Volume 88, Number 3 • July, August & September 2011

VDA Virginia Dental Association Journal

In this issue:

www.vadental.org

Full Service Personal & Business Insurance Agency

B&B

B&B Insurance Associates, Inc.

1-877-832-9113 • www.bb-insurance.com

VDA Members are invited to contact B&B Insurance for all of your insurance needs. Since 2000 when B&B was recommended by the Virginia Dental Services Corporation, they have been working with hundreds of VDA Members to provide comprehensive insurance services. B&B is ready to work with you to evaluate your insurance needs and to provide you with high-quality customer service and an expertise in the insurance needs of the dental community.

B&B Insurance, a Virginia-based, family owned agency, can fulfill all of the insurance needs for your practice, for you and for your family. Below are some of the types of coverage that are available:

For Your Practice

- General Liability
- Commercial Umbrella
- Employee Theft
- Workers Compensation
- Professional Liability
- Employee Benefits Liability
- Property and Equipment
- Group Health
- Group Life
- Business Overhead Expense
- 401K
- Employee Benefits Liability
- ERISA Bond
- Group Disability
- Business Buy-Out

For You

- Individual Health
- Individual Life
- Long Term Care
- Commercial Auto
- 412 I
- IRA
- Legal Assistance
- Medicare Supplement

For Your Family

- Home Owners
- Identity Theft Protection
- Trip Cancellation

VDA SERVICES

B&B

B&B Insurance Associates, Inc.

Please call 877-832-9113 to find out more about the VDA Services Insurance Program with B&B Insurance. The licensed agents at B&B are ready to assist you with all of your insurance needs.

Virginia Dental Journal

Member Publication
AADE
American Association of Dental Editors

Volume 88, Number 3
July, August & September 2011

HEADLINES & ARTICLES

DEPARTMENTS

The VDA central office moved to new permanent location!

The VDA staff moved into their new offices on Monday, April 25, 2011.

Please make a note of our new contact information:

Mailing address:
3460 Mayland Court, Unit 110
Henrico, VA 23233

Phone:
804-288-5750

FAX:
804-288-1880

Website:
www.vadental.org

Email: info@vadental.org
If you know the staff person you would like to email, simply use: their last name@vadental.org

Cover photo courtesy:
U.S. Navy

L-R: Captain Steven R. Clarke, Aviation Electronics Technician First Class (AT1) Fred Gilliam, Jr. Fred works in Quality Assurance (QA) as part of the VAW-123 Screwtop squadron. He is the son of VDA staffer Linda Gilliam and brother of managing editor Shannon Jacobs

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

Virginia Dental Association
3460 Mayland Ct, Unit 110 Henrico, VA 23233 804-288-5750
Email: Jacobs@vadental.org

Editor-in-Chief	Richard Roadcap, D.D.S., C.D.E.
Business Manager	Terry D. Dickinson, D.D.S.
Managing Editor	Mrs. Shannon Jacobs
Graphic Design	Mrs. Shannon Jacobs

Virginia Journal Editorial Board
Ralph L. Anderson, Carl M. Block,Cramer L. Boswell, James H. Butler, Gilbert L. Button, B. Ellen Byrne, Charles L. Cuttino III, Craig Dietrich, Dr. William V Dougherty, III, Frank H. Farrington, Barry I. Griffin, Jeffrey L. Hudgins, Wallace L. Huff, Lindsay M. Hunt, Jr., Thomas E. Koertge, James R. Lance, Daniel M. Laskin, Karen S. McAndrew, Travis T. Patterson III, W. Baxter Perkinson, Jr., Lisa Samaha, David Sarrett, Harvey A. Schenkein, James R. Schroeder, Harlan A. Schufeldt, James L. Slagle, Jr., Neil J. Small, John A. Svirsky, Ronald L. Tankersley, Roger E. Wood
VDA Component - Associate Editors
Ben T. Steele, Michael R. Hanley, Gregory Cole, Gene Ayers, Jared Kleine, Chris Spagna, Heather Brooks - Student Liason, VCU Class of 2012.

VDA Officers

President :	Michael Abbott, Salem
President Elect:	Roger E. Wood, Midlothian
Immediate Past President:	Alonzo M. Bell; Alexandria
Secretary-Treasurer:	J. Ted Sherwin; Orange
Executive Director:	Terry D. Dickinson, D.D.S.

Board of Directors
Michael Abbott, President; Roger E. Wood-President-Elect; J. Ted Sherwin–Sec. Treasurer; Alonzo M. Bell, Immediate past President; Dave Anderson - Speaker of the House; Anthony Peluso – Comp 1;Michael J. Link – Comp 2; Samuel W. Galstan – Comp 3; Benita A. Miller – Comp 4; Craig B. Dietrich – Comp 5; Scottie R. Miller – Comp 6; Ron Downey. – Comp 7; Neil J. Small – Comp 8 Advisory Members: David Sarrett; Charlie Gaskins; Richard Roadcap, Jo Koontz, VCU D-2012

Volume 88, Number 3 • July, August & September 2011

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

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

Second class postage paid at Richmond, Virginia.

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

MANUSCRIPT AND COMMUNICATION FOR PUBLICATION:
Editor, 3460 Mayland Ct, Unit 110, Henrico, VA 23233.

ADVERTISING COPY, insertion orders, contracts and related information: Business Manager, 3460 Mayland Ct, Unit 110, Henrico, VA 23233.

Message from the Editor

Dr. Richard F. Roadcap

One of those days: the crown won't seat; the mandibular block isn't working; the immediate denture wobbles and gyrates; the child (or adult) patient is uncooperative. We've all experienced them. I can't say fretful days occur less often than they did thirty years ago, when I began practice. The difference is I've come to accept them as a benign reminder of the unpredictable. GPs should be grateful for two things: dentistry remains a profession where the (overwhelming) majority of care is delivered by general dentists; and specialist referrals provide much-needed relief for difficult procedures.

When should a referral (to a dental specialist) be made? If ten generalists were asked this question, there may be nine answers. I have two criteria: for the benefit of the patient (treatment outcome will be improved by specialist referral) and to meet the standard of care (my procedures as measured against those provided by a specialist). The ADA Code – Principles of Ethics and Code of Professional Conduct – requires us to put the patient's welfare first.[1] Beyond that, the devil is in the details. Many factors come into play when deciding upon a referral: the geographic location of the specialist's office; participation in insurance plans; urgency; patient preference for a particular doctor; complex medical histories; and intangibles, whereby a referral is made intuitively. Each of us could share his or her criteria for the referral process. Patients may ask what I would do if it were a family member, but relatives manipulate and fail to follow instructions. The person in our chair is much more important than kinfolk – they're our patient who has placed their complete confidence and trust in us.

The mechanics of the referral process can be simple or complex. It may be as simple as a tear-off with an NCR copy, or involve letters, phone calls to doctors and staff, and a concurrent medical consult. Brevity can be wonderful: there's nothing like the words "Go now!" to focus a patient's attention on a problem they deem ordinary. But if we're asking them to commit to months or, in the case of orthodontic treatment, years of procedures, something beyond the 5x8 pad with a phone number circled may be appropriate. If the doctor is not willing to take the referral seriously, we can hardly expect the patient to do so. Not only should the initial documents be thorough, follow-up is needed to ensure compliance and for risk management concerns.

Good communication is the essence of the referral process. I've never regretted sending a letter to a colleague, but there are many I wish I had. Not only written correspondence but also phone calls and today's predominate form of communication, the ubiquitous e-mail, are used (be sure signed Privacy Act statements are on file). Human nature compels us to refer to doctors we know and like. A cynic would say this smacks of cronyism, but the patient will benefit from a cordial relationship between the GP and specialist. How? When the rare, but inevitable, treatment failure occurs the good will accrued over time makes it much easier to resolve a problem, without need to assign the blame. Bewildered and anxious patients are the outcome of dueling doctors.

Recent economic stress has led to ethical concerns about the referral process.[2] General dentists may be performing procedures that, in a rosy economy, would have been referred to a specialist. Do holes in the schedule invite mischief among GPs? Every specialist can recount tales of treatment gone awry and a plea from the referring doctor to make things right. As noted in the ADA Code, the principles "do good" and "do no harm" exist independent of the appointment book. Cancellations and no-shows may tempt doctors to perform procedures with which they are uncomfortable. Both patients and the profession suffer when treatments and the skills necessary to perform them are mismatched.

The skilled and versatile general practitioner is the cornerstone of our dental care delivery system. Both patients and the profession benefit when a procedure can be performed by "gatekeepers" with refined diagnostic and clinical skills. On (one of those) days when the earth seems off its axis I have to remind myself that I may be the most qualified to place a crown or gain profound anesthesia – but glad there are others who can help when needed.

1 http://www.ada.org/194.aspx

2 Wentworth, R.B. Ethical Moment JADA, 2010; 141 (9) 1125-1126

VDA Office Welcomes A New Staff Member

By: Carter H. Lyons,
Director of CE & The Virginia Meeting

As the newest employee at the VDA, I wanted to take a moment to introduce myself to you all. My name is Carter Lyons and I began working at the VDA in the middle of June. I met many of you at the Virginia Meeting and I am looking forward to meeting more of you soon. I am so happy to be part of such a wonderful organization; I already feel very welcome and right at home.

I'd like to let you know a little about myself. I live in the Richmond area with my husband, Walt, and my son, Tucker who just turned two months old. There is nothing like being a mom – it's a pretty amazing experience and I just love it. We also have two dogs, Nick, and Wilson, who love their new little brother.

I love spending time with my family and friends, reading, cooking, and playing tennis. I grew up in Harrisonburg, Virginia and moved to Richmond to attend Randolph-Macon College in Ashland. After graduating, I taught fourth grade in Hanover County for seven years.

Working at the VDA is certainly a big change, but it's an exciting one and I love my job. My main responsibility is organizing and planning the Virginia Meeting which will take place in Williamsburg next June. (I hope you are planning to attend, we would love to have you!) I also will be coordinating some continuing education efforts. I hope that you will feel free to contact me if you have questions or ideas.

I'm so happy to be here at the VDA and I look forward to getting to know you!

Compared to our 100 years of experience, our competitors simply can't fill our shoes.

VDA SERVICES

It's hard to follow in Medical Protective's footsteps. No one else has over 100 years of proven experience defending malpractice claims. No other dental malpractice competitor's financial strength is ranked higher by independent rating agencies. And today, more than ever, the financial strength, integrity and powerful backing of Warren Buffett's Berkshire Hathaway is crucial to the quality of your dental malpractice protection.

Should you trust your career to the best or something less?

Contact us today for a Protection & Price Check-Up

PROTECTION & PRICE CHECK-UP

Visit dental@medpro.com
Fax 866-417-5068
Call 800-4MEDPRO

Trust the dental malpractice experts.

MEDICAL PROTECTIVE
Strength. Defense. Solutions. Since 1899.
a Berkshire Hathaway Company

Message from the President

Dr. Michael Abbott

As we approach the dog days of summer, I want to tell you about the new VDA building on Mayland Court. VDA staff moved into the new building on April 25th.

The staff is excited about the move and, at this point, we have had the first VDA Board meeting in the conference room of the new building.

After an in-depth discussion among all the parties nominated as the control group for the new building (Drs. Abbott, Bell, Dickinson, Levine, Sherwin, and Wood), it was decided to take money from the reserve fund for this move and the purchase of the new building. If we still have a deficiency in this fund, once we have an insurance payout in hand and after the Virginia Meeting numbers are complete, we must come up with a plan to rebuild the reserves as recommended to the House by the Council on Finance and Board of Directors. I would like you to consider this between now and the House of Delegates meeting in September and let your House members know your opinion.

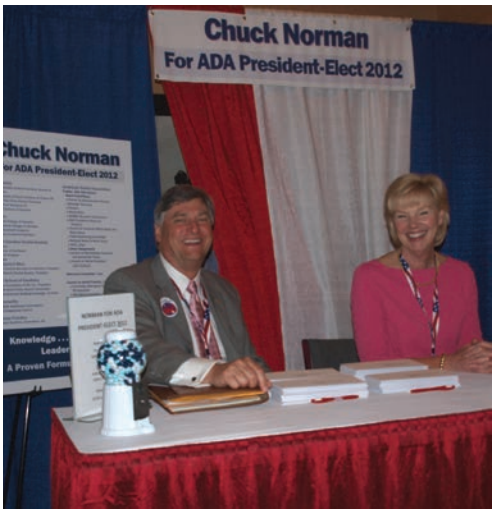
We understand the VDSC can lend us money ($125,000) and we also have a line of credit ($300,000) that can be used if needed. There are fees and interest we are trying to avoid. Dr. Ted Sherwin is still working hard to maximize the payout from the insurance company.

We feel we have performed due diligence, and feel certain you will agree to our choice. Please – stop by and visit your new VDA building. At the next Board of Directors meeting we will discuss the financial part of this purchase and look forward to sharing our excitement with you.

I hope you have an enjoyable summer, and if you are a member of the House of Delegates, please have a safe trip to Fredericksburg in September. I hope to see you there.

Dr. Chuck Norman Announces Candidacy for ADA President-Elect

By: Sharon Norman



Dr. Charles Norman and Mrs. Sharon Norman

Greensboro, NC dentist, Dr. Chuck Norman has announced his 2012 candidacy for President-Elect of the American Dental Association. Chuck is no stranger to dentistry in North Carolina or nationally. Currently, he is serving a four-year term as the 16th District Trustee to the ADA representing North Carolina, South Carolina and Virginia. Entering his last year as Trustee, Chuck is in an exceptional position to seek the highest office of our national professional association. With the unanimous support of the North Carolina Dental Society House of Delegates, Chuck kicked off his campaign during the NCDS Annual Session in Myrtle Beach, May 19-22, 2011.

Serving as Trustee is a rigorous training ground for the leadership of the ADA. Even as a freshman Trustee, Chuck was assigned to the most demanding Board committees. Chuck knows the operation of the ADA from a first-hand basis, having served on Budget, Finance & Administrative Review, Strategic Planning, Pension, Board Rules Review, Future of ADABEI, and the Special Committee on Financial Affairs, as well as serving as Liaison to the Council on Dental Education & Licensure and the Council on Membership Insurance & Retirement Plans. It is important to note that during his '96-'99 term on the Council on Dental Practice, he was selected by his peers to serve as Vice-Chair and Chair. He is an expert in the current operation and future of the ADA. Chuck understands the ADA from the perspective of a member and a leader. He represents dentistry well and will make an extraordinary President.

Dr. Norman received his BS and DDS from the University of North Carolina in Chapel Hill. He has been in the private practice of general dentistry since 1977. Having been actively involved in dentistry throughout his career, Chuck has served as President of the North Carolina Dental Society, Third District Dental Society, Guilford County Dental Society and North Carolina Services for Dentistry, the for-profit subsidiary of the NCDS. He is a passionate Carolina fan and enthusiastically supports the UNC School of Dentistry and its fund raising efforts. He has served on the Board for the Dental Foundation of NC Inc, including a two-year term as President, and is currently Co-Chair of the Dental Sciences Building Steering Committee.

Chuck is married to the former Sharon Brown of Cary, and together they have two grown children, Matthew and Emily. Sharon is a devoted church and community volunteer, and is particularly committed to her involvement in NC MOM in Greensboro. She has served as president of the Alliance to the Guilford County and Third District Dental Societies, and is an active participant in local, state and national politics. Matthew, a 2010 UNC School of Dentistry graduate, has joined his dad's dental practice in Greensboro. Matthew is married to Chandler Woodall. Emily earned her degree in Graphic Design from Elon University and is a graphic artist with The Buttercup. Emily is married to Brian Richards and they reside in Charlotte.

The Norman for ADA President-Elect Campaign Committee is chaired by Dr. Nona Breeland. While the actual election will occur in San Francisco on October 22, 2012, a well-planned and executed campaign requires financial support. Contributions from individual dentists are encouraged and welcome. Donations and other inquiries can be sent to the Norman for ADA President-Elect Campaign, PO Box 4008, Cary, NC 27519.

Editor's Note: Dr. Norman will announce his candidacy for ADA President-Elect at the ADA Annual Session in Las Vegas, NV

The Right Fit

FOR MALPRACTICE INSURANCE COVERAGE

Get competitive dental malpractice insurance coverage with protection you can trust from "A" (Excellent) rated Professional Solutions Insurance Company.*

To learn more, call **1-800-718-1007, ext. 9191,**
or visit **www.profsolutions.com.**

Professional SOLUTIONS | INSURANCE COMPANY

* Malpractice insurance is underwritten by Professional Solutions Insurance Company, 14001 University Ave., Clive, IA 50325. Professional Solutions Insurance Company is rated "A" (Excellent) by A.M. Best for financial strength and operating performance. A.M. Best ratings range from A++ to S.

