Virginia Dental Journal
Volume 89, Number 4 • October, November & December 2012

In This Issue:

Virginia Dental Association

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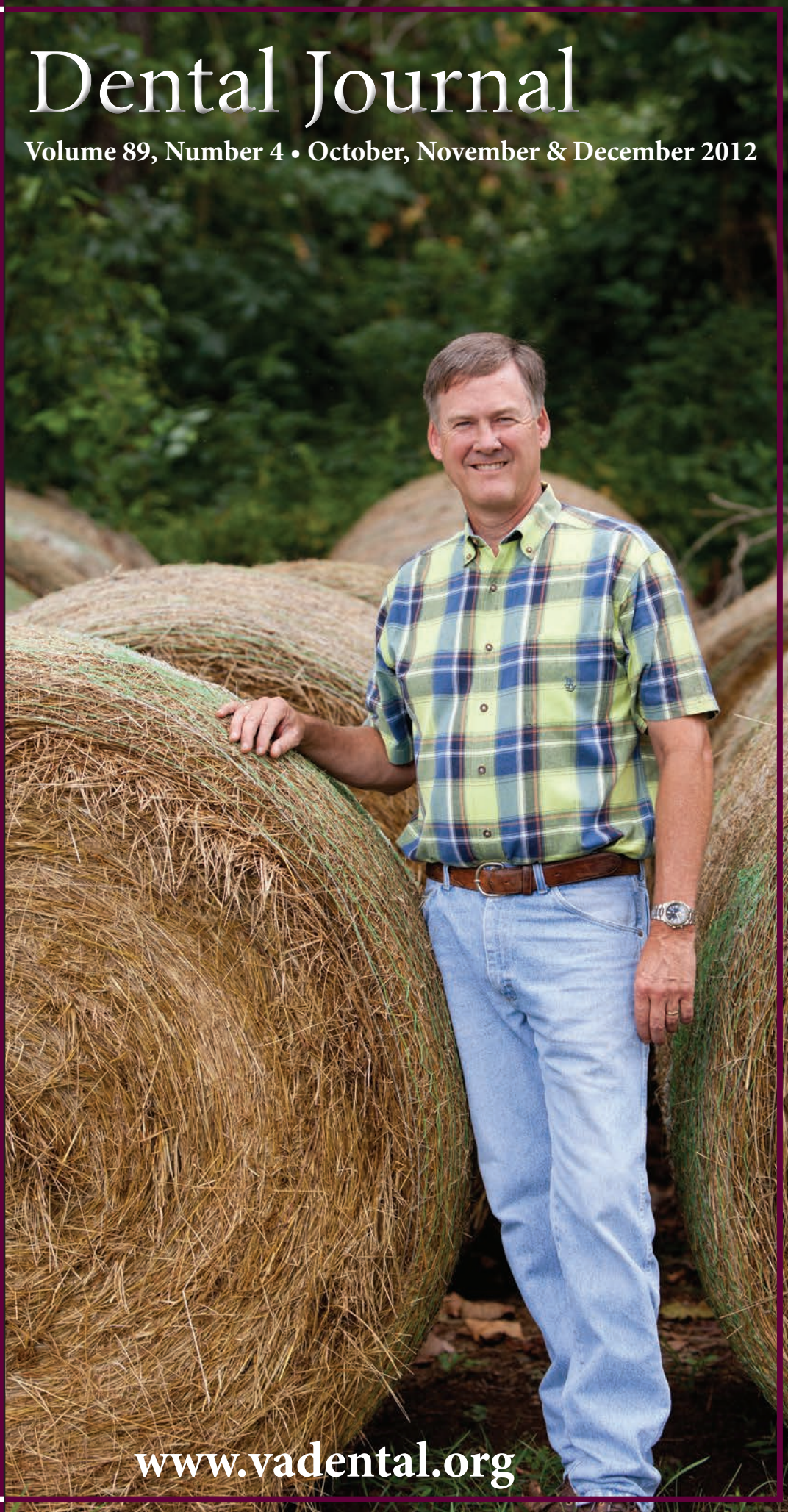

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Contents

October
November
December
2012

HEADLINES & ARTICLES

DEPARTMENTS

Dr. Kirk Norbo, 2012-2013 VDA President - at his farm in Waterford.

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.

Volume 89, Number 4 • October, November & December 2012

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MESSAGE FROM THE EDITOR

Dr. Richard F. Roadcap

In 1980 a candidate for office asked voters if they were better off than four years earlier.[1] The question has become a staple of political campaigns, with challengers hoping to capture voters' discontent, and incumbents hoping they can't recall. I've just eclipsed the five-year mark as Editor, and I'm sensing much more discontent among dentists than in 2007. Maybe it's my hastening age or the folks I hang out with, but doctors are filled with angst just like the nanoparticles that fill the resins we place in posterior teeth. What are these things that go bump in the night?

Midlevel Providers- Open any publication to read about midlevels – they're around every corner, beneath every rock, coming to a neighborhood near you. And why shouldn't we be concerned? Two years out of high school they'll be licensed to perform almost any procedure we can do after we've spent four years in college, four in dental school, and maybe one or two in residency. Of course, their fees will be lower, much lower. Feel threatened? In most states, Virginia included, you're more likely to meet Sasquatch than a midlevel. Training, funding, and licensing are all problematic. Even now many dental team members have a hard time finding employment.

New Dental Schools- When I was a student in the '70s there was one dental school in Florida. If all plans materialize there will be soon be six.[2] California now has six dental schools open, and in September plans for a dental school in Southwest Virginia were announced. Many of the recently opened schools have a modus operandi of less bricks and mortar, more off-campus training, and creative methods of funding. Will there be an oversupply of dentists? Will underfunded schools close, as many did between 1986 and 2001? It's certain that most students at the new schools will be licensed upon graduation.

Healthcare Reform- If you read Dr. Ron Tankersley's fine article in this issue, you'll see it's impossible to predict the outcome of the Patient Protection and Affordable Care Act (PPACA). On one hand, the Act fails to address dental care in any specific way. On the other hand, the law of unintended consequences is enacted. For example, if employers jettison sponsored indemnity plans for ACOs, deciding fines are cheaper than premiums, dental plans could evaporate. If ACOs decide to offer dental plans, corporate providers may be the beneficiaries, leaving sole practitioners and small groups adrift. But the lack of attention to dental care in the Act may prove to be a blessing.

Patient Expectations- From aligners to veneers, from implants to whitening, dental advertising leads patients to expect perfection, beauty, and complete satisfaction. Alas, most dentists are merely very good at what they do. Our case presentations provoke the question, "Why can't you be just like Dr. Perfect (I saw on TV)?" The gap between anticipation and reality, however small, causes profound disappointment among patients and doctors. Self-acceptance demands we persist in the face of unreasonable demands – we're never going to be Dr. P.

A Moribund Economy- Got savings? There's been no need to check their status in the last ten years or so. Like an insect trapped in amber, or scrolls in earthenware jars, a lost decade (now about twelve years running) in our economy has left retirement plans in their pre-millenial state. A lack of growth in these plans translates into a much-delayed retirement. We love our work, but we can't work forever. Not only has retirement been deferred, but also plans for practice growth, and job opportunities. Our office now receives frequent applications from qualified candidates, a rare occurrence before the recession. Is there a silver lining? Perhaps "early retirement" is once and for all defined as an urban legend.

Third Parties- Absent the repeal of the McCarron-Ferguson Act, the '40s relic that indemnifies carriers against any reasonable restraint, third-party payers continue to hold the upper hand. Patients tell us "The insurance company says not to let your dentist use those white fillings – they cost more!" Libelous, for certain, but we're defenseless in this environment. We've been dealing with insurance carriers for decades, and that's unlikely to change. Although it appears those dealings will grow more onerous, we're free to participate or not, and I will give no advice on that subject.

In 1933 a successful candidate for elected office said fear was the problem.[3] With apologies to Tom Clancy, the sum of our fears may be greater than its parts. I'm confident dentists are more perplexed now than five years ago. Our world has changed (remember the shortage of dentists?) and some of our long-held notions have perished. The years ahead – let's call them the "teens" – hold promise and peril. Dentistry has always been nonpareil among professions, setting a standard that benefits the public, advances science, and in the process rewards its members.

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1 http://www.youtube.com/watch?v=loBe0WXtts8

2 http://www.ada.org/news/6173.aspx

3 http://www.youtube.com/watch?v=amNpxQANk0M

LETTERS TO THE EDITOR

A Dental Specialty - Divided

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

To the Editor of the Journal:

This dental specialty has been named "Exodontia", "Oral Surgery", and "Oral and Maxillofacial Surgery" (OMS). Regardless of its name, the major procedures are still Exodontia, Dento-alveolar surgery, and few new minor oral procedures. The other major procedures are performed in a Surgicenter or Hospital and they are not the everyday bread and butter operations. Frequently these are procedures competitive with medical specialties.

In 1958 I published an article titled "Oral Surgery – How Long a Specialty of Dentistry?" This was written to emphasize the need and importance of integration of all the Oral Surgery programs with the same scope and educational requirements. With this philosophy all oral surgeons acquire the same postdoctoral educations and the scope of the specialty is well-defined. This makes for a strong and highly professional dental specialty.

About 12 years ago OMS had two potential available programs, each resulting as qualified OMSs and the ADA approved only a four-year accredited residency, with the option of a six-year program terminating with an MD degree. This has now resulted in two education programs. They are the single degree and the dual degree programs. In 2009-2010 48% of the total residents in OMS were in the dual degree program, with 52% in the single degree program. In 2006 there were 68 residents in the dual degree program, while in 2009-2010 there were 89 OMS residents in the dual degree program.

In the not distant past there were no Medical School based programs. In 2009 there were 9 Medical School based programs. Usually they were hospital or dental school based (most still are).

I see two educational programs leading to future OMSs, and we have two types of OMSs? If this trend continues this dental specialty will certainly be divided and as a result dentistry could lose one of its oldest and respected specialties.

I am not opposed to any progressive and effective education programs as long as the requirements are same for all future oral and maxillofacial surgeons.

Marvin E. Pizer, D.D.S., M.S., M.A.(Ed.), FACOMS (Hon.)
Past President, Virginia Society of Oral and Maxillofacial Surgeons
Past President, Middle Atlantic Society of Oral and Maxillofacial Surgeons
Retired, Diplomat, The American Board of Oral and Maxillofacial Surgery

HPV Vaccine

Leslie I. Richmond, DDS

To the Editor of the Journal:

For those who may be interested in learning more about the pros and cons of the Gardisil vaccination, I suggest you visit the Mercola.com website and search HPV vaccine to find numerous articles on Gardisil. It is not as safe as the media lead us to believe and may not be as beneficial as advertised.

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MESSAGE FROM THE PRESIDENT

Dr. Kirk Norbo

Dr. Kirk Norbo gave this speech at the 2012 VDA Governance Meeting on Saturday, September 22, 2012.

Thank you for placing your trust in me by electing me as your president. I hope to meet your expectations and ask for your support in the upcoming year as we move the VDA forward. We are facing an ever changing environment and must continue to address the increasing challenges facing our profession.

I would like to begin by thanking my family; my wife and best friend Luann, my mom and dad Pat and Gary, my son Justin, who practices with me and is a 2010 graduate of VCU, and his wife Meredith, who could be a potential ringer on our 16th District golf team, and my son Kris who is a third year dental student at VCU and finds time to play goalie for the VCU ice hockey team. My youngest son Nathan is working on a ranch in Wyoming doing some of the things I enjoy almost as much as dentistry and is unable to join us today. Also, I'd like to thank my brother, Dr. Randy Norbo, and his wife Phyllis, who are attending a family wedding and could not be here today. I am so fortunate to have such a special support group; without them, I would not have been able to rise to this position, so thank you.

In addition I would like to thank two individuals who have played important roles in formulating my decision to ultimately serve as your VDA president. First, thank you Rod Klima. Rod came to me on a couple of memorable occasions with a big smile on his face and asked me to consider serving first as NVDS Vice-President and later VDA president elect. We all know what a warm, genuine, sincere person Rod is and how much he cares about our profession so I was honored when he asked me to consider serving in these capacities. That's when I started thinking about all the great things this Association has accomplished and realized that assuming these leadership roles would be my way of saying thank you. The other individual who played an important role in my development is Ron Tankersley. After serving as your ADA President, Ron has given many lectures addressing moral values to various dental groups and continues to wave the flag of ethics for our profession. As the 16th district Trustee, he appointed me to the ADA Council on Ethics, Bylaws and Judicial affairs. This council essentially serves as the conscience of the ADA and has been made up of some truly exceptional individuals. Virginia has had four consecutive members appointed to CEBJA and I am honored to be included in this group that includes Joan Gillespie, Bruce Hutchison and Elizabeth Reynolds. Up to this point, that has been the highlight of my involvement in organized dentistry and has served to enhance my leadership skills.

Many of us take for granted all the work that goes on behind the scenes by our VDA staff. This group works tirelessly and many times goes unnoticed. They are asked to join us on after hours conference calls, weekend meetings and continue to go the extra yard for us. These dedicated individuals are the heart and soul of our association. Please join me in giving them a warm round of applause.

There are several topics, we as an association, need to address today that will influence the future of the VDA.

First of all, I think it is imperative that we make a concerted effort to educate the public about what the VDA is and who we are as members. In that vein, the proposed PR campaign that we will be voting on this weekend will begin the process. Wouldn't it be refreshing to hear that people visit their dentists because they are VDA members, not because they take their insurance? Our members should be held to a higher standard if our intention is to elevate our image in the eyes of the public. It goes without saying that a VDA dentist must focus on delivering top quality dental care while adhering to our unwavering code of ethics. It is up to our association to brand our members in such a way that the public will come to expect a predictable product or service. We must take a more active role in educating our members as to what defines a VDA dentist and address any lapses that blatantly disregard our expectations. My hope is that the PR campaign will create a clear distinction between members and nonmembers that will produce a sense of pride in our association. The advertisements will be designed to encourage the public to visit a VDA dentist. Our intention is to generate more patients for your practices and help you more effectively compete in the dental market place. The leadership of your association realizes that this program comes with a price tag and some members feel this is unnecessary. We are very aware that this proposed campaign has surfaced during less than desirable economic conditions but the benefits of this venture will be worth the $.96 a day cost to each member. I really feel this PR campaign will boost the image of our Association and make each of us proud to be VDA members.

We are all aware of our decreasing membership share that is now at approximately 67%. I would challenge each of you to reach out to a new practitioner in your community and invite that potential member to a VDA sponsored event. I would ask the Membership Committee to help with this request by identifying non-member dentists within each of our components and pair them up with one of our members. Up to this point, much of this workload has rested on the shoulders of our staff but I think each of us should take a more active role in this recruiting process. While this one effort will not solve our total membership short comings it is a step in the right direction.

With regard to the ethical standards of our members, it is up to each of us to set the bar high so that the public recognizes our standard of excellence and the commitment we make to serve them. Identifying possible infractions and referring them to our Committee on Ethics is one avenue we may choose to follow when working with members who may or may not be aware of ethical lapses. We are in no way advocating a "witch-hunt" within our membership but rather hope to motivate members to raise their standards. If we hope to raise the ethical bar within our association and more importantly improve the public's perception of dentistry we must encourage our members to take the "high road" when it comes to advertising and patient treatment. It has become all too easy for colleagues to be tempted to compromise their practice techniques. Most of us have seen advertising patterns that have become more and more questionable. This trend may continue to escalate with the recent opening of new dental schools and higher numbers of graduates. The Board of Dentistry's "no harm no foul" attitude when addressing advertising issues has allowed some to "push the envelope" realizing that penalties are rare and inconsequential. This is where our association, more specifically the Ethics Committee, will assume the responsibility of enforcing ethical shortfalls. If members truly value their affiliation with our association, positive behavioral changes will occur as each member seeks to abide by our code of ethics.

Our governance structure is currently under review by a recently formed task force, and in the next year I would expect some well thought out plans to surface that may change the manner in which we govern ourselves. Early in its deliberations this group realized that a strategic plan with the following four priorities would need to be adopted to carry out its mission. We will be voting on these priorities this weekend and are as follows:

The VDA:

1. Will be the leading authority for Virginia's dental professionals for education, information, networking, wellbeing, support and services.

2. Will develop a climate which produces innovative, diverse and creative leaders with passion and vision for the future.

3. Shall be viewed as the trusted and primary service of oral healthcare information and delivery; and be the authority on access to dental care for the profession and all Virginia citizens, and

4. Will actively encourage recruitment and retention of members.

One of the biggest questions that must be answered by this review is whether our committee structure is still relevant and effective in guiding our association. We continue to struggle in filling our committee positions from each component and finding the meaningful pieces necessary to drive good committee work. Using task forces to deal with time sensitive issues has led us to question how we do business through our committee structures. Time is critical when these emerging issues meet us head on so we must either restructure and recreate our committee structure or use a mixture of committees and task forces to more efficiently and effectively address these critical issues. If the committee component of our governance receives a vote of confidence from the task force, should the selection of the members be geographic or skill based? Should our leadership take a more active role in providing meaningful subject matter for our committees so that they will remain engaged and feel useful? Our committee chairmen must possess infectious passion that energizes each member of the group. Success of each committee therefore lies in the hands of its chairman. Should these chairmen continue to be elected from within their respective committees or should the president reassume this responsibility? These questions must be answered with well formulated criteria if the committee structure is to be re-kindled.

As most of you are aware of, Dr. Wood appointed a task force on Access to Care that did an amazing job analyzing this ongoing dilemma. This is an issue that is intertwined in our society, is complicated, and has no simple solution. We are the experts in dentistry and should continue to provide the all important answers to these difficult questions. This task force has come up with some well thought out suggestions that may serve to deliver more care to the citizens of our Commonwealth. I would personally thank this group and look forward to implementing your proposed resolutions.

Another area that I feel we can improve on, is reinforcing the private practice model that has been molded and developed for the past 150 plus years. It seems like we spend more time apologizing for the relatively small shortcomings we have in our system than we do preaching about the efficient manner in which we treat the public. The dentistry we provide in our state and in our country is recognized as the gold standard throughout the world yet we are constantly required to defend the manner in which we practice. When necessary, our association should help facilitate ways to improve delivery of care within our existing practice model. We should hold our heads high and be proud of our accomplishments.

How do you feel about corporate dentistry? You may not have an opinion about this quickly growing segment of our profession but it will definitely impact the future of dentistry. Dental students are recognizing these corporations as possible employers because of the guaranteed salaries and generous benefits. Organized dentistry may not prove to be relevant to these groups that often provide in house CE, insurance, and are generally self-sufficient. It is up to us, VDA members, to provide competitive practice opportunities for our young colleagues. If we are to perpetuate the current private practice model and consequently develop practitioners who will continue to seek our association services, we must offer positions that are clinically and financially attractive. I would propose that we establish a clearing house that would allow our members to market their practices and announce employment opportunities. This potential committee should be composed of members with skills that would aid in the transition of our retiring practitioners, while bringing prospective practice purchasers to the table. We have a large number of members who will be selling practices in the near future and a growing number of graduates who will be seeking private practice opportunities. The intent of this proposal is to provide another benefit that will help our members formulate business decisions that would result in successful transitions.

For the past decade, maybe longer, the VDA as well as the ADA has spent much time and financial resources dealing with issues such as access to care and midlevel providers. Addressing these concerns was identified as priorities for organized dentistry and with good reason. During this time, the day to day business needs of our members seems to have been lost in the shuffle while we focused on threats posed by Pew, Kellogg and other governmental agencies. We see ourselves as the "go to" dental authority in our state. If that is the case, we must not only serve as a resource for the public but also serve as the cutting edge business resource for our members. It is our responsibility to provide our members with the business tools necessary to not only be successful in the health care marketplace but more importantly see an unquestionable value in paying VDA dues. Members must feel that we care about them! I therefore would like to organize a Business Resource Task Force that will take a look at all the elements necessary to build and maintain a thriving practice. This task force will be composed of members who wish to volunteer their various business skills for the common good of our membership. Our vision should include additions to our website that makes this information easily accessible to our members. Links to other websites that would help in making educated business decisions are very important and would increase membership utilization of the VDA website. Students and young graduates are constantly asking for more business information and if we are to attract and retain them as members we must answer the call.

On the educational front, our dental school has a need for our continued support clinically, financially and philosophically. Have you considered passing on your dental expertise to our future colleagues? I think our members have a great opportunity to serve as role models while attending as adjunct faculty at VCU. Not only would you be able to help students develop clinical skills, but also educate them as to the benefits of joining organized dentistry. The students have asked the VDA to provide mentors, however, there has been an ongoing challenge to arrange convenient meeting times and venues. Extending the mentorship program into the dental school by way of our mentors serving as adjunct faculty could be a simple solution. I have personally found this to be a very rewarding experience. These students represent the future of our profession and are interested in finding out what lies ahead in their upcoming careers.

The VCU School of Dentistry is a traditional university based program attached to large academic medical center – the ideal setting for a school of dentistry. Philosophically, we should be concerned with the evolution of the new schools that have opened with little or no major university affiliations. This is being driven for odd reasons but under the guise of enhancing the access to care. In Virginia there is a problem with access to care but one that will not be solved by additional dentists being educated. But that is perhaps a discussion for a later time. William Gies, an icon in American dental history and for whom the American College of Dentists gives its highest award each year lobbied against "proprietary (dental) institutions without medical school or university affiliation". Gies stated that "it is obvious that a professional school, managed so as to pay a profit to its owners, cannot give to its students the advantages afforded by a professional school conducted as part of a university". The establishment of new dental schools that depend on large numbers of students paying higher tuition and fees will only contribute to the indebtedness of graduates. This directly impacts decisions concerning locations and styles of practices. We need to be vigilant to insure that students graduate with a strong scientific foundation that we experienced so as not to ultimately compromise our professional status. So, when the opportunity presents itself, let policy makers or other influential people know that we are dedicated to supporting and preserving dental education, grounded in science and coupled with top-notch clinical training. This defines our VCU School of Dentistry.

The VDSC continues to provide financial assistance to our association. I know

that most of you have seen the lime green cards that list the endorsed vendors. Please take another look at these companies and see if any of them may be of assistance to your practice. Prosites and Demandforce are two of the most recently endorsed groups. I have personally signed contracts with both companies and found them to be most beneficial. Prosites is a website developer that is user friendly and can be tailored to your specific practice. One of the main reasons it was endorsed is because website updates can be easily made by any member of the dental team. Demandforce serves to assist in the business aspects of dental practices by confirming appointments, surveying patients about dental visits and providing an overall analysis of patient satisfaction. Any of you seeking additional business support should consider these groups as possible partners in your practices. There has been a downturn in royalties from B and B, the endorsed insurance agency. Insurance companies have cut compensation to their agents that has in turn reduced payments to our for profit arm. We expect this trend to continue and therefore expect VDSC revenues to decrease unless utilization of the other endorsed vendors increases. So once again I urge you to seriously consider adding these services and products to your practice. Support of these vendors directly subsidizes your dues and has kept them relatively low.

In closing, I would like to spend much of the upcoming year focusing on the business needs of our members. Current economic conditions have made each of us pay more attention to profit/loss statements and in many cases we have seen decreasing incomes. It is our responsibility to provide both professional and business leadership that dentists in Virginia can rely on. Thanks for taking time out of your busy schedules to come together for the common good of our association. Our profession has been under the microscope recently so our efforts to remain unified are critical to our survival. Most of us would agree that we are truly blessed to be part of a profession that allows us to improve the health of our fellow man while experiencing a fine quality of life.

Thank you!

Delegates Approve Advertising and PR Campaign

By: Dr. Michael J. Link

After significant research and discussion among the entire membership, the VDA House of Delegates voted 113-3 to approve our first statewide marketing campaign.

The initiative, called a "Healthy Body Starts with a Healthy Mouth," will include TV commercials, a comprehensive public relations effort and a new consumer-oriented landing page with a prominent find-a-dentist feature. The major goals are patient education and enhancement of our profession. I encourage everyone to update their websites and ADA profile to take advantage of the new inquiries you should be receiving.

The 3-year campaign will begin in early 2013. Stay tuned for more details.

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An Interview with:

Dr. Kirk Norbo

2012-2013 VDA President

VDA Journal: What prompted you to run for VDA President?

Dr. Kirk Norbo: Organized dentistry has provided me with some great opportunities to develop my leadership and professional skills. I feel like the VDA has done so much for me, that I can return the favor, by serving as VDA president and help our members experience some of the same benefits.

Journal: What's the greatest challenge facing the dental profession today? How should organized dentistry respond?

Dr. Norbo: There are two equally important challenges that we must address. I feel that threats to our existing dental care delivery model from outside agencies and groups, as well as escalating dental school debt, are bound to affect our profession. We, the VDA and its members, know how to deliver care to our patients. This should not be dictated to us by groups of non-dentists who have no comprehension of how to practice dentistry. The financial status of our graduates influences practice decisions that can be altered by huge debt loads. Both of these issues can be best addressed by maintaining strong liaisons with our legislators and providing representatives to various oral health care work groups.

Journal: What legislative concerns are on the horizon, both in the General Assembly, and in Congress?

Dr. Norbo: The Healthcare Reform Act, third party payer issues and mid-level provider activity are our biggest concerns at this time.

Journal: A recent JADA article found that dental incomes have declined since 2005. Do you think this trend is temporary or secular? Should we be concerned?

Dr. Norbo: Dental incomes somewhat mirror economic conditions. Our patients are delaying elective procedures until their financial positions are improved. When the economy improves and more importantly the public gains confidence in recovery, incomes should rebound. The other factor that will play a role in profit margins is insurance reimbursements. We should be concerned with this trend of decreasing payments.

Journal: If you could accomplish only one thing during your tenure, what would it be?

Dr. Norbo: Reverse the trend in declining membership.

Journal: Why is the VDA's membership percentage declining? What should we do?

