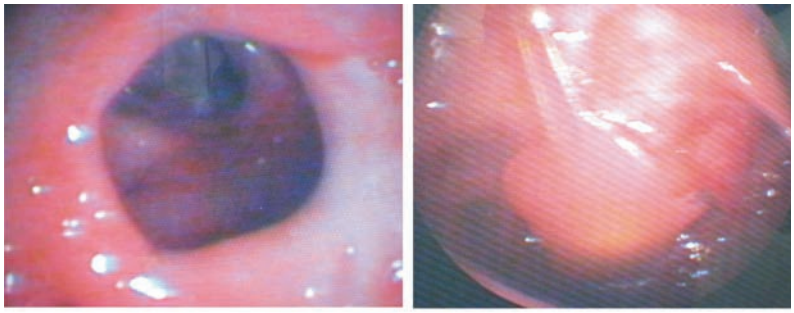


Figure 5a & 5b

DISCUSSION

A palatal lift functions best when there is residual function of the superior constrictor muscles and is especially effective if the levator muscles still have some ability to contract. A palatal lift should not completely occlude the nasopharyngeal port for hypernasality to be eliminated as this will in turn, cause inability to breathe through the nose and hyponasal speech. Wearing a palatal lift prosthesis that completely eliminates nasal breathing may also reduce the patient's willingness to wear the device. In 1967, Lang recommended the use of a palatal lift prosthesis for the neurologically compromised patient, provided concomitant speech therapy was offered.[6]

Nasal endoscopy is the method of choice to evaluate the effect of the palatal lift therapy. Reduction of hypernasality is not likely to occur until the lateral extent of the lift is increased sufficiently to reduce the size of the lateral ports.

Sounds like 'b' and 'p' are plosive sounds which require high intraoral pressure. The palatopharyngeal valving mechanism regulates resonation and speech utterance and partakes in non-speech oral activities such as swallowing, blowing, sucking, and whistling. [7,8] Palatopharyngeal insufficiency implies the presence of hypernasality, inappropriate nasal escape and decreased air pressure during the production of oral speech sounds .

Follow-up and speech therapy: - the patients were recalled after two days and one week. During the follow-up appointments, the mucosa over the palate was closely observed. The patients were able to wear the prosthesis continuously over a period of one week. The patients were then referred to a Department of ENT for speech therapy.

SUMMARY AND CONCLUSION

The purpose of this case series is to present a clinical condition which requires a multidisciplinary approach for proper rehabilitation. Remarkable changes were noted in hypernasality, nasal regurgitation of food and liquid immediately after insertion of the prosthesis.

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LEGENDS

Fig 1a &1b- The defect
Fig 2- Primary impression of defect.
Fig 3a &3b- Impression of the defect
Fig 4a &4b- Final prosthesis inserted
Fig 5a &5b- Closure of defect pre and post prosthesis fabrication

2013 VDA Elected Leadership Candidates

For the past four years it has been my honor to serve on the VDA Board of Directors representing Component two. I also serve as an ADA Alternate Delegate, and have held this position for the past seven years. Previously, I served our profession in other leadership positions, including President of the Virginia Board of Dentistry, chairman of the Virginia Chapters of the Pierre Fauchard Academy and International College of Dentistry.

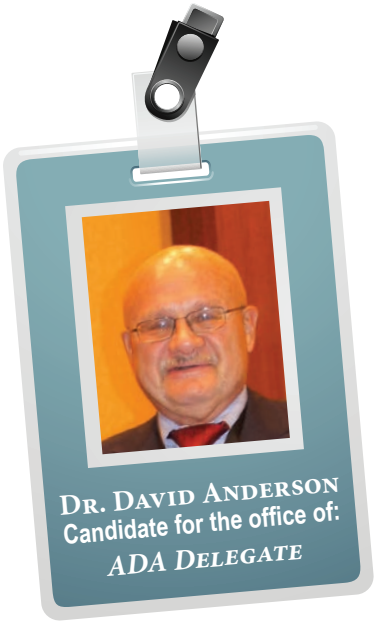
Currently, I am the Chairman of the VDA Public Relations Task Force. The Task Force was charged with devising a unique plan to bring more members into the VDA. Our Members need to feel that their VDA is responding to their needs and is pertinent in their dental practices. The VDA needs to be more responsive and relevant to our members in order to bring them value in being a member in our association. For many years, we, Dentists have not effectively communicated our achievements to the public. How can the public and other Dentists perceive our accomplishments and achievements if we do not broadcast our distinguishing goals? Moving forward, the VDA needs to bring a better message to our members and to the public.