Letter to the Editor

The Dental Doctor and Malignant Neoplasia

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

Dentists are the guardians and doctors to the gateway of the human body. As Dr. Henry Botuck states in his well written article on "Oral Sex and Oral Cancer","The title Doctor comes with responsibilities" (NOVA News, October-November 2010). It is incumbent upon Dental-Doctors to read the literature not only about oral and peri-oral diseases, but to be familiar with the general physiology and pathology of the entire body. Certainly as health professionals, we should listen and interpret the physical complaints expressed by our patients and determine the need for medical referral and investigation.

Malignant disease does occur in our field of expertise. Therefore a brief presentation on the most recent and still controversial theory as to why normal cells become malignant will be elaborated here. Like their host (the body), normal and malignant cells are intent on survival. Cellular physiologists propose the theory that because some cells have inadequate amounts of oxygen - these cells are vulnerable for malignant transformation. All cells need to produce energy to exist and function.

Normal cells receive their energy requirements by respiration with oxygen; but those cells, deficient in oxygen, with damaged respiratory enzymes, cannot produce their energy via respiration. These now abnormal cells receive their energy by fermentation of sugar which allows them to exist, but completely unable to function or cooperate with normal cells and their host. Scientists report that malignant cells contain only 60% of their oxygen requirements. In these oxygen deficient cells there also occurs significant changes in the DNA within the nucleus of the cell. The genes in the nucleus which are composed of DNA and are influenced by the DNA molecules, respond by mutation due to the hypoxic environment. Now you are observing truly malignant cells! These malignant cells multiply and rapidly produce new malignant cells, which when overwhelming the immune system, invade and destroy healthy tissues, and if not controlled - the host.

There are many explanations why some cells are deprived of their required amount of oxygen. Some of these are:

1. Inadequate amounts of oxyhemoglobin dissociation in the microcirculation.
2. Various anemias
3. Inadequate circulatory pathway to certain cells.
4. Poorly constructed cell walls and/or damaged cell walls.
5. The pH of the intercellular fluid is abnormally acidic.
6. Intracellular enzyme activity disturbed by deficiency diseases.
7. A reduction in oxygen tension due to respiratory disease.
8. Narcotic & hypnotic drugs have a depressant action on intracellular metabolic processes.
9. Circulatory failure.
10. Calcium is essential for pH control in body fluids. Some assume that if calcium is not present in sufficient levels, body fluids become acidic which also depresses the amount of oxygen.

Why would the immune system be weakened? This is frequently suspected with malignant disease. Physiologists refer to minimal function of the immune system in the very young and in the elderly. In the young, the immune system is not completely developed and in the elderly, the immune system has probably had to contain some of the following pathologic process:

1. Exposure to carcinogens from contaminated atmosphere.
2. Toxins (staph infections).
3. Stress, mental depression and excessive anxiety.
4. Diseases affecting lymphoid tissue, (i.e. lymph nodes, tonsils, spleen and thymus gland).
5. Any microbe or pathogen entering the body that could cause disease.

These events over many years could explain an overworked and weakened immune system. How does the development of the malignancy relate to the practice of dentistry and the responsibilities of the Dental Doctor?

1. For proper nutrition - the mastication of food requires a healthy dentition - in good occlusion.
2. Chronic pain or periodic pain is stress. Treat accordingly.
3. Adequate salivary function is necessary for digestion.
4. Intra-oral infections (bacterial, viral or fungal) should be eliminated as soon as possible.
5. Foci of infection such as periodontitis or impacted wisdom teeth should be eliminated.
6. Ill-fitting prostheses should be replaced with good functional dentistry.
7. When indicated, the dental doctors should advise their patients on what constitutes a healthy diet and encourage aerobic exercise (if approved by primary care physician).
8. Use every means possible to have your patient discontinue the use of tobacco and alcohol.
If you have children under the age of twelve consider the use of the human papilloma vaccine. (Check with pediatrician).
9. Protect the patient from radiation when taking radiographs. Use lead apron and cover the thyroid gland.
Advise patients how to protect their lips and facial skin from the ultraviolet rays of the sun.
10. Oh yes, do not forget to do a "cancer" examination of the head and neck periodically on all patients.
11. If your patient expresses physical complaints suggestive of a pathological process in any part of their body - refer them to their primary care physician. To make sure they comply, write a letter to their physician.
12. Do not hesitate to biopsy or refer to an oral and maxillofacial surgeon for biopsy any lumps or bumps that do not belong in the mouth or face.

With this basic information about malignant cells, it is understandable why oncologists make every attempt to increase the oxygen tension in cancerous tissue. Such efforts as having patients breathe high concentrations of oxygen, drink liquid oxygen supplement, utilize hyperbaric oxygen, hydrogen peroxide taken orally and administering intravenously and even injecting into cancerous cells have all been attempted. About ten years ago a chemical with allosteric inhibitors of hemoglobin saturation was given intravenously to enhance oxygenation in patients with cancers prior to radiation therapy. This resulted in minimal success.

Most cancers larger than 5 cm have frequently outgrown their vascularity especially in the center of the lesion. The vascular route diminishes from the periphery to the center of the cancer. Therefore, it is futile to enhance oxygenation of cancer cells utilizing the venous or arterial route in our opinion. There is ample evidence that when malignant cells are significantly oxygenated, they are extremely amenable to destruction by radiation and chemotherapy.

In our research to enhance oxygen in cancer cells, I have injected an oxygen releasing medication directly into the accessible part of the cancer, 30 minutes prior to radiotherapy. Using half the cancercidal dose of radiation, in a few sessions, our result was a dramatic response with no evidence of residual disease confirmed by microscopic examination. More studies of this technique are indicated.

When our patients are diagnosed with cancer of the mouth or face, they are referred to a surgical oncologist, radiation oncologist and medical oncologist for their opinions. I will usually phone the primary care physician and the pathologist who made the final diagnosis for any other significant data. With all of this information, the patient and I then decide the best procedures to obtain a cure. If there is a tumor board at your hospital where patients with cancers are seen and treated by specialists in oncology, your patients can be referred there. The health care professionals involved must be cooperative and not competitive to give the patient the best prognosis.

Formerly:
Adjunct and Research Professor in Medical Physiology, The American University, Washington, DC. Private practice of Oral and Maxillofacial Surgical Oncology.
Diplomate, American Board of Oral and Maxillofacial Surgery.
Chief, Oral and Maxillofacial Surgery, Department of Surgery, The Alexandria Hospital, Alexandria, VA.
Clinical Professor, Oral and Maxillofacial Surgery, School of Dentistry, Virginia Commonwealth University, Richmond, VA. Member - McLeur Cancer Clinic, Alexandria Hospital, Alexandria, VA.

For reprints of our technique of injecting oxygen into cancerous cells or reprints of our patients treated for malignant disease, call me at 703-256-1035 or write 6506 Dearborn Drive, Falls Church, Virginia 22044. Please include your address.

WWW.AFTCO.NET

AFTCO

TRANSITION CONSULTANTS

Helping dentists buy & sell practices for over 40 years.

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

Tyson W. Anderson, D.D.S. has acquired equity in the practice of **Harold M. Cruse, D.D.S.** - Midlothian, Virginia

E. Marlene Miles, D.D.S. has acquired the practice of **Michael N. Trahos, D.D.S.** - Stafford, Virginia

Khudsia M. Hyder, D.D.S. has acquired the practice of **Alan M. Padgett, D.D.S.** - Richmond, Virginia

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

Call 1-800-232-3826 today for a free practice appraisal, a $2,500 value!

Trustee's Corner

Dr. Charles H. Norman, III - 16th District Trustee

Recruitment and Retention: Why Membership Rates Are Declining

Spring has come and gone and with it, the end of basketball season, the beginning of golf season, State Dental Society meetings, and of course dental school graduation for our newest colleagues. Just like spring is a new beginning for the landscape, it is also a new beginning for our recent graduates. It is our responsibility as professionals to nurture and mentor the new additions to our dental communities. It is also a time to reflect on the value of membership in the ADA and to encourage other dentists, new and old, to become an active member of our association.

In the current political and regulatory climate, the ADA represents the voice of dentistry, as developed by you the members. It is not the bureaucrats and foundations that understand our profession, but our dentists and their staffs who serve the public every day. Strong advocacy requires an overwhelming market share, committed staff at the ADA, and adequate resources to support our initiatives in Chicago and Washington. We need those new graduates and the non-renews to sustain our efforts in advocacy, control dues increases, and stabilize our budget. Simply put, the more the merrier.

Let's take a look at where we stand at the end of 2010.

It was not that many years ago that the ADA had a membership percentage well over 70%. Times were good, the economy was strong, and so was dentistry. Last year, our market share dropped to 68% and the trend has been downward for a number of years. Certainly the economy has been a factor, but a closer look at the demographics of our membership may help explain the trend further.

In the age groups over fifty-five, the market share is from 72 to 87% with that number increasing as dentists age and there is an attrition of the total market. Similarly, the market share of those members age twenty starts at 90% and steadily declines to 73% by age thirty-five. Obviously, the value proposition of the ADA has been replaced by other influences during that period. In fact, the average market share of our dentists during their most productive years of thirty-five to fifty-five is only 66%. We must find a way to engage our members at an earlier age and keep them engaged throughout their careers. That requires the most effort at the local and component dental society level, not from Chicago or the state.

Besides age, the statistics can also be broken down into other demographics that are also revealing. General dentists join at a rate of 65% where as specialists participate at a 79% rate. A further analysis shows that, full time faculty represent a market share of 67%, women dentists at 61%, Federal service dentists at 58%, minority dentists at 53%, and foreign trained dentists at 49%. This data supports a need for a targeted approach for recruitment and retention to achieve our goals. That means an approach that emphasizes specific values that are important to each unique demographic.

Additionally, our non-renew rate consistently hovers around 3-4%, and it is likely that a colleague in your local dental society, study club, or lunch group is one of those non-renews. As loyal members, we have a unique opportunity to reinvigorate our friends who have dropped their membership and encourage them to join us again in our common cause.

ASDA membership is at an all time high of over 85% nationwide, a full twelve points higher that the ADA market share as a whole. However, upon graduation, the enrollment rates for new dentists, (ten years or less in practice) drop to 67%, a level almost identical to the overall ADA market share of 68%. We obviously have some work to do to encourage conversion and retention from ASDA to full ADA membership and that participation level is absolutely necessary for the future health of the association. New graduates are truly the lifeblood of our professional organization, and it would seem that we have a captive audience that is waiting to be asked to join, but we must take time to meet the new dentists in our communities and invite to become members.

The statistics for Virginia are similar to those nationwide with a market share of 68%, while the numbers in the other two states in our 16th District, North Carolina and South Carolina are somewhat higher at 73% and 80% respectively.

The next time you happen to meet a non-member dentist, take the time to ask them why they have chosen not to participate in our organization. Better yet, enthusiastically invite them to join us in our efforts.

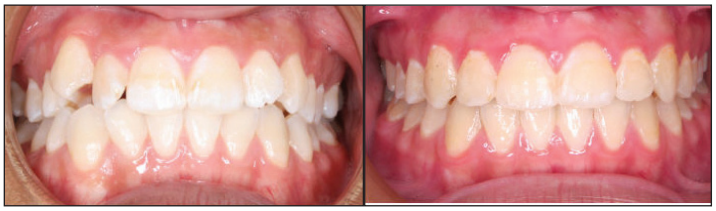
Donated Dental Services

A message from Dr. C. William Dabney and Staff:

Dr. Dabney,

Thank you for giving me a beautiful smile and a reason to smile, because there are people like YOU!

Christen Boutros



Sometimes children are in need of orthodontic care but their parents cannot afford the expenses. Christen Boutros was one of those children. Christen was referred to our office by Kerri Reed, the Dental Coordinator for Cross Over Ministry whose dentist is Dr. Charles Fralin. Christen's tooth alignment made it difficult for her to chew food and caused her to accidentally bite her cheeks and lips which caused chronic sores. We found her to be delightful, intelligent and academically motivated and were happy to donate our services.
We placed Christen's braces and were able to improve her smile in less than one year. Christen was so appreciative and a pleasure to work with. As you can see, her smile vastly improved. Although Christen was a confident young woman when we first met her, her improved smile has added to her confidence level, and as a result Christen is now beaming with a beautiful smile.

Christen is now attending a great university and we wish her the best in her future endeavors!

A Continuing Story...

By: Kate Hanger, Donated Dental Services Project Coordinator

You may remember Percy Flannagan from past VDA Journals. Percy (who goes by P.J.) applied to the Donated Dental Services program in 2008 and we tracked his progress in the journal. P.J.'s treatment was completed in 2010 and, with the help of VCU School of Dentistry, Dr. James Wallace, Dr. David Larson, and Glidewell Dental Lab, he received $6406 in donated dental care!

P.J. and his girlfriend Ella Gregory have been together for nine years. They share an apartment and hope to be able to have a house someday. P.J. and Ella help each other get through the hard times and take care of each other. You can tell that they are very much in love

P.J. referred Ella to the DDS program as she'd had all her teeth extracted at VCU and couldn't afford dentures. Like Percy she is unable to work due to seizures and relies on Social Security to cover living expenses. Ella was terribly self-conscious about her appearance without teeth and was hoping to be able to get dentures.
Dr. Karen McAndrew and her staff, along with Kyle Tuttle of River City Dental Prosthetics, helped make Ella's dream come true! Now she has a beautiful smile and will be able to enjoy healthy food again. Thank you Kyle, Dr. McAndrew, and your staff for all you do for Donated Dental Services!

If you would like more information on Donated Dental Services, please go to www.vdaf.org or contact Kate Hanger at 804-264-9010 ext. 2.

*REMEMBER: If you encounter someone you want to treat through the DDS program, just get in touch with our office and we will provide all the case management and lab work. Many of our volunteers choose to select their own DDS patients and we encourage you to do the same!

D.D.S in Chester

Last Sunday I spoke with a friend at church. He is an older gentleman and is retired, and volunteers as a driver with the Sheppard Center in Chester. The Sheppard Center provides services to disabled and senior citizens. My friend had driven Ginger in the past, before she had her mouth restored. He told me that I had changed her life. He told me that she is a different person since she had her teeth fixed, that she now carries herself in a positive manner, that she has confidence and pride in herself, that she is happy now, that she bathes and washes herself, that she doesn't have an offensive smell, that she now wears clean clothes and has a presentable appearance, even that she is looking to move out of her cabana (a trailer that is divided into 2 or 3 units) in a trailer park on Jefferson Davis Highway. All in all, my friend told me that I had changed Ginger's life for the better, that he didn't even recognize her when he first saw her. And he thanked me for what our office had done. This is why we volunteer with the DDS program.

Dr. Sam Galstan

Donating lab: Goodwin Dental Lab
Richmond, VA

D.D.S. in Virginia Beach

It took a team to bring Phyllis Bias of Virginia Beach back to good oral health. Thanks to Dr. Robert Candler (general dentist/Norfolk), Dr. Trent Conelias (oral surgeon/VA Beach) and Dr. Rod Rogge (periodontist/VA Beach) who made her new smile possible.

Full upper denture and lower partial dentures generously donated by:
Lab One
Norfolk, VA

D.D.S. in Hopewell

Occasionally we have a donated dental patient that really touches our hearts. Mr. Lino Rivera is one of those patients. Today, we received a thank you card from him. I will quote: "My appreciation for all your work and professionalism in securing my dental needs goes beyond mere words. God Bless, Lino."

Thanks,
Dr. Jonathan Ellis and Staff
Hopewell, VA

JC's Dental Lab provided the full upper denture for Mr. Rivera.
Jerry Chambliss
Hopewell, VA

Smile:

Delta Dental has the largest number of covered patients.

Having the largest dental network in the nation* didn't happen by accident. More dentists participate with Delta Dental than any other insurance carrier because they understand we offer patients the best in valuable, innovative and preventive dental benefits. And that can mean more patients for you.

Not only do we have the largest covered patient base**, but we also design our plans and services with you in mind. Founded by dentists, Delta Dental continually looks for ways to make our dental benefits plans valuable to the patient and easy for you to administer. Put the benefits of experience to work for you when you participate with Delta Dental of Virginia.

Smile....you've got Delta Dental.

Good for you. Good for your patients.

deltadentalva.com / 800.367.3531

DELTA DENTAL®

* Delta Dental Plans Association, December 2010
**Business Insurance Dental Plan Providers Directory, April 2011

M.O.M.'s Newest Arrival

By: Jeppy Moss
VCU School of Dentistry Class of 2012

At 20 feet long with 17,950 pounds of gross weight, the newest addition to the Mission of Mercy truck fleet is exactly what the doctor ordered. For the past 10 years, all of the supplies and equipment used for the MOM projects have been transported in rental trucks to and from each project. That meant that everything needed to be stored, loaded and unloaded over the course of 7 to 9 times a year. If that seems like a lot, now add in unloading and loading twice for each individual project! Needless to say, the VDA and Mission of Mercy volunteers greatly appreciate their newest member. We now have two fully equipped trucks that make things a little easier and more efficient as we prepare for each project.