Dr. Norbo: In short, non-members don't see the value in joining. The solution is complicated because we are dealing with a very diverse group of professionals. We must let all dentists know that we care about them, and want to help them be successful in the day to day operations of their practices.

Journal: Let's say I'm a new graduate, working part-time, with lots of student debt. Why should I join organized dentistry?

Dr. Norbo: Advocacy is still the best reason for any young person to join organized dentistry. Another important reason to join the VDA is for the networking opportunities. It is easy for us to get caught up in our practices and feel like we are isolated. Talking to other members with similar concerns develops a camaraderie that is invaluable.

Journal: You've been an advocate of mentorship programs. Define them for our readers. Why are they important for the future of dentistry?

Dr. Norbo: The VDA really only has one formal mentorship program and that is organized by the Mentorship Committee. The committee has paired up VCU dental students with volunteer VDA mentors and invited both groups to meetings with guest speakers. These gatherings have provided networking opportunities for students and mentors with a goal of transitioning students into the practice community. Mentorship efforts are critical to the development of our new practitioners by passing along information that will help them make well guided decisions and opens doors to great friendships.

Journal: While we're on the subject of mentors, who were yours? Tell us how they changed your life.

Dr. Norbo: When I joined the NVDS I was mentored by a group that included Dave Whiston, Doug Wendt, H.J. Barrett, Rod Klima and Dave Anderson. Their support as I was establishing my new practice was invaluable as they made me feel like I was their equal. This group gave me guidance as to how I should go about dealing with my patients but more importantly encouraged me to become a leader in the VDA.

Journal: Finally – what would you like to be doing five years from now?

Dr. Norbo: I would still like to be practicing dentistry with my sons Justin and Kris. My intention is to pass along a profession that will be as good for them as it has been for me.

VDA
Virginia Dental Association

Developing Your Social Media Strategy

Brett Bazzini

DATE: Thursday, October 25, 2012

TIME: 5:00pm-6:15pm

COST: Free to all VDA Members and their staff

CREDIT: 1

Visit www.VADENTAL.org to Register

COURSE DESCRIPTION (LECTURE VIA WEBINAR):
This one hour webinar will cover new channels of marketing, advertising, and communications that make up the social media space. Using case studies and real-world examples, this course will explore ways practices are embracing online social networks, blogs, podcasts, and even Twitter, to create brand awareness and buzz.

COURSE OBJECTIVES:

- Understanding the social media marketing landscape and its impact on traditional marketing strategy
- Integrating social media marketing into practice marketing and overall business strategy
- Leveraging your social media footprint to increase your bottom line and position yourself as a thought leader

SPEAKER BIO:
Brett Bazzini has 5 years of experience in sales consulting and joined Demandforce in early 2012. He's worked with Silicon Valley startups as well and has consulted in a wide variety of industries including IT, clothing companies, and independent services, helping them become more efficient and their profits and marketing reach. He's seen the exponential growth of the Dental team at Demandforce and looks forward to sharing success stories from other dental practices that have benefitted from online patient communications and marketing tools. Mr. Bazzini is an employee of DemandForce.

FOR MORE INFORMATION: Go to our website at www.vadental.org or contact Carter Lyons, VDA Director of Continuing Education at lyons@vadental.org

CANCELLATIONS: To cancel a registration for this webinar please contact Shannon Jacobs at jacobs@vadental.org by **October 24, 2012**.

COMMERCIAL SUPPORT FOR THIS PROGRAM PROVIDED BY: Demandforce Growth. On Demand.

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Ethics goes to the movies

By: Ethan Puryear, VCU School of Dentistry, Class of 2014

In 2008 the ADA created an ethics video contest for dental students. Videos entered in the contest must show an ethical dilemma that highlights one or more of the ADA code of ethics principles. All entries must be original works with no copyrighted video or music included. Winners are announced and displayed at the ADA Annual Session. Students from VCU's class of 2014 have submitted an entry for each of the last two years.

Our video for the 2012 contest was titled "The Spirit of Dentistry." It is the story of a student who separates a file while performing a root canal treatment on a patient. The student must decide between being honest about the separated file and losing the endodontic case or keeping quiet and finishing his last endo requirement for graduation. At this point he is visited by a mysterious character who offers a glimpse into the past and the future of the student's career.

Initially, the student is shown a flashback to his preclinical endo lab. In the flashback the student is shown modifying a competency tooth before turning it in. Although the student is dishonest with his professors, he justifies the situation because no patients were harmed since it was "just a lab." The spirit also shows the student what his future will look like if he continues to make similar decisions. In the flash forward the student is in front of the board of dentistry. As the board members read off the allegations brought against the now practicing dentist, he realizes that these poor decisions have compromised the care provided to his patients. Seeing these situations helps the student look past his graduation requirements and make the decision that is best for the patient.

Making the ethics video forced us to think through common ethical scenarios. We wanted to show a student who was not a bad person but someone who made a few bad decisions in tough situations. We consulted with faculty members on what situations were most likely to get dentists, including student dentists, in trouble. We were advised that everyone makes mistakes but that it was important to handle those mistakes in an ethical manner.

As students, we are not burdened with marketing a practice, billing insurance and that first student loan payment is still a year or two away. Many of us are still forming opinions about our personal treatment philosophy and how we want to practice in the future. Making the ethics video was not only fun but in some ways forced us to consider these aspects of dentistry that we do not deal with on a day to day basis yet. Stay tuned to see the results of this year's ADA student ethics video contest. In the meantime, grab some popcorn and see the links below for previous winners and VCU's current entry.

To watch previous contest winners visit: http://www.ada.org/4064.aspx

Editor's Note: The VCU student entry "The Spirit of Dentistry" received honorable mention (2nd place) in the ADA Ethics Video contest for 2012. The video will be played at the annual session, and is (will be) posted on the website www.ada.org. Congratulations to Ethan and his fellow students on their accomplishment.

Ethan Puryear is in the Class of 2014 at VCU School of Dentistry. He currently serves on the VDA Ethics and Judicial Affairs committee.

The Virginia Plan - *Improving Access to Care and Medicaid Utilization*

By: Dr. Ted Sherwin

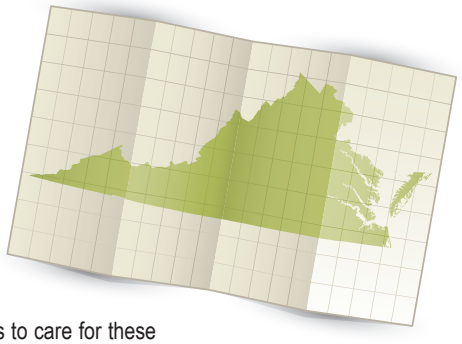
Executive Summary

With dwindling public funding for oral health care beginning in the 1980s, state and national concerns have risen regarding oral health care in the United States. During the intervening years the discrepancy between those who receive care and those who do not has led to a national debate which was highlighted with the release of the Surgeon General's Report (Oral Health in America: A Report of the Surgeon General; 2000). This debate was framed around addressing the needs associated with access to care and utilization of care. Unfortunately, the press and others have labeled the debate as an access issue; and while there certainly is a component of the problem that is related to finding a dentist, the larger issue in the Medicaid population is: why don't families who have free coverage use dental services when they are available? Therefore, solving problems of utilization of care should also be a primary concern given that funding is already available. Until current efforts to increase the number of participating dentists and overcoming barriers associated with utilization by families covered under Medicaid/CHIP are exhausted, there is little reason to explore new and costly workforce initiatives.

As a profession, dentistry has a legacy of commitment to serving and protecting the public. This legacy of service has demonstrated that there is a link between the strength of our profession and the oral health of the public. In Virginia, we can be proud of the role our members and the VDA have played in reducing problems associated with access to care and utilization of care. For the VDA to further its well recognized leadership role and positive public image we must look for new opportunities to collaborate with all those concerned about oral health, promote oral health literacy particularly among covered Medicaid families, and encourage each of our members to participate in service to the public. It is therefore with great excitement that in April 2012 our leadership announced The Virginia Plan: The VDA's Plan for Improving Access to Care and Medicaid Utilization Rates in Virginia.

Background

What is universally recognized within the pediatric oral health care community is that tooth decay remains one of the most preventable chronic diseases of childhood. Tooth decay, if left untreated and permitted to progress, can cause significant pain, loss of school days, and infections that can result in death. While patients who have availed themselves of dental services in the United States have enjoyed the highest quality dental care in the world, many children are not receiving appropriate care. Particularly frustrating is that while all children covered by Medicaid and the Children's Health Insurance Program (CHIP) have coverage for dental services, ensuring access to and utilization of these services has been problematic. In Virginia, only 144,000 of 550,000 Medicaid eligible children utilized dental services in 2005. At that time, access to care for these children was challenging since only 650 Virginia dentists participated in Medicaid due to low reimbursement rates, burdensome administrative procedures, concerns about managed care, and patient missed appointments.



In 2012, Virginia's Medicaid dental utilization rate improved to 58% compared to 26% in 2005. The number of participating providers has increased to 1695 dentists providing greatly improved access. This remarkable turnaround was due in large part to the Smiles for Children program initiated in July of 2005 through the efforts of collaboration between the VDA, DMAS (Department of Medical Assistance Services) and a number of other stakeholders. With innovation and collaboration, Virginia roughly doubled children treated and dentists that provide their care. By comparison, the utilization rate for all children (this includes commercial insurance, private-pay and Medicaid) across the US is 78.9%[1]. While we cannot stop our efforts to provide every child a dental home; closing the gap suffered by the under privileged is a worthy effort for the VDA.

The success of Virginia brought national recognition in 2010 when the State was identified as one of 8 best practice states by the Federal Government's Centers for Medicare & Medicaid Services (CMS). CMS's focus in reviewing these states was on pioneering best practice programs that increased dental utilization rates. Virginia was cited for the following:

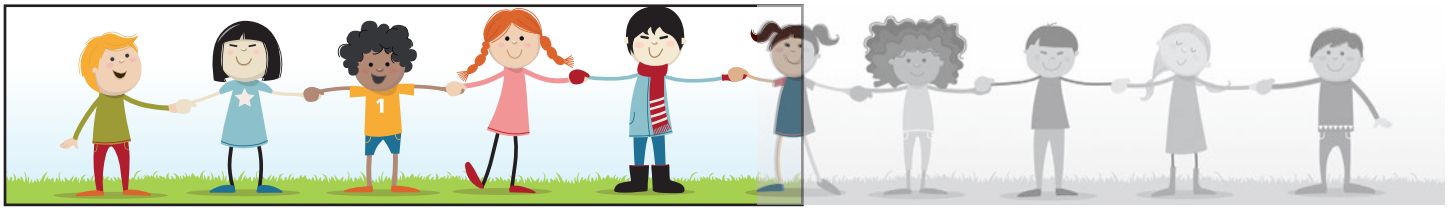
- Increase in dental rate reimbursement
- Establishment of a single contractor to administer Smiles for Children
- Support from the Governor, Legislature, Virginia Dental Association and Medicaid Director
- Dental Stakeholders Initiatives
- Increase in the number of participating dentists

[1] Pg 319, Table 98; National Center for Health Statistics. Health, United States, 2011: With Special Feature on Socioeconomic Status and Health. Hyattsville, MD. 2012.

2005

26% Utilized Medicaid Dental Service

2012



58% Utilized Medicaid Dental Service

Ted Gallagher, CMS Associate Regional Administrator, stated the following in his cover letter to Virginia's CMS Review:

> "Above all, it is clear that success in improving access to oral health care for children in Virginia is based on a commitment from leadership to remove barriers to provider participation in the Medicaid program, establish fair reimbursement rates, and identify and eliminate unnecessary paperwork and prior authorizations. We commend you for your success in improving dental access to children in Virginia."

The VDA Perspective

The Virginia Dental Association believes that each child deserves a dental home and that the VDA is strongest when we are actively engaged in improving the oral health of the public. The VDA also believes with limited public funding, the best return in our future efforts lies in overcoming the barriers that prevent those who need care from seeking it. In particular, there is a great need to improve oral health literacy, mandate a dental exam for every child, and find additional ways to increase the number of participating dentists in Medicaid. The VDA, the leading advocate for oral health care in Virginia, remains dedicated to increasing the utilization of dental services provided by dentists and improving access by increasing both the number of dentists willing to help those who are in need as well as increasing the number of dental services provided. Therefore, in September 2011, VDA President Dr. Roger Wood appointed a Taskforce to further improve access to care and utilization of care.

Purpose/Goal

The Taskforce's purpose was to review the best practices of the other 7 states cited by CMS and to identify specific activities in other states that could be adapted by Virginia to further improve access and utilization. The beauty of this approach is that every idea we put forward has proven workable and successful in one of the other best practice states and therefore is substantiated in a way that makes our endeavors to enact needed changes easier. The goal of this Taskforce is to suggest ideas for improving oral care to low income Virginia children who most need care but are not receiving it.

Method

Each member of the Taskforce reviewed a CMS identified best practice state and brought forth the ideas that helped create the success in each of those states. The Taskforce met in January 2012, compiled all ideas and selected the 8 that were most likely to be successful in Virginia. Each member was assigned one of the 8 best practice ideas to further research and submit a written report detailing their findings. Without exception, the recommendation was made that the VDA should move forward on each of these ideas for improving access to care. The Report was presented to the VDA Board of Directors in April 2012 and was approved by the Board as submitted.

Results

With the approval of The Virginia Plan, by VDA leadership, the process of implementation for some ideas has begun while other ideas are in the midst of being fully researched and developed. Staged development of each of these ideas can be seen in The Virginia Plan in Action. With additional development and research, some ideas may not be deemed practical or workable. Hopefully most ideas presented here will lead to real differences in access and utilization of care over the next few years. An important outcome of the Virginia Plan and its associated concepts, regardless of success of each idea, is that the Virginia Dental Association is recognized as the leader in oral heath in Virginia by virtue of its work on proposed solutions to access and utilization of dental care.

Conclusion

The VDA cannot sit idly by, resting on past success, while others attempt to define the role of the dental profession in this arena. We must tell our story, but more importantly we must provide leadership, collaboration, and investment of our time through action. The Virginia Plan is the VDA's map for action to improve access and utilization of care using the existing workforce model where all patients are under the care of the most qualified to provide care; a dentist. The Virginia Plan builds on a successful and recognized public legacy of service that has defined us through the years. The VDA will also seek new opportunities to collaborate with other stakeholders, both inside and outside the profession. We all must work together with a common goal in mind-bringing care to the populations that will be part of our future. The VDA promotes and encourages its members to participate in service to the public. It is hoped that in addition to improving oral health care in Virginia, we further strengthen the VDA's leadership role in providing an opportunity for oral health care to all citizens of Virginia.

Access to Care Taskforce: Members: Drs. Ted Sherwin (Chair), Elizabeth Bernhard, Karen Day, Sam Galstan, Monroe Harris, Frank Iuorno, Catherine Oden Fulton and Cynthia Southern

Special thanks to: Elise Rupinski, Drs. Terry Dickinson, Kirk Norbo, Ron Tankersley and Jackson Brown.

Editor's Note: Dr. Ted Sherwin can be reached at tedsherwin@yahoo.com

The Virginia Plan - *In Action*

Collaboration

A key component for success of the Virginia Plan is the VDA's ability to reach out to external stakeholders who have similar goals in order to shape strong working relationships and partnerships where working together achieves a greater impact than working on our own. In CMS's Summary of Eight State Reports - partnerships and collaborations among State partners and stakeholders was listed as one of the common activities for success in all eight states. The work of the VDA and the State of Virginia was used as an example in the Report. For the Virginia Plan to achieve its ambitious goals it will be largely dependent on the VDA's ability to establish effective partnerships.

UPDATE: Since April 2012, meetings with the following have occurred and have led to agreements to work together in collaboration on one or more of the ideas in the Virginia Plan:

- Dan Plain, Senior Health Care Services Manager, DMAS(Department of Medical Assistance Services)
- Mary Foley, Executive Director of MSDA
- DMAS and Virginia Department of Health
- Medicaid-CHIP State Dental Association(MSDA)
- VCU School of Dentistry
- Virginia Oral Health Coalition

The Virginia Plan

Highlights from the VDA's Access To Care Task Force

Broken Appointments

Studies have shown that Medicaid patients are more likely than non-Medicaid patients to break dental appointments without proper notification to the provider. This leads to a frustrating situation for providers as they have open chairs when they could be seeing patients. Virginia's Smiles for Children dental Medicaid program has in place a system to reduce broken appointments. The VDA would like to meet with dental practices in Virginia that are successfully seeing many Medicaid children to find out their best practices to reduce no-shows then bring these ideas to a meeting with other stakeholders to identify ways to improve the current system and reduce the number of broken appointments.

UPDATE: Meetings with interested parties are being scheduled and work has begun to identify some successful Medicaid practices in Virginia to study and garner best practices that can be shared across other providers.

Dental Champion

Having a dental champion or strong advocate in the state has proven a good way to bring more attention to access to dental care concerns and to assist with legislation that is aimed at improving access to care. Once a champion is found, this person would collaborate with the VDA in its efforts to improve access to dental care for Medicaid eligible children.

UPDATE: The Task Force has identified key activities for a dental champion and has discussed time commitments and expectations with other states. A list of potential champions in Virginia is being developed currently.

Dentist Loan Repayment Program

Virginia currently has a program in place to provide loan repayment for dentists who provide Medicaid services in areas identified as underserved. In 2011, 13 dentists received loan repayment awards of $20,000 and funding through the Federal Government will continue through 2012. If Federal funding is discontinued, the VDA will work with other stakeholders to identify ways to fund this successful program which has helped to distribute providers to where there is a great need.

UPDATE: VDH did receive the HRSA grant and there will be loan repayment funds available. No further action is needed on this initiative.

Head Start Programs

Head Start programs require children to receive a dental screening within 45 days of registration. There is a lack of providers to do these screenings and provide follow-up care. So, the VDA will plan to work with members and especially pediatric dentists to encourage them to form relationships with their local Head Start programs. By providing screenings for children, and oral health education for parents, providers can have a great impact on the oral health of this vulnerable population.

UPDATE: Along with VDA efforts in a Statewide Education/ Literacy Campaign that provides oral health education to parents, the VDA has met with the VA Oral Health Coalition to support their work in VA Dental Home Initiative. A program that links early childhood educators with local dentist. In addition the VDA will work in concert the VOHC and Head Start to identify and enlist member dentist to screen children in areas were a dentist has not been identified to help the Head Start program.

Legislators and Reimbursement Rates

Establishing/maintaining good communication with legislators is essential to keeping dental Medicaid reimbursement rates at levels that will allow for a strong participation rate among dentists. While Virginia has had success in increasing rates for Medicaid and has a strong relationship with legislators, there are ways to improve these relationships and reiterate the importance of maintaining reimbursement rates. A quarterly e-newsletter will be developed that VDA legislative contacts will share with their delegates and senators. This communication will provide a constant message about the importance of Medicaid reimbursement rates and the successes that Virginia has serving those children in need of dental care.

UPDATE: The VDA Legislative Committee has taken up this initiative and has worked with our lobbyist to develop the first communication to Legislators. The first edition will be sent out via a personalized email to Legislators in September. Included in the e-publication are statistics and information about the various VDA programs aimed at improving access to care.

Mandated Dental Screenings for School Aged Children

In California and many other states, requiring dental exams or assessments for public school entry has been shown to be successful. Depending on the language used (i.e. exam vs. assessment) these laws require either a dentist or a more broad group including dental hygienists, physicians, etc. to evaluate the child's oral health and provide recommendations for future treatment if necessary. The idea here is to introduce legislation in Virginia that will require dental exams (note: not assessments) for entry into the public school system. The legislation would need to have some measures that would ensure compliance among schools.

UPDATE: The VDA Legislative Committee has created a sub-committee to research strategies and tactics of other states that have successfully mandated exams for children to assess the viability of enacting such a program in Virginia. If it is determined viable, the goal is to bring this idea to the VDA House of Delegates in September 2013 for possible inclusion in the 2014 legislative initiatives.

Medicaid Deferred Compensation

There are currently three states that allow Medicaid provider reimbursements to be placed in tax deferred retirement plans. These programs have proven a successful way to encourage more providers to participate in the Medicaid program as the tax savings can help offset the loss from performing procedures at or below cost. With more providers, utilization rates also increase which would improve overall dental health among children covered by Medicaid. In order to enact such a program, legislation will need to be introduced to allow Medicaid reimbursements to be tax deferred into a retirement account.

UPDATE: The VDA Legislative Committee has created a sub-committee to research other states that have successfully implemented Medicaid deferred compensation for providers so we can evaluate the viability of enacting such a program in Virginia. If it is determined viable, the goal is to bring this idea to the VDA House of Delegates in September 2013 for possible inclusion in the 2014 legislative initiatives.

Statewide Education/Literacy Campaign

A statewide education/oral health literacy campaign could be used to increase the number of Medicaid providers and Medicaid eligible children receiving care and provide valuable education to parents, care takers and primary care physicians about the importance of proper oral care. In order to fund such a campaign, grant monies would be sought from various sources. In partnering with the Medicaid-CHIP State Dental Association(MSDA) and working with stakeholders from across Virginia, messaging could be honed and the program could be implemented to not only increase the number of providers but to increase demand for dental services from the Medicaid population once they receive education about the importance of oral health care.

UPDATE: The VDA has contracted with the MSDA for the development of grant proposals to fund this campaign. The MSDA is doing initial research on the program and will be working to develop grant proposals in 2013.

THE Virginia MEETING

A program of the Virginia Dental Association

September 18–22, 2013

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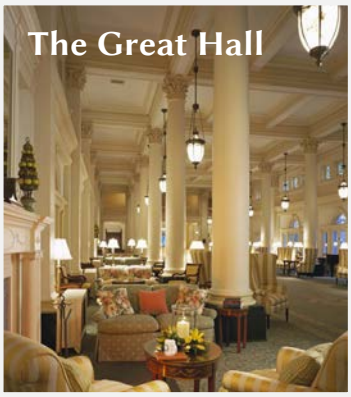

Welcome New Members

September 2012

Tidewater Dental Association

Dr. Ruth Abraham graduated from Virginia Commonwealth University in 2001. She received her certificate of Advanced Education in General Dentistry at University of Maryland in 2002. She now practices with Virginia Beach Department of Health and at Virginia Beach Mercy Dental Clinic in Virginia Beach.

Dr. Jeremy Davidson graduated from the University of Washington in 1999. He specialize in orthodontics in Triservice Orthodontic Residency Program which he completed in 2008. Dr. Davidson is currently practicing in Virginia Beach.

Dr. Keenan Davis graduated from University of Michigan School of Dentistry in 1995. He specialized in prosthodontics at Virginia Commonwealth University School of Dentistry, which he completed in 1997. Dr. Davis is working with Partners in Dental Health in Virginia Beach.

Dr. Kimberley Gise graduated from the University of Maryland in 1998. She completed a graduate practice residency at Mercy Medical Center. Dr. Gise is currently practicing in Parksley.

Dr. Daniel M. Jones graduated from University of Maryland School of Dentistry in 2012. Dr. Jones is practicing at Konikoff Dental Associates, Inc. in Virginia Beach.

Peninsula Dental Society

Dr. Garima Gupta graduated from University of California San Francisco School of Dentistry in 2012. Dr. Gupta practices at Kool Smiles in Newport News.

Dr. Christian O. Meyers graduated from Virginia Commonwealth University in 2011. Completed a General Practice Residency at Hampton VA Medical Center. Dr. Meyers is practicing in an associateship with Daniel S. Williams and Associates in Hampton.

Dr. Ashley Nester graduated from Virginia Commonwealth University in 2008. She receive her certificate of Advanced Education in General Dentistry at La Jolla VA in 2009. Dr. Nester practices in Williamsburg.

Dr. Joseph Ramahlo graduated from The State University of New York at Stony Brook in 2010. He complete the Advanced Education of General Dentistry program at Miami VA Hospital in 2011. Dr. Ramahlo practices in Williamsburg.

Southside Dental Society

Dr. Bryson Dunham graduated from Virginia Commonwealth University in 2011. Dr. Dunham practices with Dr. Steven Castro in Chester.

Dr. David Keeton graduated from University of Kentucky College of Dentistry. He specialized in pediatric dentistry at University of Texas San Antonio Health Science Center. Dr. Keeton is currently practicing in Midlothian.

Dr. Stephanie Ledbetter graduated from New York University College of Dentistry in 2011. Dr. Ledbetter practices with Sam English Dentistry.

Dr. Corin Marantz graduated from Stony Brook School of Dental Medicine in 2009. He complete a specialization in periodontics at Virginia Commonwealth University School of Dentistry in 2012. Dr. Marantz practices with Drs. Ragsdale & Slagle, LTD in Petersburg.

Dr. Tonya Parris-Wilkins graduated from Virginia Commonwealth University in 2003. She completed a general practice residency at The University of North Carolina in Chapel Hill. Dr. Parris-Wilkins practices at Southside Family and Cosmetic Dentistry, P.C. in Colonial Heights.

Richmond Dental Society

Dr. Molly Adler graduated from Virginia Commonwealth University in 2012. She will complete a Graduate Program Residency at Hunter-Holmes McGuire in 2014.

Dr. Brittney Andress graduated from Case Western Reserve University in 2012. Dr. Andress is currently located in the Richmond area.

Dr. Adrian Avram graduated from Iuliu-Hatieganu University in 2002. He is practicing in Richmond.

Dr. Sheldon Bates graduated from Medical University of South Carolina in 2010. He specialized in orthodontics at Virginia Commonwealth University School of Dentistry.

Dr. Khushboo Jain graduated from Virginia Commonwealth University School of Dentistry in 2012. Dr. Jain is located in the Richmond area.

Dr. Patrice Jones graduated from the University of Mississippi in 2011. Dr. Jones practices with Dr. Charles W. Martin in Richmond.