I am committed to working to solve the many problems facing dentistry today. Some of our demanding issues are: the reduction of membership in the VDA, how Dentistry will be affected by the Affordable Care Act, the expansion of a new dental school in the southwestern part of the state, the influence of third party payers, the growing number of large group practice models and reduced access to care for the underprivileged, and the list continues to grow each year. Our newly elected ADA President-Elect Dr. Chuck Norman stated so eloquently in his address at the ADA annual meeting that, "We must adapt to changing realities or face the prospect of becoming less relevant." Adapting to realities is what the VDA needs to do to stay relevant to the public, legislators and to our members.

The Virginia Dental Association has been blessed with outstanding leadership that has positioned us to be the leading authority in Oral Health care for Virginia. Indeed, our leadership has long been the envy among other states. However, we cannot sit back and rest on our past success; we must be ready to adapt to an ever-changing environment. As leaders, we need to ensure that we are making a difference in serving the dental needs of the less fortunate, while meeting our member's needs.

When it comes to resolving issues, I work hard to build consensus while being committed to never compromising our core values. Whatever the problems are, we can solve them by working together. As your President, I will devote my time and resources to continuing the fine work of this Association while moving us forward in keeping the Association strong and relevant. I am uniquely qualified to represent you, the Dentists of Virginia, and I respectfully ask for your vote.

It has been an honor and a pleasure to serve the VDA as your current Secretary/Treasurer. Over the past 18 months I have learned a lot about the activities of our organization and the wonderful people who give much of their time and abilities to see that we maintain a viable organization. Overall, we have a strong, financially stable association, but many challenges are ahead of us to assure that we sustain our status as a leader amongst other dental associations. I am proud to be an active member of the Virginia Dental Association and I ask for your vote for a second term as your Secretary/Treasurer. I will continue to work to the best of my ability, to serve our membership and the Board of Directors. Thank you very much for your consideration.

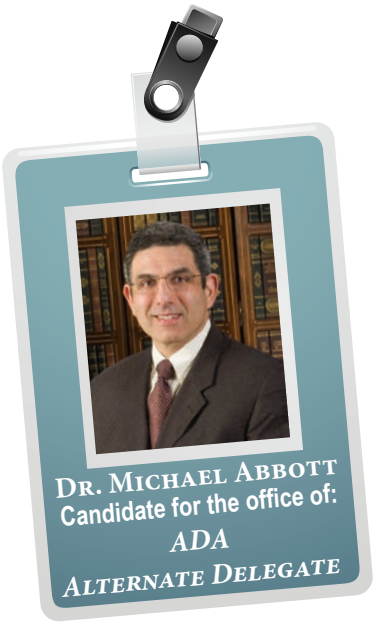


Representing Virginia's dentists at the ADA House has been an honor, privilege and for me, a necessity. I love my profession and have an aversion to all those who know little or nothing of our grand life's work and tell us how our profession should be run. If we do not stand together and vigilant, a well meaning government and profit motive driven insurers will drive the profession I love. I have enjoyed my stay but this will be my last election. Younger colleagues must step up and keep our profession viable and for the benefit of our patients.