The Isuzu box truck (pictured above) was an extraordinary gift made possible by many gracious supporters of the VCU School of Dentistry and Mission of Mercy projects. For the past six years, an annual alumni golf tournament has been put on by 25 students stretching from the classes of 2008 to2014. The students have worked diligently to raise money for the school through this event. The tournament has grown each and every year as alumni and sponsors come together to support an excellent school and even bigger cause. We would like to extend a special thank you to some of our continued sponsors including Henry Schein Cares, Dexis, Dr. Baxter Perkinson and Associates, VDA Services, Pelton & Crane, and the MCV Foundation for making such a wonderful gift possible.

M.O.M. Project Returns to Emporia

By: Jamie Neal

Missions of Mercy returns this year to Emporia – Saturday, November 5, 2011. Patients from Brunswick, Sussex, Southampton, and Greensville Counties, as well as the city of Emporia will be treated. Also, patients from neighboring counties in North Carolina are expected. The site will again be Greensville County High School gymnasium. Hours on Saturday will be 8:00 a.m. to 5:00 p.m. Dr. Harold Neal and wife Jamie Neal, project organizers, say volunteers are also needed at 1:00 p.m., Friday, November 4, to screen patients prior to treatment on Saturday. Dentists, hygienists and assistants are encouraged to sign up as a large turnout is expected.

Lodging will be available for those staying overnight. A block of rooms has been reserved at the Hampton Inn in Emporia, at a rate of $79 per night. Please mention this event when making a reservation. For hotel accommodations, call (434) 634-9200. A dinner for volunteers is planned for Friday evening, and registration will be available online at www.vadental.org, or by phone, (804) 288-5750. Breakfast and lunch will be provided Saturday for all volunteers. An information packet will be mailed prior to the event.

Missions of Mercy

JOIN THE M.O.M. TEAM!

Upcoming Projects:

Wise M.O.M.
July 22, 24, 2011

Grundy M.O.M.
October 1-2, 2011

Emporia M.O.M.
November 5, 2011

For more information on the Mission of Mercy Projects and to register online please visit us at www.vdaf.org

Contact: Barbara Rollins
804-288-5750 FAX: 804-288-1880
email: rollins@vadental.org

Missions of Mercy
Virginia Dental Association Foundation

Donated Dental Services
Virginia Dental Association Foundation

give kids a smile!
Children's Dental Access Program

vdaf
Virginia Dental Association Foundation

www.vdaf.org

The **VDA Foundation** has a new website!

www.vdaf.org

Register for MOM projects, learn more about our programs, and direct your friends, family and patients to make donations to support our mission of providing access to dental care to all Virginians.

VDAF is a 501(c)3 nonprofit organization which funds the Mission of Mercy, Donated Dental Services, and Give Kids A Smile programs. All donations are tax deductible and go directly to funding our outreach initiatives. Please support the Foundation in any way you can.

www.vdaf.org

Patient Tickets Key to Roanoke M.O.M. Success

By: Alison Jorgensen, Roanoke M.O.M. Project Manager

Patient in Dental Area at the 2011 Roanoke Missions of Mercy Project.

The 2011 Roanoke Mission of Mercy (MOM) Project, the fourth for the Roanoke Valley, saw some significant changes. Though the event was held at the same location as the previous three clinics, organizers implemented new processes, including the ticketing of patients. Overall, the event was a success, seeing 985 patients over 1002 visits utilizing 721 volunteers for a total value of $954,956 during the two-day clinic held on April 1 and 2.

In previous years, patients lined up outside of the Roanoke Civic Center, waiting all night along one of the area's busiest streets. In addition to the long wait, often in unfavorable weather conditions, organizers turned away almost as many as were seen. This process was one that weighed heavy on the minds of law enforcement and project organizers. Discussions about how to improve the situation resulted in the idea to ticket patients.

Working with one of the largest employers in the area, Advance Auto Parts, MOM team members set-up the ticket line in the donated parking lot of the Advance Auto Parts headquarters the night before the ticketing event. Mission of Mercy team members worked with local media early on to get the message out to patients that everyone wishing to receive services during the event would need a ticket to do so and that tickets would be given one per person. Portable toilets were donated from a local company and two off-duty Sheriff's officers were used to provide security overnight, but the line did not really begin forming until around 7AM. Nine hundred tickets were given out in just under 45 minutes (100 tickets were given to local partner organizations). Only about 20 individuals were turned away, much less than the hundreds in previous years, and they understood that there were simply no more tickets to give away. This proved a smooth process for all involved, while eliminating the long lines overnight at the event venue.

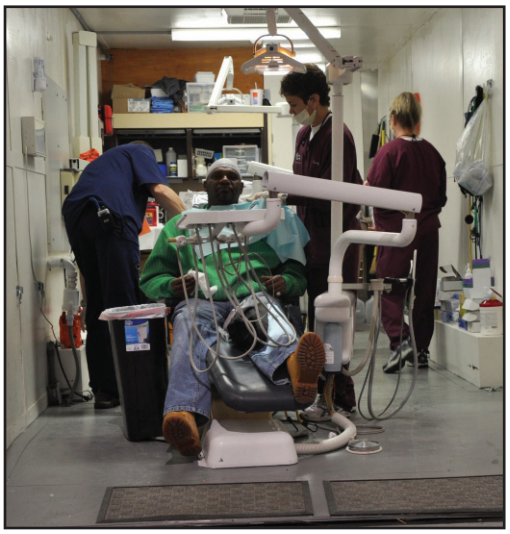
Those who arrived at the venue before the gates opened at 5:00AM on the project days were told that if they had a ticket to come back at 5:00AM, if they did not have a ticket that they would not be seen. When patients entered the parking lot, they were directed where to park and told to enter the Exhibit Hall, which had been secured for the event and was also an improvement this year. In the Exhibit Hall, patients had access to seating, restrooms, a community resource fair, and health videos. This process made for a much calmer project. Patients were not upset about having to wait outside and this created a much more relaxed tone for the entire project.

The rental of an x-ray truck from the North Carolina Dental Society was also an improvement. This truck allowed four patients to receive Panorex images simultaneously. X-Ray has always been a bottleneck at the Roanoke project and this helped the process run more smoothly.

In addition to these changes, project organizers agreed to fund 25 sets of a new denture product from Larell Dentures. These dentures were received by patients who had teeth removed at previous Roanoke MOM projects to ensure no swelling for maximum fit. Thirty-five patients were able to receive top, bottom, or full sets of dentures. The product is done, from start to finish, in 2 – 3 days. Organizers hope to secure additional funding to provide this service at future Roanoke MOM projects. Dentures are one of the most pressing needs in the area.

One set-back experienced this year was that the Virginia Oral Surgeons conference was scheduled for the same weekend, after the Roanoke MOM date had been set. This decreased the number of oral surgeons available for the project, but with the help of Dr. Terry Dickinson of the VDA, oral surgeons from surrounding states were able to help fill the gap.

Overall, the 2011 Roanoke Mission of Mercy Project was a success from all angles. Patient surveys (742 of 985 returned) were overwhelmingly positive. Organizers will soon begin planning for the 2012 project, making more improvements to ensure another smooth and successful project.



Denture Patient in Dr. Steve Alouf's Trailer at 2011 Roanoke Missions of Mercy Project.

A BIG THANK YOU TO ALL THE 2011 Roanoke M.O.M and NOVA M.O.M. PROJECT VOLUNTEERS!

Roanoke:
Dr. Gavin Aaron
George Aberth
Ashley Adams
Dr. Katie Adams
Molly Adler
Dr. Nazir Ahmad
John Aiken
Dr. Jack Allara
Dr. Stephen Alouf
Bobby Amos
Dr. Steven Anama
Dr. Sandra Andrew
Laura Arnold
Courtney Ashby
Samantha Ashe
Brittany Aubrey
Britney Avila
Donna Ayers
Cynthia Ayles
Sharice Aziz
Tina Bailey
Emily Baker
Dr. Thomas Balmer
Elvi Barcoma
Jillian Barnes
Regena Barthelemy
Nomundari Batkhuu
Kristin Baugher
Patricia Beckner
Farrah Beg
Virginia Behan
Dr. David Black
Carlos Blackmon
Ona Blankenship
Tommy Bond
Connie Booher
Sallie Boone
Najib Bouchebel
Tracey Bourassa
Brooke Bowling
Becki Brantingham
London Brown
Dr. Brian Brumbaugh
Chasity Burke
Rhianna Busch
Deborah Byrd
Heather Byrd
Kerri Campbell
Natalie Cannon
Jenna Caprara
Bria Carlisle
Kristaleen Carter
Maria Chang
Houman Chegini
April Christian
Courtney Clark
Dr. Michael Clark
Taneisha Clark
Steve Clawson
Caroljoy Cleckner
Dr. Dennis Cleckner
Taylor Clifton
Andy Coalter
Taylor Colbert
Autumn Collins
Larraine Collins
Anne Compton
Alexa Cook
Stacy Cornett
Dr. James Cornick
Renee Craven
Crystal Crespo
Dr. Ivona Cristi
Eugena Curtis
Lisa Cutler
Dr. Steven Daniels
Laura Darnell
Dr. Gerald Davis
Nina Davis
Tiffany Deacon
Brenda Dennis
Paula Derbyshire
Dr. William Deyerle
Claire Dickey
Dr. Randy Dickey
Tia Dimowski
Monica Dinh
Truong Dong
Jigmey Dorjee
Stephanie Dorsman
Brittni Drew
Darlene Drew
Shannon Dudley
Ashley Duncan
Brandi Duncan
Misty Dunnivan
Dr. Sunny Duong
Al Durham
Daniel Durham
Dr. David Durham
Damon Dyson
Shana Eddy
Kema Effiong
Keith Eldridge
Sean Eschenbach
Karen Evans
Tayeeb Faruk
Gail Felton
Oliver Flood
Jordan Foutz
Vicky Fuzaylovav
Susan Gauldin
Jessica German
Alexandra Glass
Greg Gray
Lauren Greaves
Cristina Green
Lyndsay Green
Toshia Greenburg
Wendy Gruver
Melinda Gullotti
Dr. John Gunsolley
Pamela Gunsolley
Jessica Gutierrez-Arnold
Ryland Gwaltney
Colleen Hailey
Dr. Barnette Haley
Jennie Hall
Kelly Hall
Dr. Sheila Hardee
Dr. Justin Hardison
Dana Harmon
Heather Harris
Dr. John Harris III
Dr. Howard Harrison
Dr. James Hartigan
Tabitha Hawkins
Patricia Hayes
Jerod Haywood
Sherry Hearne
Megan Hedrick
Heather Herrera
Julia Hill
Bridgette Hoover
Dr. Nathan Houchins
Stacy Houchins
Amy Howad
Dr. Rick Huffman
Chi Hyun Hwang
Caitlin Irish
Dr. Jay James, III
Brandy Jenkins
Dr. Richard Joachim
Juston Johnson
Susanne Johnson
Dr. David Jones
Dr. David Jones
Lauren Jones
Jessica Jurbran
Mary Kerr
Dr. George Kevorkian
Dong Soo Kim
Monique Kincer
Dr. Robert Kinney
Angela Kinsey
Doug Kitchin
Kandice Klepper
Nancy Kovach
Karen Kraus
Lee Kreger
Anouri Lacks
Dr. Penny Lampros
Sally Ledford
Greyson Leftwich
Chasity Leighty
Dr. Tom Leslie
Toni Leslie
Dr. Casey Lesser
Britany Lester
Kassie Long
Dr. Jonathan Lubeck
Dr. Sean Lynch
Denver Lyons
Fatima Maarouf
Emily Maas
Jaime Majure
Rachel Markham
Nick Marks
Angela Martin
Tracy Martin
Jennifer Mattox
Dr. Ericka McBrine
Ashley McClain
Dr. Bob McClanahan, Jr
Dr. Jim McClung
Dr. Maston McCorkle
Linda McIntosh
Lora Meador
Dr. Robert Merian
Sarah Middlemas
Betsy Midkiff
Mary Miles
Dr. Scott Miller
Dr. Michele Mills
Tracey Minton
Diane Mitchell
Dr. Lorenzo Modeste
Paris Modjarrad
Vali Mohler
Valerie Mooney
Will Moore
Cynthia Mora
Anna Morgan
Dr. Garner Morgan
Dr. William Morris
Jeppy Moss
Dr. Lloyd Moss
Dr. James Muehleck
Dr. John Nardone
Liz Neal
Rusty Neal
Joslyn Nelson
Julia Niculescu
Kristoffer Norbo
Phyllis Norbo
Dr. Randy Norbo
Dr. James Northern
Kathleen Northern
Dana Nunley
Kate Obaugh
Dr. Edward O'Keefe
Miranda Okubo
Kriss Orellana
Ginny Oyler
Laura Padgett
Dr. Brian Palank
Nick Pappas
Anne Parcell
Dr. Young Park
Amber Parker
Camden Parks
Heather Parrish
Dr. Al Parulis
Monali Patel
Debbie Paxton
Dr. Joseph Penn
Erica Penque
Amy Perdue
Casey Phipps
Stephanie Pierce
Andrea Powers
Marie Price
Dr. James Priest
Rini Pullagura
Nancy Pullen
Daniela Ramos
Disa Raulf
Kathryn Redford
Carla Reece
Sheli Rexrode
John Reynolds
Dena Riggs
Britney Ritt
Kyla Roach
Marty Robertson
Te'etta Robinson
Dr. Juan Rojas
Christy Roth
Yueh Ru
Tammy Runion
Dr. Dean Russell
Jackie Saban
Sina Sadeghi
Megan Sampson
Azita Sarmadi
Ashley Schmidt
Geoff Schreiber
Robbie Schureman
Heather Seal
Jessica Searing
Dr. Brittany Semones
Dr. Robert Semtner
Dr. Travis Shannon
Dr. Philip Sherrill
Monica Shui
Dr. Bryan Sicher
Debbie Silveira
Gail Silveira
Kelci Simonson
Dr. John Singleton
Dr. Victor Skaff Jr.
Sean Skellington
Chelsea Smith
Dr. Eric Smith
Tracee Sokolik
Dr. Merritt Sparger, Jr.
Leslie Spira
Kaleigh St. Clair
Matthew Stafford
Brant Stanovick
Denise Stokes
Lauren Stone
Marty Sullivan
Dr. Keith Taylor
Dierdre Terlep
Diane Thacker
Jessica Thai
Christopher Thurston
Dr. Linda Till
Matthew Tomoda
Kimberly Tran
Dolly Trevey-Boitnott
Dr. Cassidy Turner
Dr. Veronika Vazquez
Debbie Viahos
Dr. Gus Viahos
Jocelyn Villalbos
Stephanie Vlahos
Brandie Waldron
Christina Waldron
Dr. Caroline Wallace
Dr. Larry Wallace
Garnett Wam
Chris Whitefleet
Katelyn Wilkins
Arlene Will
Jenny Will
Eric Wilson
Rene Wolfe
Christine Wolters
Dr. Roger Wood
Joseph Wright
Daniel Yeager
Leena Abdel-Qader
Clara Adams
JoAnn Adams
Tom Adams
Beatrice Ake
Theodore Ake
Linda All
Rebecca Almond
Ezra Amiss
Darla Anderson
Ericka Anderson
Mary Anderson
Cynthia Andrews
Asad Ansari
Jacques Arnold
Linda Arrington
Patty Atkins
Renee Baldwin
Patrick Bales
Matt Banghart
Nancy Bannister
Edward Barnes
Mary Barnes
Richard Beatty
Shelia Bellamy
Michelle Belton
Julia Bethel
Tiffany Bohm
David Bowers
BC Brandt
Pete Brandt
Robynne Bransden
Brittany Breen
Ken Briggs
Danielle Burks
Sylvia Byun
Tammy Carter-Hill
Janet Chambers
Philip Chang
Rosalia Chavez
Catherine Christensen
Anuja Chumble
Ron Clark
Laura Claytor
Dorothy Cleary
Stephanie Clements
Candi Clemenz
Dotsy Clifton
Debbie Cobb
Maria Conley
Dee Copenhaver
Judith Cornwall
Crystal Couch
Carolyn Couser
Debbie Cox
Cecina Craft
Chris Craft
Elizabeth Creamer
Maggie Cronise
Nancy Cronise
Marc Davis
Cliff DeMars
Mary Ann DeMars
Katherine Desilva
Holly Dickard
Robert Dickard
Nicholas Dolenuck
April Donner
Martha Donoho
Sharon Doss
Kenneth Eliason
Kandy Elliott
Kate Ellmann
Natalie Ellmann
Tammy Epperly
Anne Exile
George Ferguson
Brianna Ferrell
Donna Foley
Sue Frankel