Dr. David Lui graduated from Tufts University in 2005. He specialize in oral and maxillofacial surgery at University of Pennsylvania School of Dental Medicine. Dr. Lui serves as an assistant professor of oral and maxillofacial surgery at Virginia Commonwealth University School of Dentistry.

Dr. Kenneth Murry graduated from Case Western Reserve University in 2012. Dr. Murry is located in the Richmond area.

Dr. Padmalatha Navubothu graduated from University of Michigan School of Dentistry in 2012. Dr. Navubothu is located in Richmond.

Dr. David Roberts, Jr. graduated from Virginia Commonwealth University in 2012. Dr. Roberts is practicing at Davey Crockett Dentistry in Richmond.

Dr. Manpreet Sarao graduated from the University of Colorado at Denver in 2010. He will specialize in endodontics at Virginia Commonwealth University which he will complete in 2013.

Dr. Preeti Sastry graduated from Virginia Commonwealth School of Dentistry in 2012. Dr. Sastry practices in Montross.

Piedmont Dental Society

Dr. Michael Mayerchak graduated from University of Louisville in 1988. He specialized in endodontics at Wilford Hall Medical Center in 2002. Dr. Mayerchak practices at Blue Ridge Endodontics in Roanoke.

Dr. Jennifer Rypel graduated from the University of Alabama in 2012 and practices in Roanoke.

Dr. Breanna Velander graduated from University of Nebraska Medical Center in 2012 and will be practicing in Salem.

Southwest Virginia Dental Society

Dr. Matthew Tomoda graduated from Virginia Common Wealth University School of Dentistry in 2011. He completed a Graduate Program Residency at Washington DC VA Medical Center. Dr. Tomoda is located in Blacksburg.

Shenandoah Valley Dental Association

Dr. Courtney Ashby graduated from Virginia Commonwealth University in 2012. She is located in Culpeper.

Dr. Hazem Seirawan graduated from Damascus University in 1993. He specialized in pediatric dentistry in 2012 at NOVA Southeastern University. Dr. Seirawan will be practicing at Community Dental Center in Charlottesville.

Dr. Vishal Shah graduated from Boston University in 2010. He received his certificate of Advanced Education in General Dentistry in 2011 from Virginia Commonwealth University. Dr. Shah practices in Winchester.

Northern Virginia Dental Society

Dr. Alvin Amante graduated from University of the Philippines in 1993. He specialized in pediatric dentistry at University of Rochester Eastman Institute for Oral Health. Dr. Amante practices with SmileZ Pediatric Dental Group in Gainesville.

Dr. Basma Armanious graduated from University of Pennsylvania School of Dental Medicine in 2005. She continued her studies at Manhattan Campus of the VA NY Harbor Healthcare System. Dr. Armanious is located in Falls Church.

Dr. Mark Armanious graduated from Temple University in 2006. He specialized in oral and maxillofacial surgery. He practices at Whiston, Patterson & Corcoran, Ltd. in Falls Church.

Dr. Navdeep Aulakh graduated from Howard University College of Dentistry in 2004. Dr. Aulakh practices in Annandale.

Dr. Mala Britto graduated from Louisiana State University School of Dentistry in 2002. She specialized in pediatric dentistry. Dr. Britto currently practices in Northern Virginia.

Dr. L. Jackson Brown graduated from the University of Missouri at Kansas City in 1969. He completed a Ph.D. of Economics and Epidemiology in 1985. Dr. Brown is located in the Leesburg area.

Dr. Kevin Bunin graduated from the University of Maryland in 2009. He received his certificate of Advanced Education in General Dentistry in 2010 from York Hospital in Pennsylvania.

Dr. Sara Bunin graduated from the University of Maryland in 2010. She specialized in pediatric dentistry at Children's Memorial Hospital Northwestern in Chicago, Illinois. Dr. Bunin currently practices in Burke.

Dr. Doyon Chung graduated from University of Pennsylvania in 2012. Dr. Chung is practicing with United Dental Group, Tysons in Vienna.

Dr. Joshua Fein graduated from The University of North Carolina in 2009. He specialized in endodontics at the University of Maryland, which he completed in 2012. Dr. Fein practices with NOVA Micro Endodontics in Reston and Springfield.

Dr. Norma Gutierrez received her certificate of Advanced Education in General Dentistry at NOVA Southeastern University in 2009 with a concentration in Special Needs. Dr. Gutierrez is practicing at Northern Virginia Dental Clinic in Sterling.

Dr. Zaneta Hamlin graduated from Howard University in 2012. Dr. Hamlin is currently located in Arlington.

Dr. Timothy Imafidon graduated from Howard University in 2011. He specialized in pediatric dentistry. Dr. Imafidon is practicing in Midlothian.

Dr. Komal Karmacharya graduated from Virginia Commonwealth School of Dentistry in 2012. Dr. Karmacharya is located in Chantilly.

Dr. Natasha Khurana graduated from University of Maryland in 2007. She specialized in pediatric dentistry at New York University, finishing in 2009. Dr. Khurana practices in Gainesville.

Dr. Hyo Lee graduated from Virginia Commonwealth School of Dentistry in 2001. She specialized in endodontics at University of Florida College of Dentistry. Dr. Lee practices in Vienna.

Dr. Yeonju Lee graduated from Seoul National University in South Korea in 1994. She specialized in periodontics at University of Nebraska Medical Center, College of Dentistry in 2010. Dr. Lee currently practices with McLean Smart Dental in McLean.

Dr. Nitika Mittal graduated from Virginia Commonwealth University in 2010. She specialized in orthodontics at Indiana University. Dr. Mittal is now practices at Guleria Orthodontics in Reston.

Dr. Steven Robertson graduated from Indiana University School of Dentistry in 2000. He specialized in Oral and Maxillofacial Surgery at Eglin, Air Force Base in Florida. Dr. Robertson practices in Fairfax.

Dr. Lindsay Roskelley graduated from Tufts School of Dental Medicine in 2009. Dr. Roskelly is currently practicing in Woodbridge.

Dr. Aman Sabharwal graduated from Virginia Commonwealth University School of Dentistry in 2011. He completed an Advanced Education in General Dentistry at Temple Kornberg School of Dentistry in 2012. Dr. Sabharwal is practicing with United Dental Group, Tysons in Vienna.

Dr. Ritu Shah graduated from University of Pennsylvania in 2010. She specialized in pediatrics at University of Rochester Eastman Institute for Oral Health. Dr. Shah practices in Warrenton.

Dr. Samira Shenasi graduated from Howard University College of Dentistry in 2012. Dr. Shenasi is currently located in Reston.

Dr. Danielle Smart graduated from Meharry Medical College School of Dentistry in 2010. Dr. Smart currently practices in Fredricksburg.

Dr. Philip Spory graduated from the University of Washington in 2008 and is practicing in Northern Virginia.

Dr. George Tsai graduated from The University of North Carolina in 2011. Dr. Tsai practices at Neibauer Dental Care in Northern Virginia.

Dr. Veronika Vazquez graduated from Columbia University in 2005. Dr. Vazquez is currently located in Northern Virginia.

Dr. Armen Zarookian graduated from Boston University in 2008. He receive his certificate of Advanced Education in General Dentistry in Fresno, California in 2009. Dr. Zarookian is looking to practice in Northern Virginia.

Dr. Sadia B. Zubairi graduated from Temple University Kornberg School of Dentistry in 2004. Dr. Zubairi is currently located in Great Falls.

In Memory Of...

Dr. Eugene Kanter	Tidewater Dental Association	Virginia Beach	July 26, 2012
Dr. Jack C Kanter	Tidewater Dental Association	Virginia Beach	August 19, 2012
Dr. Robert T. Edwards	Southside Dental Society	Franklin	May 21, 2012
Dr. Wilford Frank Falls, Jr.	Southside Dental Society	Franklin	January 11, 2012
Dr. William H Fitzgerald	Southside Dental Society	Clarksville	June 25, 2011
Dr. Joseph I Koliadko	Southside Dental Society	Hopewell	June 14, 2011
Dr. Edwin A. Gendron, Sr.	Piedmont Dental Society	Martinsville	February 9, 2012
Dr. John Bolon	Piedmont Dental Society	Roanoke	February 27, 2010

Board of Directors, Actions in Brief

June 16, 2012

I. Items that require action by the House of Delegates:

A. The following Bylaw and Policy changes were approved:

1. Background: There exists confusion over current guide lines about the use of the official VDA email list. To correct this issue, the following resolution is proposed:

Resolution: In the Policy statement for use of VDA email addresses: Item #3 – a) delete the word 'will' and substitute the word 'may'. B) Delete the words 'VDA members and VCU dental students, so that #3 now reads: The VDA may redirect an email from the VCU School of Dentistry and the VDA components, provided the email meets the screening requirements of the VDA.

2. Resolution: Distribution of the VDA email directory shall be limited to official business of the VDA, VDA components or VCU School of Dentistry. All commercial entities or nonofficial business should direct their requests to the VDA Journal or Etch, not to the VDA email directory. (Policy)

3. Background: The ADA 2011 House of Delegates adopted that the Sturgis Standard Code of Parliamentary Procedure was to be replaced by the American Institute of Parliamentarians' Standard Code of Parliamentary Procedure (upon release) to serve as ADA parliamentary authority. This document is now available and the VDA should consider its use as well.

Resolution: VDA Bylaws Article IX "Parliamentary Authority" be replaced with the following: The current edition of the American Institute of parliamentarians' Standard Code of Parliamentary Procedures shall govern this organization in all parliamentary occurrences that are not provided for in the law, in the VDA Constitution, Bylaws and Policies.

4. Background: The current model for reimbursement allows for the reimbursement of actual expenses (up to the ADA rates) of executive board members (president, president-elect, secretary/treasurer, im mediate past president, speaker of the house, parliamentarian and editor) when attending required VDA meetings such as Board of Directors, committee, Virginia (Annual) Meeting, Governance and VDA subsidiaries.

Resolution: Change the current VDA officer reimbursement policy to allow only the active president, president-elect, and secretary/trea surer to receive reimbursement for actual travel expenses. (Policy)

5.Background: The number of members reaching the status of active life member is increasing each year. Because active life members receive a 50% reduction in dues this is causing a significant loss of income. To reduce the amount of lost income and to help maintain the reserve fund a change in the percentage of dues reduction is proposed.

Resolution: The benefit of 50% dues reduction for active life members be changed to 25% effective January 1, 2013.

6. Background: The membership Committee asked the Council on Finance to establish a protocol to allow members to make monthly payment of annual dues. The Board of Directors approved the referral of this request to the COF. The Council agrees that allowing members to make monthly payments should help with members' cash flow making the payment of dues more affordable. The benefit should be of value to our membership by helping to recruit new members and helping to retain our current members.

Resolution: The VDA implement an installment program to allow the payment of dues on a monthly basis. The Council on Finance recommends that the Bylaws and Policy of the VDA be amended to allow the establishment of an installment payment program.

A. Amend Bylaws Article I, Section 7 as follows: Dues: The annual dues shall be paid on or before January first of each year. Dues, unpaid ninety days thereafter, shall automatically terminate the membership. An installment program will be offered as an alternative method for the payment of dues. Dues, unpaid 90 days after a missed payment, shall automatically terminate the membership.

B. Amend VDA Policy by adding item 13 in the Administrative section.

13. The VDA will offer the option of an installment plan for the payment of dues, special assessments and any additional voluntary payments. This benefit is offered to all active and active life members. Every year, upon receipt of the dues invoice, a member may indicate the preference to pay in full by January 1st, or to enroll in the installment plan. The plan is for a period of 10 months to begin in January and conclude with the last payment in October. A member joining after January will have the dues prorated and divided by the months remaining with the last payment in October. A service charge to help cover plan expenses will be assessed. The method of payment would be debit or credit card, or other payment method recommended by the VDA staff. This program will be administered by the VDA staff with oversight by the Secretary/Treasurer and the Board of Directors.

Budgetary Impact: The installment Plan will negatively impact the VDA budget and the budgets of individual components. Most of the impact will be realized in the first year of implementation. The plan will result in a reduction in dues revenues because of all plan dues being collected over the 10-month period. The number of participants in the plan will determine the degree of impact. To minimize the impact, current members should be encouraged to continue paying their dues as in the past. On the positive side, there may be an increase in dues revenues over the years as a result of better retention of current members and the addition of new members.

There will also be an increase in expenses. Plan service charges will offset some of the expenses of fees charged by the various payment methods that may be utilized. There will be increased staff time in the collection of dues and monitoring the plan. Increased utilization will require increased staff time and expense.

B. The following items were considered and approved:

7. Resolution: The VDA adopt the Governance Task Force document "VDA Priorities" as the basis for our developing strategic plan:

VDA Priorities:

1. Will be the leading authority for Virginia's dental professionals for education, information, networking, wellbeing, support and services.
2. Will develop a climate which produces innovative, diverse and creative leaders with passion and vision for the future.
3. Shall be viewed as the trusted and primary service of oral healthcare information and delivery; and be the authority on access to dental care for the profession and all Virginia citizens.
4. Will actively encourage recruitment and retention of members.

8. Background: Last year's House of Delegates voted for the VDA to pursue legislative action to pass a bill regarding registration of dental laboratories. It came to the attention of the VDA that the Board of Dentistry was opposed to this legislation. Therefore, after the bill was introduced the VDA asked for it to be carried over to next year. As it stands now, the bill will be considered during the 2013 General Assembly session.

Approved: A resolution that the VDA withdraw lab bill HB267/SB342, presented to the 2012 General Assembly, at the beginning of the 2013 General Assembly session.

9. 2012 Life Members: Component 1: James W. Baker, John W. Burton III, Roger H. Cahoon, William W. Cox, Alfred R. Guthrie, Jr., Robert A. Iervolino, Edward J. Weisberg. Component 2: Sidney Becker, Ray A. Dail, Martin J. Menges, Jr., George L. Nance, Jr., Philip J. Render, Thomas J. Morris, Laurence A. Warren. Component 3: John M. Bass, George J. Lake, Jr., Robert L. O'Neill, Reed D. Prugh, William N. Thornton III. Component 4: G. P. Burns, Jr., Gilbert L. Button, Bruce S. Janek, Edward D. King, Richard H. Lee, James D. Lilly, Jr,. Norman J. Marks, Michael O. McMunn, John F. Monacell, James L. Riley, Stephen A. Saroff. Robert B. Steadman, David M. Swisher. Component 5: Charles R. Burt, Garrett E. Hurt, Robert J. Krempl, George A. Levicki, Raymond F. Mallinak, Herbert C. Manry, William D. Owen, D. M. Parker, Ronald S. Sharpley, Nathan C. Stephens. Component 6: Bobby L. Brown, B. N. Cox, Clinton W. Howard, James E. Kilbourne, Jr., John D. Lentz, Leighton E. Lawrence, Peter J. McDonald, Douglas C. Niemi, James M. Roberson, Walter D. Shields Component 7: Alan J. Bream, Stephen J. Brown, Paul Gerometta, W. B. Hanna, Patrick D. King, Leo Mallek, John R. Roller. Component 8: Robert M. Block, Albert M. Boyce, Robert E. Copeland, John G. Daley, Mark Egber, Michael A. Fabio, Michael J. Green, John W. Harre, Patrick D. Hart, Gregory Ivy, Ronald D. Jackson, Carroll A. Johnston, Abraham A. Katz, J. D. LaBriola, Ralph A. Lazaro, William R. Lazear, Zachary Leiner, Gary L. Ogrosky, Rodney S. Mayberry, John A. Mercantini, William J. Nanna, Gregory Nosal, Michael V. Piccinino, Peter L. Passero, Wayne G. Rasmussen, E. A. Reeves, III, Thomas C. Roberts, Leslie A. Rye, David P. Sibley, Ronald D. Silverman, Andrew M. Sklar, Charles L. Sours, Jr., John Stephenson, Anthony C. Viscomi, Roger F. Vorcheimer, Bruce S. Wyman.

II. Reported as Information Only:

A. The following items were reviewed and the noted action taken:

1. Approved: A resolution that the Board of Directors allots up to $14,000.00, from the Board's Discretionary Fund, to the PR Task Force. This will allow the Task Force to have a complete plan and specific ideas to present to the HOD in September.

2.Approved: A resolution that the VDA Board of Directors will present a proposed - statewide public relations campaign to the 2012 House of Delegates. If this proposal is accepted, a special assessment is anticipated to be $350 a year for three years per member.

3. Background: The ADA Principles of Ethics and Code of Professional Conduct hold the practice of fee splitting as unethical. The Virginia Board of Optometry prohibits fee splitting and the VDA should propose that the Virginia Board of Dentistry prohibit it as well.

Approved: A resolution that the Virginia Dental Association petition the Board of Dentistry requesting that fee splitting by dentists be a prohibited practice.

The VCU School of Dentistry 2012-2013 AEGD residents. Back row: (from left to right) Dr. John Seisman, Dr. Brian Herod, Dr. Emily Caudill; front row: Dr. Michael Reimer, Dr. Emily Keeton, Dr. Ashlie Davis.

What exactly is an AEGD?

Debra R. Haselton, DDS, Professor, VCU School of Dentistry; Director, AEGD Program

"What do you do at the school?" That is a question I am frequently asked, and my answer, "I direct the AEGD Residency Program," is often followed with a quizzical expression from the person asking the question. Even though Advanced Education in General Dentistry (AEGD) programs have been around for more than 20 years, many do not have a strong understanding of the nature of AEGD training.

Consider this – there are 61 dental schools in the United States that train approximately 4,700 predoctoral students, and 92 percent of dentists in private practice are general practitioners. With that in mind, roughly 4,230 new dentists will enter the profession of dentistry as general dentists. Although dental school training provides the new dentist with sound basic clinical knowledge and skills, many patients present to the generalist with a host of complex dental problems that challenge even the seasoned dentist. And while many new general dentists are fortunate to have good mentors as they associate in their first practice, many do not have this opportunity to work with a more experienced dentist or group of dentists. Some may choose to locate in more rural areas and will not have the ability to easily refer to specialists for more difficult treatment needs. Therefore, additional general dentistry training in the form of an AEGD can be strongly beneficial.

There are two types of general dentistry advanced training programs. The General Practice Residency (GPR) has been around a little longer than the AEGD and is perhaps better known. Dental students commonly ask which type of program they should consider. GPRs are often, but not always, associated with hospitals; therefore the training received may be more hospital-oriented. AEGD programs are generally, but not always, more oriented toward general private practice. Some AEGD programs are run and function similarly to GPRs and vice versa. Programs may be one or two years. AEGD programs more commonly last one year. Currently there are 191 GPR programs with 908 residents and 89 AEGD programs with 530 AEGD residents. Both AEGD and GPR programs must be accredited by the Commission on Dental Accreditation (CODA), which exists under the auspices of the American Dental Association. CODA stipulates educational and clinical elements that must be included in the training for both AEGDs and GPRs. However, beyond that, each program has its own unique features. These often relate to the location, patient pool, facility and faculty members' areas of expertise. Therefore, it is important for the student contemplating advanced general dentistry training to look at a number of programs to determine which program might best fit his or her needs. A good recommendation is for students to think about how they would like to practice and then look for a program that will prepare them to do those types of procedures. Many students opt to apply to military AEGD programs if they plan to enter military service.

The AEGD program at VCU School of Dentistry was initiated in 1994. The program is fully accredited by CODA and accepts six residents for each academic year. The VCU AEGD offers a diverse educational experience with a strong focus on the patient needing complex restorative treatment. In particular, there exists a goal to strengthen treatment planning skills. Residents also work in tandem with other specialty residents to deliver advanced interdisciplinary treatment. During their year in AEGD, residents gain experience not only in the technical aspects of more complex dentistry, but also in managing a greater volume of patients. Their confidence level increases as they are exposed to new treatment techniques, gain more experience working with and managing members of the allied health team and utilize materials and equipment that may be different from that which they experienced in dental school. Although residents are paid a small stipend and defer a year of private practice income, for most it is a valuable trade as they reflect on what they were able to do and learn in the short span of one year. The goal of our program is to help residents to 'jump start' their careers and allow them to function at a higher level when they begin to practice.

Strengthening preparation for private practice is not the only benefit of AEGD training. General dentists also may become Board-certified through The American Board of General Dentistry. In order to apply, candidates must obtain educationally qualified status before they can apply to sit for the written examination. At a minimum, candidates must complete a one-year CODA accredited GPR or AEGD program and 600 CDE hours to be considered educationally qualified. Therefore, AEGD training provides a starting point for the general dentist seeking Board certification.

In today's world, advanced education is not only a great idea, it is becoming a necessity. As patients become more educated consumers of all that dentistry has to offer, they choose to see dentists whose training and skills can provide those services. Experiences provided in an AEGD program give new graduates an added advantage as they enter into the dental profession.

Dr. Debra Haselton is the Professor and Director of the AEGD Program at the VCU School of Dentistry. She can be reached at drhaselton@vcu.edu

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Awaken the Sleeping Giant in your Practice

By: Dr. Jared Klein, Associate Editor, Component 7

At 11:00 a.m. your receptionist asks you to return a call to a patient who received an oral appliance two days prior. First thought—What's wrong? Is he in pain? Did the appliance break, not fit or just not work at all? Upon returning the call, the first words from the patient are bizarre and shocking: "You're not giving up dentistry to do this full time, are you? Because when people discover you treat this, you won't have time for anything else." The appliance was for obstructive sleep apnea (OSA) and this marked the first patient I had treated for this ubiquitous condition.

Three years ago, as part of the VCU Master Track program, I was formally introduced to OSA and the role of dentistry in helping treat this, not-so-silent, condition many patients struggle with. I listened to the lecturers (physicians and dentists, alike) with moderate interest. "Leave this to the MDs", I thought. "Are you kidding me, in addition to the typical exam that includes an oral cancer screening, perio charting, identifying restorative needs, etc., now they're expecting me to look for signs of sleep apnea", I lamented. Then, from the back of the room came a man, who had waited nervously for over two hours, to read aloud, never looking up, word for word, his personal testimony of the impact a dentist and an Oral Appliance had made in his life. Visibly choked up, he turned to Dr. Michael McMunn, to express gratitude for literally changing his life. The first two hours of this meeting had been a blur, filled with thoughts of why I even had to concern myself with treating a condition for which I'm not even licensed to diagnose. The final hour, my thoughts were filled with impressions left by the words of a patient whose life had been changed by a simple, yet prudently prescribed appliance. In the following weeks and months, I came to shamefully admit to myself, I'd been seeing the symptoms of OSA in my patients for years, but just never recognized what had been so obvious, once given an understanding and appreciation for its signs. An elongated uvula, high vaulted palate, bruxism, retrognathia, thick neck, scalloped tongue, and enlarged tonsils just to name a few. My focus to this point, with exception of an oral cancer screening, had been, at the least, saving a single tooth or eliminating infection, and at most, comprehensive full mouth reconstruction. Now through a simple visual exam and short patient questionnaire, I had the ability to, not only improve my patient's lives, but potentially save their lives. "Save a life?", you might ask. Consider: Why would a stroke ever occur during sleep? Have you ever wondered why someone's heart rate and BP would be so high while asleep? My assumption was always high stress and HBP. Either way, won't they have more stress and HBP during waking hours, rather than at rest? Could the real culprit be lack of oxygen? I was ashamed and embarrassed that I'd never made the connection. A lack of O_2 would naturally lead to an increased heart rate and subsequent increase in BP. This is exactly what happens in the patient with sleep apnea—a reduction in O_2. Consider a few facts that may shed some light. Studies show that 92% of stroke victims have sleep apnea. People with OSA are four times more likely to have a heart attack. Typical O_2 saturation levels are around 95%. Some OSA patients can have levels that fall to the 70% range. To put this in perspective, hook yourself up to a pulse oximeter, and hold your breath for as long as you can. Your O_2 saturation will not drop more than 3 percentage points. Take a minute and at least introduce your patients to the effects of sleep apnea. You'll be amazed with their response. If they don't have sleep apnea, they'll know of someone, usually a close family member, who has sleep apnea. A simple screening and questionnaire will reveal that one in four adult men and one in nine adult women have some degree of sleep apnea. With an average practice made up of around 2500 patients, there are approximately 400 patients who may suffer from sleep apnea in each practice. For more details, relating to the role of dentists in treating sleep apnea, check out the American Academy of Dental Sleep Medicine online at www.aadsm.org . Also, look for information on the state level by visiting the Virginia Academy of Dental Sleep Medicine www.vadsm.org . Local pioneers in this field include Erika Mason, DDS (President VADSM) and Michael McMunn, DDS (immediate past president of VADSM).

Dr. Jared Klein practices in Madison. He is the Associate Editor for the Shenandoah Valley Dental Association

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Save the Date!
Free Continuing Education Opportunity!

The Virginia Department of Health, in collaboration with the Virginia Dental Association, is offering a two-day training for general dentists wishing to increase their ability to provide care for children with special health care needs and very young children. The speaker is Dr. Matthew Cooke, a pediatric dentist and the Director of Healthy Athletes, Special Olympics of Virginia. In addition to his pediatric dental background, Dr. Cooke is a physician and dental anesthesiologist, giving him a unique perspective on children's oral health needs. Dr. Cooke will present a one-day lecture on Friday including an overview of special health care conditions, patient behavioral management techniques, infant oral health assessment and prevention, and sedation. Participants will hone their skills in a hands-on clinical session on the following Saturday. A total of 10.5 hours of Continuing Education Units will be earned. Upcoming location: November 30 – December 1, 2012 in Chesapeake. Registration is limited to 15 dentists per site plus one auxiliary staff member per dentist. Preference will be given to dentists practicing in the Eastern Coastal/Tidewater parts of the state. For further information and to register, please contact Kami Piscitelli, R.D.H. at kami.piscitelli@vdh.virginia.gov or (804) 864-7804.