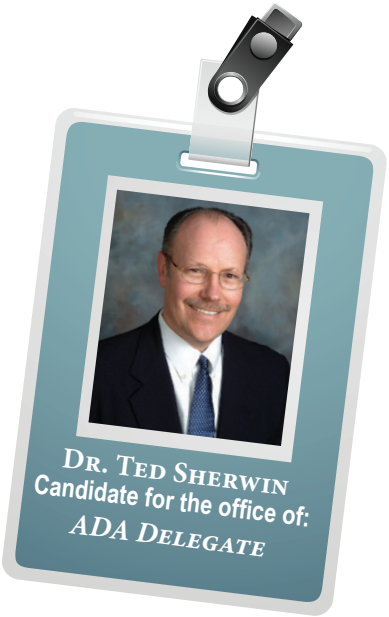
The Virginia Dental Association is uniquely positioned to represent the interests of thousands of dentists throughout our state. Their concerns regarding key issues such as: access to dental care, dental education, the dental workforce, student concerns, and membership must be addressed. Leadership through cooperation and a clear vision of the VDA's future are essential to our continued growth and prosperity. I have been privileged to serve as an Alternate Delegate for the past six-years. If elected to serve as a Delegate to the ADA House, I will dedicate my years of proven leadership in the military, academics, administration and community service to advance the goals of the VDA and our profession.

2013 VDA Elected Leadership Candidates

Our profession is currently experiencing numerous challenges and stresses from many external sources such as regulatory agencies, third party payers, and policy makers that have no first-hand knowledge of the practice of dentistry. When combining these stresses with the additional problems of an extended recession and the many unknowns of the Affordable Healthcare Act; it is easy to conclude that our Profession and our Association must adapt and position ourselves if we are to survive in the future. In order to combat these issues we need to maintain a strong association and to regain our market share of membership. Having served the Association in various leadership positions in the past, and currently serving on the ADA Council on Communications, I feel that I can effectively continue to represent the VDA as a Delegate to the ADA. I humbly ask for your support for the office of ADA Delegate.

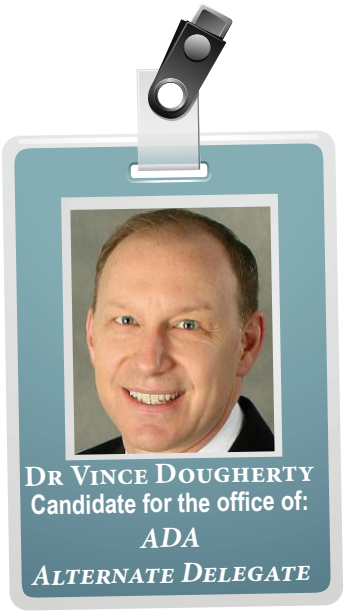


It has been my honor over the last several years to serve the Virginia Dental Association in numerous leadership positions and I previously served my component on the Board of Directors and as your President. I would now like to further my service to the association by respectfully requesting your vote for ADA alternate delegate. My combination of leadership experience and management training well qualifies me to effectively confront the many external forces which our profession continues to encounter. I pledge to do my best to serve you and represent all members of our association on the ADA delegation. Thank you in advance for your consideration and support.



This is such an exciting time to be serving in organized dentistry. Whether it is at the state or national level there seems to be great effort to meet the current and future needs of our profession. I would like to continue to be part of the process at the national level as a Delegate for the VDA.

During the past eight years of service as an Alternate delegate, I have had the privilege to serve four times as District Chair of our Observation Team on Budget and Finance. In addition, I have had the honor to serve the House on ADA Board of Trustee Committees for Strategic Planning and Budget and Finance. These have been terrific opportunities to work with other members of our District Delegation as well as other delegations to build consensus on key issues facing our profession. I ask for you support for a first term as Delegate in order to build on this experience.



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

I have the will, the confidence, and the passion for the position. I promise to represent you in the best way possible. Serving as ADA Alternate Delegate and as past President of Northern Virginia Dental Society, I have acquired leadership and decision making skills to act on your behalf. One of today's critically important issues is access to care. As past chair of the VDA task force on access to care and work force issues, I feel I have the knowledge to make informed decisions. Any vote that I cast will be based on the following question, "Does this strengthen the doctor/patient relationship?"

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

2013 VDA Elected Leadership Candidates

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

I look around and see a fast changing world. The American Dental Association needs to be able to interact with the government at both the state and federal level to quickly and accurately assess how the ever changing healthcare system will affect our patients, our practices and ourselves. I am asking for your help to continue to fight against corporate intervention and government regulation. Your vote will help me to fight for the practices that we have worked so hard to build, so that they may continue to thrive.