Janis Fugel
Rob Fulson
Sara Gains
Katie George
Lauren Gibson
Kristen Gilliam
Issac Goode
Lee Gouffray
Robin Haldiman
Kristin Hanfman
Connie Harden
Jerry Hardesty
Darlene Harris
Judith Harrison
Gary Helton
Bridget Hengle
Joan Hirt
Bobbie Hite
Donna Hoffman
Frank House
James Huang
Denny Huff
Sylvia Hunter
Erin Hutchinson
Patricia Hyer
Richard Ingraham
Jennifer Irizarry
Judy Jackson
Ferida Jerausek
Jan Johnson
Patty Johnson
Loretta Jordan
Jae-Woo Jung
Madonna Justice
Dragana Kalinic
Karen Kappesser
Daniel Karnes
Jordan Katyal
Donna Kennedy
Kimberly Kessel
Pam Kestner-Chappelear
Ann Kidd
Kames Kiefer
Dado Kim
Eric Kim
Sooryung Kim
Vivian Kim
Darline Kingery
Tapitha Kingery
Diane LeBlanc
Ernie Lefebvre
Eileen Lepro
Lena Levesque
Trish Lewis
Roseline Lexima
Elizabeth Lochbrunner
Linda Long
Dana Mabry
Kristianne Macaraeg
Rose Marti
Teresa McCadden
Tonya McCain
Brantly McCarty
Michelle McCloud
Lucy McDonald
Debbie McPeak
Andrew Meador
Wendy Mellenthin
JoAnn Minter
Krista Mobley
Ashley Montgomery
Samantha Montgomery
Mary Morgan
Mary Jane Morgan
Robert Moss
Anne Muranowski
Samuel Murdock
Tracy Murray
Lorraine Nash
Jacnique Nazario
Phillip Ngugen
Tin Nguyen
Maria Nichols
Carolyn Niday
Tammy Oliveira
Kathy Ong
Janet Pagans
Elizabeth Page
Jennifer Park
Melinda Payne
Elaine Payne-Alexander
Gerald Peterson
Helen Pham
Sandra Phillips
Deborah Pickeral
Jenny Poland
Sonja Preston
Sheelin Prinzinger
Naveera Rashid
Molly Read
Nitya Reddy
Relissha Rhett
Maria Robertson
Grisell Robinette
Nancy Robison
Jacinda Romero
Deidre Rowe
Lisa Russell
Vivian Sanchez-Jones
Carla Santos
Connie Scaggs
Kay Seib
Joan Shell
Pam Shepherd
Richard Sifton
Amy Silcox
Whitney Simmons
Lewis Singer
Jon Smallwood
Linda Smith
Nakia Smith
David Snodgrass
Ann Sprouse
Lawanna Stanton
Veronica Stewart
Donna Stone
Tim Strawn
Margaret Stultz
James Sung
Lisa Sutphin
Janine Swenson
Corey Taylor
Peggy Templeton
Sharron Terry
Corey Thompson
Margot Thompson
Astrid Thornhill
Susan Tilley
Holly Todd
Tammie Tuck
Jennifer Tummarello
Carmilla Tyree
Catherine Valdez
Vanessa Villalobos
Jennifer Walker
Victoria Walker
Ric Walters
Brad Waltman
Mabel Webb
Marie Webb
Marie Webb
Mike Webb
Charles Webster
Wayne Wells
Tonya Wendell
Teresa Wiley
Doug Williams
Laura Williams
Mica Wilson
Kathy Womack
Martha Womack
Rebecca Wright
David Wymer
Tracy Yates
Pat Young
Harvey Youssef
Tracey Yurechko
Judith Anderson
Jacqueline Baker
Nena Barnett
Laura Boitnott
Kathryn Booth
Jessica Brown
Terri Bryant
Ann Bui
Jeanne Cason
Jennifer Cassidy
Sara Clark
Susan Corrigan
Victoria Cox
Sharon Darnell
Ana Maria de Vera
Sabrina Finch
Nancy Garrabrant
Deborah Hodges
Benjamin Horton
Robin Hosey
Debra Huff
Diane Hylton
James Ingrassia
Dorothy Johnson
Mary Justice
Gail Langabeer
Bradford McDaniel
Cynthia McDowell
Raymond McGinley
Stacy McLaughlin
Barbara Miller
Judy Murray
Edie Naughton
Christine Nguyen
Wanda Nguyen
Sue Nixon
Barbara Pack
Tarak Patel
Lisa Pendleton
Barbara Phifer
Terri Phlegar
Marsella Pickeral
Melanie Reed
Dr. Randy Rhea
Linda Rickabaugh
Suzanne Shaver
Lorraine Smyth
Shauna Spanos
Pam Stokes
Annette Strickland
Beverly Sturgill
Melanie Suga
Jane Thomas
Patrice Tisdelle
Hope Trachtenberg-Fifer
Gregory Ulmer
Tiffany Vandervort
Derek Vanhill
Dianna Via
Joan Via
Carolyn Walker
Dr. Michelle Whitehurst-Cook
Jessie Whorley
Juanita Whorley
Kate Zedler

NOVA:
Dr. Peter Cocolis, Chair
Dr. David Anderson
Ms. Stacia Brooks
Dr. Ted Corcoran
Dr. Vince Dougherty
Dr. Tim Gocke
Mr. Mike Grable
Ms. Cathy Griffanti
Ms. Becky Hallinger
Ms. Catherine Johnson, RDH
Dr. Howard Kelley
Ms. JoAnn Knox
Ms. Andrea Lomrantz
Dr. Fernando Meza
Dr. Paul Olenyn
Ms. Betty Peebles
Mr. Jerry Prentice
Mr. Tom Wilson
Ms. Eleonore Yee
Dr. J. Douglas Bramwell
Dr. Jeffrey Ackerman
Dr. A K Ahrabi
Dr. Shazia Anjum
Dr. Robert Argentieri
Dr. Lawrence Ayers
Dr. Dina Bambrey
Dr. Dick Brigleb
Dr. Pierre Cartier
Dr. Jenny Cheung
Dr. Frank Delatour
Dr. Robert DeWitt
Dr. Kathy Dillon
Dr. Gregory DiRenzo
Dr. James Donahue
Dr. Tamer Elhady
Dr. Neal Emad
Dr. Raymund Favis
Dr. Mel Felber
Dr. Philip Ferris
Dr. Louis Filippone
Dr. Eric Foretich
Dr. Ashkan Ghaffari
Dr. Ralph Gallimore
Dr. Paul Gibberman
Dr. Kenneth Giberson
Dr. Richard Goldin
Dr. Mark Gordon
Dr. Garrett Gouldin
Dr. Peter Hanna
Dr. Ronald Hauptman
Dr. Jessica Hill
Dr. Charlton Ho
Dr. Michael Hurley
Dr. Syed "Kalim" Hussaini
Dr. Neal Jones
Dr. Pooja Kasperowski
Dr. Chad Kasperowski
Dr. Sean Kelliher
Dr. Jeremiah Kelliher, Jr.
Dr. Bijan Kooshki
Dr. Lawrence Kotler
Dr. Linda Le
Dr. Robert Levine
Dr. Paul Levine
Dr. Maureen Locke
Dr. Christine Mai
Dr. Audrey Maiurano
Dr. Nikta Marvdashti
Dr. John Mercantini
Dr. Kevin Mistry
Dr. Bhavana Mistry
Dr. Jeffrey Moon
Dr. Robert Morabito
Dr. Malcolm Murray
Dr. Mirweiss Nawaz
Dr. Howard Ngo
Dr. Steve Nguyen
Dr. Reza Nikpourfard
Dr. Raymond Niles
Dr. Justin Norbo
Dr. Kirk Norbo
Dr. Gregory Nosal
Dr. W. Joseph Pace
Dr. Adrian Patterson
Dr. Long Pham
Dr. Michael Piccinino
Dr. Michael Pichardo
Dr. VaCora Rainey
Dr. Cyrus Ramsey
Dr. Carter Reeves
Dr. Thomas Richards
Dr. Al Rizkalla
Dr. Adam Roca
Dr. Aurelio Roca
Dr. Jeffrey Rothman
Dr. Jessica Russo Revand
Dr. Leslie Rye
Dr. Michael Schulte
Dr. Craig Scimeca
Dr. Sumit Sharma
Dr. Kim Silloway
Dr. Neil Small
Dr. Mark Smith
Dr. Kathryn Smith
Dr. Stephen St. Louis
Dr. Ryan Taylor
Dr. Andrew Thompson
Dr. Besi Tong
Dr. Linh Tran
Dr. Annah Tran
Dr. William Wang
Dr. James Willis
Dr. Carol Wooddell
Dr. Bruce Wyman
Dr. Brenda Young
Dr. Henry Zussman
Jacqueline Atkinson, RDH
Sherry Bashem, RDH
Mary Boyle, RDH
Ingrid Bustamant, RDH
Lan Chau, RDH
Diana Corbin, RDH
Susan Daugherty, RDH
Kari Deitering, RDH
Porshca Eley, RDH
Remay Feldman, RDH
Kerry Garvey, RDH
Colleen Golenor, RDH
Afshan Hashemi, RDH
Heather Howard, RDH
Catherine Johnson, RDH
Alice Keosann, RDH
Holly Knowles, RDH
Joyce Kwiatkowski-Speiler, RDH
Alla Lester, RDH
Nancy Martin, RDH
Vicky McHuen, RDH
Leslie Minion, RDH
Melissa Nicholson, RDH
Priscilla Ofosu, RDH
Phuong Pham, RDH
Lien Phan, RDH
Sandra Ramirez, RDH
Taisha Reynolds, RDH
Sheila Richards, RDH
Mahshid Sarihifard, RDH
Ashley Schulte, RDH
Ajeng Soemantoro, RDH
Dawn Southerly, RDH
Lisa Thompson, RDH
Chester Torkornoo, RDH
Leonor Vega, RDH
MaryJane Villaflor, RDH
Pam Walters, RDH
Georgia Yankey, RDH
Mervat Alwan
Magali Ameller
Saba Atske
Hanna Baluch
Nella Baraoidan
Krissy Barentine
Megan Barnaby
Julie Benalja
Princess Brown
Patricia Calzada
Carol Chavez
Elsy Cienfuegos
Kara Corbin
Kathleen Donahue
Marcus Emad
Nasim Faridani
Gillian Flower
Genet Gedle
Bahareh Ghonsul
Brad Gocke
Yeworkhua Habte
Kimberly Howell
Shannon Hummer
Sagal Ibrahim
Sydney Jimenez
Patty Jordan
Melina Jordan
Patty Jordan
Bri Klotz
Hewan Kressa
Adrian Little
Zakia Mahmoodi
Jay Maiurano
Maria Melgar
Allyson Montgomery
Kathy Mulloy
Liz Naber
Regina Neal
Monica Nguyen
Luann Norbo
Asma Omari
Andrea Ornelas
Diego Perez
Jessica Poblete
Maria Popal
Marie Reeves
Laura Rios
Meredith Roberts
Patricia Rodriguez
Larry Salyer
Adrienne Salzon-Cowley
Angela Sanchez
Staci Sander
Sara Santiago
Jannette Sedo
Meredith Sellers
Marjon Shahban
Matt Sherwood
Barbara Smith
Shelby St. Louis
Quinn St. Louis
Cecilia Taylor
Terri Tesema
Robyn Toler
Bianca Troncoso
Khanh Truong
Christina Turner
Lily Vela
Susan Yamashita

THERE'S A REASON WHY...

VDA Services Selected ProSites®

Endorsed by:

VDA SERVICES

"Endorsing ProSites was an easy decision. As the industry leader, ProSites has been the choice for thousands of dentists nationwide."

Lanny R. Levenson, DDS
President, VDA Services

The Ultimate Website Solution™

Superior Website Designs
Impressive, high-quality website designs convey a professional image of you and your practice.

Unlimited Pages
Smile Gallery, Online Appointment Request, Meet the Doctor, Internet Links Page, and more, **FREE OF CHARGE.**

Patient Education
Customizable patient oriented content on dentistry procedures, FAQs, and much more.

Search Engine Optimization (SEO)
Pages are optimized for maximum exposure on top search engines like Google, Bing, AOL, and Yahoo!

Free MediaMed™ Patient Education Videos
High-quality multimedia videos educate patients and increase case acceptance.

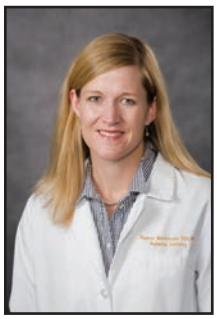
Also Available
Social Media and Local Search Marketing Services.

PROSITES®
Website Design and Internet Marketing

No Obligation, Free Trial at www.prosites.com/vda
Call Today! (888) 932-3644

Family Oral Education with Clinical Guidelines for Pediatric Dental Care

By: Tegwyn H. Brickhouse, DDS, PhD
Associate Professor and Chair-VCU School of Dentistry, Department of Pediatric Dentistry



This article focuses on the family's role in the oral health status of the individual child and the impact caregivers may have in the prevention of early childhood caries (ECC). Caregivers play a vital role in filtering the interaction between the child and his/her environment through feeding habits, oral hygiene care, and other preventive practices/services they make available to their child.

Preventing and controlling early childhood caries (ECC) and promoting oral health requires a complex set of strategies that involve individual families, professional medical and dental services, public health activities, and health policy initiatives. Most evidence-based efforts to address ECC have focused on biologic processes or clinical care, rather than the factors that predispose a child to early childhood caries. The characteristics of ECC and the availability of preventive methods support primary prevention as an important approach for addressing this pervasive pediatric health problem and its serious consequences.

Primary prevention involves risk assessment to identify families at high-risk for their children to develop ECC, the timely delivery of appropriate educational material (anticipatory guidance) to families/caregivers/parents, and the desire on the part of families/caregivers/parents to receive, comprehend, and implement preventive dental health measures. The oral health education needed to prevent ECC encompasses a wide variety of topics, including oral development, the transmission of oral bacteria, the dental disease process, oral hygiene, diet and feeding practices, and fluoride modalities. These areas of education are analogous to and parallel important preventive processes, including anticipatory guidance, risk assessment, and the establishment of a dental home.[1-4]

This article will focus and expand on specific areas related to family oral health education, including oral health literacy, family/patient counseling, motivational interviewing versus traditional patient counseling, and parental attitudes towards oral health.

Oral health literacy

Oral health literacy is thought to be an important determinant of oral health that intersects with other factors (for example, family attitudes and motivation) in numerous ways.[5] Literacy is not the only pathway to improved oral health outcomes, but it is important that any preventive efforts aimed at affecting ECC should consider literacy.[6] The ADA has defined oral health literacy as "the degree to which individuals have the capacity to obtain, process, and understand basic oral health information and services needed to make appropriate health decisions."[7]

Delivering educational information to the caregiver is the foundation of primary prevention; however, this is only one part of the preventive process. The family must then be able to visualize (for example, read, watch, listen) and comprehend the material they have received, and implement the desired actions (for example, behavior, tooth brushing, feeding habits) as part of the child's preventive health routine. The AAPD's *Clinical guideline on infant oral health* calls for early risk assessment to identify parent-infant groups who are at higher risk for ECC.[8] Suggestions regarding oral health communication for families include communicating at a basic level, avoiding jargon terms and allowing the patient to explain his/her story without interruption. It is important to limit new concepts to no more than three per visit and use pictures, graphics, and real devices for demonstration. It is helpful to ask the caregiver questions (using "how" or "why" to evaluate comprehension). Another effective strategy is to ask the caregiver/parent to repeat back to you or your staff the oral health information provided to them in their own words. The primary goal is to convey oral health education orally and only use written material as a message for the family to take-home. Parental health literacy skills have been shown to have an effect on their child's health, and it has been hypothesized that higher parental educational levels will increase the likelihood of parents providing preventive dental care for their child.[9] Oral health care providers must appropriately and effectively educate those families whose children are at risk for ECC.

The educational program should be as tailored to fit the audience and must include basic information on oral development and the disease process, oral hygiene training, diet and nutrition, and fluoride interventions. Important aspects of educational programs may include visual and written information, a demonstration of a visual (knee to knee) examination and oral hygiene, counseling or motivation to instill preventive attitudes which is followed by an evaluation of the caregiver's understanding and acceptance of preventive oral health behaviors.