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Annual Exams

Jackie Holloman, B&B Insurance

" If I'd known I was going to live this long, I would have taken better care of myself."
-James Hubert "Eubie" Blake

It's that time of year again -- time for your annual exam with your physician. Time to ensure that everything is in good working condition and to ensure you are doing what you can to maintain a healthy lifestyle. You've had all the tests and answered all of the questions, and now you are awaiting the results.

While many of us think to get our annual physical exam, most do not think about an annual examination of your insurance portfolio. Just like you visit your physician on an annual basis, you should be reviewing your insurance policies with the same vigilance. Markets change, family and business situations change, carriers go out of business and as we all know, laws change.

Is your current insurance still meeting the need it was initially purchased for? Are the kids grown and gone? Are you a grandparent? Are you nearing the magical age of 50 or better 65? Are you a widow, widower? Do you now have partners in your dental practice? If you should sustain and injury, and don't die, how will you pay your bills? Who will take care of you?

These are just some of the questions that need to be asked, and your insurance agent should be able to answer them. If not, why not?

In addition to an annual review of your policies, this can also be a great time to ensure that all of your information is up to date and that you have current contacts for each policy. In the event of something unexpected happening, making multiple phone calls and dead-end inquiries trying to track down a policy is the last thing that you want your family to have to deal with. When looking at your portfolio of policies, it may make sense to consolidate them under one, full service insurance agency. That will allow for a comprehensive annual review and also provide one single point of contact for any questions or concerns regarding insurance coverage.

So as you make that appointment for your annual physical, consider an annual exam of your insurance coverage and needs.

In order to help with the complex nature of insurance needs, at B&B Insurance we have assembled a staff of specialists in every product line: to review, analyze, and then make recommendations based on each client's individual needs. Here at B&B Insurance Assoc., Inc. we provide that peace of mind of knowing you are being well taken care of. For a no-obligation review of your insurance portfolio please contact B&B Insurance Associates, Inc. at 877-832-9113 or online at www.bb-insurance.com.

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Using Technology to improve your "Empty Chair Syndrome"

By: Dr. Minh Tran

It is no secret that the economy has taken its toll on office production nationwide. Additionally, some areas are witnessing an influx of new offices. So here are a few digital marketing services to be aware of that may help keep you on the same playing field with the other doctors and possibly put you ahead of the pack.

ZocDoc
http://www.zocdoc.com/
ZocDoc offers patients the option to book appointments online or through their smart phone. This allows flexibility for patients, as they can schedule an appointment 24/7, and don't have to wait to speak to a receptionist to book an appointment, be put on hold, etc.

Of course, this greatly benefits the dental groups as well. It increases their patient base by attracting new patients who are looking for dentists, and also helps fill the often last-minute cancellations that typically occur between 10-20% of the time. Finally, it frees up the overworked office staff from the phone so that they can attend to their other administrative duties, making the office work more efficiently.

The average wait to see a dentist is over 21 days. More than 40% of ZocDoc users are able to see a dentist within 24 hours, and more than 60% of them can see an dentist within 3 days. This service is free to the patient, and the dental group pays a small fee to be listed on the site. Currently, more than 1.5 million people are using ZocDoc to book their appointments.

Dr. Oogle
http://www.doctoroogle.com/
DR.Oogle claims to have about 161,881 patient reviews and recommendations of dentists and dental specialists. Patients can post dental questions and receive dental advice from interested dentists in their location. Dr. Oogle is a nationwide dentist directory and is a registered dental referral service in the State of California.

Yelp
http://www.yelp.com
Yelp was founded in 2004 to help people find great local businesses like dentists, hair stylists and mechanics. Yelpers have written over 30 million local reviews. Every business owner (or manager) can setup a free account to post photos and message their customers. Yelp can also be easily accessed via smartphones. You want to keep your eyes on this site to see what your patients are saying about your practice.

Angie's List
http://www.angieslist.com/
Angie's List is a word-of-mouth network, helping more than 1.5 million members find the best service companies and health care in their area. A company representative states, "We take the integrity of our data very seriously and verify that the reports we receive are valid and legitimate. Further, companies cannot pay to be rated on the List. Businesses have to earn their way to great ratings by doing quality work for our members, who in turn can elect to file a report and share their experiences. We not only let you know who is doing the best work at the best price, but we can also warn you about companies to avoid based on our members' feedback. "

Google Places
http://www.google.com/places/
Google Places is new to the reviews scene. You may want to keep your eye on this site from time to time.

Yahoo! Local
http://local.yahoo.com/
Also new to the reviews scene. You may want to keep your eye on Yahoo! as well.

Groupon
http://www.groupon.com
Some dentists have choice words about their terrible experience with daily deals sites and the patients that these sites attract. Other dentists, however, have had such great success that they have returned for a second round. The jury is still out on the daily deals services. Competitors: Living Social, Google Offers, AmazonLocal Deals. Please see ADA Code of Ethics, Section 4.E.1

Demandforce
http://www.demandforce.com/vda/
Demandforce, endorsed by the VDA as the premier choice for online patient communications and marketing for its members, allows dentists to communicate with their patients and increase production and efficiencies. Demandforce is the only patient communication solution that automatically collects real patient reviews and publishes them across hundreds of sites and search engines, including Google, Facebook, and Citysearch – without patients having to manually add them on those sites themselves.This benefits the practice by having the same amount of reviews across multiple sites rather than patient reviews only appearing on a limited amount of sites. Demandforce also helps practices grow by reactivating lost patients and getting current patients back in more often with easy to use promotions and newsletters.

Lighthouse 360
http://www.lpmg360.com
Lighthouse 360 is an automated patient communications system for dental practices and has been recognized as one of 16 companies to receive the Pride Institute's Best of Class Technology Award for 2012. Lighthouse 360 is highly popular on the discussion forums.

Competitors:

Demandforce, Smile Reminder, TeleVox, Sesame, Patient Activator
http://www.lpmg360.com/competitors

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Dr. Minh Tran practices in Springfield. He serves on the VDA Communications and Information Technology Committee. This is the third article in a series. He can be reached at sharpwitz@gmail.com

VADPAC- Making a difference for Dentistry in Virginia

By: Bruce Hutchison, DDS - Chair, VADPAC

Dear VDA Members:

I want to thank you very much for your membership in the VDA. Among so many other benefits your continued participation helps shape our positive and forward-looking legislative and regulatory policies. Over the past several years, even in the midst of challenging and uncertain economic times, the VDA has been increasingly vigilant about engaging in legislative and regulatory debates that have had the potential to impact our profession – i.e., the insurance companies' ongoing and relentless efforts to chip away at our financial stability, the doctor patient relationship, and our patients' ability to access care; our ability to assign benefits; securing funding for the VCU Dental School expansion; the lingering threat of mid-tier providers trying to break into Virginia; and sustaining Medicaid funding for children across the Commonwealth.

And rest assured, the General Assembly and its 140 members are going to make decisions in 2013 that have the very real potential to affect you and your practice. I am proud that so many of our members (1,500+) have chosen NOT to sit on the sidelines and instead get involved through financial support of VADPAC and personally engaging policy makers in their home districts. Make no mistake these two ingredients – contributions to those that support our policies and grassroots engagement – make for a powerful and sustaining force in the halls of the Capitol. The VDA has often been a model for legislative success and we need do everything in our power to keep it that way.

However, as you are finding on the front lines every single day in your practice, times remain challenging for you, your staff and your patients. Budgets remain tight, margins are thin and you are working harder for less long-term financial security. All the while, the uncertainty seems to be only increasing as insurance companies find new, more innovative ways to boost their own profits; the impact on our profession if the Affordable Care Act (aka Obamacare) is implemented remains murky at best; and the overall economic forecast has never been less certain. All the while, in 2013 statewide offices for Governor, Lt. Governor and Attorney General – and all 100 House of Delegates seats – are up for grabs which make for an ever-changing (albeit interesting) political climate in Virginia.

It is with this background in mind that I believe VADPAC and the VDA are at a crossroads – we must redouble our efforts in this time of uncertainty to ensure we protect our profession. Together, we can expand access, quality and affordability for our patients while ensuring the investments we have made into our careers and our businesses remains on solid ground. I challenge each of us in 2013 to stretch ourselves and give generously to VADPAC like never before with the goal of support from every single VDA member. It is not too dramatic to call this a call to arms for our patients and our profession as a whole – I hope you will accept this call in earnest when the 2013 dues statement comes out. Together- we can make a difference.

Thank you in advance for your participation. You can help to lead the way for yet another successful legislative year and provide an even more stable foundation for the future. Also, please mark your calendar to attend the 2013 Day-On-The-Hill, to be held January 18, 2013. I hope to see you there.

Dr. Bruce Hutchison practices in Centreville. He is the Chair of Virginia Dental Political Action Committee (VADPAC)

Fundraiser for Senator Tommy Norment in Williamsburg

L-R: Dr. Edward Owens, Dr. John Piche, Dr. Ray Lee, Senator Tommy Norment, Dr. Bill Bennett, Dr. Mike Schroer

The VDA hosted a fundraising luncheon on July 26th in honor of Senator Tommy Norment at the Center Street Grill in Williamsburg. The event was chaired by Drs. Ray Lee and Bill Bennett. They attended the lunch along with other VDA members from his district- Drs. Edward Owens, Jon Piche and Mike Schroer. Support was also expressed in the form of contributions by several other members. Senator Norment has been an incredibly valuable ally to dentistry throughout his career and was recently honored, once again, by his colleagues as he was elected Majority Leader of the Virginia Senate during the last General Assembly Session. He represents the 3rd Senatorial District in the Commonwealth.

VADPAC Update

Component	% of Members Contributing to Date	2012 VADPAC Goal	Amount Contributed to Date	Per Capita Contribution	Amount Needed to Reach Goal
1 (Tidewater)	39%	$45,000	**$40,958**	$251	$4,042
2 (Peninsula)	**41%**	**$26,000**	**$26,096**	**$266**	**Over $96**
3 (Southside)	**42%**	**$12,500**	**$13,387**	**$279**	**Over $887**
4 (Richmond)	**36%**	**$62,500**	**$68,061**	**$304**	**Over $5,561**
5 (Piedmont)	**41%**	**$28,100**	**$32,379**	**$259**	**Over $4,279**
6 (Southwest)	**49%**	**$25,000**	**$25,351**	**$305**	**Over $351**
7 (Shenandoah)	39%	$30,000	**$26,897**	$261	$3,103
8 (Northern VA)	**37%**	**$132,000**	**$136,430**	**$288**	**Over $4,430**
TOTAL	39%	$361,100	**$369,559**	$277	**Over $8,459**

Total Contributions: $369,559

Goal: $361,100

Surpassed Goal by $8,459

VADPAC would like to recognize components 2, 3, 4, 5, 6 and 8 for surpassing their goals for the 2012 year. As we near the end of this year, we are so appreciative to all who made contributions. We were able to surpass the goal, however; with only about 40% of the VDA membership contributing in 2012, VADPAC has the potential to grow substantially in the coming years.

We urge members to submit contributions when sending in your 2013 VDA dues payments. 2013 is an election year and your contributions will be imperative to securing the livelihood of the practice of dentistry.

WHEN YOU GIVE TO VADPAC, YOU ARE RAISING THE VOICE OF DENTISTRY.

Please contribute!

Contact Laura Givens at givens@vadental.org **or 804-523-2185 with questions.**

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Oral Surgery Abstracts

Mardinger O, Zvi YB, et. al. A retrospective analysis of replacing dental implants in previously failed site. Oral Surg Oral Med Oral Pathol Oral Radiol 2012;114(3):290-293

Although it is well known that implants have a high success rates, a fairly significant failure rate ranging from 3%-8% has been noted after the first year as a result of various complications. The original implant site generally has reduced alveolar bone height and width making it more difficult to re-implant. Despite this, re-treatment is still indicated. According to this study, only four previous studies have investigated the outcome of re-implantation with general consensus that re-implantations have a lower survival rate than implants in virgin sites, with survival rates associated with implant type and implant site-related factors. This study evaluates the survival rate of placing implants in previously failed implant sites and the factors associated with their outcomes.

Retrospectively, this study evaluated the placement of 144 implant fixtures in previously failed sites from 1994-2009. The collected data incorporated several variables: A) patient characteristics including – demographic, general health status, and smoking habits; B) implant characteristics including – manufacturer, site, type of restoration, reason for failure, early or late failure, time interval between insertion and removal of implant; C) bone anatomy of failed implant sites characterized as: minor bone loss – implant replacement be performed without augmentation; moderate bone loss – implant replacement requires simultaneously grafting with guided bone regeneration (GBR); severe bone loss – implant replacement can only be performed after bone grafting.

The survival rate of the replacement implants replacing previous failed implants was 93%. The survival rate with a second replacement implant was 85%. No correlation was found between the ASA groups, smoking habits and failure rates. No significant differences among the diameter and length of the first implant and the replacement implants were noted, however, the replaced implants tended to be shorter. The time interval between the first implant failures to replacement was 4.8 ± 5.45 months. After the first implant failure, 54% of the sites had minor bone loss and replacement was performed without the need for bone augmentation; 39% of the sites had moderate bone loss and required replacement of bone to be performed simultaneously with GBR, and 7% had severe bone loss. A correlation was found between the amounts of bone loss to the need for local augmentation, however, after site augmentation, correlation was not found between the previous site bone loss and failure of the replaced implant.

The authors claim that the bone volume losses as a result of implant failure can be corrected by local bone augmentation, suggesting that the bone characteristics of failed implant sites are similar to any extraction site after appropriate therapy. The authors ultimately conclude there is a high survival rate of replaced dental implants in sites of previously failed implants. However, additional research is needed to investigate the cause of re-implantation failure. Furthermore, a detailed analysis of original implant failure and re-implantation failure correlation should be investigated.

Ammar Sarraf, DDS, Chief Resident, Oral & Maxillofacial Surgery, Virginia Commonwealth University

Bonine FL, Larsen PE. Effect of chlorhexidine rinse on the incidence of dry socket in impacted mandibular third molar extraction sites. Oral Surg Oral Med Oral Path Oral Radiol Endodontol 1995; 79(2): 154-158

This study is designed to test the private practice clinical significance of using 0.12% chlorhexidine gluconate rinse in a nonrandomized prospective study and the reduction of incidence of post operative dry socket (DS) after the surgical removal of third molars. In this study 371 patients, for a total of 654 impacted thirds, were tested over a three-year period in three different groups. Group 1 was the control with no treatment. Group 2 received two weeks of postoperative Peridex® rinse 15mL BID. Group 3 received the same concentration Peridex® immediately prior to surgical removal of thirds in a one-time treatment. Patients on antibiotics or those with active cases of pericoronitis were excluded from the study. All patients received 10 mg dexamethasone IV along with sedation and local anesthesia with 2% Lidocaine with 1:100,000 epinephrine. Each site received 75 mg of tetracycline placed on Gelfoam® and sutures placed to secure. Patients received 800 mg ibuprofen that evening in addition to being prescribed a 6-day tapered dose of methylprednisolone. Parameters evaluated for DS included: abnormal healing, presence of necrotic tissue, exposed bone, and absence of clot. Diagnosis of DS was defined by increasing pain three days after surgery, continuous pain with no clot or putrid smell. There is a statistically significant reduction ($p < 0.001$) of DS in group 2 versus group 1. Only 7% of the extraction sites in group 2, versus 16% of both group 1 and group 3 developed DS. Overall this represents a reduction of 56% with the use of postoperative 0.12% Peridex® rinse. For current smokers, there was an additional statistically significant reduction ($p <0.05$) in incidence of DS when using the two-week regimen. Finally, the preoperative Peridex® rinse shows apparent benefit. In summary, patients undergoing surgical removal of third molars strongly benefit from postoperative prescriptions for 0.12% Peridex® BID.

Dr. Luke Dohman, Resident, Oral & Maxillofacial Surgery, Virginia Commonwealth University

Bagheri S, Meyer R, et al. Microsurgical Repair of the Inferior Alveolar Nerve: Success Rate and Factors That Adversely Affect Outcome. J Oral Maxillofac Surg 2012; 70 (8): 1978-1990.

Trigeminal nerve injury is an unfortunate complication associated with common dental procedures. Dentoalveolar surgery, implant placement, endodontic therapy and even anesthetic injections can lead to devastating neuralgias. These injuries can lead to orofacial dysfunction due to alterations in speech, mastication, hygiene and retention of saliva.

This study consisted of 167 patients who underwent Inferior Alveolar Nerve (IAN) repair. The clinical outcome of repair was assessed. Outcomes were measured base on a well defined term used in the nerve repair literature of functional sensory recovery (FSR). This is defined as being able to distinguish superficial pain and touch 2 point discrimination of varying degrees with no hyperalgesia. Patients were classified based on severity of injury and followed for at least 12 months after surgery. The most common cause of IAN damage was third molar removal (37.6%). Other common dental causes include implant placement (8.1%) and endodontic therapy (4.8%).

After microsurgical repair, 81.7% of patients regained FSR. A significant correlation was found between increasing patient age and unfavorable outcomes. The chance of FSR showed a linear decline of 11% with each month of time between injury and repair. Also noted was a threshold drop of achieving FSR beginning at 12 months. There was no correlation between success of repair and cause of IAN injury.

The authors conclude that IAN repair is indicated in observed injuries or in unobserved injuries with persistent unacceptable sensory recovery. Younger patients tend to have better outcomes. Finally, given the likelihood of success, it seems advantageous to refer patients for IAN evaluation and repair early after a suspected injury.

Matthew N. Maxfield, D.M.D, Resident, Oral & Maxillofacial Surgery, Virginia Commonwealth University

Leung YY, Cheung LK. Coronectomy of the Lower Third Molar Is Safe Within the First 3 years. J Oral Maxillofac Surg 2012; 70(7): 1515-1522

The extraction of third molars is the most common procedure performed by oral and maxillofacial surgeons. There are several potential risks and complications associated with the procedure but particular attention is paid to the possible damage to the inferior alveolar nerve (IAN). The inferior alveolar nerve enters the medial aspect of the mandibular ramus, travels through the mandible in the inferior alveolar nerve canal and exits at the mental foramen to provide sensation to the lower lip and chin. Damage to the IAN can occur during extraction of the third molars, which may result in temporary or permanent hypoesthesia, hyperesthesia or dysethesia.

Despite the potential risks of third molar extraction there are several conditions and potential risks of retaining third molars that necessitate extraction including pericoronitis, infection, damage to second molars and pathology.

The Panorex® is the most common radiograph used for diagnosis of impacted third molars. Radiographic findings that are suggestive of potential involvement of the third molar roots and the IAN are: darkening of the root, abrupt narrowing of the root, interruption and loss of the white line of the IAN canal, displacement of the IAN canal, abrupt narrowing of one or two of the white lines of the IAN canal.

Recently a new technique, coronectomy, has been used to allow for removal of the coronal portion of a third molar and leaving the roots that are involved with the IAN. As a result of leaving the roots, the procedure prevents the potential damage to the inferior alveolar nerve. Several studies have shown the immediate success of coronectomy but the current study looks at the morbidity of coronectomy over a three-year follow up period.

The current study included 98 patients with 135 coronectomies that completed follow up at 3, 4, 12, 24 and 36 months. Post-operatively patients were evaluated for lingual and IAN deficit, pain (on a visual analog scale), presence of infection, dry socket, root eruption into the oral cavity, time for reoperation and development of pathology.

Of the 135 coronectomies, one resulted in hypoesthesia that returned to normal at the 12 month follow up. The study showed there was a low incidence of infection (4.4%) and pathology (0%). At post operative week one 43% of patients reported pain with a mean of 3.0 out of 10.0 on the visual analog scale which is consistent with pain reported after extraction of third molars. Finally, root migration was found to stop at 12 to 24 months in 75.2% of the cases. Despite the high incidence of root migration only 4 of 135 (3%) cases resulted in root migration that required removal. All four cases resulted in root removal with no affects on the IAN. The current study further proves that coronectomy is a safe procedure and the potential long-term risks and complications were very low as exhibited by the three-year follow up period.

Dr. Daniel Braasch, Resident, Oral & Maxillofacial Surgery, Virginia Commonwealth University

Saia G, et. al. Occurence of Bisphosphinate-related Osteonecrosis of the Jaw After Surgical Tooth Extraction. J Oral Maxillofac Surg, 2010; 68(4):797-804

Bisphosphonate-related osteonecrosis of the jaw (BRONJ) is a relatively rare but potentially serious complication of treatment with nitrogen-containing bisphosphonates (NBPs). BRONJ is defined as the presence of exposed bone in the oral cavity that does not regress within 8 weeks in a patient currently or previously exposed to NBPs and have not undergone radiation therapy in the craniofacial region. Subjects treated with high-dose intravenous NBPs or with oral NBPs for more than 3 years are at greater risk for BRONJ. This study was designed to assess the occurrence of and risk factors for BRONJ in high risk patients exposed to NBPs that require surgical tooth extraction.

This cohort study included patients treated with NBPs between March 2006-2008 with the following criteria: 1) metastatic bone disease or multiple myeloma treated with high-dose intravenous NBPs or non-malignant bone disease treated with oral NBPs for at least 3 years; 2) one or more unsalvageable teeth requiring extraction; 3) lack of bone exposure and of clinical and radiographic signs where dental extraction were performed; 4) absence of previous radiation therapy; and 5) lack of clinical and radiographic evidence of jawbone metastases. First examination included patient's clinical, medication and dental history. NBPs usage was recorded in terms of type, dosage, and duration. The second examination was performed within 2 weeks of the first examination.

Sixty patients were enrolled in this study who had 180 teeth extracted, 103 in the mandible and 82 in the maxilla. Median age was 65 years, female patients (70%) were more common than male patients, and cancer related disease (72%) was the most common reason for NBP use. Zoledronate (63%) and Pamidronate (40%) had been the NBPs most commonly used, whereas neridronate (7%) and risedronate (3%) had been used infrequently. BRONJ was detected at 3 months of follow up in 4 bones and at 6 months in 1 further bone. Stable mucosal coverage of alveolar socket was achieved in 50 patients two weeks after surgery. Surgical wound dehiscence without bone exposure was found in 10 patients. Three patients had osteomyelitis at baseline where 2 developed BRONJ 3 months of follow up and one at 6 months. Three patients with osteomyelitis at baseline had no dehiscence or bone exposure at 12 months of follow up. NBPs restarted 1 month after extraction and persistent alveolar socket was detected at 12 months in all cases.

This study was able to demonstrate that occurrence of BRONJ is low, the most cases develop within 3 months of follow up, and that baseline osteomyelitis is a strong risk factor for BRONJ. Simple tooth extraction is reported to have a higher rate of BRONJ development, and this is the reason why surgical extractions are preferred. Use of oral NBPs has not been generally linked to BRONJ in patients with osteoporosis or metabolic bone disease. However use of oral NBPs for more than 3 years is considered a risk factor for BRONJ. Current guidelines suggest that cancer patients taking high dose intravenous NBPs should not undergo tooth extraction and, alternatively, teeth should be left in place and treated by endodontics or periodontal means. A drug holiday from 3-6 months has been advocated. Impairment of bone remodeling depends on type of NBP, time of exposure, cumulative dosage and route of administration. Oral NBPs are less potent than intravenous NBPs. It has been suggested that teeth extraction in high-risk NBP users should be atraumatic and not interfere with local vascularization. In conclusion after 12 months of follow up, BRONJ was rare outcome in high risk NBP users who underwent tooth extraction by use of surgical method. Also baseline osteomyelitis was a very strong risk factor for BRONJ development.

Farzaneh Rostami, DDS, Resident, Oral & Maxillofacial Surgery, Virginia Commonwealth University

Huang I-Y, Chen C-M, Chuang F-H. Caldwell-Luc procedure for retrieval of displaced root in the maxillary sinus, Oral Surgery, Oral Medicine, Oral Pathology, Oral Radiology, and Endodontology 2011: 112(6): e59–e63

Extraction is the most common surgery performed in the dental office. Although most cases are simple, complications can occur. Displacement of a tooth or root fragment into the maxillary sinus is rare. Rothamel et al. recorded only one patient in a review of 1,596 cases of maxillary third molar extraction in 2006. The aim of this study was to describe the standard diagnostic procedure and the application of the Caldwell-Luc approach for the retrieval of a displaced root from the maxillary sinus.

This retrospective study of 24 patients (14 male and 10 female) who were referred from dentists and other specialists between 2005 to 2008 underwent a Caldwell-Luc approach for retrieval of root tips in the sinus. Ages ranged from 14 to 55 years (average 26.4). Other variables included the gender, the tooth number, the size of root fragment, the type of displacement the delay between displacement and retrieval, the length of operating time, and any complications. Imaging was used preoperatively (Panorex®) to localize where the tooth was in the sinus and if it appeared adherent to the overlying sinus membrane. The patient is asked to shake his or her head and a repeated radiograph was taken to check for any change in position of the root. Three types of teeth were noted 1) mobile type: root changed location, 2) fixed type A: root located between sinus membrane and bone; and 3) fixed type B: root in the sinus cavity and fixed by adherent membrane.

There are three surgical methods that are described based on the type of root in the sinus. All patients are initially placed in the supine position. After administering local anesthesia a vestibular incision is made from the canine to the first molar region, and a full-thickness mucoperiosteal flap is reflected to expose the canine fossa. A bone window approximately 4-5 mm in diameter is made distal to the apex of the canine and above the apices of the premolars by 5 mm. If the root's smallest diameter exceeds 5 mm this window can be widened, but with care to avoid injury to the infraorbital nerve. For the mobile type a suction tip is placed in the posterior sinus and retrieval is achieved with the suction for when the patient is in the supine position the root tip will be displaced to the posterior sinus wall. For the fixed types, the membrane is elevated from the bone and in fixed type A patients it is usually adjacent to the socket of the extracted tooth and is usually removed without difficulty. If this fails—or if the fixed type B is present (with the membrane adjacent to the root) — a curette is used to loosen the fragment and let it fall into the posterior sinus, and then the removal is completed as for the mobile type.