As a member of the Delegation to the ADA I have used my budgetary experience to help scrutinize the ADA Budget Proposals and ensure that our dues dollars are spent in the best possible manner and that any dues increases are justified. I have an understanding of how the ADA House works to voice the desires of the membership. I have been active in my support of Organized Dentistry and ask for your support to elect me as an Alternate Delegate.

The House of Delegates of The American Dental Association adopts the budget and develops the policies and programs of our Association. As a member of the VDA and the 16th district delegations, I have been active in the delegation and I am seeking to continue this as an Alternate Delegate to the ADA. I am committed to a broader involvement base which will enhance my commitment to the VDA and serving my colleagues, its members. I will be open minded and listen to any member who has an opinion and will formulate a position which will best benefit our Virginia members not just the needs of only a few.

Welcome New Members

Tidewater Dental Association

Dr. Amen Alemayehu – Virginia Beach – Virginia Commonwealth University – 2011

Dr. Arnold J. Berger – Virginia Beach – University of Kentucky College of Dentistry – 2010

Dr. Louis C. Berger – Virginia Beach – University of Kentucky College of Dentistry – 2009

Dr. Michael Folck, II – Virginia Beach – University of North Carolina – 2000

Dr. Irama L. Forbes – Norfolk – University of Puerto Rico – 2008

Dr. Michael D. Gigliotti – Virginia Beach – Virginia Commonwealth University – 2012

Dr. Mark A. LaRusso – Virginia Beach – University of Illinois, Chicago – 1994

Dr. Julia C. Latham – Virginia Beach – University of Michigan – 2011

Peninsula Dental Association

Dr. Michael L. Hutchings – Yorktown – University of California, San Francisco – 1980

Richmond Dental Society

Dr. Yuriy Abramov – Richmond – State University of New York at Stony Brook – 2012

Dr. Leslie J. Fina – Reedville – New York University – 2008

Dr. Gary R. Hartwell – Richmond – West Virginia University – 1966

Dr. John M. Peroutka – Richmond – Virginia Commonwealth University – 2003

Dr. Erika A. Sachno – Richmond – Virginia Commonwealth University – 2002

Dr. Bhavik Sailesh Desai – Richmond – University of Pennsylvania – 2010

Piedmont Dental Society

Dr. Monica Jethwani – Roanoke – University of Colorado – 2011

Dr. Javeria Mirza – Summerfield, NC – University of Medicine and Dentistry of New Jersey – 2009

Dr. Peggy Lovecchio – Salem – Meharry Medical College – 2007

Southwest Virginia Dental Society

Dr. Sherry Slone Baker – Clintwood –University of Louisville – 1996

Dr. Christopher W. Thurston – Abingdon – Virginia Commonwealth University – 2012

Shenandoah Valley Dental Association

Dr. Noemi Cruz-Orcutt – Charlottesville – University of Iowa – 2011

Dr. Jeff Dickson – Winchester – University of Louisville – 2007

Dr. Nicholas A. Minutella – Charlottesville – University of Maryland – 2011

Northern Virginia Dental Society

Dr. Sheila Agullana – Woodbridge – University of Colorado – 2011

Dr. Rachel A. Agunga – Alexandria – Ohio State University – 2011

Dr. Mohammad S. Aman – Leesburg – Boston University – 2009

Dr. Jennifer C. Bobbio – Ashburn – Virginia Commonwealth University – 2010

Dr. Nancy Su-Fang Chang – Arlington – University of Pennsylvania – 2009

Dr. Neelam Jharar Dube – Reston – New York University – 2011

Dr. Richard B. Grundy – Centreville – Virginia Commonwealth University – 1995

Dr. Justin M. Hardison – Manassas – University of Connecticut – 2009

Dr. Michael H. Kim – Leesburg - University of Michigan – 2003

Dr. Suhad Kim – Leesburg – University of Detroit Mercy – 2003

Dr. Sushant Mahajan – Gainesville – University of Pennsylvania – 2010

Dr. Monica Neshat – Great Falls – Virginia Commonwealth University – 2003

Dr. Chuong C. Phan – Leesburg – Howard University – 2001

Dr. Larry G. Reyes – Arlington – University of Maryland, Baltimore – 2011

Dr. Kelly D. Richardson – Fairfax – Virginia Commonwealth University – 2008

Dr. Afreen S. Sayeed – Fairfax – University of Texas Health Science Center at Houston – 2010