Oral development

Family oral health education related to oral development should consist of dental and oral milestones, such as the eruption of the first tooth, sequence and timing of eruption, teething, development of occlusion, and anatomical landmarks. Healthy teeth in early childhood can provide a positive self-image, improve quality of life (that is, no need to miss school due to tooth pain), and proper retention of the primary teeth—which allows a child to maintain space for the developing permanent dentition.

The first developmental milestone discussed is the eruption of the first tooth. The average age for eruption of the first primary tooth is six months and it typically occurs between six to eight months; however, some children may be as old as one year before the first teeth appear. After the first tooth erupts, parents should understand the timing and sequence of tooth eruption and what teething might entail for their child. The primary incisors (centrals and laterals) typically begin to erupt at 6 to 12 months of age. The first molars erupt at approximately one year and the second molars at approximately two years. For most children, all 20 primary teeth have erupted by three years. It is important to convey to parents that eruption patterns are predictable but that variations are common and this should not be a source of anxiety; however, the earlier their child's teeth erupt, the greater the child's risk for ECC.[10]

Teething

Teething symptoms include fussiness, increased sucking behavior, and loose stools. Teething is a natural process and usually occurs with little or no problem; however, some infants may exhibit a low grade fever, diarrhea, gastrointestinal disturbances, increased salivation, and skin eruptions.[11] There is no evidence that teething causes fever and/or diarrhea. Temperatures higher than 38.1°C (100.6°F) are not associated with teething and should be evaluated for other causes.[12, 13] If signs or symptoms persist for more than 24 hours, parents should have a physician examine the infant to rule out upper respiratory infection, ear infections, or other common childhood conditions.

Symptomatic relief of teething discomfort includes sucking on cold teething rings or washcloths. Palliative care for teething includes increased fluid consumption and non-aspirin analgesics. Parents should be aware of the symptoms of the teething process, which can include fussiness, irritability, and sleeplessness; sore and tender gums when teeth begin to erupt; and/or increased drooling and chewing.

Visual examination

During a visual examination, the dentist can indicate oral anatomic landmarks (for example, the palate, alveolus, and frenulae attachments). Dentists can show parents the difference between the incisors and molars and the relationships that result in healthy occlusion. After the completion of the primary dentition (at approximately two years of age), the dentist and parent can discuss the purpose of the primary teeth as space maintainers for permanent teeth, the development of permanent teeth, and their position and timing. The dentist can also explain that maxillary permanent teeth develop facial/buccal to the primary teeth, while mandibular permanent teeth develop lingual to the primary teeth.


Figure 2

An important aspect of a good visual examination is the positioning of the patient and the child. The parent must feel comfortable and capable of visualizing the toothbrushing they will provide for their child. "Knee to knee" or "lift the lip" training for providers and parents is beneficial in providing for proper technique for both examining and brushing their child's teeth. Figure 2 show the ideal "knee to knee" position for an infant examination and oral hygiene training.

Home care and oral hygiene training

Parents are responsible for their children's oral hygiene practices and should receive guidance as to how and when to start brushing their infant's teeth. Parents should begin cleaning an infant's gums before the teeth erupt, using a moistened cloth or finger sponge. Positioning of the parent and child is an important component of oral hygiene. The parent should brush the child's teeth while sitting behind the child and supporting the child's head (Fig. 3). This position may require the parent to sit in a chair behind a standing child or sit on the floor with the child's head between and arms under the parent's legs.

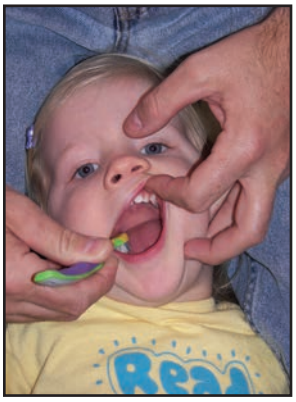


Figure 3

Brushing should focus on removing plaque and debris. Important areas of the teeth to brush include the junction between the gingiva and teeth and the pits and grooves of the molars. Toothbrushing should commence with the eruption of the first tooth. It has been shown that the earlier toothbrushing begins, the less likely children are to develop tooth decay.[14] Children should participate in the brushing routine at an early age, but parents should supervise tooth brushing at all times and brush the child's teeth themselves at least once a day until the child is approximately eight years of age. A personal analogy used to determine when a child is capable of brushing their own teeth is when they are able to write in cursive letters.

Motivational interviewing

Strategies for providing education and direction to parents about their oral health are changing from the traditional persuasion approach of health education to individualized interventions such as anticipatory guidance and motivational interviewing (MI). Motivational interviewing is a technique that may be used with parental counseling and guidance.

MI is a brief counseling approach that focuses on the skills one needs to motivate others and provides strategies to move patients from inaction to action.[15] MI has been used successfully for treating drug addiction, diabetes, diet behaviors, and medication compliance. Evidence for the effectiveness of MI for both physiological and psychological conditions resulted in treatment effects of reducing targeted behaviors from 50-75%.[16]

MI has been used to counsel parents and mothers of infants and children at high risk for dental caries.[17,18] The goal of an MI counseling session is to establish rapport with the parents and then provide and discuss options for infant oral health and caries preventive behavior. Parents receiving MI counseling in addition to traditional written and audio-visual education had infants with significantly lower levels of dental caries when compared to infants whose parents did not receive MI counseling.[19] MI focuses on open-ended questioning, affirmations, and the reinforcement of self-efficacy, reflective listening, and summarizing, all used in a direct manner.[20] Counselors encourage the parent(s) to talk and offer supportive listening without judgment, so as to help the parent identify the discrepancies between their current behavior and dental health for their child. The table displays dietary and non-dietary options for caries prevention.

Parental attitudes of infant oral health

Parents and families often face difficult challenges on a daily basis, especially families at high risk for ECC. Often, parents do not understand the link between their child's oral health and overall health, and some may not be aware of the risk factors and ramification of living with and treating ECC.[21] Parents play a critical role in their child's health but little is known about their ability to make behavior changes and affect the oral health care of their child.

The parent's readiness for behavioral changes has four stages: pre-contemplation, contemplation, preparation/action, and maintenance.[22] With ECC, parents may begin at the pre-contemplative stage where they are unaware of or in denial concerning ECC or the risk of ECC. During the contemplative stage, parents acknowledge the presence/risk of ECC but are ambivalent or may be considering the steps they want to take in addressing ECC. Next, the parent may take action by seeking treatment or preventive care or services. After taking action, the parent focuses on maintaining their child's oral health and avoiding recurrence.

Several factors can influence a family's ability to make changes to their preventive oral health practices; including cultural influences and the parent's own dental anxiety or fear.[23] Psychosocial factors that can influence parents' ability to engage in preventive health practices include poverty, stress, and depression. It has been documented that several maternal behavioral and psychosocial factors are associated with children's brushing practices at home and levels of ECC.[24, 25] According to the literature, parents with low oral health self-efficacy tend to have children with higher rates of dental caries.[26, 27] These states of parental readiness and self-efficacy appear to be modifiable and are a point where interventions may cultivate oral health preventive habits and reductions in ECC.

Menu of Options for Infant Oral Health
Clean your baby's teeth as soon as they appear.
Use a smear of fluoride toothpaste
Do not add anything sweet or sugary to bottle.
Wean child from the bottle; focus on night-time.
Hold baby when feeding
If baby wakens at night, give water
Limit sipping and snacking
Bring your baby to the dentist 2 times per year for fluoride varnish

Children and families should be targeted with professional interventions, including oral screenings, risk assessment, effective counseling/anticipatory guidance (including motivational interviewing), oral hygiene training, and effective preventive services, such as the professional application of fluoride varnish.

Summary/Conclusion

This article focuses on specific areas related to family oral health education, including oral health literacy, family/patient counseling, motivational interviewing versus traditional patient counseling and parental attitudes towards oral health. Summarized below are helpful areas for which dental providers can focus professional interventions to help increase the effectiveness of family oral health education:

• Oral Examinations with Knee to Knee



Northern Virginia Completes 9th M.O.M. Project

By: Dr. Peter Cocolis

On March 11 and 12, 2011, with the generous support of more than 220 Northern Virginia Dental Society members and their staffs, and over 250 community volunteers, our ninth Northern Virginia Mission of Mercy was a resounding success! Over the course of the two days 742 people were treated and over $268,000 worth of free dental treatment was rendered. Our volunteers amassed 2,610 hours over the weekend which can only be attributed to the caring and generous attitude of all our volunteers and organizations.

Jerry Prentice, a local business owner and representative of the Boy Scout Order of the Arrow, commented, "It is truly amazing to see this many people working together to achieve a goal. I have been part of many community service projects before, but never seen one achieve so much in so little time with so many volunteers from different areas." This statement says it all, without all the people, the help and the ideas, this project would not be a success. It is a success because of all those who participate. Thank you all who helped make this project a success! We're looking forward to our March 9 & 10, 2012 MOM Project!

- Risk assessment
- Effective anticipatory guidance with motivational interviewing
- Illustrative aides to oral hygiene training and healthy behaviors

References

1. Nowak AJ, Casamassimo PS. Using anticipatory guidance to provide early dental intervention. J Am Dent Assoc 1995;126(8):1156-1163.
2. Nowak AJ, Casamassimo PS. The dental home: A primary care oral health concept. J Am Dent Assoc 2002;133(1):93-98.
3. Nowak AJ. Oral health policies and clinical guidelines. Pediatr Dent 2007;29(2):138-139.
4. Hale KJ, American Academy of Pediatrics Section on Pediatric Dentistry. Oral health risk assessment timing and establishment of the dental home. Pediatrics 2003;111(5 Pt 1):1113-1116.
5. National Institute of Dental and Craniofacial Research, National Institute of Health, U.S. Public Health Service, Department of Health and Human Services. The invisible barrier: literacy and its relationship with oral health. A report of a workgroup sponsored by the National Institute of Dental and Craniofacial Research, National Institute of Health, U.S. Public Health Service, Department of Health and Human Services. J Public Health Dent 2005;65(3):174-182.
6. A national call to action to promote oral health. NIH Publication No. 03-5303. Rockville, MD.: U.S. Department of Health and Human Services;2003.
7. ADA House passes resolutions on oral health literacy (ADA resolution13H-2006). Available at: www.ada.org/prof/resources/pubs/adanews/adanewsarticle.asp?articleid=2236. Accessed March 30, 2008.
8. American Academy of Pediatric Dentistry. (2006). Guideline on infant oral health care. Reference Manual 2009-2010;31(6):95-99.
9. *Literacy and health outcomes*. Available at: http://www.ahrq.gov/clinic/epcsums/litsum.htm. Accessed December 16, 2007.
10. Mohan A, Morse DE, O'Sullivan DM, Tinanoff N. The relationship between bottle usage/content, age, and number of teeth with mutans streptococci colonization in 6-24-month-old children. Comm Dent Oral Epidemiol 1998;26(1):12-20.
11. Barlow BS, Kanellis MJ, Slayton RL Tooth eruption symptoms: A survey of parents and health professionals. ASDC J Dent Child 2002;69(2):148-150.
12. Macknin ML, Piedmonte M, Jacobs J, Skibinski C. Symptoms associated with infant teething: A prospective study. Pediatrics 2000;105(4 Pt 1):747-752.
13. Wake M, Hesketh K, Lucas J. Teething and tooth eruption in infants: A cohort study. Pediatrics 2000;106(6):1374-1379.
14. Creedon MI, O'Mullane DM. Factors affecting caries levels amongst 5-year-old children in County Kerry, Ireland. Community Dental Health 2001;18(2):72-78.
15. Britt E, Hudson SM, Blampied NM. Motivational interviewing in health settings: A review. Patient Educ Couns 2004;53(2):147-155.
16. Rubak S, Sandbaek A, Lauritzen T, Christensen B. Motivational interviewing: A systematic review and meta-analysis. Br J Gen Pract 2005;55(513):305-312.
17. Weinstein P, Harrison R, Benton T. Motivating parents to prevent caries in their young children: One-year findings. J Am Dent Assoc 2004;135(6):731-738.
18. Weinstein P, Harrison R, Benton T. Motivating mothers to prevent caries: Confirming the beneficial effect of counseling. J Am Dent Assoc 2006;137(6), 789-793.
19. Weinstein P. Motivate your dental patients: A workbook. Seattle: University of Washington;2002.
20. Harrison R, Benton T, Everson-Stewart S, Weinstein P. Effect of motivational interviewing on rates of early childhood caries: A randomized trial. Pediatr Dent 2007;29(1):16-22.
21. Schroth RJ, Brothwell DJ, Moffatt ME. Caregiver knowledge and attitudes of preschool oral health and early childhood caries (ECC). Int J Circumpolar Health 2007;66(2):153-167.
22. DiClemente CC, Velasquez MM. Motivational interviewing and the stages of change. *In:* Miller WR, Rollnick S, eds. Motivational interviewing: Preparing people to change addictive behavior. New York: The Guilford Press;1991:191-202.
23. Wong D, Perez-Spiess S, Julliard K. Attitudes of chinese parents toward the oral health of their children with caries: A qualitative study. Pediatr Dent 2005;27(6):505-512.
24. Finlayson TL, Siefert K, Ismail AI, Delva J, Sohn W. Reliability and validity of brief measures of oral health-related knowledge, fatalism, and self-efficacy in mothers of African American children. Pediatr Dent 2005;27(5):422-428.
25. Finlayson TL, Siefert K, Ismail AI, Sohn W. Maternal self-efficacy and 1-5-year-old children's brushing habits. Comm Dent Oral Epidemiol 2007;35(4), 272-281.
26. Reisine S, Litt M. Social and psychological theories and their use for dental practice. Int Dent J 1993;43(3 Suppl 1):279-287.
27. Litt MD, Reisine S, Tinanoff N. Multidimensional causal model of dental caries development in low-income preschool children. Public Health Rep 1995;110(5):607-617.

Community Dental Clinic Hits $3 Million Worth of Services Since 2006

Reprinted with Permission from the *Martinsville Bulletin*

Chad Flanagan (second from right), a 2003 Martinsville High School graduate who now is in the Virginia Commonwealth University dental school and an extern at the Community Dental Clinic in Martinsville, talks with Drs. Edward "Chopper" Snyder (from left) and Mark Crabtree, both of the Piedmont Virginia Dental Health Foundation, which operates the clinic. At far right, clinic dentist Dr. Risa Odum works on a patient. The clinic has provided $3 million worth of services in the past five years. (Bulletin photo by Mike Wray)

The Community Dental Clinic has provided more than $3 million worth of basic dental care services to local adults and children since it opened nearly five years ago.

The clinic on Fayette Street in Martinsville passed that milestone on Wednesday, according to Dr. Mark Crabtree, president of the Piedmont Virginia Dental Health Foundation, which operates the clinic.

The clinic staff, students and volunteer dentists have performed 15,091 diagnostic services, 7,599 preventive services, 6,643 fillings, 617 root canals and 6,217 extractions during 13,242 appointments since it opened in August 2006, it stated in a release.

That amounts to $3,003,103.04 worth of services — calculated on local market dental fees, according to Crabtree — that have been provided to unemployed and uninsured adults and children eligible for Medicaid benefits in the community.

With the commitment of Virginia Commonwealth University (VCU) and funding from The Harvest Foundation, the clinic has ramped up its service levels each year and now has achieved a return of $1 million per year of care being delivered to those in need, the release stated.

In addition to Harvest grants, the clinic generates Medicaid payments and receives fees and patient payments and co-payments based on their ability to pay, Crabtree said. The minimum payment is $20 per visit, regardless of the procedure performed, he added.

The clinic is operated by the Piedmont Virginia Dental Health Foundation and staffed by students — called externs — from the VCU School of Dentistry and School of Dental Hygiene and the Danville Community College Dental Hygiene program. Local dentists volunteer to supervise the students.

"We receive requests from organizations across the entire commonwealth for the School of Dentistry to provide students to help meet the profession's obligation to serve the oral health care needs of the public and we must weigh carefully our options for student placement in the community," said Dr. David Sarrett, dean of the Virginia Commonwealth School of Dentistry. "The Community Dental Clinic in Martinsville meets the goals for our students' learning by promoting civic engagement while addressing societal needs. For these reasons, this site is at the top of our list of community partners."

Kim Isringhausen, director of the Division of Dental Hygiene and Community-Based Education in the VCU School of Dentistry, said the relationship benefits local residents and dental students.

"Through our partnership with the Community Dental Clinic, students are provided the opportunity to develop professional and community relationships that have enormous influence in shaping their attitudes, clinical skills and self-confidence. In turn, oral health care is accessible in a community where timely and necessary care may otherwise not be available," Isringhausen said.