The most frequent tooth involved was the maxillary first molar; the length of the root fragments ranged from 3 to 7 mm. Seventeen of these roots were mobile and 7 fixed (4 being located between the sinus membrane and the bone and 3 immobilized by the sinus membrane. Twenty-three of the operations were completed in 30 minutes, and only 2 patients had a temporary complication of sinusitis. No infraorbital paresthesia occurred. Fourteen of the referrals were referred within several hours, 1 with an oroantral fistula greater than 5 mm. The dentist had attempted removal of the root via the socket but failed. It was treated with Gelfoam® and suture. For OACs greater than 5mm Gelfoam® alone was used for closure. The authors do not recommend retrieval via the socket, because of the risk of permanent OAC and infection.

There is abundance of information on Caldwell-Luc procedures, although most papers do not describe in detail the application of the Caldwell-Luc approach to root retrieval. This study was able to demonstrate an effective way to categorize and describe an effective surgical procedure for the retrieval of root tips from the maxillary sinus.

Dr. Osama Soliman, Resident, Oral & Maxillofacial Surgery, Virginia Commonwealth University

Hassan KS, Marei HF, Algal, AS. Does Grafting of Third Molar Extraction Sockets Enhance Periodontal Measures in 30- to 35-Year-Old Patients? J Oral Maxillofac Surg 2012; 70(4):757-764

Very commonly, impacted mandibular third molars are associated with periodontal osseous defects distal to the second molar, especially when coexisting with periodontal disease. Multiple studies have investigated the result of third molar extraction on these periodontal defects, and the effectiveness of some intraoperative techniques such as scaling and root planning of the distal surface of the second molar and flap design to achieve primary closure, all of which has showed no or little benefit to increase bone height in this area. The purpose of this study was to evaluate the effectiveness of using xenograf plus membrane in the third molar extraction socket on improving periodontal attachment distal to second molar .The patient pool was composed of 14 patients aged 30-35 with no systemic disease and with bilateral horizontally impacted mandibular third molars. Split mouth technique was implemented, where each patient had one control and one grafted site to minimize the variables. Patients prepared for surgery with good oral hygiene, scaling and root planning and then re-evaluated to ensure low plaque index. All procedures were performed by the same surgeon, using the same technique. After third molar extraction, the distal surface of second molar was scaled and root planned. One socket was packed with Bio-Oss® and covered with Bio-Gide® membrane, the other socket was left as control and both sites closed primarily. Patients were prescribed Augmentin® for one week and Peridex® for 6 weeks postoperative. Patients were followed and assessed at 3,6,9 and 12 months postoperative. Evaluation consisted of clinical exam measuring gingival index, pocket probing depth (PPD) and clinical attachment level, as well as radiographic exam by comparing to pre-op radiographs using a computer software image. The authors have found significant improvement of the periodontium in the grafted site over the control. Grafted sites showed PPD 3.1 +/- 0.4, clinical attachment gain of 3.01 +/- 1.03 vs. non grafted sites which showed PPD 4.8 +/- 0.5 and clinical attachment gain of 1.25 +/- 0.65. These values were at the 12 month follow-up. Finally they conclude that grafting osseous defects distal to the second molar after extraction of mandibular third molars with xenograft will predictably result in significant PPD reduction, clinical attachment gain, and bone fill, which could prevent future periodontal defects.

Fahad Alsaad, DDS, Resident, Oral & Maxillofacial Surgery, Virginia Commonwealth University

Oliveira MA, Gallotini M, Pallos D, et. al. The success of endosseous implants in human immunodeficiency virus–positive patients receiving antiretroviral therapy. A pilot study. JADA 2011; 142(9): 1010-1016

Forty patients had implants placed by one provider in the posterior mandible. These patients were divided into three groups: one composed of human immunodeficiency virus (HIV)-positive patients receiving protease inhibitor (PI)–based Highly Active Antiretroviral Therapy (HAART); a second composed of HIV-positive patients receiving nonnucleoside reverse transcriptase inhibitor–based HAART and a control group composed of HIV-negative participants. All implants placed in this study were asymptomatic and fully osseointegrated without clinical complications at the 12-month follow-up. Of the HIV+ participants, their CD4+, viral load and neutrophil counts were compared as well. The use of endosseous dental implants in HIV positive people was shown to be a good, reasonable, predictable and well-tolerated treatment option, despite CD4+ cell count, viral load levels or type of ART received.

The exclusion criteria is this study included patients with HIV-related oral lesions and specific systemic disorders, such as people undergoing chemotherapy or radiotherapy, diabetes mellitus, chronic kidney disease, chronic liver disease or blood dyscrasias; pregnant women; long-term users of steroidal anti-inflammatory drugs; patients receiving hormone replacement therapy; and smokers. An antibiotic and anti-inflammatory medications (amoxicillin 500 milligrams every eight hours for five days; piroxicam 20 mg every 24 hours for three days) starting one hour before the surgical procedure. Pure titanium implants (Implus® implants, Serson Implant, São Paulo), with a 3.5-mm minimum diameter and a length ranging from 10 to 16 mm were placed for each patient in the posterior mandible. Implants were loaded 6 months after placement and were followed with a 6 and 12 month follow up. Twelve months after implant loading, the incidence and levels of bleeding on probing and plaque among all participants enrolled in the study were not statistically significant. Despite the participants HIV status and despite their HAART protocol, levels of viral load and CD4+ cell count, there were no incidences of implant failure, infection, pain, swelling, dehiscence or fenestration.

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

Ozkurt Z, Kazazoglu E. Zirconia Dental Implants: A Literature Review. J Oral Implantol 2011; 37(3): 367-376

Titanium implants are widely considered to be the standard of care for long term restoration of edentulous areas. Titanium implants, however, are not without drawbacks. One of the principal drawbacks includes a dark grey color which is often visible through peri-implant mucosa. This is particularly visible in the presence of a thin mucosal biotype. Additionally, titanium implants create unfavorable soft tissue conditions in some instances (i.e. gingival recession) which may lead to compromised esthetics, particularly in the anterior and premolar regions.

In response to these shortcomings, novel implant technologies have been developed to improve post operative esthetics. Zirconia implants appear to be a suitable replacement for titanium implants. Zirconia has a tooth like color, is biocompatible, and has stronger mechanical properties than titanium.

The purpose of this literature review article is to summarize research articles conducted on zirconia dental implants, compare them with titanium dental implants, and provide information on zirconia implant osseointegration.

A PubMed search from 1975-2009 was conducted using the keywords: zirconia, zirconium dioxide, dental, and implant. The inclusion criteria utilized was as follows: Articles were related to zirconia dental implants, full text and abstracts of articles were used, and orthopedic zirconia implants were excluded from the review.
Search resulted in 108 articles. Of those, 37 studies met the inclusion criteria of the review (30 laboratory studies, 2 case reports, 2 review articles). Studies utilized in the review article investigated the following parameters: osseointegration and bone-implant contact, surface analyses, removal torque testing, strength, and stress analyses.

Conclusions of the literature review found that osseointegration of zirconia implants may be comparable to that of titanium implants. Zirconia implants had low stress distribution that was very well distributed. When coated with zirconia particles, titanium implants had better initial bone healing and resistance to removal of torque. Clinical studies demonstrated excellent cosmetic results with unchanged peri-implant marginal bone levels and stability comparable to that of titanium implants.

Although preliminary results are promising, more research should be conducted to evaluate the long term stability and esthetic outcomes.

Samir Singh, DMD, Intern, Oral & Maxillofacial Surgery, Virginia Commonwealth University

Bell LC, Diehl D, Bell BM, Bell RE. The immediate placement of dental implants into extraction sites with periapical lesions: A retrospective chart review. J Oral Maxillofac Surg 2011; 69(6): 1623-1627.

Success rates of implant placement into immediate extractions sites have been well studied, however no data is specific to placement of implants into sites with periapical lesions. The aim of this study was to evaluate success of dental implants placed into immediate extraction sites with chronic periapical pathology (PAP).

This study was designed as a retrospective chart review. All patient records from a private oral surgery office that underwent extraction with immediate placement of implants from 2001 to 2009 were reviewed. Data reviewed included radiographic presence or absence of periapical pathology in extraction site and on adjacent teeth, presence of preoperative soft tissue swelling, implant stability, tooth number and type, graft type, postoperative pain or infection, smoking habits, age, and gender. Periapical pathology (PAP) was defined as a radiographically visible periapical lucency on a tooth with carious pulpal exposure or evidence of failed root canal treatment, not associated with acute pain or soft tissue swelling (must be chronic). Success was defined as successful osseointegration, successful restoration, and absence of evidence of bone loss or peri-implantitis.

A total of 655 patient charts were reviewed, with 922 implants placed. Of these, 285 were placed into sockets with PAP, and the remaining 637 implants were placed into sockets with no signs of pathology. Overall success of implants placed into sockets without PAP was 98.7 (8 failures). The overall success rate of implants placed into sites with PAP was 97.5% (7 failures). This difference was not statistically significant ($P > .05$). Various other comparisons were made, including whether tooth extracted was anterior, posterior, or from the maxilla or mandible, single tooth or multiple teeth, and type or restoration. There was no statistically significant difference among any of these groups. However, when implant placement into sites where adjacent teeth had PAP was compared to that with no adjacent PAP, a significant difference was noted. An 81% success rate was observed for those implants placed into sites with adjacent PAP versus a 100% success rate for those implants placed into sites with no adjacent PAP.

Placement of implants into immediate extraction sites with observed PAP showed no significant difference as compared to implant placement into sites with no observed PAP. Thus this practice may be considered as an acceptable treatment option. However, care should be taken to treat and resolve any adjacent PAP prior to immediate implant placement, as remaining adjacent PAP has been shows to cause as much as a 20% increase in rate of implant failure.

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

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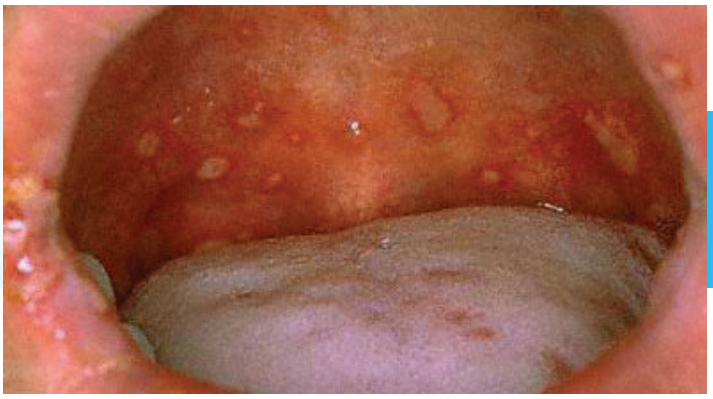
PathologyPuzzler

with Dr. John Svirsky

A 25 year-old white male dental student presented to my office with the following history. His children had a low fever a week prior with mild symptoms lasting a few days. A week after his children's fever ended he developed a higher fever and was much sicker than either of his children. He developed the fever after a heavy workout in the gym (I am not sure if this plays any role but he wanted all to know he goes to the gym) and the fever worsened, peaked at 100.5° F and lasted 48 hours . A sore throat accompanied the fever and on the second day worsened and progressed. Lesions of the oropharynx and tonsillar area were the first to appear (Figure 1). The oral findings continued for another two days and the student was miserable but not enough to stay home and keep his classmates and the school from being exposed!

Figure 1



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

1. Aphthous stomatitis
2. Cytomegalovirus
3. Hand-foot-and-mouth disease
4. Herpangina
5. Infectious mononucleosis
6. Mumps
7. Primary herpetic gingivostomatitis
8. Rubeola (measles)

Continued on page 45

The PPACA and Dentistry in Virginia

By: Dr. Ronald L. Tankersley, Past President, American Dental Association

The Patient Protection/Affordable Care Act (PPACA) is among the most partisan and polarizing legislative initiatives in recent history. That's probably because many its provisions epitomize the divide between the worldviews of conservatives and progressives in the United States. Worldviews aside, the PPACA will significantly impact medical care. But, the impact on dental care in Virginia is uncertain.

None of us can predict the ultimate ramifications of the Act's mandates, rewards, penalties, taxes, and regulations. But, we can discuss the major provisions of the Act that may affect dentistry in Virginia.

Accountable Care Organizations (ACOs)

ACOs were incorporated in the PPACA at the request of the Centers for Medicare and Medicaid Services (CMS). They are organizations of health care providers that "agree to be accountable for the quality, cost, and overall care of Medicare beneficiaries who are currently enrolled in traditional fee-for-service programs". To qualify as an ACO, the organization must satisfy the government that it is capable of providing all needed healthcare to at least 5,000 patients. Organizations fulfilling these requirements will, typically, be major hospitals and very large medical groups. However, major insurance companies that currently operate Health Maintenance Organizations (HMOs) have announced that they also intend to form ACOs. The main difference between ACOs and HMOs is that ACO patients are permitted to receive care out-of-network.

The government will determine the anticipated costs for providing healthcare services to their respective mix of Medicare patients and reimburse the ACO accordingly. Government regulators will determine whether reimbursements will be based on capitation some other criteria. The ACO will determine the distribution of the funds among its providers and facilities. If the ACO can provide healthcare for less than the government's estimate, the balance will be shared between the ACO and the government.

Dental services are not required in ACOs. So, they may not have any direct impact on dentistry. However, it's likely that the ACOs will contract with groups other than Medicare. So, they may elect to provide dental services. If they do, large and corporate dental groups would be likely candidates for providing the care. That could have an impact on dental care in Virginia.

Medical Device Tax

The PPACA levies a 2.9% excise tax on manufacturers for sales of medical devices. Typically, increased costs for manufacturing are reflected in the cost to consumers. Of course, in this case, dentists are the consumers. Dentists who participate in dental benefits plans will not be able to offset their increased costs by increasing fees for patients in those plans. So, this tax will, likely, result in lower net revenues for dentists.

Mandated Employer Healthcare Benefits

The PPACA mandates that businesses with 50 or more employees provide health insurance for their employees or pay a significant fine. Since there are few dental practices in Virginia with 50 or more employees, the impact for most dental practices should be minimal. However, it is anticipated that many employers will opt to discontinue healthcare coverage for their employees and pay the fine instead. Obviously, patients with employers who provide dental benefits will lose those benefits. The magnitude of the impact on dentistry in Virginia is unknown.

Oral Health Prevention, School Sealant Programs, and Mid-level Providers

To address the access issue, the PPACA provides for school-based centers to provide oral health services, school sealant programs, and limited funding for development of mid-level providers.

The long pipeline required for implementation of these types of initiatives and the limited funding provided in the Act will probably result in minimal impact on dentistry in Virginia at this time. If implemented, the impact on dental care in the future could be significant.

Expanded Dental Medicaid

The PPACA expands state Medicaid coverage to cover about 16 million more children. The government will fund this expansion for the first few years and partially fund the expansion thereafter. But, funding for dental benefits under the Medicaid expansion is not properly addressed in the Act. The U.S. Supreme Court ruled that the Medicaid expansion in the Act is optional. Virginia's Governor has announced that he doesn't plan to exercise that option. So, the impact on dentistry for Medicaid patients in Virginia should be minimal.

State Insurance Exchanges

The PPACA requires states to set up an American Health Benefit Exchange (AHBE) for individuals and a Small Business Health Options Program (SHOP) for employees of small businesses. The respective states will determine whether the AHBE and SHOP will be separate or combined. They will also determine whether their Exchanges are developed by the states alone, the states in partnership with the Federal government, or by the Federal government alone. Pediatric dental benefits are required in the Insurance Exchanges. Existing plans in the state will serve as the "benchmark" for the level of coverage. There will be government premium subsidies for middle and low income individuals and families.

The "benchmark" for dental benefits plans in most states, including Virginia, will probably be their respective dental Medicaid/SCHIP plans. Even though the Act permits patients to purchase insurance outside the Exchanges, proprietary dental benefits companies seem to be scaling back their benefits to be competitive with premiums in the Exchanges. The only consumer information required by the Act is the premiums and the levels of reimbursement to providers.

Many patients currently receive a higher level of dental care than that likely to be offered by the Exchange's plans. The number of patients who will self-pay for a higher level of care and the number who will decide that a higher level of dental care is unnecessary are unknown. It's also uncertain whether dental benefits plans will eventually offer more robust products than their state exchange products. But, the 40% tax levied by the Act (beginning in 2018) on employer-sponsored plans exceeding the government's established premium limit may discourage such products.

It's anticipated that many employers will stop offering health coverage to their employees and direct them to the State Insurance Exchanges for coverage. So, the level of dental benefits offered by Virginia's Insurance Exchange is likely to impact the level of dental care offered in Virginia in the near future.

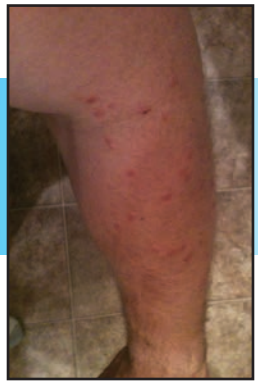
I was appointed Chair of the VDA's "PPACA Taskforce". Members of the taskforce are Drs. Terry Dickinson, Frank Farrington, Mike Link, Ralph Howell, Charlie Cuttino, Mike Abbott, and Ted Sherwin. Our task is to monitor the implementation of the PPACA in Virginia and make recommendations that we believe are in the best interests of the oral health for Virginian's as we go forward. If there are significant new developments, we will keep you informed.

Dr. Ronald L. Tankersley practices in Newport News. He is a Past President of the VDA and ADA. Dr. Tankersley can be reached at ronald.tankersley@omsp.com

PathologyPuzzler

with Dr. John Svirsky

Figure 2



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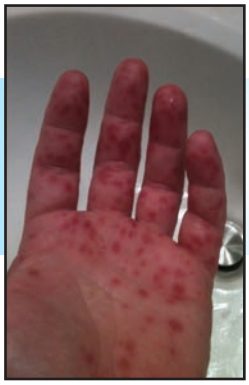

Figure 4

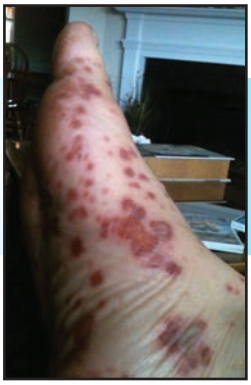

Figure 5

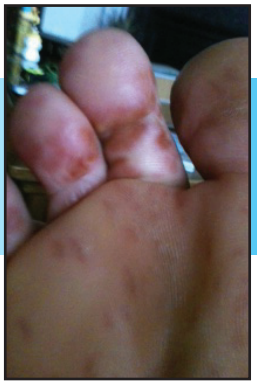

Figure 6

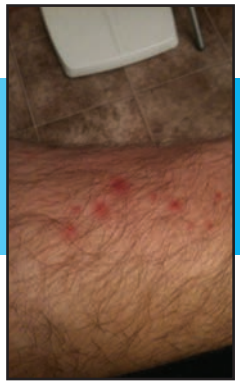

Figure 7

Continued from page 43

From the history a number of acute viral conditions could be considered which include hand-foot -and-mouth disease, herpangina and primary herpetic gingivostomatitis. All of these diseases start out with the patient feeling sick with a low-grade fever and developing painful oral lesions within two days. The location of the lesions predominately on the oropharynx and tonsils suggest herpangina. The lack of gingival lesions and the age of the patient make a primary herpetic gingivostomatitis less likely. Hand-foot-and-mouth disease usually has oral lesions that precede the skin lesions .

Aphthous stomatitis can be excluded since fever and feeling sick are not related to this condition. Also there should be a recurrent nature to aphthous lesions. Cytomegalovirus (Herpes type 5) is usually asymptomatic (90%) and can be found at any age. The 10% that are symptomatic have flu-like symptoms and also organ involvement. This disease is usually found in immunocompromised individuals and not easily transmitted to healthy individuals. It is found in AIDS patients at a much higher rate than the general population.

Infectious mononucleosis (Herpes type 4) is a symptomatic disease related to Epstein-Barr virus (herpes type 4 virus). The symptoms of mononucleosis are more prolonged with head and neck lymphadenopathy. Oral lesions are not a component of this disease, although some patients get oral petechiae.

Mumps usually present with flu-like symptoms and salivary gland swelling, most often the parotid, that typically peaks in two to three days. Intraoral findings include swelling and redness of Wharton's and Stensen's duct openings. Sublingual swelling is also reported. Oral lesions, other than the glandular involvement mentioned, are not typically found in mumps.
Measles also presents with flu-like symptoms and the oral lesions that are small, non-painful, blue-white macules of the labial and buccal mucosa (Koplik's spots). As the oral lesions fade, the fever continues and an erythematous maculopapular rash develops. Measles can be serious in immunocompromised patients.

I withheld the information that would have made this an easy diagnosis. According to the patient four days after the onset of fever and the oral lesions, small, red, flat lesions appeared on the palms (first skin involvement) (figure 2) and moved up the arms (Figure 3). The palm lesions (figure 4; day 4) and oral lesions continued to worsen in severity, size and number over the next 24 hours and lesions started to develop on the feet (figure 5; day 3). After four days post onset of fever the lesions continued to increase in number and intensified on the feet (figure 6) and showed up on the legs (figure 7), lower arms, nose (figure 8), vermillion border, and genitals. Some of the lesion blistered and erupted and others began to harden without eruption blistering. All the lesions were painful to pressure and a few caused pruritis. New lesions stopped forming eight or nine days after the onset of fever. All the lesions began the healing process and the areas of the hands and feet desquamated. When areas of the hands and feet desquamated, new and tender skin was formed underneath and was extremely painful. The "peeling" lasted three weeks and the patient had two finger nails and one toe nail fall off two weeks after the virus. He also has scarring on the medial surface of his foot.

In most cases the disease is not nearly as severe as it was in this case. His children were barely affected at all.

HFMD is a common disease classified as a coxsackievirus, usually A16 in the enterovirus family. Infants and young children are the most commonly infected and the disease is contagious with a three to seven day incubation period. It occurs in epidemics and as would be expected in day care centers, nursery schools, and early school years.

The presenting symptoms as in this case are flu-like symptoms and sore throat with difficulty in swallowing. Oral lesions typically precede the skin lesions which usually occur first in the hands. The name of the disease, as it implies, usually affects the hands and feet following the fever. As in this case, other areas of the body can be affected. The lesions are painful and treated symptomatically. The disease usually runs a course of one week, and since it is viral antibiotics are unnecessary. The disease is typically mild in older children and adults (not in this case). Most adults get the disease from their infected children and severe complications are unusual.

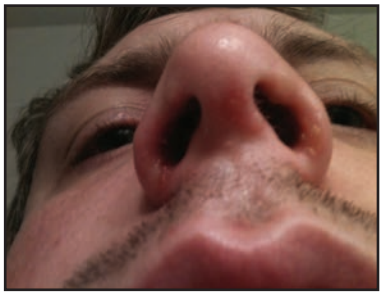

Figure 8

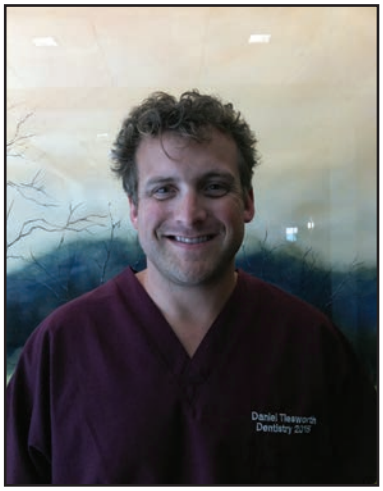

Figure 9

This case was submitted by and on Daniel Tiesworth (a second-year dental student). I asked Daniel why his wife escaped the family outbreak and he responded without skipping a beat, "I am not surprised she didn't get the virus, I'm pulling all the weight ….I'm like Mr. Mom." (Figure 9: picture of Daniel in his D-2 garb in front of a Dr. Baxter Perkinson original at the VCU School of Dentistry)

Communication - The Gateway to Dental Education

By: Fred Certosimo, MSEd, DMD

" Nothing in life is more important then the ability to communicate" Gerald Ford

The purpose of this paper is not to examine the cultural and technological reverberations of communication in our society, but rather to discuss the importance of effective communication in dental education, and how this is accomplished. . For it is only by maximizing dental educators' communication efficiency and effectiveness, can we better educate dental students to succeed in our "instant access" society. Dental educators must communicate with their students in various educational settings (clinic, lecture, seminar, laboratory, social) using a panoply of teaching methods such as: visual and/or auditory (tell-show-do), behavioral modeling, questions and answers and integrated teaching.[2] Clearly and concisely communicating with our students with consistency and over a span of many years is a challenge for even the most gifted educators. Yet, whichever the method, effective communication is essential for dental education to be successful. It must be noted that effective communication is not unique to the dental education. The qualities of great teachers discussed in the paper are seen in elementary, undergraduate, graduate or professional education. Clear and concise two-way communication is an essential element of all teaching, without it educational understanding and progress is impeded.

Effectively communicating and presenting pedagogical concepts remains one of Boyer's six standards of excellence in scholarship[3] and is a hallmark of dental education. Although the challenges of effectively communicating with our students are formidable, this paper will demonstrate that the rewards of the student and teacher connecting are immense. The rewards of this process will remain with both the student and the teacher throughout their professional careers.

Communication *vs.* Connecting

Why is it that two dental educators of similar educational backgrounds and communication skills can present a lecture, facilitate a seminar or teach a clinical technique to a student, but with two different outcomes? For one professor, the student has that "light bulb moment."[4] The student understands and can demonstrate the desired outcomes and is further inspired to embrace higher levels of learning. Conversely, the other professor with that same student experiences a perplexed gaze, frustration and a total lack of understanding.