Dr. Shima Shadman – Vienna – Virginia Commonwealth University – 2012

Dr. David M. Treff – Alexandria – New York University College of Dentistry – 2008

Dr. Claudia C. Villarroel-Soto – Falls Church – Universidad del Valle, Bolivia – 1995; Howard – 2007

Dr. Anas Zainul Abedeen – Fredericksburg – University of Baghdad – 2003

In Memory Of:

Dr. Dennis Cleckner
Virginia Beach
Tidewater Dental Association
March 1, 2013

VDA Board of Directors Actions in Brief

1. The following items was considered and the noted action taken by the Board of Directors during meetings held in January and February 2013:

A. Approved - Background: The VDA executive director no longer serves as the executive director of the Virginia Dental Association Foundation and the VDA Relief Fund. Therefore, the following Bylaw change is recommended:

Resolution: In Article IV, Section 4 – strike the following:
G.g Serve as the Executive Director of the Virginia Dental Health Foundation and the Virginia Dental Association Relief Fund.

B. Background: Quality dental programs are vital for our citizens' health and the reputation for that quality and rigor often takes decades to build while requiring an extraordinary financial commitment to successfully operate, therefore, be it

Resolution: The Virginia Dental Association's membership is not in favor of establishing a new dental school at Bluefield College in Tazewell and plans to take an active role in educating all stakeholders on the significant financial risks of and flawed rationale for the proposed project.

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Bank of America

Practice Financing 800-497-6076
Bank of America Practice Solutions

Patient Financing 800-300-3046 Ext. 4519
CareCredit

Collections 804-282-9007
Transworld Systems/Green Flag

PRODUCTS & SERVICES

For your dental office

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SolmeteX

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VDA Services Gloves

Marketing & Communications 800-210-0355
Demandforce

Payroll Services 800-729-2439
Paychex

Website Design 888-466-7975
ProSites

VDA Services is a service mark of the Virginia Dental Association. VDA Services is a program brought to you by the Virginia Dental Services Corporation, a for-profit subsidiary of the Virginia Dental Association.

VADPAC -- When We Give Together, We Have a Stronger Voice!

Thank you very much to so many of you for your past support of the Virginia Dental Political Action Committee (VADPAC). Your support, along with nearly 1,500 of your colleagues from across the Commonwealth, has helped to shape our positive and forward-looking legislative and regulatory policies. As noted in the article which begins on page 55, the VDA had a very successful 2013 General Assembly and our membership is often held up as a model for legislative triumph and victory – we need to keep it that way! All 100 seats in the House Delegates are up for grabs in November which makes our participation in the form of people and money critical in 2013 and beyond. Your participation will ensure we sustain the very positive reputation our members have in the halls of the Capitol and protect the profession for future generations.

Your generosity has played a large part in protecting the dental profession and our patients. Our profession continues to face down, among other things, an extended economic downturn and the threats from and burdensome red-tape of insurance companies, both of which impact our ability to serve the most vulnerable patients. **And, it is for that reason that we must remain more vigilant than ever in protecting patients and our profession. We need your generous support today!** If you have not already contributed to VADPAC or, if you would like to increase your contribution, please contact Laura Givens at givens@vadental.org or 804-523-2185.

2013 DAY-ON-THE-HILL SETS STAGE FOR GENERAL ASSEMBLY DELIBERATIONS

End-of-Session Review Underscores Success of January 18 Event

By: Laura Givens, VDA Director of Legislative & Public Policy

One never knows what January's weather will bring to Richmond. With snow falling the day and night prior to the highly anticipated January 18 event, there was a bit of apprehension in the capital city and surrounding areas.