Dr. Risa Odum, staff dentist at the Community Dental Clinic, stated: "The dental externs give us the ability to help many more people than we could in a traditional dental office setting."

"The demand for dental services at the community dental clinic remains very high," said Crabtree. "We deeply appreciate VCU's continuing commitment to our clinic and to everyone who had a part in helping us to achieve this level of service to our community."

The need for the clinic's services has increased as the area's unemployment rate has risen and remained high, he said.

At one point the waiting list for clinic services was down to six months, Crabtree said, but he was not sure where it stands now. Emergency cases are handled quicker, he added.

Seventy-five percent of the area's dentists volunteer at the clinic. They are: Drs. Charles E. Ayers, Crabtree, Craig B. Dietrich, Gregory T. Gendron, Charles W. Jenkins, Michael L. Jones, David C. Jones, James A. Jordan, Michael E. Lavinder, Raymond F. Mallinak, J. Peyton Moore Jr., James K. Muehleck, John W. Rhoday, James W. Shearer, Edward "Chopper" Snyder, George A. Stermer Jr., Denise J. Unterbrink, James L. Wilson, Fred B. Caffey, Laura R. Mallinak, Emily Mallinak, Walcey C. Burris III, Marvin Perdue and Ruff Wheless.

Snyder praised their efforts.

"This level of success is made possible by the volunteer efforts of the local dental community. Our local dentists are a group of dedicated professionals who continue to give generously of their time supervising externs," he said.

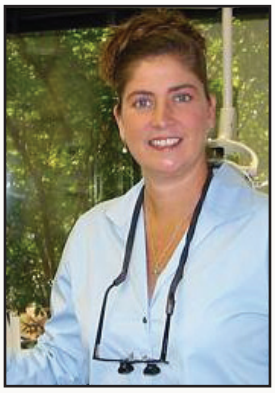
VCU School of Dentistry has appointed local dentists as well as Dr. Susan O'Conner from Galax, Dr. Rudy Wolf of Bedford and Dr. Fawzia Bhavngri of Roanoke to serve as faculty adjunct clinical instructors.

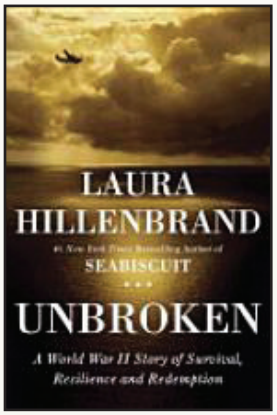
"Dr. Mark Crabtree has done an amazing job with this clinic. He has had many reason to give up on the project along the way - but, he never did. His persistence in his mission and goals for the community define him as a leader in the access to care movement. This isn't the "final" answer, but certainly is a significant part of the solution. He and the community of dentists who support this mission are to be commended by all of us."

- Dr. Terry Dickinson, Executive Director, Virginia Dental Association

Extraoral

By: Dr. Elizabeth M. Wilson





Unbroken-A World War II Story of Survival, Resilience, and Redemption

By:Laura Hillenbrand

ISBN- 978-1400064168, $27.00
Publisher: Random House (2010)

Every patient I have mentioned this book to this morning has grabbed my hand, and said, "Isn't it wonderful?" or something similar. I haven't come across a book like this in a good while – what's called "a sleeper" in the movies. A lot of people I know are reading it. I suggested it to my Dad; he was already reading it. Same for my VMI grad brother and many others. I found it through a recommendation myself (friend and classmate). You have to respect that kind of word of mouth. Plus, it's written by Laura Hillenbrand who wrote *Seabiscuit. Seabiscuit* is universally loved, right? Well, she could have just called this one *Louie*. Once you read this book, you'll have so much compassion, respect, and love for Louie and all our men in uniform.

His full name is Louis Zamperini. His family is Italian- American and struggling to get by in California during the Depression. What sets Louis apart from many others of his time, is that Louis can run, fast, so fast he winds up at the 1936 Olympics in Germany. Here, the story really begins as Louis' life as an adult unfolds. We are aware war is looming, but Louis' fate remains a mystery.

Louis eventually winds up enlisting in the military. His testing and acuity place him as an airman. Although loved by the ladies, this is a most dangerous assignment during the war, certainly because of the risk of war, but mostly because of the risk of an accident.
As an airman in the Pacific, he becomes simply Zamp. His family now includes his fellow airmen and their extended families. What begins as an easy transition into adulthood, however, soon morphs into the ultimate test for Zamp and his fellow crew.

A rescue mission gone awry; circling sharks, unending ocean, all are early trials for Zamp who has no idea what real, danger lay far ahead, outside of the ocean.

Truly this story is yet an additional glimpse into this rare generation of men – known as the "Greatest Generation".

Grab a copy of *Unbroken*; you won't want to miss it. Ask some of your patients, and see if they've been touched by Louis' story too.

We owe all of our servicemen our gratitude. As I write this on Memorial Day, I am glad to be able to express mine. To all our men and women in uniform: Thank You!

Editor's Note: *Dr. Elizabeth Wilson has been a practicing dentist in Richmond since 2001. She is a delegate to the VDA, a member of the Board of Directors for the Richmond Dental Society and is adjunct faculty at the VCU School of Dentistry. Email her at e.wilson45@verizon.net.*

The Debate on the Opening of New Dental Schools

By: David C. Sarrett, D.M.D., M.S., Dean - VCU School of Dentistry

There are currently 58 dental schools in the US that graduate approximately 4200 new dentists per year. In the early 1980s, the number of new dental graduates per year was nearly 6000. This high number of graduates was artificially created by federal grants to increase enrollment in dental schools and to open new dental schools. Soon dentists complained they were not busy and a dental career did not look as promising financially as it once had. As the grants ran out and the applicant pool began to wane, dental school enrollment declined due to reductions in class size and closures of schools. All dental schools that closed were private schools. The year 2000 was an inflection point as the last school closed and the first new school announced its opening. This new school is in Ft. Lauderdale, Florida at Nova Southeastern University and was the first dental school ever to be associated with an osteopathic medical school. Of note, it is also a private university.

Since 2000, twenty new dental schools have either opened, announced they were opening in the next few years, or are under serious consideration. Existing dental schools have also begun to increase their enrollments. First, this is in response to concerns there is an insufficient number of dentists. Second, there is a concern the impending retirement of dentists (who graduated in the days of over 8000 graduates per year) will only worsen the perceived shortage. Assuming that all of these proposed schools open and the existing schools increase enrollment, it is estimated there will be an increase of 1200 to 1600 additional graduates per year. In the dental education community there is heated debate as to whether or not we actually need this increase in dental graduates and what the affect will be upon the profession. The new schools promote their intention to follow a "new model" of dental education that is community-based. Some have stated they may not even have a home-based clinical facility, the norm among traditional dental schools. Sadly, the US does not have a health care workforce strategy and neither does the dental profession. The opening of new dental schools and increased enrollments are driven mostly by anecdotal experiences in local areas under the rubric of increasing access to care to underserved populations. These are not evidence-based decisions and are unlikely to solve the access issues.

What are the issues being debated by the dental education community? They fall into two categories. First, will increasing the number of dentists help remedy the access to care problem? Second, will we be producing scientifically oriented practitioners who are prepared to manage the increasing complexity of the patients they will face?

There is disagreement on whether adding additional dentists will improve access to oral health care – for those who do not visit a dentist regularly. It would seem logical that if we had more dentists, some would choose to practice in underserved areas simply because of supply and demand. Experts who discuss this issue separate the need for dental care in a population from the demand for dental care in a population. In general, need is greater than demand and dentists set up practice in areas of high demand for dental care. The key to improving access is to increase the demand for dental care in populations with high need for dental care. Increasing demand is generally thought to happen if there are increased means to pay for the care. Many argue that there are plenty of dentists, but they are not distributed according to the need for care. Thus, if a solution is found to increase the demand for dental care in areas of need for dental care, dentists will migrate toward those new areas of demand.

Student debt is an important factor that determines where new graduates choose to practice. The average educational debt of dental graduates is around $200,000. This fact alone drives new dentists to practice in high demand areas so they can earn enough to pay back their student loans. Programs that assist new dentists with repaying their student loans are effective in attracting practitioners to practice in areas of need. Maintaining dentists in such areas long-term will be determined by the inherent demand for dental care. Thus, communities that would like to increase the number of dentists should work to develop programs to increase the demand for dental care (to keep dentists in the area) and provide student loan repayment incentives (to initially attract dentists to the area). It is agreed that loan repayment is more effective than scholarships in attracting new dentists to a particular area. Students who enter dental school with the goal to practice in a certain geographic area often find their plans change due to other life events and opportunities. Thus, scholarship programs that require a return to service upon graduation often result in students choosing to repay their scholarships, including penalties, rather than honoring the service obligation.

There is debate on the impact of the proposed new dental schools on the preparation of new dentists for future dental practice. Some of the leaders of existing dental schools are expressing concern that a rapid rise in the number of dental schools could lead to lower quality education. They contend there are in- sufficient numbers of qualified dental faculty members to fully staff the existing dental schools, let alone new ones. Another criticism: the majority of the proposed new schools are not associated with research intensive universities and this will result in programs that lack scientific rigor. A few voices are calling for a "new Gies Report" to examine the status of dental education. The Gies Report, Dental Education in the United States and Canada, was published in 1926 and reported on research funded by the Carnegie Foundation for the Advancement of Teaching. The Gies Report created the vision that dental education must be based on scientific foundations and be provided as a higher education health profession. The report made a clear distinction between dental education provided by institutions of higher education compared with proprietary schools or preceptorships. Another concern is the declining emphasis on biomedical sciences in the dental curriculum. This seems counterintuitive to the increasing medical complexity of dental patients, particularly the elderly and children.

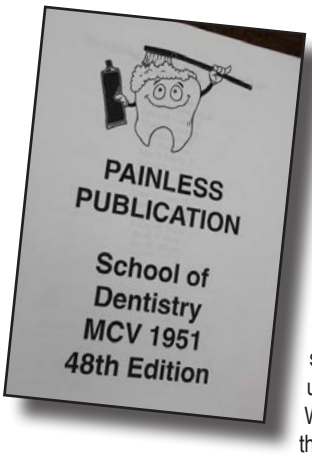
The proponents of the new dental schools argue that a new type of dental graduate is needed, one who will be interested in public service. They report placing more emphasis on the applicant's service profile than existing dental schools with the desired outcome being graduates who will seek employment in community clinics. These new schools are organizing with fewer departments and with less emphasis on the specialty areas of dentistry. The new schools also tend to have fewer administrators and a higher dependence on part-time faculty members. Despite these new schools having tuition and fees above many existing dental schools, the leaders of these schools are not concerned with having sufficient dental applicants. They point to a strong national dental applicant pool as being able to sustain the admissions to new schools. It will be interesting to follow what happens over the next few years, but it is clear that more dental schools will open. Let's hope we do not create a bubble, as happened in the 1980s.

Gies Report can be found at:
http://www.adeagiesfoundation.org/about/Pages/AboutWilliamJGiesandtheGiesReport.aspx

Reunited: Class of ’51 shares a common bond

By: Heather Brooks, VCU School of Dentistry, Class of 2012

There are many things in dental school that bring members of each dental class together, and it all begins in our first days of Gross Anatomy and learning to carve teeth in Dental Anatomy. We make life-long friends, some find spouses, children are born, and many other changes begin in our days at dental school. Each class has these experiences in common, but one class shared an added bond: every student in the DDS Class of 1951 from the Medical College of Virginia, School of Dentistry, was a military veteran, having served in World War II. During this year’s alumni reunion, a military tribute was organized by the students and faculty of VCU School of dentistry with prior or future military commitments, honoring the DDS Class of 1951 for their service to dentistry and to their country.



As the alumni and widows of alumni arrived at the Dental School on April 16th, they quickly became reacquainted with old friends, talking of current and old times. The day began with a tour of the Tompkins-McCaw Library where the alumni, their widows, and families had the opportunity to see antique dental equipment in the dental museum and all 60 years of the *Painless Publication*, a collection of letters, poems, and announcements written and distributed to each member of the class. Each year one student would act as editor, and the duty shifted from student to student, moving on down the alphabet, until every dentist had served as editor for a year. When each class member had served for one year, they started the tradition over and continued until this year, 2011, which marks the 60th and last edition of the *Painless Publication*. These journals have been added to the archives at the Tompkins-McCaw Library and are available for viewing.

The Tribute Ceremony to the Medical College of Virginia, School of Dentistry’s Class of ’51 was then welcomed by Dr. Fred Certosimo who introduced speakers Jodi Koste, Dr. Jim Burns and Dr. David Sarrett. Jodi Koste, archivist at the Library, led the tour and gave each alumnus a copy of selected letters to the editor that had been written over the last sixty years. Dr. Jim Burns and Dr. David Sarrett welcomed the twenty-one esteemed guests, updated the alumni on the advances of dental school, and reminded them of what times were like 60 years ago. Upon entering dental school, the 48 students immediately were administered tests, including chalk carvings, that would later make up the perceptual ability portion of the Dental Aptitude Test (DAT). The school didn’t have an elevator back then – students had to carry their lab instruments up a flight of stairs.

Dr. Tom Koertge flew in days before the event and presented to the Class of ‘51 an American flag that was flown on three different aircraft in Afghanistan (where he served). The flag will remain at VCU School of Dentistry for use in future military promotion ceremonies and other events. Additionally, a commemorative coin was minted to celebrate this event and given to each alumnus and family member. Dr. Bob Bigelow played “Taps” during the ceremony to honor those veterans who have passed away. As the ceremony ended, the honored guests gathered at the entrance of the Crockett Lounge, for the unveiling of a plaque. The commemorative plaque includes symbols of each of the armed services and photos of each of the alumni during dental school. Additionally, the plaque details their unique experiences in World War II and describes the Painless Publication for future generations.

Dr. Tom Koertge

This ceremony was held to honor a special class: a simple “thank you” from future generations to the nine living veterans of war and dentistry and their families. Their commitment to country and endurance to maintain contact with one another over sixty years is inspiring. May we all have the blessing of growing old, seeing the fruits of our labor, seeing the differences we have made, and seeing ourselves in younger generations who exhibit the same excitement for life and dentistry that we had during our first days in dental school.

Class of ‘51 alumni and guests

A three-month deployment to Iraq

By: Dr. Howard Baranker

(L) Saddam Hussein, (R) Dr. Baranker

I was deployed to Iraq from January to April 2009. This was my second mobilization, the first being to Ft. Eustis in 2003. It seems the Army has improved the process quite a bit since then as I had six days notice in 2003; this time I was notified more than three months in advance. There is a unit at the Army's Reserve Center dedicated to helping soldiers mobilize with ninety days' notice, so there was a lot of support.

As one would expect the toughest part was preparing everything at home for my absence. I have my own dental practice with no partners. I was fortunate to find two retired dentists to work in my office three days per week which was good enough to keep things going. I had to teach my wife all that I had learned in twenty years of running a small business in three months. The amount of paperwork it takes is mind boggling. Again I am fortunate to have such a wonderful spouse as she worked very hard to learn it all and did a great job.

January 3 was the tearful goodbye to my wife and daughter, and then I was off to Ft. Benning, Georgia. I was there for a week; I met the other dentists who were part of my ninety day rotation to Iraq. We were part of the 360th Medical Company, a dental unit from Ohio. At the Ft. Benning center about 400 people are trained and flown out every week to places all over the world. Most went to Iraq. More than half going through the center are civilian contractors. We did receive some training in things like IED (improvised explosive device) awareness and weapons qualification. Also at Ft. Benning I was issued four duffel bags loaded with equipment including 40 pounds of body armor, four different cold weather systems, and my weapon. I never used the vast majority of the stuff I was issued but it sure was fun dragging it half way around the world!

After Ft. Benning the next stop was Camp Buehring in Kuwait. Kuwait is the transit point for everyone deploying to Iraq and Afghanistan . The facilities are primitive, there are no trees or water, and after a few days there I was very anxious to get to Iraq so I would finally be settled somewhere. In Kuwait there are briefings about Iraq and "roll over" training while waiting for a flight going north.

On January 14 I finally arrived in Mosul, Iraq. I was assigned to FOB (Forward Operating Base) Diamondback, a relatively small post. In Kuwait I was told that Mosul was the last strong hold of Al-Qaeda in Iraq and accounted for 70% of the IEDs and 100% of the suicide bombings in Iraq. Diamondback is unique in that it's right in the city. People's homes and city buildings are just beyond the gate.