The answer may be that although both teachers have communicated, only one connected. Maxwell defines "connecting" as "ability to identify with people and relate to them in a way that increases your influence over them" and further proposes that while many of us communicate, few connect.[4] Although there are many levels of personal connection by far the most important and effective method of connecting is one-on-one. In fact, 80-90% of all connecting occurs during one-on-one encounters.[4] This presents the ideal opportunity for dental educators who interact with students in small groups, and especially for those educators teaching one-on-one clinical dentistry, to maximize their connection.

The key element in connecting with the student is finding a common ground on which to build. Maxwell states: "If I had to pick a first rule of communication – the practice above all other that opens the door to connection with others – it would be to look for common ground."[4] He points out that there are four barriers to finding common ground:

- Assumption "All miscommunications are a result of differing assumptions." 5;
- Arrogance since "Arrogant people seldom meet people on common ground."6
- Indifference in which individuals are aloof to the views and desires of others; and
- Control in which one attempts to limit the thoughts and actions of others. 4

Felber states: "If you can learn to pinpoint how those around you experience the world, and really try to experience the same world they do, you'll be amazed at how effective your communication will become."[6]

Although finding common ground serves as the foundation for connecting with students, mutual respect, concern, trust and shared values[7] play significant roles in transcending ineffective communication and genuinely aid teachers in connecting with their students. Trust is the cornerstone of all relationships. It is visibly demonstrated through "consistency, reliability and integrity."[8] Without a mutual trust the student-teacher relationship is incapable of growth. Johnson and Ridley state: "Shared values undergird strong relationships. We are drawn to people that share our sense of right and wrong, our sense of justice, and our beliefs of things we deem important in life."[8] In short, we easily form a kinship with individuals we trust, who share our values, and the potential for a positive connection is enhanced.

Connecting occurs on four levels: visual, intellectual, emotional and verbal "using the right words with the right emotion while being intellectually convincing and making the right visual impression. And all these need to be performed with the right tone of voice, the right facial expressions and positive body language."[4] It is not an overstatement to say the connection takes time, trust, perseverance and energy; and if that is not enough of a challenge, the message must be presented in the most clear, yet concise manner possible.

Great Teachers

"Simplify, simplify!"[9]

In order to effectively communicate and connect the dental educator must simplify concepts and techniques so that a student can better understand them. In short, teachers must make their message clear, concise and deliver it in an uncomplicated manner. However, often in the educational process, the opposite occurs, Beckley writes: "The emphasis in education is rarely placed on communicating ideas simply and clearly. Instead, we're encouraged to use more complicated words and sentence structure to show off our learning and literacy… Instead of teaching us how to communicate as clearly as possible, our schooling in English teaches us how to fog things up. It even implants a fear that if we don't make our writing complicated enough, we'll be considered uneducated."[10] John Maxwell comments: "Educators take something simple and make it complicated. Communicators take something complicated and make it simple."[11]

Effective teachers are not measured by the depth of their knowledge or their intellectual capacity nor their clinical skills but rather by the effectiveness of their teaching methods which are ultimately judged by what their students learn and are able to apply. Connecting with our students in a manner that allows us to transfer complex concepts in a manner that is understandable, retainable and

practical should be our goal as dental educators. Albert Einstein, whose life work consisted of quantifying and qualifying the complex, stated "If you can't explain it simply, you don't understand it well enough."[12]

Qualities of a great teacher

What are the qualities of a teacher whose class students cannot wait to attend? How do we quantify the traits of the exceptional educator who keeps their students engaged, on task and eager to learn more? Can we list the qualities of the rare teacher who delivers the "Aha" [13] moment and connects with their students in a transformational way? Hamlin provides answers to these questions, and catalogs many of these engaging qualities in her book *How To Talk So People Listen* as (the teachers are): "warm, friendly, interesting, organized, honesty (integrity), knowledgeable, creative, organized, inspiring, confident, open and funny."[14] A few of these qualities are self evident, while others may require more description:

Interesting

All educators encounter the challenge of presenting lectures and pedagogical materials with similar modes of delivery year after year, sometimes with only minor variations in the content. If left unchecked the teacher may go on autopilot. This will lead to a monotonous, disconnected communication outcome. Weissman states: "When you go into autopilot, however, your presentation comes across as 'mailed in', and the result is an audience that is uninvolved, unmoved, and unconvinced."[13] He further adds that to connect with our students, we must strive to "Create the illusion of the first time, every time."[13] Each time a teacher presents a lesson, demonstrates a technique or mentors a student, it should be as if it were the first time that teacher ever presented these concepts and principles, because for that student, it is.

Knowledgeable

Knowledge of the subject is a prerequisite for dental educators. Hamlin states that knowledge and/or confidence "are very reassuring. Since the speaker has obviously done his or her homework, we listen with trust and the assumption that listening will be both beneficial and definitive."[14] Kenny proposes that knowledge coupled with role modeling is the essence of professional character development: "Knowledge and skills are essential, but putting them together in a competent and caring response to patients' needs is learned in personal interaction."[15]

Creativity (imagination)

"What is creativity? … it's a kind of voodoo ability that certain imaginative people are born with, some manage to learn, and still others admire but will never quite master. In essence, it is the ability to make something out of nothing."[16] The creative teacher strives to make their lessons relevant, topical and on task, yet delivers the message in an innovative manner which appeals to and delights the student's educational needs. Creative educators: "pursue unusual solutions to problems, question accepted standards in the field, and display energetic excitement in the face of challenge."[8] Employing technologies such as DentSim®, digital dental impressions and cone-beam computed tomography (CBCT) are just a few examples of the modern technologies available. However, the innovative educator builds on these technologies by marrying them to sound teaching principles. This serves as a force multiplier whose only limits are the student's talents and the teacher's abilities.

Honesty (Integrity)

It strains the imagination to imagine the bond between student and teacher existing without honesty and integrity. Eller states: "You trust a person's integrity because his or her character remains whole despite pressure. This is a person who doesn't fold in a crunch; doesn't lie, cheat, flatter; doesn't fake credentials… doesn't blame others for his mistakes or steal credit for their work."[16] Educators of integrity "confront problems, mistakes and shortcomings… ensure congruence in word and deed."[8] Honesty, integrity and character are intricately woven into the fiber of a great teacher and the distinguished legacy of dental education. William Shakespeare expressed it best: "No legacy is so rich as honesty."

Authenticity

To effectively communicate, it is important to mean what you say and say what you mean. In his book, *Am I Making Myself Clear*, Felber writes:"A lack of authenticity can lead to strained relationships, where communication is clouded and feelings and intentions are hard to determine. Keeping lines of communication clear and honest are important elements in relating to others." [6] The wise teacher whose deeds reflect their words will better connect with students.

Inspiring – "Dream great dreams"[18]

Dental educators play a major role in the professional development of our students. They should inspire, motivate and pass on knowledge. Exceptional teachers mentor their students by "framing the possibilities"[17] of their professional careers, then assisting them in designing a road map necessary to make these possibilities a reality for the student. Hamlin states: "Inspiring appeals to our deeply rooted willingness to follow a leader or raise our own thoughts to absorb another's enthusiasm and innovation."[14]

Seeing your students as a "10"

"It is the supreme art of the teacher to awaken joy in creative expression and knowledge."[19] The teacher who makes the biggest impact on students is usually not the brightest professor, the gifted researcher or even the greatest clinician. Rather, it is the teacher who recognizes the potential that lies within each their students, imparts an encouraging work environment and provides the encouragement for the student to exceed their expectations – in short, great teachers view their students as a "10."[20] The memories of those educators who encourage their students to tap the unbridled resources within themselves and inspire them to make their dreams a reality, will forever remain within the student. John Adams wisely reflected: "Encouragement is the oxygen of the soul."[21]

In addition to practicing these essential communication skills, it is imperative that educators teach their students how to communicate more effectively: "The number one criteria for advancement for professionals is an ability to communicate effectively."[22] Mastery of these "soft" skills, will better prepare them to connect with their patients, staff, professional colleagues and their communities.

Very few educators possess all of the admirable qualities described by Sonya Hamlin. It is ironic that some educators who do possess many of these qualities fail to maximize on their effectiveness as connectors and ultimately, as teachers. Buckingham states: "The real tragedy of life is not that each of us doesn't have enough strengths, it's that we fail to use the ones we have." [23] Ben Franklin called these wasted qualities "sundials in the shade."[23]

Hamlin further enumerates several negative characteristics of a teacher, which include: "monotonous, vague, pompous, closed, nervous, stuffy, patronizing and intense."[14] Since we have all experienced these shortcomings in some of our own teachers or even recognize them in our colleagues or within ourselves, it is unnecessary to expound on the negative characteristics. It is more enlightening to mention the *Four Unpardonable Sins of a Communicator:* "unprepared, uncommitted, uninteresting or uncomfortable."[6] Any one of these "sins" will hamper communication and marginalize the ability of the dental educator to connect. It is essential that teachers recognize these deficiencies and devise a plan to address these concerns. The greatest tragedy to an educator is the inability to recognize these "unpardonable sins" in themselves, while continuing to assume they are connecting with their students. George Bernard Shaw stated: "The greatest problem with communication is the illusion that it has been accomplished."[6]

Summary

Communication is an essential element of dental education. The teacher must be capable of clearly transferring information (knowledge) in a manner which connects with the students, relays a sense of purpose and inspires them to new heights. Clark and Crossland state: "The heart of the matter …is to communicate so compellingly as to raise consciousness, conviction, and competence."[24] This

must be effectively accomplished through the delivery of a clear and concise message employing many of the principles discussed in this article. In summary, the message must "Inform, Involve, Ignite and Invite."[25] Effective communication and connection with the student is an ongoing process with the potential of great rewards for the student, the teacher, the patient, and the dental profession. As dental educators we have the unique opportunity to positively influence the lives of our students. Henry Adams wisely observed: "A teacher affects eternity: he can never tell where his influence stops."[26]

The opinions or assertions contained in this article are the private ones of the writer and are not to be construed as official or as reflecting the views of the Virginia Commonwealth University School of Dentistry, Virginia Commonwealth University or the Commonwealth of Virginia.

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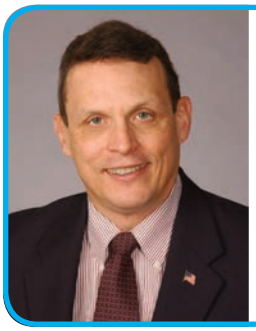

Dr. Fred Certosimo, MSEd, DMD; Associate Professor and Chairman, Department of General Practice, Virginia Commonwealth University School of Dentistry. Dr. Certosimo can be reached at ajcertos@vcu.edu

Assessing the New Patient:
Risk Management Considerations

Kathleen M. Roman

The question: Recently, a doctor posed a question to her risk management consultant: Is it a poor business decision to provide the patient with a complete treatment plan before care is initiated? The questioner feared that providing the entire plan to the patient would obligate the doctor to provide all of the care, regardless of whether or not the patient would be able to pay. In tough economic times, many doctors might have the same concern.

Business goals versus clinical goals: The doctor's question represents a perfect example of the business versus health care conundrum. Does the wisest course of action, when viewed from a business perspective, place the doctor at risk from a clinical perspective—and vice versa? The doctor probably will want to do some "sifting" of the issues to determine which hat to wear during her analysis. Although it may be simplistic, dentists sometimes need to be reminded that: 1) Dentistry isn't obligated to be solely altruistic in its relationship to patients, and 2) The desire to earn an honest profit isn't something that dentists should feel guilty about.

Initiating the doctor-patient relationship: There's an old adage that says, "An ounce of prevention is worth a pound of cure." This is certainly true in health care. Dentists could do themselves a big favor by thinking about the potential risks and benefits associated with accepting new patients. Too many doctors accept any warm body that walks through the door demanding care. From a clinical perspective, dentists often find that the patient who poses the greatest liability risk is the patient who manifested problematic behavior right from the start. In an introductory appointment, this patient gives signs that he or she is:

- Hostile toward the health care community: "You're the third dentist I've come to in this crummy town; those other guys don't have a clue!"
- Suspicious of the doctor's motives: "So, what are we going to extract today, fifty dollar bills or hundred dollar bills?"
- Disinclined to follow home care regimens: "I'm not real good about brushing and flossing is just a pain. Besides, if everybody's teeth were in great shape, you'd be out of a job!"
- Non-compliant with clinical recommendations or treatment plans: "Yeah, my last dentist was always 'on me' about seeing a periodontist, too, but that's not an option. So—end of discussion, OK?"
- Rude and dismissive to staff: "Your so-called dental hygienist gave me all this flack about cleaning my teeth and having X-rays, but I'm here to see a dentist, not waste my time and money on all this other stuff."
- Lax about accepting their financial obligations: "Well, I'm not sure if my insurance covers dental care or not; I forgot my card today. Let's just get started and I'll bring the card in next time I have an appointment."

The dentist who accepts these patients may be accepting clinical *as well as* business risk. A certain amount of "up front" communication should take place before the doctor decides to accept a patient. In order to better understand the local market, some practices regularly ask prospective patients how they were referred or heard about the practice. What is the name of the patient's previous dentist? It might serve the doctor's purposes to know why the patient is changing dentists: has the patient just moved to the area or has the patient been discharged by a local dentist for non-compliance?

It's really a partnership. Just as the dentist will assess the patient as a candidate for a particular procedure, so too will the dentist assess the patient's ability to comply with the treatment plan. Is the patient willing and capable of fulfilling the role of partner in his or her own care? If at all possible, dentists need to make this determination before initiating care. Is the patient suffering from a mental illness? Is the patient physically unable to follow instructions? Does the patient have emotional baggage that makes her hostile to the concept of complying with a treatment plan? These are important questions that dentists sometimes overlook.

Some dentists are willing to assume all the responsibility for the doctor-patient relationship and, by so doing, assume the risks as well. Many patients need to be reminded that they are partners in their own care and that they have obligations to fulfill if the doctor is to be able to provide them with excellent care. If patients seem unwilling to accept this responsibility, the doctor should diplomatically but firmly let them know that he cannot continue to treat patients who aren't willing to be active participants in the process.

In addition, the clinical assessment occurs in conjunction with the financial assessment. Have the practice's payment policies been explained to the patient and does the patient understand that payment is expected at the time of service? Many doctors will not initiate care until the payment/insurance issues have been resolved. These are all business processes but they affect the doctor's ability to provide care. If he can't turn an honest profit, it doesn't matter how talented a clinician he is—he won't be able to stay in business.

Set the tone, right from the start. Some dentists use the initial meeting with the patient as a consultation, clearly stipulating that the conversation will help determine whether or not this particular practice can best meet the patient's needs. If the doctor hones in on the types of problematic behaviors listed above he can opt to refer the patient elsewhere because he hasn't examined the patient, developed a treatment plan, or committed to treat the patient. "As you know, Mrs. Rysk, the purpose of our meeting today was to determine your expectations for dental care based on your past treatments and your current needs. Having listened to your goals, I believe that your requirements may extend beyond the capacities of this practice. So, of course, there's absolutely no charge for today's meeting, and I'm going to give you the number of the local dental referral agency. Be sure to tell them what you've told me and they should be able to help you locate a practice that can help you. I've enjoyed meeting you and wish you the best of luck."

Unless the patient was experiencing a dental emergency when she came to the office, the doctor should be able to dismiss Mrs. Rysk before accepting the responsibility to treat her.

The new patient who wants to be treated immediately because of pain or an emergent condition may require more careful screening and additional safeguards to ensure payment. If the practice is in the habit of accepting this type of patient, it might be wise to develop a written policy that sets forth the type of emergency patients the doctor is willing to examine and treat—and the type of patient who will be referred elsewhere. It is important that the rationale for this policy should be to ensure that appropriate care will be given to address the patient's needs and expectations.

Dentists should never use this type of policy as a means of avoiding clinical conditions, i.e., patients with AIDS. A further benefit to the doctor who implements this type of policy will be the ability to refuse to treat patients who

seem to be interested only in obtaining pain medication. "Gee, Doc, if you can just give me enough medication to get through the weekend, then I'll come back on Monday and we can get this taken care of." This type of patient, having received a pain killer, often disappears never to be seen again. The dentist hasn't been successful in treating a patient; he's been duped.

Policies help. The dentist and staff will benefit from developing policies for the assessment of potential new patients. Staff training, for example, might include questions that might help identify the demanding patient or the individual who seems to have a different agenda from obtaining dental treatment. Written policies will also provide a "fair" means of assessing newcomers to the practice. The non-compliant may be charming and complimentary and the cooperative patient may be less than warm and fuzzy. By having specific policies, it's possible to remind people that they have stepped outside the expectations of the practice and that, in order to continue as patients, they need to climb back on board.

Conclusion: Risk management provides dentists and their teams a chance to identify and reduce potential areas of miscommunication or poor business process – before they cause patient irritation or injury. Risk management strategies also give doctors better control of their practices and a chance to improve patient satisfaction while also reducing potential liability.

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Kathleen M. Roman is risk management education leader for Medical Protective, the nation's oldest professional liability insurer, serving the healthcare professions since 1899. Kathleen can be reached at: kathleen.roman@medpro.com

Difficult Conversations

By: Dr. James Schroeder

Not long after entering practice you realize one skill you did not acquire in dental school is the ability to have difficult conversations or what I sometimes call courageous conversations. For the scope of this article I am referring to the leadership hat you wear or leave in the closet in your day-to-day practice. These conversations often involve issues or behaviors related to staff, patients, associates or partners. I find the majority of dentists and physicians avoid these difficult moments by focusing on what they were trained for and enjoy. We wishfully hope "perhaps they will go away if I ignore it long enough". Unfortunately, left unaddressed they often only get worse and impact both the morale and performance of the office. Rather than leaving the office with a sense of satisfaction each night you go home ruminating and often grinding your teeth over an unaddressed issue. At this point if you can not relate to what I am writing consider yourself fortunate and you can put this article in recycling. For those of you that exclaim "That's me!" read on.

Following are some tips for getting unstuck and avoiding the serious consequences of avoiding the difficult conversation. First of all, can you identify the issue and person or persons that are involved or have you avoided it so long you now call it normal?

I will list a few examples that I have encountered both in my own career and now as a consultant /coach in medical and dental offices.

1. The employee or office manager that uses intimidation or bullying their co-workers to gain their desired outcome.
2. The low performing employee that is ignored and brings the performance standards to a level that makes co -workers or you want to scream!
3. The associate whose relationship skills are demeaning to staff or driving patients out the back door.
4. The patient that started out in the practice, but has now developed demanding or abusive expectations, and everyone dreads the moment they enter the door. Equally frustrating is the employee who develops similar expectations of their co-workers.
5. The new employee who never is accepted or allowed to develop and be part of the team, also known as "the clique syndrome".
6. The doctor's tool box for coping is anger, frustration or manipulation or, better yet, passing it on to the office manager.

As leaders of the practice a different skill set is required to address the issues above. We are accustomed to completing procedures such as a crown, endodontics or surgery. With leadership and the development of people it is an ongoing process that requires our continuing influence. We all recognize patients refer patients and return to our office not only because of our great margins, our endo fill or our perio graft but because of the experience they encounter with our team. Following are steps to short-circuit the toxic situation.

1. Man up! Acknowledge and commit to addressing the issue. Have a conversation with a trusted colleague or your spouse. Hopefully if you have raised this issue 10 or 15 times they will ask, "When are you going to take action?"
2. In a calm, reflective moment write out the specific issue, how long it has been occurring, the consequences of this performance or behavior and the people involved.
3. List the different choices you have and the anticipated consequences of each choice. Dismissal, train and develop, coach; perhaps you need legal advice or coaching before starting the process.
4. Commit to a date that you will address the issue and do not let yourself rationalize to do it later.
5. Identify what will look different in the employee behavior or performance to demonstrate that they have clarity and understanding of your expectations. Be specific and try to eliminate ambiguity.
6. Offer coaching, counseling or skill training depending on the situation. Sometimes the person may need development and your investment in them will turn them around into an outstanding employee. We are all a work in progress!

Take the time to develop a process that brings you to a place that puts light on the situation in an objective manner. Practice and refine a process that brings about action and results in growth. Recognize your own strengths and weaknesses in your leadership style. Commit to growth in this area, not unlike a continuing education course in cosmetics or surgery. Allow your brain to think objectively and analyze the various components, much like we approach a complex dental case. View moving forward and looking at your steps as win- win. We are doing no one any favors by ignoring these issues…everyone suffers. Understanding and developing our leadership skills is one of the most underdeveloped skills in our tool box. It impacts every facet of our office from profitability to the enjoyment of our profession.

I am including a reading list to enhance your lifelong learning. Please feel free to contact me with questions or comments.

- *The Truth About Leadership*, By James M. Kouzes and Barry Z. Posner
- *Developing the Leader Within You*, By John C. Maxwell
- *Good to Great: Why Some Companies Make the Leap…and Others' Don't,* By Jim Collins
- *Lead Change*, By John P. Kotter
- *The Motivating Team Leader,* By Lewis E. Losoncy
- *Jack: Straight from the Gut*, By Jack Welch and John A. Byrne
- *On Becoming a Leader*, By Warren G. Bennis

Dr. James Schroeder practiced in Richmond. Please email him your experiences and questions to be addressed in future columns.

drjimschroeder@gmail.com

Dentists, Nurses Join Forces
Dental and medical collaboration at Wise 2012

By: Audrey Snyder, PhD, RN and Pat Tisdelle, MSN, RN

For many years the Virginia Dental Association has been a partner with the Health Wagon, a nurse-managed health clinic based in southwest Virginia, providing dental services for the medically underserved in this area through a Remote Area Medical (RAM) event. The Health Wagon is the local organizer that coordinates the various teams providing services over a three day event each summer. On July 20-22, 2012, 1,379 volunteers gathered in Wise, Virginia to provide medical, dental, and vision services at the Virginia-Kentucky Fairgrounds. The dental clinic saw 1306 patients and provided 5046 encounters for care (RAM, #675 2012 recap). Only 3% of the patients were children. The dental area is staffed with volunteers who provide cleanings, fillings, dentures and extractions. Many patients from the local area come to RAM intent on seeing a dentist or to have their vision or hearing checked. All patients go through a triage process, and if their blood pressure is elevated above 140/90 or their glucose is greater than 126 fasting, or 200 nonfasting, they are seen by physicians and nurse practitioners from the University of Virginia Health System. The MDs and RNs staff an urgent care area to provide prompt treatment of concerns that may affect the patient's dental or vision care that day. Patients may present with hyperglycemia and need glucose control prior to their dental procedure. Many patients are fasting or hold their routine medications if they come to the event intending to have blood drawn for laboratory analysis. These scenarios can complicate dental care. Medical concerns are often identified first during the triage process and then treated in urgent care. Once their dental needs are met, the patient can later be seen in the medical clinic. The medical clinic is staffed with physicians, nurse practitioners, nurses, students and general volunteers from throughout the state.

Patients are screened at the dental clinic by nurses from the medical team. The nurses verify the dental patient's medical history, medications and allergies. They focus on identification of medications that may prevent a specific procedure, for example, anticoagulants. Point of care testing of INR can be performed on site. They also confirm the need for premedication, for example if antibiotics are needed for a patient with a joint replacement, or perhaps a prosthetic heart valve. They confirm vital signs and if patients are waiting for a period of time they repeat vital signs pre-procedure and again post-procedure. The nurse's role in dental care also includes identifying all other medical, social, and education needs and referring patients to the medical clinic, social worker, or patient educator for intense education sessions as needed. Each of the nurses provides just-in-time patient education as they work with them through the dental clinic process. The nurses assist the patients with changing gauze post-procedure and teach them how to do it themselves. A gauze changing station was also staffed by the nurses at the pharmacy this year. The nurses work closely with the dentists and physicians to ensure the best care possible for the patients.

When a medical emergency or complaint occurs in the dental area, the nurses first respond, provide immediate interventions and call for assistance from the task force team who provides on-site emergency response. The patient is moved to the emergency room tent when conditions warrant. Common emergency concerns include hypoglycemia, chest pain, syncope, heat exhaustion, and altered mental status. The nurses play a vital role in the immediate response and help locate family members when patients are transported by emergency services. Medical, nursing, and dental students help staff the area with the nurses and learn a great deal about dental emergencies and patient education. At the 2012 event RAM event 1,269 patients received collaborative care between the dental team and the medical clinic nurses staffing the dental area. These collaborations ensure the best care possible for patients presenting for care and provides one model for nursing integration into dental care services.

Audrey Snyder is the Nurse Coordinator, Community Outreach, University of Virginia Health System and Assistant Professor at the University of Virginia School of Nursing in Charlottesville.

Pat Tisdelle is a nurse in Dr. Michael Tisdelle's Dental office in Charlottesville. She is also the High School Dental Assisting Instructor at Charlottesville Albemarle Technical Education Center and has been a M.O.M. volunteer for over 10 years.

An Interview with:

Dr. Lawrence Wallace

LARELL One Step Denture™

Editor's Note: Dr. Wallace, inventor of the Larell One Step Denture®, was interviewed at the 2012 Wise Missions of Mercy project. His techniques have been used successfully at other M.O.M. locations and outreach projects.

VDA Journal: You're an oral surgeon. What inspired you to develop a new method of denture delivery?

Dr. Lawrence Wallace: I was in Oral Surgery private practice for 25 years, took out thousands of teeth, and I saw the devastation: emotionally, physically, and psychologically of taking out all of one's teeth. I really didn't think much about it until I had been retired from practice about 12 years. I looked at a two-step denture program that was being promoted for nursing homes, but it never gained acceptance. I wanted to give back to the community as dentistry has been very good to me.

Journal: How did you go about testing techniques and materials?