A few inches of snow, however, could not stop the VDA from completing its mission on the Hill. The weather may have inhibited some from attending, but it couldn't keep our group from one of the most important mornings of the year for the profession of dentistry and its patients. Nearly 100 dentists and dental students arrived ready and able to deliver the VDA's message to General Assembly members.

Day-On-The-Hill participants were familiar with the VDA's principal concern as the 2013 session began: preserving the oral healthcare safety net run primarily by the Virginia Department of Health. Last year, budget reductions proposed by the Governor posed serious threats to oral healthcare access for thousands of disadvantaged Virginians.

You may recall that, in 2012, the VDA and its members lobbied to have funding restored for local dental clinics managed by the Virginia Department of Health. Thanks to the hard work of the VDA and its members, we were successful. Budget money was restored for these programs, and the General Assembly directed the VDH and local clinic stakeholders to study this program. That study was conducted last year.

Unfortunately, the study did little to assuage the VDA's concerns about the program. At the same time, it was apparent that additional General Assembly funding would be necessary to transition the program to a **preventive care model**. In brief, this meant that the VDA's commitment to preserving access to oral healthcare would be tested again, this time by the 2013 legislative session where the VDA would propose additional money for the transition and continue to advocate for more cost effective means to meet these needs.

Dentists and VCU dental students gathered for breakfast that cold January 18 morning and received the remarks of **Delegate M. Kirkland Cox** before departing for the Hill. Delegate Cox, the House Majority Leader, addressed the importance of grass roots political action in achieving benefits for the profession's patients and discussed many of the key issues the legislature would be looking to tackle.

Delegate Cox, a tireless and committed legislator, was introduced to Day-On-The-Hill attendees by his friend and VDA Board of Directors' member, **Dr. Sam Galstan**. Delegate Cox, as Dr. Galstan observed, has an acute understanding of how legislation and the state budget impact dentistry. Dr. Galstan also noted that Cox has provided a consistently high level of leadership across the healthcare field during his legislative career.

Day-On-The-Hill participants also received a briefing from VDA lobbyists **Chuck Duvall**, **Denny Gallagher and Tripp Perrin.** The issues covered in their presentation and the results of VDA lobbying on these topics during the session are as follows:

Preserving the Oral Healthcare Safety Net While Local VDH Dental Clinics Transition to Preventive Care:

As noted above, the VDA and its members are committed to preserving access to oral health services for Virginians in need. To this end, the VDA asked for approval of budget language and a $967,944 General Fund appropriation to continue funding through the fiscal year beginning in July for clinics managed by the Virginia Department of Health. Day-on-the-Hill participants told legislators that the VDA's budget language constitutes a "road map" for a successful transition to preventive care while the appropriation means that dental services would continue for thousands of Virginians.

Final Legislative Action: The General Assembly approved both the VDA's "road map" budget language and the appropriation of $967,944 in General Fund money to continue operation of local VDH clinics in the fiscal year beginning July 1, 2014. The legislature also appropriated $696,362 in non-General Fund dollars for these programs for the same period.

Medicaid Expansion: Day-On-The-Hill attendees asked legislators that if Medicaid is to be expanded, the same partners responsible for Virginia's successful *Smiles for Children* should be involved: DMAS and its Dental Advisory Committee and the VDA.

Final Legislative Action: The General Assembly established a Medicaid Innovation and Reform Commission to oversee the development and implementation of Medicaid reforms before Virginia expands this program. Richmond **Delegate John O'Bannon**, a physician and Commission member, said, *"Medicaid is the fastest growing item in the state budget, and Medicaid expansion without significant reforms could wreck Virginia's finances. We need to make sure that patient-centered cost saving reforms are fully implemented before we think about moving forward."* The General Assembly's approach to Medicaid expansion is currently being reviewed by the Governor.

Definition of Dental Hygiene: The VDA supported legislation introduced by **Delegate Dickie Bell** (R-Staunton) to modernize the definition of dental hygiene. Legislators were informed during Day-On-The-Hill meetings that Delegate Bell's bill does not change any of the current education and training requirements

for dental hygienists nor does the bill change a dental hygienist's "scope of practice". Delegate Bell introduced the measure at the request of the Virginia Dental Hygienists Association. Both associations worked together to make the bill acceptable to dental hygienists and dentists.