At the clinic were two dentists. My partner was a Major Hall from California. There were also two dental techs and a sergeant in charge of enlisted personnel. Again I lucked out. The five of us got along very well, were committed to the mission of taking care of the soldiers and worked extremely well together as a team. The sergeant ran the clinic, and the rest of us only had to worry about treating patients - as it should be! We stayed very busy working six days per week. Most of our patients were US soldiers but we also saw a large number of contractors both American and from many different countries. We did not see any Iraqis, though. This is US policy so they don't become dependent on us. Also, it is a security risk. The clinic was in fairly good condition, so we could do just about anything. Supplies were an issue as we were an "outlying" FOB at the end of the supply chain.

The accommodations at Diamondback were good. We lived in Containerized Housing Units (CHUs) with hot showers and clean flush toilets. The food was so good I gained about ten pounds in the first few weeks until I learned to pace myself at the dining hall. There was a gym but it was usually crowded so I usually ran on the streets. Recreational facilities were reasonable; occasionally a movie was shown. Internet connections were available in the CHUs for a fee. The weather was very good that time of year. Mosul, near the border with Turkey, is cooler and wetter than the rest of Iraq.

For security reasons only personnel on a specific mission are allowed outside the compound. Inside the "wire" in our little cocoon I always felt very safe and things were usually peaceful. Every now and then however we had a reminder that there was a war going on. Being so close to the city one would routinely hear explosions. Car bombs are the favored weapon of the enemy, and small arms fire is constant. Sometimes the booms would be close enough for the buildings to shake. Soon the word would get out on how "effective" the attack was. During my deployment we had 11 killed from our community. One was killed in a rocket attack on the FOB, a rare occurrence but worrisome because of our proximity to the city and the complete randomness of its victims.

After a few months I was starting to get tired of the same routine and feeling a bit caged up since it was forbidden to go outside. I had the good fortune of being invited to a Dental conference in Baghdad for a week. Traveling in country was quite an experience and it was a great morale boost to see another place and to meet the other dentists in Iraq to trade experiences with and learn from.

In mid-April the replacement dentists arrived and the process was reversed: first, to Kuwait to await transport back to Ft. Benning and then home.

Overall, it was a very positive experience. I saw some interesting sights, met some incredible people and came home with a very satisfying feeling of having contributed to the successful completion of the Army's mission in Iraq.

Editor's Note: Dr. Howard Baranker is a VDA member and practices in Sutherland.

Serving the Best and Bravest

By: Dr. Leonard V. Jackson

(L) Gen. David Petraeus, (R) Dr. Jackson

In June 2006, I was called by the Office of the Surgeon General to notify me that my name was on the list for deployment to Iraq within the year. He asked me if I would think at what time of the year I'd want to be deployed. I returned the call and received my request for fall of 2007. This would be my 2nd deployment. I served in Southeast Asia during the Viet Nam conflict. At the time of the phone call, I was a retired dentist, playing golf, travelling and spending time with my family.

I left my home October 24, 2007, to travel to Fort Benning, Georgia, for training. I reported to the CRC (Conus Replacement Center) at Fort Benning filled with anticipation and excitement. My roommate was a good friend, Dr. William Hunt of Newport News. We were members of the same unit in Richmond, the 7202nd Medical Service Unit. At the Center we received training for various types of IEDs (improvised explosive devices), weapons and weapons qualification. We were there about a week. The most surprising thing at the Center was that there were as many male and female civilian contractors going through military training as the soldiers. We boarded the plane at Fort Benning, for Kuwait. We had a stopover in Leipzig, Germany for refueling.

We arrived in Kuwait on the morning of November 1, and were sent to Camp Buehring, a desolate area where sand and tents were plentiful. There I met my fellow dentists going onward to Iraq. All dentists in the tent were now members of the 307th Medical Company, from California. In our tent there were beds which could sleep up to 16 soldiers. There were quite a few of us, most were dentists, some were neurosurgeons, and others were orthopedic surgeons and general practice physicians. No females. We were Iraq-bound. We received additional training and our duty assignments at Camp Buehring before going forward to Iraq. We flew to Iraq on a C-130 cargo plane. The trip lasted approximately 90 minutes, landing at Baghdad International Airport.

I spent three days with Bill Hunt as he assumed his Officer-in-Charge duties at Camp Liberty's dental clinic. I flew on a Black Hawk helicopter with my three duffel bags. The duffel bags contained MOPP (Mission-Oriented Protective Posture) gear, additional uniforms and some personal items. The helicopter had mounted machine guns, in the event of an attack. Black Hawks always flew in pairs. We landed and I was quickly taken to my duty station, FOB (forward operating base) IBN Sina Hospital in the IZ (International Zone), commonly known as the "Green Zone." IBN Sina Hospital a former Ba'athist hospital was the subject of an HBO documentary several years ago, called, "Baghdad ER." The hospital had bright marble walls and flooring, an automatic door opener and impressive staircases. The latrines were unisex. Both sexes used the latrines at the same time, using different stalls. The dental clinic was on the first floor, next to the ER. It had a large waiting area with huge benches. The clinic itself had three dental operatories, digital x-ray room and a storage area where an incredible amount of equipment and supplies were kept.

There were two dental commands in the clinic: the 307th, which I was in charge of, and the 86th CSH (Combat Support Hospital), headed by Dr. Sam Johnson, whom I knew from Fort Jackson, South Carolina. We worked very well together. We were already good buddies and the relationship continues to grow even today. We graduated from dental school the same year and share similar interests.

Sometime during the Thanksgiving holiday, IBN Sina Hospital and the surrounding area received mortars from a faction of Al-Qaeda. Sam and I were on the way back from the PX (Post Exchange) when all hell broke out. We spent a considerable length of time in a concrete bunker. When we returned to the hospital, we discovered that the hospital suffered some damage, but no one was hurt.

During a typical day in the clinic, Sam and I treated approximately 40 patients. We performed operative, oral surgery and emergency care. The clinic was open from 8:00 a.m. to 6:00 p.m., Monday through Friday and 8:00 to 1:00 on Saturday and on Sundays by appointment only. The appointments were for Iraqi dignitaries and those involved with counterespionage. Our weapons, which we carried everywhere, had to be checked each morning before 7:30 a.m. by the dental clinic's sergeant in charge, Staff Sergeant Stevie McCall, for accountability purposes. Sam and I had dental techs who assisted us.

Our patients were: U.S. Army, Air Force, Marines personnel, multinational forces, embassy staff, state department personnel, civilian contractors, Iraqi government officials, Iraqi military personnel and Iraqi civilians. Many of the multinational forces personnel could not speak English which made treating them a little difficult. I spoke just enough Hindi, Swahili, and Spanish to get them to relax and point to the areas of concern in the mouth with their fingers. I spoke some Arabic to the Iraqi people: thanks to Dr. Shaman Al-Anezi for tutoring me before I deployed!

I was fortunate to have a picture taken with General Petraeus during his visit to one of Saddam Hussein's palaces. I also was photographed with Ryan Crocker, former ambassador to Iraq and have a picture of Condoleezza Rice, during her visit during the Christmas holidays. I also had the pleasure of meeting with my Congressman, J. Randy Forbes (VA-R, 4th District) who was visiting Iraq and Lieutenant General Eric Schoomaker, the Surgeon General of the United Army and Commanding General, United States Medical Command.

It was the end of January 2008 and nearing the end of my tour and soon be returning home. I met up with Bill Hunt at Camp Liberty after I rode on the" Rhino" (armored bus with a military police escort). I had to ride the Rhino due to poor flying conditions for Black Hawks. We returned to the Replacement Center at Ft. Benning, Georgia, just before the Super Bowl, February, 2008. On the flight to Ft. Benning, we had stopovers in Budapest, Hungary and McGuire AFB, New Jersey. We turned in our gear, including our weapons. We were debriefed and given a physical examination and allowed to return home to our families and love ones.

My experience in Iraq is one which will be forever remembered. It had and still has a profound effect on me since I was in the company of some of the best and bravest war fighters and people in the world. I am honored to have served with them. Some of the soldiers I treated in the dental clinic one day, and I would see them being treated in the ER for life threatening wounds the next. As a member of the Army and a dentist, I am proud to have been able to contribute to the overall mission in Iraq.

Editor's Note: Dr. Leonard Jackson is a VDA member and practices in Richmond.

ENTERPRISE: WE ARE LEGEND!

By: Captain Steven R. Clarke, D.D.S.

L-R: Captain Steven R. Clarke, Aviation Electronics Technician First Class (AT1) Fred Gilliam, Jr. Fred works in Quality Assurance (QA) as part of the VAW-123 Screwtop squadron. He is the son of VDA staffer Linda Gilliam and brother of managing editor Shannon Jacobs

Have you noticed this practice advertisement in your professional journal?

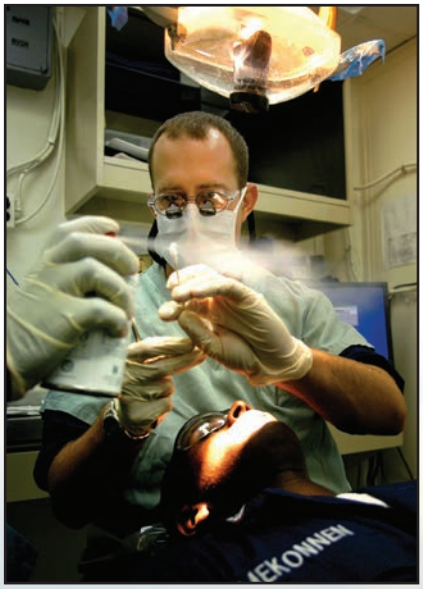
Large Group Practice: Looking for an energetic, mission oriented practitioner for an expanding group practice with a Global Force for Good. A challenging world-wide setting, with 5000+ full-time patients. Dynamic and well trained office staff including hygienist and onsite dental prosthetic laboratory. Six state of the art dental operatories wired for digital and panoral radiography. NO OVERHEAD OR CASH FLOW ISSUES! Group profit over $1,000,000 during the previous 12 months. Must be willing to travel on a legendary mobile dental unit longer than three football fields. Gas mileage not a concern! Income commensurate with experience. Substantial benefits package and retirement plan. Fully funded continuing educational opportunities available each year and selection for advanced dental education programs based on performance. INTERESTED? CALL 1-800-USA-NAVY!

The USS ENTERPRISE (CVN-65) is the eighth ship to bear this historic name, as well as the first nuclear-powered aircraft carrier, and next to USS Constitution, the oldest active commissioned ship in the Navy. She is also the world's largest active warship. Commissioned Nov. 25, 1961, Enterprise was originally designed for a twenty-five year service life, but due to maintenance and upkeep, Enterprise has served for nearly fifty years and has been engaged in every major combat operation over the past five decades. It is estimated that two hundred and fifty thousand Sailors have served aboard Enterprise. Affectionately known as "The Big E", she is a robust one thousand, one hundred and twenty-three feet in length, displaces ninety-four thousand long tons (over two hundred million pounds), and is powered by eight nuclear reactors. From her first deployment in support of the Cuban Missile Crisis through her current twenty-first deployment, ENTERPRISE has met every challenge.

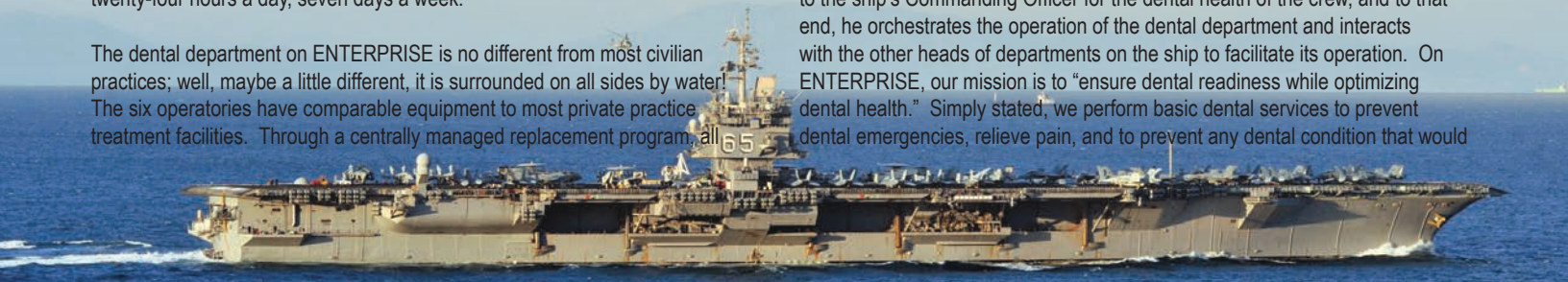
ENTERPRISE is a floating city, with all the professional services needed to sustain a community; "mechanics" to keep the "wheels" turning, food services preparing more than twenty thousand meals each day, a full service laundry, medical, a security force, a post office, a daily newspaper, a TV station with satellite links, religious ministries providing over twenty observances each day, storekeepers with massive storage areas, and a fully functional airport with fuel storage facilities. There are no normal working hours; ENTERPRISE operates twenty-four hours a day, seven days a week.

The dental department on ENTERPRISE is no different from most civilian practices; well, maybe a little different, it is surrounded on all sides by water! The six operatories have comparable equipment to most private practice treatment facilities. Through a centrally managed replacement program, all major equipment items are replaced at the end of their recommended service life, usually every five to ten years. Due to the demanding conditions of the shipboard environment; temperature fluctuations, high humidity, vacillating power supply, and constant use, this replacement process ensures state of the art upgrades are available. Digital radiography is the standard, for both intra-oral and panoral radiograph units, and employs a central data storage server to share images in the six functional operatories. Our central sterilization room processes more than one hundred and fifty items per day to ensure optimal patient safety and infection control. Do you have a full service dental prosthetic laboratory in your practice? ENTERPRISE does, and has the ability to fabricate most prosthetic restorations and appliances. The greatest challenge is space. Unable to simply knock out a wall, add an addition, or move to a new location, all equipment upgrades must be retrofitted into the original existing spaces, utilizing existing plumbing and electrical supply. It's similar to refurbishing your 1961 hot rod using 2011 parts!

Staffed by a dedicated team of seventeen officers and enlisted personnel, the members of this organization are composed of a diverse blend of several different training programs and military experience. The enlisted personnel (the "dental Corpsman") are assigned for a period of two to three years. Junior enlisted personnel have completed recruit training (boot camp), basic Corps school (the entry corpsman training program), and a six week dental orientation program (basic dental training). Some may also have served at a previous duty stations before reporting to the ship. The more senior enlisted "dental Corpsmen" have a wide range of training and experience, and include an expanded functions technician trained in advanced chair side assisting; prosthetic laboratory technicians; a dental hygienist (yes only one for five thousand active patients); an operating room surgical technician; and a Chief Petty Officer who coordinates the daily operation of the department (our office manager). The dental officers assigned consist of three general dentists, a comprehensive dentist (a hybrid with advanced training in general dentistry), and an oral and maxillofacial surgeon. The senior dental officer is known as the Head of Department (HOD). He is responsible to the ship's Commanding Officer for the dental health of the crew, and to that end, he orchestrates the operation of the dental department and interacts with the other heads of departments on the ship to facilitate its operation. On ENTERPRISE, our mission is to "ensure dental readiness while optimizing dental health." Simply stated, we perform basic dental services to prevent dental emergencies, relieve pain, and to prevent any dental condition that would



Lt. Matthew Conquest, of Flushing, Mich., prepares to perform a pulp test on a patient in the Dental department aboard the nuclear-powered aircraft USS Enterprise (CVN 65). U.S. Navy photo by Mass Communication Specialist Seaman Nowie Solis



Jan. 31, 2011: The aircraft carrier USS Enterprise (CVN 65) transits the Strait of Gibraltar. Enterprise is deployed as part of the Enterprise Carrier Strike Group supporting maritime security operations and theater security cooperation efforts in the U.S. 5th and 6th Fleet areas of responsibility.
(U.S. Navy photo by Mass Communication Specialist Seaman Jared M. King

Lt. Cmdr. Michael Booth and Hospital Corpsman 2nd Class Quincy George perform oral surgery to remove wisdom teeth from a patient in the dental office aboard the nuclear-powered aircraft carrier USS Enterprise (CVN 65). U.S. Navy Photo by Mass Communication Specialist 3rd Class McKinley Cartwright

restrict a crewmember from accomplishing their assigned tasks onboard. Once these basic dental needs are met, the focus shifts to treatment of all other dental requirements.