Dr. Wallace: I started by getting this concept in my head, and thinking about it – I thought about the concept for over a year, looking at dentiform models, and playing around with them. I thought about making a denture for all the different kinds of patients. I measured over 1,000 edentulous models. I took twelve different measurements on each model, and put the measurements into an Excel spreadsheet, and charted the results. I could see break points (these were natural breaks) and found there were five different groups of model sizes, with very few outliers. My first templates were solid acrylic, and they could not be adapted to the models. They fit well but required too much trimming. It was here I had an "Aha!" moment. What if we used a thermoplastic material? With that we could adapt it to palates, tuberosities, etc. The thermoplastic material would fit about 99.5% of everybody, and could be modified to fit just about clinical situation. Also it didn't really matter whether the patient was Class I, Class II, or Class III. Very, very few patients would need a custom denture.

Journal: Explain the role of Missions of Mercy projects in developing the Larell Denture.

Dr. Wallace: It has been extremely important. I called Terry Dickinson two days after the VDA building burned down – my timing wasn't very good – to discuss using our dentures for the Virginia Mission of Mercy program, being certain it would be a benefit. Terry returned my call in the midst of the issues with the building and getting the association relocated. He said "I am going to refer you to Scott Miller and Steve Alouf, and let them try it out. If you can get past Scott and Steve you may be onto something." I went to Scott's office and we did twelve dentures on six patients. They really saw that this was something different. Three months later I'm at my first MOM clinic. Virginia has been very good to me, very welcoming. We did 40 dentures at our first clinic. We went on to larger clinics at Roanoke, Wise, Grundy, and Gloucester. Now we're expanding into twelve other states. Virginia has been very helpful in other ways: we have an arrangement to train dentists through the Virginia Health Care Foundation. Debbie Oswalt, their executive director, has been very enthusiastic about our program. I see these dentures as helping patients with nutrition, self-esteem, even getting employment.

Journal: What has been the biggest surprise when delivering Larell Dentures at MOM projects? Have there been other surprises?

Dr. Wallace: I didn't expect to have the real acceptance we have achieved, especially among prosthodontists. Prosthodontists in all parts of the country see the value in what we are doing. Prosthodontists in Houston, Colorado, Minnesota, everywhere. GPs are skeptical, but once they see the procedure and how well it works we make believers of just about everybody.

Journal: Let's say I'm using the Larell Denture in my office for the first time. How much time should I allow for completion?

Dr. Wallace: If you're new at it I would set aside two hours. If they are edentulous the main concern is undercuts. This is no different than with a conventional denture. So it is good to have a consult ahead of time. Treatment plans are often financially guided. You follow the principles of denture construction, and develop a treatment plan acceptable to you and the patient. Patients sometimes forgo more sophisticated overdentures so they can afford the implants. The Larell Denture gives them an implant option – it frees up some funds.

Journal: How would you go about setting fees, in comparison to conventional dentures? Should there be a fee for adjustments?

Dr. Wallace: I'd suggest $1200 for an upper and lower set. This is fair to the doctor. After two or three cases the doctor is netting $800 per hour, and the patient is getting it for half of what they normally would. Conventional dentures are offered, and the Larell Denture is offered as an alternative. Is it as good? The satisfaction rates are the same. Studies have shown with conventional dentures 70% of the patients are satisfied, 20% are somewhat satisfied (they have problems typically with the lower denture) and 10% are dissatisfied. It's the same for Larell Dentures. Will they last as long? Yes, they will. Their useful life is the same as a conventional denture. It's our ethical duty to offer alternatives – it's why our patient stays with our practice, and why our profession stays exemplary.

Journal: What are the contraindications for the Larell Denture?

Dr. Wallace: There are no specific contraindications, virtually none. You must understand what your patient's expectations are. We are obligated to follow the

scientific principles of denture construction; fit form and function. Our dentures can eliminate cost and access as reasons to not have dentures.

Journal: Do you foresee this technique being taught in US dental schools? What do the prosthodontists think?

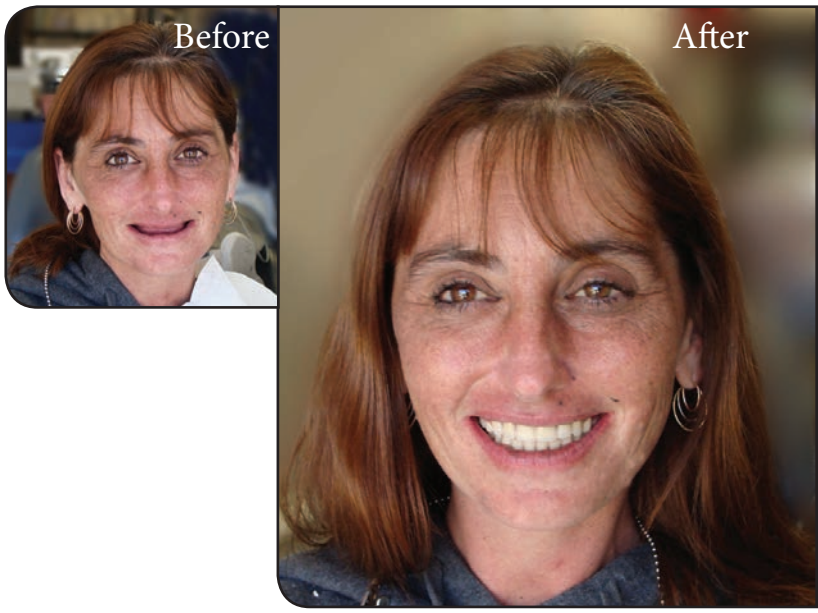
Dr. Wallace: Dr. David Felton, the dean at West Virginia, has invited me and my clinical experts, Dr. Stephen Alouf and Dr. Scott Miller to lecture and teach the undergraduate students the technique. We'll be adjunct Professors of Prosthodontics at WVU. We plan to take this to other dental schools, and show this as an alternative to the senior dental students. Also, we plan to publish an article in the JOP (Journal of Prosthodontics), which will give us a lot of credibility.

Journal: Have you done any trials with patients in Long Term Care Facilities, i.e., nursing homes? Are there any differences in their treatment protocol?

Dr. Wallace: Interestingly, we are being accepted by LTCFs, and the reasons are many. Dentists don't like going to nursing homes – they're understaffed and there's no money for transporting patients, especially for many trips to the dental office. But a denture in one visit provides a good alternative for nursing home patients. They're cost effective and it provides a much-needed service. The nursing home companies are on board with this. There was a study done in Boston that found that only 80% of edentulous patients actually had dentures, and of those that did have them, most were grossly inadequate. Nursing home residents often have a different diet that requires them to eat soft or pureed foods, or they need thickened liquids. They require dentures for adequate nutrition and can now have them.

Journal: By now there have been many patients treated by this method. What's been your most gratifying experience?

Dr. Wallace: Seeing the absolute joy in the face of the patients who get their dentures, and knowing we're fulfilling a real need. Those needs are there, not only at MOM projects, but also in our private offices. Like I said in the June issue of "Dentistry Today", giving back is always something I wanted to do.



Nursing Home Residents: A Population in Need of Dental Care

By: Patricia Brown Bonwell, RDH, BSDH, MSG, PhD

According to the Administration On Aging, adults age 65 and over numbered 39.6 million in 2009, an increase of 4.3 million or 12.5% since 1999. The population 65 and over increased from 35 million in 2000 to 40 million in 2010 (a 15% increase) and is estimated to increase to 55 million in 2020 (a 36% increase for that decade). According to the US Census Bureau, 5% of adults 65 and over reside in nursing home facilities. In 2009 4.1% of adults 65 and over resided in institutional settings such as nursing homes (1.4 million). However, the percentage increases dramatically with age, ranging (in 2007) from 0.9% for persons 65-74 years to 3.5% for persons 75-84 years and 14.3% for persons aged 85 and over.

Impaired oral health may adversely affect diet, nutrition, sleep patterns, psychological status, social interactions and other activities of life in some older adults. Research findings suggest that the improvement of oral health may have a positive impact on general health and may delay mortality. Maintaining good oral health is a critical factor in maintaining overall health and well being in older adults. The paradigm of dental care for the older adult population has changed from predominantly denture care to an increase in periodontal therapy procedures and complex restorative procedures including esthetic dentistry, orthodontics and the placement of implants. This results from the increase in life expectancy accompanied by the number older adults retaining some or all of their natural dentition. The rate of edentulism in the U.S. has declined significantly. This shift increases the need for routine preventative and restorative dental care. Upon entering a nursing home facility, many residents have maintained their oral health and retained much of their natural dentition.

The issue of providing oral/dental care to nursing home residents is a challenging one. Residents of nursing home facilities often present with complex medical histories and health status. The prevalence of dental pain in nursing home residents, especially those with dementia, is high. In 1987 the Omnibus Budget Reconciliation Act (OBRA) was introduced and became effective on April 1, 1990. This legislation states that all nursing home facilities receiving Medicaid and Medicare reimbursements must provide routine and emergency oral health care to their residents. However, despite this mandate, there seems to be a disconnect with regard to the importance of the oral-systemic relationship when it comes to the provision of dental/oral health care to residents. Awareness and funding seem to be two major factors impacting the provision of care to this population. Limited awareness of the significant need for professional dental care accompanied by limited awareness of the need to implement an interdisciplinary approach for the provision of oral health care contributes to minimal dental care provided to nursing home residents. Many direct care providers, primarily outside of the dental field, are unaware of the importance of the oral-systemic relationship and its impact on the quality of life. This lack of knowledge contributes to a minimal amount of routine daily oral health care for nursing home residents.

The irony lies in the heightened awareness of the minimal amount of funding available for reimbursement of dental services rendered to this population, creating a service barrier. Upon enrolling in Medicare and retiring from the work force, the majority of older adults lose employer provided dental coverage. Virtually all residents in nursing home facilities are enrolled in Medicare, which does not cover routine dental care services. A large majority of residents, especially in non-private facilities, are enrolled in Medicaid. In Virginia Medicaid does not cover routine dental care services and only provides a minimal amount of reimbursement for approved extractions. The awareness of the lack of coverage provided by these programs discourages the provision of professional dental care. Despite the fact that a small amount of residents have dental coverage through pension plans or other sources, most often they do not receive the needed dental care because of the overshadowing assumption of limited or no dental coverage. Beyond the scope of dental coverage, funding for care is impacted by decisions made by family members of facility residents. In many instances needed dental care is declined by a family member who acts through the Power of Attorney decreed. The lack of personal funds leads to the needed dental procedures not being performed.

An interdisciplinary partnership has been advocated by researchers in hopes of improving oral health for residents of long-term care facilities as well as for independent non-facility members of the geriatric population. The Lucy Corr Foundation has assisted with the development and implementation of a new model of interdisciplinary dental care for residents of Lucy Corr Village (LCV). Much needed support for this model has been provided by Dr. Jim Revere, Chair of the Lucy Corr Foundation, Dr. Pam Parsons, GNP and a Lucy Corr Foundation Board Member, Debra Marlow, President of the Lucy Corr Foundation, and Jim Musgrave, CEO of Lucy Corr Village. The initiative has been underway for the past six years, with community grant funding received in the last three years used to modernize the dental clinic, purchase necessary supplies and provide financial support for a part time Dental Coordinator. The Dental Coordinator schedules volunteer dentists to complete bed side oral exams. The Dental Coordinator then appoints the residents to be seen in the on-site dental clinic or referred out as necessary. The Lucy Corr Village Dental Clinic acts as a free dental clinic as all dental care services provided in the clinic are rendered by volunteer dental health care professionals and dental hygiene students. With volunteer community dentists and help from the VCU School of Dentistry's Dental Hygiene Program, arranged by the Dental Coordinator, LCV has been able to increase the number of nursing home residents treated from 6-8 residents per month to over 40 residents per month. Services include basic restorative care, periodontal therapy, routine adult prophylaxis, fluoride applications, care of removable prosthetics, denture relines and the fabrication of new dentures. Dental professionals who volunteer their time and talents, like Dr. Michael Hanley, who has been a staple in the development and implementation of the dental care model at LCV, truly make a difference in the lives of nursing home residents. Dr. Hanley dedicates at least one half day Friday a month to providing dental care to LCV residents. Dr. David Beam has volunteered his services at LCV for the past ten months by also providing dental care services one half day Friday a month. Any volunteer time donated is greatly appreciated. For example, Dr. Leonard Jackson was only able to volunteer a few hours one Friday during the summer, but in that short amount of time, needed bedside exams were performed.

Educating health care providers is important to improving awareness. Grant funding received by the Lucy Corr Foundation from the Virginia Center on Aging - Geriatric Training and Education Initiative enabled the provision of interdisciplinary training of health care students and professionals in the oral health needs of underserved long term care residents. Students and professionals from the following disciplines benefitted or will benefit from the training: Nursing (Nurse Aids, Licensed Practical Nurses, Registered Nurses, and Nurse Practitioners), Occupational Therapists, Physicians, Dietitians, Dental Care Providers (Assistants, Hygienists, and Dentists), Pharmacists and Nursing Home Administrators. The Dental Coordinator scheduled five in-service training sessions to be offered to all direct care providers and health care professionals employed

by LCV. These in-service training sessions were held at LCV and were video recorded and are being made available to other Virginia nursing home facilities with the assistance of the Virginia Health Care Association. This training will support the delivery of daily routine oral care by direct care providers, leading to an improvement in oral health status of residents and enhancing their quality of life. This training aided the host facility as well as others who obtain the video of the training sessions, by meeting accreditation requirements for continuing in-service training to direct care providers and healthcare professional employees and nursing home administrators.

Also as part of the interdisciplinary training program implemented by the Lucy Corr Foundation, the Dental Coordinator organized a training seminar/webinar held at LCV for licensed healthcare professionals. An interdisciplinary approach to providing and maintaining oral health for dependent and independent members of the geriatric population was covered in this course. The class addressed the educational preparation needed to provide oral health care to dependent and independent members of the geriatric population, and offered continuing education credits to healthcare professionals. The webinar was also recorded and is available as an online self paced course on the VDA's website (www.vadental.org) The online training also offers CE credits.

The older adult population is increasing in size and the number of nursing home residents is anticipated to grow. Given the link between poor oral health and systemic disease, increased education of nursing home healthcare providers and staff supports delivery of proper oral care techniques. Statistical analysis, stemming from data collected from the five in-service training sessions and the one half day seminar/webinar supports the use of an interdisciplinary educational approach to oral health care in the geriatric population. There is still the issue of funding for the provision of dental care services to nursing home residents. One approach is that taken by Lucy Corr Village, in which the dental clinic acts as a free clinic providing dental care services through the time and talents donated by volunteer dental professionals and students. There is also the political approach addressing policy change. Even in the current economic climate, there are some policy reforms being advocated. However, during the time that elapses between the policy proposals, approval and implementation, members of the nursing home population are going without much needed dental care. Please take the time to contact a nursing home facility near you and see how you may be able to contribute your time and talents. Providing dental care to residents in a nursing home facility is a great way to give back to the community.

Patricia Brown Bonwell, RDH, BSDH, MSG, PhD; Dental Coordinator, Lucy Corr Village.

Dr. Bonwell can be reached at pbonwell@lucycorrvillage.com

Can Someone Tell Me How to Get To Grundy?

By Dr. Diana Marchibroda

Mirela Serifovic (DA), Dr. Diana Marchibroda and dental assistant, Angelina Cobb

It is starting to get light and there is warm dampness in the air; a familiar feeling as I drive in with the cavalcade. In the distance I see tents, people milling around their cars which substituted as their bedrooms the previous night. As I get closer, I see the lines of people, lots of people everywhere holding their pink paper like it was a winning ticket.

Once again, I am at Wise.

I always approach this event with some amount of apprehension, wondering if the lighting will be sufficient, will I get a good hand piece, or find instruments that are familiar to me. I hope to find a comfort zone, be thoroughly prepared and ready to deal with the overwhelming magnitude of problems. It is as though I am entering a different world, one that seems so foreign to mine yet in some respects so comfortable.

Then all of a sudden, my first patient appears. Ready, set, go…I am off! The apprehension is gone, no time for that. There is a job to do that is greater than my simple concerns. I must do what I can, with whatever resources I have.

I am here for my twelfth visit to the MOM Project doing dentistry for the underserved in the mountains of southwest Virginia. It is not a place for "Beauty Parlor Dentistry," this is the "Real McCoy"! In some ways it could be compared to a M.A.S.H. unit as I might imagine one, or a remote village in some third world country, but no….it is our back yard. Of course, if it was a perfect world, we would do this so much differently, however given the lack of resources and providers, until change occurs, this is as good as it gets.

The needs of these simple people cannot be imagined. For me, I love hearing the stories the people share. I say "love" with my tongue in my cheek, because how do you say "love" when most of the stories revolve around suffering? I mean "love" in a way that is to be interpreted as a story that hits your heart, brings a sense of awareness, and gets close to the bone. The stories can touch you in a way that awakens you; they weave us together as human beings attempting to achieve something better. Everyone has a story and I get a front row seat.

My first patient Dorian, a 28 year old male with tears in his eyes, says to me "the aspirin is tearing my stomach up" as he describes the constant pain the three abscessing teeth have given him for the last several months. How does he stand it? That thought can take your breath away. However, I cannot explain to you the great feeling it is to be able to afford a solution, have an impact, and allow him to wake up to an easier tomorrow.

It is tough to try to wrap your head around the dilemma of why Janice, a young woman with several non-restorable front teeth, is so reluctant of having them removed. She is not afraid of the procedure itself, but she is starting a new job and is sure she cannot go without teeth. She doesn't have the money to pay for care later when the pain really kicks in. "I will just have to deal with it," I hear her say as she walks away. She is "between a rock and a hard place" as the saying goes and what is so desperately sad is that she knows this only too well.

In my world, I don't ever have to make such decisions.

I notice an unusual amount of attrition on a Will's incisors and occlusal surfaces. In trying to help him understand bruxism, I brought up the subject of stress. "Well…." he begins in a slow and methodical way, " yeah…in the last 2 years, I lost my wife, became disabled, lost my job, lost my home. Yeah", speaking quietly, eyes closed, "I guess that I am stressed."

Hmmm…and to think that I was stressed because I didn't consume my usual quota of coffee so as to avoid those Job Johnnies.

The concept "access to care" is not something they can comprehend or afford. Their understanding of what constitutes good oral health care is very dysfunctional. They come up with all sorts of reasons that cause their problems…from medicines, childbirth, heart surgery, to "It was the crappy toothbrush and toothpaste I was given in jail that destroyed my teeth", a response of a 26 year old woman. As another woman remarks quite simply, "It was the meth".

"Wow", I thought as I study her mouth, "yeah…meth… I guess you are right". It is difficult at times to know how to respond to their issues (as my mind quickly pages through past journal articles trying to remember…). However, I must keep in mind my purpose is to help, not to judge.

I know I am blessed to have a skill that can so easily benefit others. The reality is, it is not the big house, or the cool car, but rather it is those things that cannot be measured that truly determine our success in life. These "Wise Moments" enrich me in ways nothing else can.

The day is over, my old legs ache from standing and I am thirsty and hungry. As I glance around at my equally as weary friends, a certain aura of accomplishment, fulfillment, and thankfulness for our own fortunes is acutely apparent. The hugs, kisses, and shaking hands replace the need for words because we all get it. The "goodbye" is rather, "See you next time," because for us, there will be a next time.

I am walking toward my car and I notice Dorian in the distance. We make eye contact and I receive the slightest smile and a bit of a wave as we both leave. His tears are gone. What I know for sure is that tomorrow is going to be a better day for the both of us.

Wise County M.O.M.: Long Hours and a Lot of Bananas

By Cheryl Harris, Virginia Project Director, and Felix Layne, Vice President of Finance, DentaQuest

Since 2005, DentaQuest has been a proud participant in the Wise County Missions of Mercy (MOM) program, to date helping to bring desperately needed dental care to more than 16,400 people in Southwest Virginia.

For several years, DentaQuest has taken the lead in running the "snack shack" at the Wise County event, making sure coffee, drinks, and snacks were available to the 370 volunteers providing dental care over the course of three days. We also helped deliver lunches and dinners to our volunteers, to keep them working with patients instead of standing in line for food. Whatever we could do to keep the dental care team comfortable and functional, we did – and as in years past, 2012 was another wonderful opportunity for us to work with the Virginia Dental Association Foundation (VDAF).

Getting to collaborate with the VDAF and be part of the team on the ground has been a true honor. We've done this for a few years now, and it's always inspiring to see our organizations come together to help so many people. This year alone, 1,453 local residents received treatments valued at $1.4 million. These treatments included 1,251 x-rays, 1,969 fillings, and 3,467 extractions, and the denture teams of Dr. Scottie Miller and Dr. Steve Alouf provided 105 complete dentures and denture procedures.

I know I can speak for all of us when I say how lucky we feel to be part of MOM. It's both heartbreaking and heartwarming to see hundreds and hundreds of people who otherwise might never get the care they need. The stories we take back from MOM speak not only to DentaQuest's mission of bringing better oral health to all, but to the overwhelming need for more accessible dental care in so many American communities.

One of the most touching stories of 2012 comes from Dr. Cathy Turner, who needed to provide services to both a 21-year-old man with severe special needs and his father, who had raised his son as a single parent. Both father and son needed dental care, but the father was willing to sacrifice his own chance to make sure his son, who is confined to a wheelchair and requires several medications, received treatment. Further complicating the situation was the need for someone to stay with this delightful young man during his father's treatment; this deeply devoted parent wasn't willing to leave his son unattended even for a short while.

Thanks to Dr. Turner, Cheryl, Patrick Finnerty, longtime MOM volunteer and president of the Virginia Dental Association Foundation, Angela Kish, Senior VP of Operations, Bridget Hengle, DentaQuest Provider Relations Representative, and others, both father and son received care that day. These folks had to go the extra mile for a family in need, and they found a way to make it work, from sitting with the son while his father was in the dentist's chair, grinding necessary medications for injection during the wait, and moving the two men through patient triage, to getting them the dental care they both needed. This is what MOM is all about: seeing people living healthier lives, seeing the gratitude on their faces, and knowing we helped make a difference.

"My favorite part of MOM is talking to and helping patients," says Patrick Finnerty. "I help set up all of the equipment and chairs the day before the clinic and then help take things down and pack everything up. And during the clinic, I coordinate the movement of patients through the patient triage area, making sure they get their initial triage to determine which services they need."

And then there's the behind-the-scenes preparation. Cheryl and Bridget once again piloted our two minivans stuffed with $2,500 worth of snacks and drinks. Christine Hohl, Provider Relations Supervisor, and Angela also brought great energy and dedication to the 2012 DentaQuest team. Of course, we keep track of the most popular snack offerings from year to year, always noting what will travel well and stay good in the summer heat.

This year's surprise hit? Bananas! We bought four cases of bananas in 2011, in response to a dentist whose hands were cramping during the long, hot workdays. This year, we made sure to have plenty on hand – nearly 400 pounds of them, in fact, each one decorated with a small DentaQuest sticker. And the Keurig coffeemaker provided by the VDAF was a definite crowd-pleaser. In fact, we went through more than 30 gallons of water to keep everyone in coffee.

Supporting a Mission of Mercy is hard work with great outcomes. As DentaQuest works to improve the oral health of all, we hope that we will need fewer and fewer Missions of Mercy because greater numbers of people will be aware of oral health prevention education and will be able to get the care they need.

First "VSU Cares" MOM Provides Critical Dental Services

By: Samuel W. Galstan, DDS, MPH

On June 8-9, 2012, Virginia State University's first "VSU Cares" provided free dental services to 426 patients from local communities. The program, a partnership between VSU, the VDA Foundation's Missions of Mercy project, the Southside Dental Society and Virginia Commonwealth University, provided nearly $203,000 in donated care.

There were over 400 volunteers including:

- 56 dentists
- 134 dental assistants and dental students
- 46 medical support staff, including nurses
- 21 pharmacists and pharmacy support staff
- 145 non-medical volunteers

Services delivered included:

- 425 restorations
- 369 routine extractions
- 150 surgical extractions
- 83 cleanings
- 4 root canals

One in ten residents within the Virginia Crater Economic Development District has no health insurance and more than one in three is without dental insurance. This project allowed many at-risk individuals the opportunity to obtain free dental care. Nearly 20% of Virginians live in an underserved area for dental care as reported by the Virginia Employment Commission 2000 Population Project. Often those with lower income, the uninsured and underinsured, the elderly, and the disabled are left without dental care, facing pain, discomfort, and embarrassment. Clinics like the Missions of Mercy provide free dental care and bring hope to Virginians in need. Since 2000 the VDA Foundation has provided more than $27.7 million in free dental care to over 46,000 patients, through 61 projects.

"Virginia State University, the Virginia Dental Association, the Missions of Mercy, along with the surrounding businesses, civic and social groups and community leaders have a lot to feel good about," said Delegate Rosalyn R. Dance, whose district includes most of the VSU Cares service areas. "This is a project that showcased the Greater Petersburg Area at one of its finest hours; teaming together to provide a much needed service to so many with the single reward of a smile, a tear or just a thank you." State Senator Henry Marsh also toured the project.

VSU President Keith T. Miller said the event demonstrated cooperation even at the most basic level. "VSU Cares was the embodiment of our Building a Better World concept. Virtually every sector of VSU was involved in the program, along with our partners from the public and professional sectors and our corporate sponsors. Because these groups worked together and more than 400 volunteers were inspired to give of their time and talents, we were able to provide these important health services to our neighbors with few other options."

VSU raised over $40,000 in private donations from corporate partners, VSU alumni, faculty and staff, and supporters. Major corporate support was provided by HCA/John Randolph Medical Center; CIGNA; B.I. Chemicals, Inc.; Virginia Area Health Education Centers; Cardinal Health; Midlothian Rotary Club; Sheetz; Gerdau Ameristeel; Dentaquest; the Richard Bland College Rotaract Club; and the Lawrenceville Alumnae Chapter of Delta Sigma Theta Sorority, Inc.