Final Legislative Action: The General Assembly approved Delegate Bell's bill (HB 1349) on a series of unanimous votes in both the House and Senate. The legislation is now pending before Governor McDonnell.

Affordable Care Act: Before the January 18 Day on the Hill, Governor McDonnell announced that Virginia would not establish its own healthcare exchange, deferring instead to the federal government. Nonetheless, it was possible as the General Assembly began its work that legislation would be introduced to establish a state-based exchange for use at a later time. In this event, the VDA asked that legislators include a **stand-alone dental plan** to insure competitive markets that would produce more consumer choice and better patient benefits.

Final Legislative Action: The General Assembly passed legislation authorizing the State Corporation Commission's Bureau of Insurance to license and regulate insurers who want to offer policies under the federal program ultimately agreed upon by Virginia and federal authorities. This legislation is currently being reviewed by the Governor and all subsequent developments in this regard will be closely monitored by the VDA.

New Dental School Proposed: Near the end of this year's General Assembly session, the VDA Board of Directors asked that a number of amendments be added to legislation designed to help fund a dental school in Tazewell County. This project, a joint venture of Bluefield College and Tazewell County, was the basis for legislation patroned by **Senator Phillip Puckett**. In the VDA Board's eyes, the association's amendments were necessary to ensure – at the outset of this project – that financing would be authorized only if the Southwest Virginia Health Authority receives " *… a prospectus, operational budget, and five-year business plan … together with identification of all revenue and funding resources required to fully meet the five-year operational budget."* With Senator Puckett's gracious acceptance, the VDA's amendments were adopted by both the Senate and House. Senator Puckett's legislation, Senate Bill 1347, is now pending before Governor McDonnell.

The VDA thanks all member dentists, VCU dental students and other members of the dental community who participated at this year's Day-On-The-Hill. We hope that this event will continue to grow in the years to come; a review of the past several General Assembly sessions certainly gives proof to the success and importance to the Day-On-The-Hill activities.

Please mark your calendars to attend the 2014 Day-On-The-Hill: January 17, 2014.

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








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VDA Member Spotlight: Dr. David Black

By: Dr. Gene Ayers, Associate Editor, Component 5

Dr. Black

Dr. David Black currently serves on the VDA Board of Directors as the Component Five representative. Beginning that journey, Dr. Black, with diploma in hand from West Virginia University School of Dentistry, settled in Vinton with wife Barbara, and opened a solo dental practice in 1971. The usual hard work of building a practice ensued, but not without thought of giving to his community.

David was instrumental in establishing the Bradford Free Clinic in Roanoke and, as a volunteer, helped it grow. He enjoyed teaching radiology for dental assistants at the local community college as well as serving on numerous local volunteer boards. Among these, continuous service on his church vestry board led him to become involved in dental missionary trips, including time spent in Bolivia, Haiti, and Jamaica. When the time came he was a natural fit to serve as local chairman for the M.O.M. projects in Roanoke, Virginia.

Dr. Black has served his dental community as Roanoke Dental Society Treasurer, President of Fifth Component (Piedmont) Dental Society, VDA House of Delegates member, Component representative for VADPAC, local arrangements chairman for the VDA Roanoke state meeting and as a member of the Council on Sessions. His participation has led to recognition as a Fellow of the VDA and the International College of Dentists. Continuing education has been Dr. Black's passion. He has completed continuum courses with the Pankey Institute, Dawson Academy and Nash-Rosenthal Cosmetic Dentistry and numerous individual courses. He has been active in the Academy of Cosmetic Dentistry and the Academy of General Dentistry. Recently David merged his solo practice with the Harvey Dental Group for a new direction for full-time practice emphasizing restorative and cosmetic dentistry.

Though he has thrived on dental activity of all sorts, the real life focus for David has been his wife, two daughters and seven grandchildren, the latter moving him more energetically than ever. Like so many others like him in dentistry, Dr. Black looks back on his career, grateful for the satisfaction and opportunity to serve that dentistry provides.

Dr. and Mrs. Black, grandchildren