Leadership from VSU was provided by Drs. Jewel Hairston (Agriculture), Karen Faison (Nursing), Ayana Conway (Criminal Justice), Gwen Thornton (Social Work), and Kim Gower (Business). Dr. Samuel W. Galstan of Chester was the lead dentist from the Southside Dental Society and Barbara Rollins is the Missions of Mercy coordinator for the VDA.
Screenings and triage were conducted Friday afternoon, and pre-screened patients were given the first appointments on Saturday. All patients received blood pressure screening, blood glucose screenings and review of their medication and medical history. Postoperative prescriptions were written by the VCU School of Pharmacy, and filled at Walgreens at no cost.

The project partners are committed to decreasing disparities in the region's health care delivery system, and hope to organize future outreach projects. VSU plans to hold their second annual "VSU Cares" on June 15, 2013.

On Wednesday, August 22, 2012, the Chesterfield County Board of Supervisors presented a Resolution honoring the VSU Cares Mission of Mercy Dental Outreach project that was held at VSU on June 8-9, 2012, where 426 patients received more than $ 202,000 worth of free dental care.

Pictured from left to right: Mr. Millard "Pete" Stith, (VSU Office of Development); Dr. Karen Faison, (VSU Nursing); VSU President Dr. Keith Miller; Dr. Ayana Conway, (VSU Criminal Justice); Dr. Gwen Thornton, (VSU Social Work); Ms. Dorothy Jaeckle, Vice Chairman, Chesterfield County VA. Board of Supervisors; Dr. Sam Galstan, Chester, VA., Lead Dentist, Southside Dental Association/VDA; Mrs. Barbara Rollins, Virginia Dental Association's Director of Logistics, Mission of Mercy Projects; and Mr. Stephen Elswick, Chesterfield County VA. Board of Supervisors.
Not pictured but receiving Resolutions were: Dr. Jewel Hairston (VSU Agriculture) and Dr. Terry Dickinson (VDA Executive Director).

Picture courtesy of Mr. Don Kappel, Director of Public Affairs, Chesterfield County VA.

L-R: VCU Cares TEAM, Dr. Karen Faison (Nursing), Dr. Jewel Hairston (Agriculture), Dr. Ayana Conway (Criminal Justice), Dr. Kim Gower (Business), and Dr. Gwen Thornton (Social Work).

The Patient Protection and Affordable Care Act Effects on Dental Care

Keri Discepolo, D.D.S.; Andrew S. Kaplan, D.M.D.

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Health care reform has been a subject of debate long before the presidential campaign of 2008, through the presidential signing of the Patient Protection and Affordable Care Act (PPACA) on March 23, 2010, and is likely to continue as a topic of discussion well into the future. The effects of this historic reform on the delivery of healthcare and on the economy are subject to speculation. While most people are at least generally aware that access to medical care will be improved in many ways, few people, including many in the dental profession, are aware that this legislation also addresses oral health disparities and access to dental care. It is the purpose of this paper to review how dental care is currently accessed in the United States and where oral health care disparities exist, to suggest approaches to alleviating these disparities and to delineate how the changes in dental policies found in the PPACA hope to address these concerns.

Background: The problem of oral health disparity and access to dental care were highlighted by a number of events, among them, the release of a pivotal report by the surgeon general entitled "Oral Health in America: A Report of the Surgeon General"1 in 2000, followed by a second report in 2003 entitled "A Call to Action to Promote Oral Health."2 Simultaneously, there was an erosion of state Medicaid programs, leading to decreased reimbursement for dental care and a subsequent decrease in participating dentists, and little-to-no adult coverage in many states.3 There was a well-publicized 2006 lawsuit brought by the American Dental Association and the Alaska Dental Association against the Alaska Native Tribal Health Consortium over the training of mid-level dental practitioners—dental health aide therapists—and high-profile tragedies that included the death of a 12-year-old Maryland boy as the result of an untreated dental infection.4,5 The debate on PPACA called attention to these issues as organized dental communities weighed in on how dentistry should be involved in this historic legislation.

Dental care in the United States is provided predominantly through private practice. Wendling has summarized that as of 2007, there were 181,725 active dentists in the U.S.; of these, 166,837 were in private practice.6 The article states that roughly two-thirds of the U.S. population accesses the private practice delivery system over a given 12-month period. "This is a market-based delivery system, owned and run by professionals and regulated at the state level composed primarily of dentists in private practice who are paid by third party payers or directly from consumers."7

The remaining one-third of the population experiences difficulty in accessing care through the traditional fee-for-service private practice model. This is because of the maldistribution of dentists, low or no Medicaid reimbursement and lack of personal dental insurance (up to 43% of the population).8 These patients are more likely to have higher rates of decayed teeth and more advanced periodontal disease and other pathology, complicating the delivery of care.6,9,10

The segment of the dental profession that provides care to the most needy comprises the "dental safety net." The dental safety net includes hospital, dental school and dental hygiene school clinics; health centers; for-profit Medicaid dental practices; hospital emergency rooms; Veterans Administration hospitals; prison dental clinics; Indian Health Services; and volunteer dental programs. In addition, 20%, or about 30,000 private and group practice dentists in the United States, are Medicaid providers.11 The separate pieces of the safety net are loosely organized, variable in program content and policy, and fail to meet current needs of the population.11

In 2009, in light of the coming Health Care Reform Bill, the Institute of Medicine (IOM) held a workshop entitled "US Oral Health Workforce in the Coming Decade" to discuss existing trends in dentistry and to offer suggestions on how the needs of the underserved might be met in the future.12 These ideas were later published as a series of papers in a special edition of the Journal of Public Health Dentistry.3,6,8,9,11,13,14 These papers addressed the design of an ideal oral healthcare system, with emphasis on improving access to care in rural and urban areas and institutional settings and making improvements to the dental safety net in general. The problem with access was underscored by noting that in 2007, there were 4,230 dental health professional shortage areas identified in the United States.8 It was estimated that it would take 9,642 additional practitioners to meet the needs at that time—and that does not take into account the huge influx of children who will, theoretically, soon be covered for dental care under the PPACA.

One suggested solution is to emphasize the cost-effective technique of preventing dental caries and periodontal disease. Prevention education could be performed by dental auxiliaries, including dental hygienists and expanded duty dental assistants (EDDAs). The ADA proposed creating a community dental health coordinator (CDHC). The CDHCs would, preferably, be people from the community trained to teach prevention and tobacco cessation and to facilitate access and utilization of dental diagnosis and treatment and who would return to serve their community in these capacities.6

Perhaps the most controversial of all the suggested access-to-care improvements is the development of the "mid-level" practitioner. This includes using dental hygienists and dental assistants in new ways and creating new types of providers, including:

- The previously mentioned CDHC proposed by the ADA.
- The advanced dental hygiene practitioner (ADHP), an advanced education, master's level practitioner who can perform restorative procedures, pulpotomies, temporary crowns and simple extractions.8
- The dental therapist or dental health aid therapist (DHAT), a person with two years post-high school experience who performs restorative procedures, pulpotomies, temporary crowns and simple extractions of primary teeth. These therapists work under the general supervision of a dentist and on collaborative teams. The model is currently used in rural areas of Alaska.8
- Nurse practitioner model, a person who works collaboratively with a dentist in a private dental office and becomes part of a healthcare team, so the patient can have both oral healthcare and primary healthcare delivered.8

PPACA Specific to Dental Care

In response to the access-to-dental-care problems and the suggested solutions to them, the Patient Protection and Affordable Care Act authorizes, within its 2,500 or so pages, several major changes in policy and funding as relates specifically to dental health. These policy issues are discussed in detail in other publications and are briefly summarized in Table 1.15,16

Policy Arguments

From the Obama/McCain presidential campaign through passage of the PPACA, there were a number of special interest dental groups working behind the scenes on healthcare reform. Some of these groups included the American Dental Association (ADA), American Dental Hygienists Association (ADHA), Academy of General Dentistry (AGD), American Academy of Oral and Maxillofacial Surgeons (AAOMS), American Academy of Pediatric Dentistry (AAPD), Children's Dental Health Project (CDHP) and several other smaller organizations. Some of these groups supported the PPACA, largely based on one or two issues, while others offered broad support for the legislation. Most of the major dental organizations opposed the legislation, based on several key issues.

In Favor of PPACA

Among those dental groups that supported the legislation, the CDHP seemingly was centrally involved in shaping the final dental provisions of the bill. The group's mission, "creating and advancing innovative solutions to achieve oral health for all children," was brought much closer to realization by passage of the legisla-

tion.17 The legislation will provide dental coverage to virtually all children (with the exception of illegal aliens) and through other provisions, at least in theory, will dramatically improve access for that treatment.

Workforce grants supporting the development of mid-level practitioners and Title VII grants for dental resident and dental hygiene programs will help expand access. Grants for school-based health centers will provide dental care, and the standards set for access for those with disabilities fall squarely within CDHP's mission. Public education programs, school-based dental sealant programs and dental caries management form a low-cost way to dramatically improve oral health. CDHP termed this a "systems fix" approach, where prevention and management intervention will occur at community, family and individual levels.17 It is also notable that the CDHP is the only dental organization, to the authors' knowledge, that advocates for the public and, specifically, for children and does not represent the profession.

Other dental organizations, representing different facets of the dental profession, were more one-dimensional. The ADHA supported the legislation mainly because of the funding provided for "alternative dental providers" and the funding specified under Title VII for training dental hygienists (in addition to the funding for dental residents, practicing dentists and dental students).18 The Hispanic Dental Association, while opposing support for developing the mid-level practitioner, supported the legislation in general with the focus on access to care for the underserved. The National Dental Association, an organization representing mainly black dentists, supported the legislation, but made an argument against a two-tiered system, whereby the poor and minorities, who often present with the most advanced and complex problems, would be treated by practitioners with less training.16

Opposed to PPACA

The most prominent organization of the dental profession is the ADA, representing some 160,000 dentists. The ADA was involved with lobbying efforts, but ultimately opposed the legislation based on three major issues summarized in a letter to Speaker of the House Pelosi and signed by the ADA and six other dental organizations that govern most of the dental specialties (not including the specialties of public health, endodontics and radiology) and the AAPD.19 Below is a summary of their arguments against the bill:

1. Medicaid funding for dentistry is not properly addressed. Without increases in reimbursement to dentists, the legislation will increase the number of covered children, which will increase demand for services but will not increase the supply of dentists who can afford to treat these patients. They also expressed concern about continued Medicaid administrative barriers and a lack of data-gathering initiatives to help improve Medicaid coverage.
2. No basic adult dental benefit was addressed, so adults in underserved communities will continue to have difficulty accessing dental care.
3. They argued against the funding for development of the mid-level practitioner model calling it, in effect, a two-tiered system, whereby dental care would be provided to the underserved by non-dentists with less training. They also expressed concern about the use of Title VII funds, formerly reserved for dental residents and partially for training dental hygienists.

The AGD, the largest organization supporting general dentists, published a lengthy white paper, which argued against mid-level practitioners.20 In addition to some of the arguments previously stated, the AGD asserted it would be unlikely for these practitioners to create economically viable offices or clinics. The academy also expressed concern for the health and safety of the patients they treat (an assertion not supported in the literature); and it argued that access could better be improved through tax credits to dentists working in underserved areas, scholarships to dental students who agree to practice in an underserved area and recruitment of dental students from underserved areas, who would have a higher likelihood of returning to practice in those areas.15

AAOMS, the largest organization representing oral and maxillofacial surgeons, opposed the legislation on similar grounds; it was especially opposed to the mid-level practitioner having the privilege of tooth extraction.16 In addition, it shared concerns about a lack of adult coverage, the vagueness of what will be covered for children (especially the removal of wisdom teeth) and the lack of improvement in reimbursement rates.

Although there is no doubt that PPACA has gone further than any other government program to alleviate oral health care disparities in this country, it will likely fall short of the expectations of its supporters.

Passage of this bill provides authorization for its provisions but does not guarantee funding. Funding is a highly political issue that will change with time. Some of the pieces of this legislation do not become operational until 2014, most notably, the state insurance exchanges, along with the mandated provision of essential oral health benefits. The 2010 mid-term elections produced dramatic changes in national and state governments, a shift from Democratic to Republican control in many cases. With the serious financial issues facing the country, appropriating funds may not be so easy. Cuts in some of the provisions of the PPACA are likely. Provisions of the bill will also be affected dramatically at the state level with the election of many more Republican governors.21

School-based centers providing oral health services, along with school-based sealant programs, may help with access to care, but children in underserved areas often have significant dental disease before school age and need emergency dental intervention,10 so earlier access, perhaps at 1 year of age, would be preferable. On a positive note, the public education campaign for parents and children is an inexpensive and powerful way to improve oral health of the underserved.

The mid-level practitioner effort will likely experience difficulty. Because the legislation specifies at least seven different entities, the $15 million dollars of funding over five years will be quite sparse for any one program. These different groups will have to compete with each other to get established and will, at best, be small movements relegated to limited geographic areas. There is a mandate that each program be accredited by the Commission on Dental Accreditation (CODA), which is a complex and lengthy process.

Conclusion

This paper discusses the current status of the provision of dental care and the problems in providing care to the underserved. Approaches to improving access to dental care were reviewed, along with a summary of the oral care provisions in the PPACA. The organized dentistry arguments both for and against these provisions were summarized and the authors' argument that health care reform will fall short of expectations of its proponents in the oral health care arena was presented. The reasons for the shortfall include likely political difficulties in appropriations at the federal and state level, given the change in government and the poor economy; failure to address the low fees for dental care from Medicaid; difficulties in changing state dental practice acts; and oversight nationally by CODA.

Queries about this article can be sent to Dr. Discepolo at
keri.discepolo@ynhh.org.

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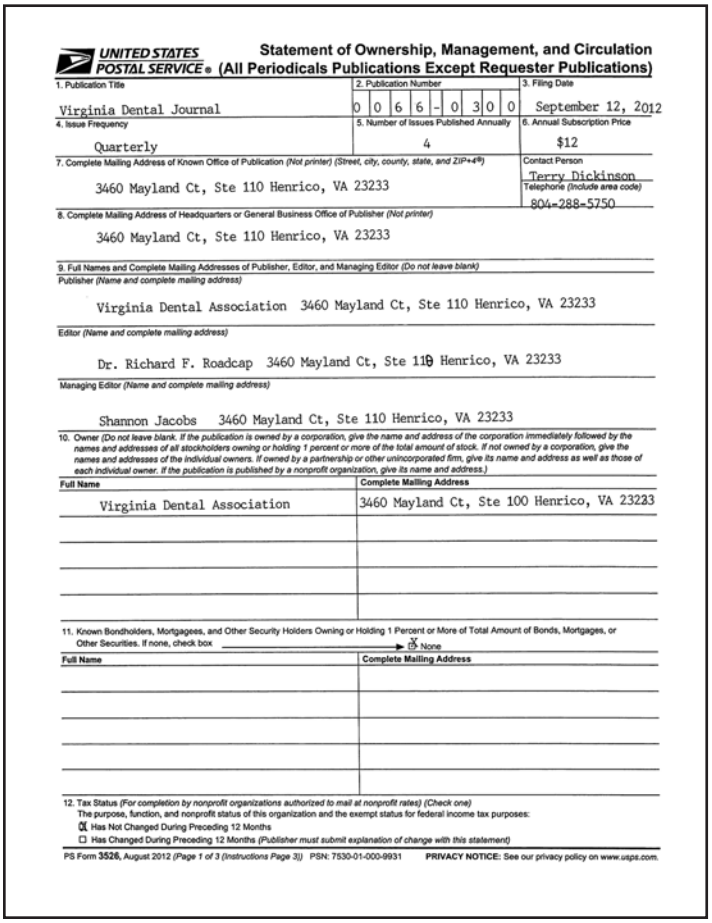
Table 1
Summary of Major Provisions of PPACA Affecting Dental Care15,16,20

1. In order for a "qualified health plan" to be able to participate in the Healthcare Exchange, it must include (among other provisions) "pediatric services, including oral and vision care." (The legislation notably leaves out any required coverage for adults.)
2. Each state is permitted to allow insurance companies to offer the pediatric dental benefit through a stand-alone plan or in conjunction with a qualified health plan as long as the plan contains the essential dental health benefits required by HHS.
3. The Medicaid and CHIP Payment and Access Commission (MACPAC) is charged with review and the updating of payments to dental professionals. (The legislation notably leaves this as a gray area.)
4. Medicare Advantage plans generally paid more than comparable services in the Medicare Fee for Service plans for comparable services. These additional payments in some cases paid for dental services. The PPACA requires that the higher payment first be applied towards cost-sharing reductions, second toward wellness and preventive care and, lastly, toward extra benefits not available in FFS plans, including dental coverage.
5. The bill supports the creation of various "Oral Healthcare Prevention Activities," including funding for:
   a. A national public education program on prevention of oral diseases such as periodontal disease and caries that must be targeted to specific groups: e.g. elderly, pregnant women, children, disabled and minorities.
   b. A research-based dental caries management program provided to community-based dental providers, including the Indian Health Service.
6. School-based dental sealant programs.
7. Establishment of "oral health leadership and program guidance" through the Centers for Disease Control (CDC).
8. Updating and expanding the CDC's National Oral Health Surveillance Programs to be required in all 50 states, including:
   a. The Pregnancy and Risk Assessment Monitoring System.
   b. The National Health and Nutrition Examination Survey.
   c. The Medical Expenditures Panel Survey.
9. Grants for school-based health centers, including "referrals to and follow up for oral health services."
10. Medically accessible equipment for the disabled, including that found in dental offices.
11. Health workforce provisions, including:
   a. Creating new "dental cluster" health training programs to include, general, pediatric, public health dentists and dental hygienists. This provision allows grants to pay for student and resident training, financial assistance, program development, loan repayment for students and faculty and the provision of technical assistance in pediatric dental training programs.
   b. Establishment of "demonstration projects" for "alternative dental health care providers, including CDHCs, Advanced Practice Dental Hygienists, Independent Dental Hygienists, Supervised Dental Hygienists, Primary Care Physicians, Dental Therapists, Dental Health Aids or other as deemed appropriate by the Secretary of the HHS.
12. New and expanded "teaching health centers" to train primary healthcare providers, including dentists, in general and pediatric residencies in ambulatory patient care centers.
13. There are also a number of other issues that affect small business and, therefore, private dental practices but are beyond the scope of this paper.



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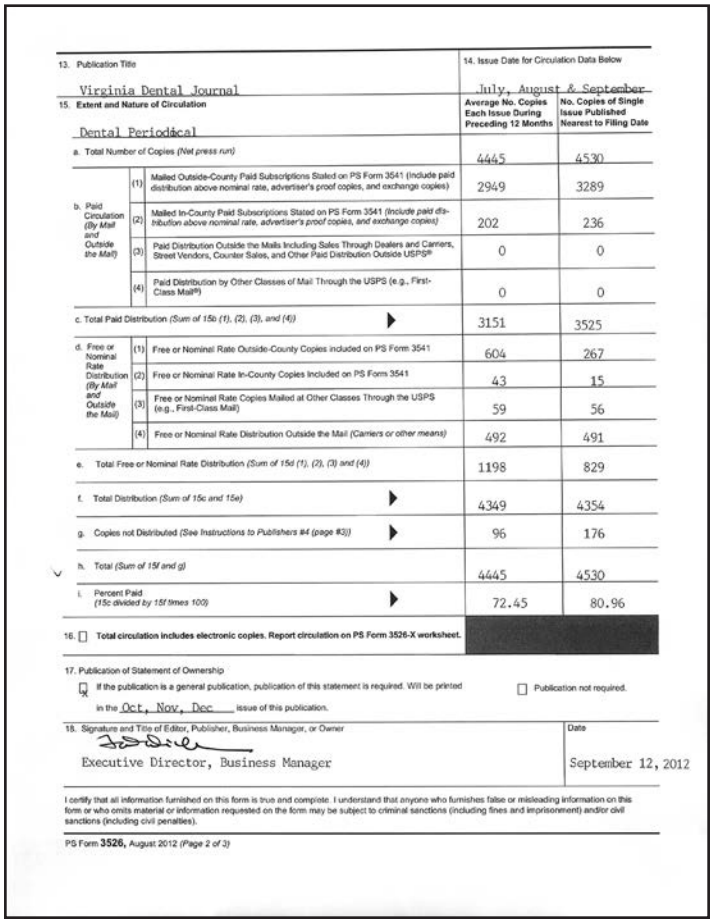

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VDA MEMBER SPOTLIGHT: *Dr. Ross Epstein*

By: Dr. Catherine Oden Fulton

CONTINUED FROM BACK COVER - MEMBER SPOTLIGHT

Many educational pieces are on display throughout his office, such as a Wilkerson dental chair with an armrest for the dentist near the patient's mouth and lion's claw feet. When asked how 100-year-old dental equipment compares to today's, Ross said, "The antiques in my collection were built to last three or four generations. We're lucky to get a decade out of modern equipment." Many of the antiques are surprisingly sophisticated, featuring hot and cold water, warm air, and heated mouth mirrors. The hand carved woodwork with inlays that include gold and rubies, handcrafted metal hinges, hidden drawers for valuables and elegant paneling are just what you'd expect in a fine antique.

Ross's expertise has developed to such a high level that he claims, "With just three to five questions, I can determine which of the 250 dental cabinets made in the U.S between 1850 and 1940 is being discussed." After buying one cabinet sight unseen, Ross made a startling discovery upon its arrival. "The first thing I checked was the largest of its hidden drawers," he said. "To my delight, I found a roll of 20 dollar gold pieces."

For many years after the War Between the States, there was animosity between the North and South. Sometimes this antagonism surfaced in decisions about government procurements. For example, a portable dental chair made in Georgia could be easily folded and carried by one soldier. However, a heavier dental chair requiring two men to transport it was chosen for a U.S. military contract. The selected chair was manufactured by the northern company of S.S.White.

Dr. Epstein lectures on dental history and is a past president of the Academy of Dental History, which was established in 1951 to preserve our profession's history. This year's annual meeting of academy members will be held in Vienna, Austria. "Europeans have a great interest in dental history and antiquities," said Epstein. "The Austrian customs department has arranged for private parties in various museums throughout the city." In fact, American enthusiasm for dental antiques is growing, as evidenced by the increasing value of case sets.

On the top of Dr. and Mrs. Epstein's wish list is an Archer Seven rosewood dental cabinet. There are only three known to be in existence and of these, two are already in museums. If you know the whereabouts of one, or if you are interested in learning more about your older dental equipment, instruments or documents, you are welcome to contact either of them. They also encourage dental enthusiasts to join the Academy of Dental History.

In the July 1889 edition of *Dental Review*, Dr. John R. Patrick wrote, "Every age should profit by the experience of the preceding ones; but without a record of what has been accomplished each investigator commences a new series of trails, and wanders over the same ground in search of truths which have long been discovered; or adopt theories that have been long ago discarded." It is because of dedicated men like Drs. Patrick, Swanson, Epstein and others that the history and science our profession continues to be pursued and appreciated. The Virginia Dental Association is fortunate to have Dr. Epstein as one of our members.

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VDA MEMBER SPOTLIGHT: *Dr. Ross Epstein*

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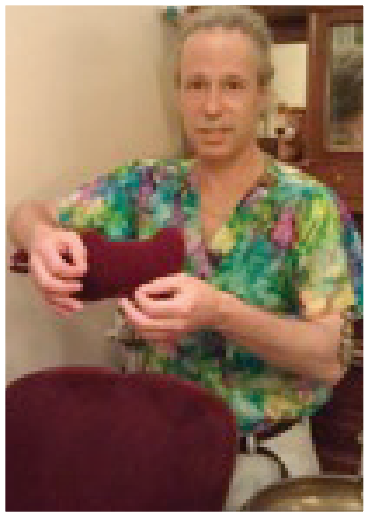

Bloodletting was the dental treatment of choice for pyorrhea in the 19th century. It was based on the belief that there was too much blood in the patient's body. The procedure was abandoned a century ago. Now that vampires are all the rage in literature, the movies, and on TV and many dentists have felt the effects of the down economy, we may be missing a sensational marketing opportunity. Perhaps it's time to reinstitute this age-old technique. If so, bloodletting instruments and other equipment from the 1800s are readily available in Dr. Ross Epstein's collection of dental antiques.

Dr. Ross Epstein is a general dentist in Newport News. He and his wife, Linda, have been collecting dental antiques since 1992. "My wife is a former copyright editor of a number of Washington DC magazines," Epstein said. "She can scour 400 to 500 pages a week of various listings, searching for historic dental artifacts." An old Listerine advertisement hanging in his office sums up their marriage: "Till Breath do us part." Their passion for collecting started when they were dating. Ross had just graduated from dental school. In the interim before he took the board exams, the young couple travelled the back roads of Tennessee with $500 from his grandmother. Inside a shop they bought a set of ivory handled dental instruments that his future wife remarked would be perfect for framing. The set, designed by J.D. Chevalier, soon hung in his dental office. Today, Dr. Epstein has thousands of large and small antiques in his collection dating from roughly 1850 to 1940.

Soon after his trip to Tennessee, Ross met his mentor, Dr. Ben Swanson, Jr. of Baltimore College of Dental Surgery, the world's first college of dentistry, founded in 1840. Dr. Swanson has a master's degree in dental history and is the founding executive director of the National Museum of Dentistry, which is an affiliate of the Smithsonian Institution. Within its 7000 square feet, one of its most notable historic artifacts is a set of George Washington's ivory dentures. Ross has an autographed copy of Swanson's book, *32 Terrific Teeth*. Ross has finished a book of his own, which is not yet published and he is currently researching a second one on early dental fees. He has also been instrumental in establishing museums from Virginia to Nevada. At one time, the larger pieces in his collection included 100 cabinets, 40 dental chairs and 12 case sets. Although he only parts with duplicate items, by helping to furnish museums, trading and selling, he has reduced his personal collection to 14 dental cabinets, six dental chairs and ten complete case sets.

Continued on page 63