Sounds pretty similar to any civilian group practice, right? The dentistry, yes! "Drilling and filling" and basic oral surgery procedures are no different, but, there are some interesting and challenging distinctions. How would your practice function if you changed the office staff completely (including dentists) every two to three years. Do you cross train your personnel to function in every position? Can your hygienist run your front desk? There are no temp services or quick hiring capabilities here. This constant turnover requires a robust orientation and training program to ensure new personnel are familiar with their duties and responsibilities. That training program is our responsibility. Not only change your staff every two to three years, but rotate those five thousand patients during that same period, all with new dental needs. "Our cup runneth over" with patient treatment needs. Do you have a systematic quality assurance program that evaluates patient treatment every three months? Our peer system routinely reviews a percentage of patient records for accuracy and appropriate treatment and incorporates that analysis into the providers credentials file. Who performs your building maintenance? That's our job too, as well as, maintaining the fire fighting stations and the watertight doors to prevent flooding. When was the last time you forecast and stocked all needed dental equipment, materials, repair parts, and supplies to provide patient care for the next six months? Again, another of the department staff's duties! In your community, if there is a significant catastrophe with a large number of casualties, does your practice respond? Ours does, manning shipboard treatment facilities, operating the blood bank, and augmenting the ship's surgical capacity.

There's one more additional duty the dental department is tasked to perform on ENTERPRISE and that mission is the liberty mission; to be a positive representative for the United States when visiting ports of call both overseas and at home. When was the last time you had an all expense paid trip to Portugal, Turkey, Bahrain, Greece, or Spain? Have you seen a night launch of the Navy's hottest fighter aircraft; crossed the equator and become a coveted "shellback"; or sailed through the Red Sea and Suez Canal? There is no question, these young men and women excel at this mission, and have some fun at the same time.

So as you can see, dentistry is only a portion of what the dental department on ENTERPRISE does every day. The ship has a motto: WE ARE LEGEND! Enough said.

"Shellbacks"

More than 3,600 Sailors aboard deployed aircraft carrier USS Enterprise (CVN 65) went from being a pollywog to becoming a Shellback, June 22, 2011.

For centuries ships' crews have been tested by more seasoned Sailors to ensure they are seaworthy. The Navy traditionally conducts the ceremony after crossing the equator or 'line,' a tradition dating back to the Middle Ages.

King Neptune, the mythical god of the sea, detects an infestation of 'pollywogs' and deems it necessary to take control of the ship to rid it of this plagued condition. King Neptune is represented by the most senior Shellback aboard, usually a senior officer or chief petty officer who became a Shellback decades earlier.

Enterprise's Dental Officer, Capt. Steven R. Clarke, became a Shellback at the age of 58, after serving 37 years in the military.

"It was fun! My dad was a shellback and now I am a shellback. It was another chance my dad did that I've now done," said Clarke, whose father crossed the equator on USS Ranger (CV 4). "Additionally, it was great to become Shellbacks with the Dental Department. We're used to working together as a team, but this time we had the opportunity to have fun as a team."

U.S. Navy photo by Mass Communication Specialist Seaman Alex R. Forster

To learn more about the USS ENTERPRISE (CVN-65) go to http://www.enterprise.navy.mil/. The ENTERPRISE arrived home on Friday, July 15, 2011 from their six month deployment supporting maritime security operations and theater security cooperation efforts in the U.S. 5th and 6th Fleet areas of responsibility.

Editor's Note: Captain Clarke is a 1984 graduate of VCU-MCV School of Dentistry. He began his military career in 1974 as a Marine Corps officer and upon graduation from dental school accepted a commission in the Navy Dental Corps. He has served as the Dental Department Head on USS ENTERPRISE (CVN-65) for the past three years. He leaves active duty in October 2011, retiring after completing more than 37 years of military service. Dr. Clarke is an ADA member (Federal Dental Services).

Dentistry for individuals with disabilities

By: H. Barry Waldman, DDS, MPH, PhD, Distinguished Teaching Professor Department of General Dentistry, Stony Brook University, NY
& Steven P. Perlman, DDS, MScD, Clinical Professor Pediatric Dentistry, The Boston University School of Dental Medicine Private practice pediatric dentistry Lynn, MA

Abstract

There are more than 818,000 individuals with disabilities in Virginia, 54 million in the United States and more than a half billion throughout the world who will survive and be in need of health care (including dental services). The issues related to the care of individuals with disabilities increasingly will impact on the economic and social realities throughout the world as increased numbers of these individuals continue to survive; in particular, individuals with developmental disabilities and the burgeoning geriatric populations. Despite formidable obstacles, the fact is that many dentists do provide needed care to many of these patients. Nevertheless, need is to expand the preparation of future dentists and augment the abilities of current practitioners.

Key words: Disabilities, special needs, dental education, continuing education

Background

There are more than a half of a billion people in the world who are disabled as a consequence of mental, physical and/or sensory impairments. (1) Disability is an umbrella term, covering impairments, activity limitations, and participation restrictions that is used regarding individuals with "special needs". For example, the World Health Organization (WHO) refers to an "…impairment as a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individuals in involvement life situations." (2) Thus a disability is a complex phenomenon reflecting an interaction between features of a person's body and features of the society in which he or she lives.

The issues related to the care of individuals with disabilities increasingly will impact on the economic and social realities throughout the world as increased numbers of individuals with disabilities continue to survive; in particular, individuals with developmental disabilities and the burgeoning geriatric populations.

In the United States

"Did you know? Of the 69.6 million families in the United States, more than 20 million families have at least one family member with a disability." (3)

There are more than 54 million residents of the US with disabilities – 32.5 million with a severe disability – totaling 18 percent of the population. Individuals are represented in all age groups, including four million children ages 6-14 years with disabilities and 72 percent of individuals 80 years and older. (4) Within the next two decades one-in-five residents of the country (in six states, one-in-four) will be sixty-five years of age and over with associated high rates of disabilities. (5)

In Virginia

In 2008, 818,000 Virginia residents were reported to have one or more disabilities, including 85,000 less than twenty-one years of age and more than 325,000 seniors.

- The proportion of individuals with disabilities increased with age, reaching more than half the population 75 years and over.
- More than 407,000 individuals with disabilities were between 21 and 64 years.
- More than 444,000 individuals had ambulatory disabilities. (Table 1)
- By race/ethnicity, the proportion of individuals with disabilities in Virginia ranged from 4.6 percent of Asians to 18.8 percent of Native Americans. (Table 2)

Table 1. Prevalence and number of individuals with disabilities in Virginia by age: 2008 (6)

Age	Prevalence	Number with a disability	Among six disabilities* Greatest number		Smallest number	
			Numbers in 000s			
All ages	10.7%	818,000	Ambulatory	444	Self care	157
Less than 5**	0.5	2,600	Hearing	2	Visual	1
5-15***	4.9	54,000	Cognitive	43	Visual	6
16-20	5.2	28,800	Cognitive	26	Self-care	2
21-64	8.9	407,300	Ambulatory	219	Self care	70
65-74	24.2	123,700	Ambulatory	79	Visual	19
75 and over	51.2	201,600	Ambulatory	135	Visual	41

Note: Numbers have been rounded

* Visual, hearing, ambulatory, cognitive, self-help, independent living disabilities
** Only the two sensory disability categories for the very young were included in the survey.
*** Children ages 5-15 were not asked about an "independent living disability"

Table 2. Prevalence of disabilities in Virginia by race for working age persons (ages 21-64): 2008 (6)

	Prevalence
White non-Hispanic	10.2%
Black non-Hispanic	14.3
Asians	4.6
Native Americans	18.8
Other races	9.8

Deinstitutionalization

During more than three decades, changing social policies, favorable legislation for people with disabilities, and class-action legal decisions that delineated the rights of individuals with intellectual/developmental disabilities have led to deinstitutionalization ("mainstreaming," i.e., establishment of community-oriented group residential settings) and closure of many state run large facilities.

In the past, large state facilities (to some degree) offered a wide range of in-house health services provided by medical and dental staff employees. Almost all of the current community residential facilities, however, are too small to provide in-house intramural services beyond the annual examination required in some states. As a consequence, the residents in community facilities are dependent upon local practitioners for health services. Compounding the problems further is the reality that deinstitutionalization is correlated with worsening oral health status as a consequence of the "…greater independence (that) may lead to less rigorous daily oral care and less supervision of diet." (7)

In the past

Dentist students seldom were prepared to provide services to individuals with special needs. Since the mid 1950s, a few dental schools have introduced instruction in the care of patients with special needs. These efforts were made to overcome dentists' reluctance to treat these patients because of their lack of knowledge and experience in clinical management. However, by the end of the 1990s and until 2004, a series of studies had found that during the four years of

education, more than half of US dental schools provided fewer than five hours of class room presentations and about 75 percent of the schools provided from 0 to 5 percent of patient care time for the treatment of patients with special needs. (8-12). A national study of dental hygiene programs reported comparable findings. (13)

As a result, one should not be surprised that only 10 percent of general dentists responding in one study indicated that they treated children with cerebral palsy, intellectual disabilities, or medically compromising conditions often or very often. The study also noted 70% rarely or never treated children with cerebral palsy in their practice. (14)

In 2001, under the auspices of Special Olympics, the authors proposed that the Commission on Dental Accreditation (CODA) reestablish standards which had been deleted in the mid 1990s that ensured that dental and dental hygiene student graduates were competent in providing oral health care to individuals with special needs. The lack of adequate primary education for health care professionals to provide care to special needs populations was emphasized at the 2001 Surgeon General's Conference on Health Disparities and Mental Retardation. (15)

The National Study of Children with Special Health Care Needs highlighted the finding that "the service most commonly reported as needed but not received was dental care…" (16) Numerous local and regional reports provide a general appreciation of the needs. (17,18) The general population with disabilities has significantly higher rates of poor oral hygiene, gingivitis, and periodontitis than do members of the population without disabilities. There is a wide range of caries (tooth decay) rates among people with disabilities, but overall, their rate is higher than the general population. Much of the variation stems from where people reside, i.e. institutions, community group residences or private homes. (19-21)

In late 2002, the House of Delegates of the American Dental Association unanimously adopted a resolution to improve access to comprehensive dental services for persons with special health care needs. Finally, in 2004, the Commission on Dental Accreditation (CODA) adopted the accreditation standard that, "Graduates (of dental schools and schools of dental hygiene) must (sic) be competent in assessing the treatment needs of patients with special needs." (22) However, as a consequence of major opposition by some members of CODA, the standard does not require the actual treatment by dental students for individuals with special needs. Nevertheless, some programs do require the clinical treatment of individuals with special needs. Since the change in CODA standards, efforts have been made to extend the requirements to include actual treatment. As increasing numbers of new dental school graduates complete their training with this added educational opportunity, care for individuals with special needs should be more available.

What about continuing education for current practitioners?

An extended series of articles has emphasized the value and need for continuing education (CE), including the types and settings, as well as delineating CE requirements for relicensure. However, limited concern is evident in program listings for the care of individuals with disabilities.

"The most obvious needs are in practice management, practical occlusion concepts, all areas of esthetic dentistry, implant prosthodontics and implant surgery, because they are not taught in depth in most dental schools." (23)

A recent listing from the American Dental Association on CE requirements for dentists and auxiliaries specifies numbers of hours of CE during relicensure cycles for each state, Puerto Rico and the District of Columbia; none are listed for Colorado and only a basic life support requirement is reported for Wyoming. Several states mandate CE on specific topics – AIDS/HIV, infectious disease control, child abuse identification, CPR, domestic violence and ethics. Only Georgia requires CE in "cultural competency." (24)

A review of program brochures for some of the larger regional dental meetings,

and the ADA 2009 Annual Session provides indications of the CE course areas emphasized during these sessions. For example:

- The 2009 Greater New York Dental Meeting included 51 presenta tions on implants, 8 on laser treatment, 2 on Botox and 16 on money management; none on patients with special needs.
- The 2010 Yankee Dental Congress included 10 presentations on implants, 5 on lasers, 35 on money management and 3 on patients with special needs (including two regarding autism).
- The 2009 California Dental Association: the art and science of dentistry included 42 presentations on business/practice administration and licensure, 16 sessions on restorative services, 8 on pathology, 2 on snoring/apnea and one on special needs (medication of neuropsychiatric conditions).

- The 2009 American Dental Association Annual Session included 180 programs including one session on treating special needs (Treating Aging America – Time to Doctor Up). (25)

Since many states already have adopted specific categories for continuing education subject requirements for licensure renewal, the addition of continuing requirements for the care of individuals with special needs would seem appropriate to provide a basic foundation for practitioners with limited formal dental school preparation for care of this population.

Added barriers

"Individuals with disabilities and individuals with complex health problems may face additional barriers to dental care." (26) These include:

- Economic limitations. While the median income of individuals with disabilities (lowest among individuals with cognitive disabilities) is less than that of individuals without disabilities, it should be emphasized that individuals with disabilities are in all economic ranges. (6)

- Lack of health insurance, e.g. Medicaid dental care, a program for the poor and near poor and upon which many individuals with disabilities are dependent, is an elective inclusion in state programs for adults; many do not provide for care for adults beyond the relief of pain and suffering.

- A complex, and often confusing, bureaucratic system for approvals and payment.

- Increased patient time requirements and patient guidance difficulties.

- Disturbance of other patients.

- Inadequate facilities in many dental practices.

Conclusion

1. Thousands of dentists do provide services to individuals with a wide range and severity of disabilities in their private offices and as volunteers in community settings. For example, at the 2010 Special Olympics National Games in Nebraska, members of the Nebraska Dental Association and Missions of Mercy volunteered to screen and educate one thousand athletes and provided more than 1,600 needed dental procedures. (27).

2. The reality is that increasing numbers of youngsters and the not so young with disabilities survive and now reside in our communities, rather than in an institutional setting. Many of these individuals with specials needs are in families currently being treated by practitioners and as such, practitioners are being called upon to meet the needs of these family members.

3. The facts are that the more than 800,000 individuals with disabilities in Virginia, the tens of millions with disabilities in the United States and the hundred of millions throughout the world are but the early stages of burgeoning populations of individuals with disabilities who will survive and be in need of health care (including dental services); particularly the geriatric populations.

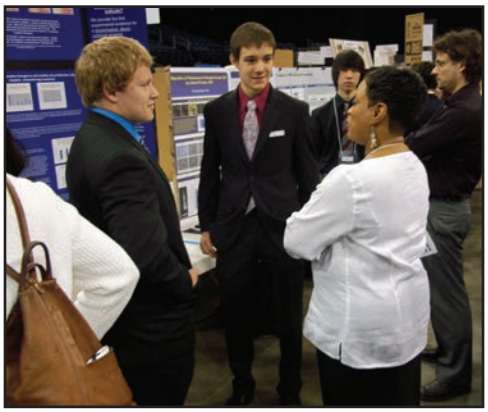
4. The need is to strengthen educational programs, both in dental schools and in the availability of continuing education programs, to better prepare practitioners to provide needed care for individuals with disabilities. The necessity is to financially support the needed care, facilitate the payment mechanism, and carry out those functions which would better prepare our communities for the increasing number of individuals with disabilities, and increase the number of practitioners providing services and expedite that care.

References

1. United Nations. World program of action concerning disabled persons. Available at: http:www.un.org/esa/socdev/enable/diswpa01.htm Accessed January 4, 2011.
2. World Health Organization. Disabilities. Available at: http:www.who.int/topics/disabilities/en Accessed January 6, 2011.
3. Census Bureau. Disability Finders Network. Available from: http://www.disabilityfinders.org/census Accessed February 4, 2011.
4. Disabled in Action. Facts about disabled in the U.S. population. Available at: http://www.disabledinaction.org/census_stats.html Accessed January 10, 2011.
5. U.S. Census Bureau. Interim projections: ranking of states by projected percent of population age 65 and older: 2000, 2010 and 2030. Available at: "http://www.census.gov/population/projections/PressTab3.xls" Accessed December 21, 2010.
6. Cornell University. 2008 Disability Status Report: Virginia. Available from: http://www.disabilitystatistics.org Accessed February 3, 2011.
7. Edelstein BL. Dental and interdisciplinary workforce approach to oral health care for vulnerable and special needs populations, p60; in Sixth Annual Report to the Secretary of the U.S. Department of Health and Human Services and to Congress from the Advisory Committee on Training in Primary Care Medicine and Dentistry. November 2006.
8. Fenton SJ. 1993 survey of training in the treatment of persons with disabilities. InterFace 1993;9:1,4.
9. Fenton, SJ. Universal access: are we ready? Spec Care Dent 1999;13:94.
10. Fenton SJ. People with disabilities need more than lip services. Spec Care Dent 1999;19(5):198-199.
11. Romer M, Dougherty N, Amores-Lafleur E. Predoctoral education in special care dentistry: paving the way to better access? J Dent Child 1999;66(2):132-135,138.
12. Wolff AJ, Waldman HB, Milano M, Perlman SP. Dental students' experiences with and attitudes toward people with mental retardation. J Amer Dent Assoc 2004;135:353-357.
13. Goodwin M, Hanlon L, Perlman SP. Dental hygiene curriculum study on care of developmentally disabled. Boston: Forsyth Dental Center, 1994.
14. Casamassimo PS, Seale, NS, Ruchs K. General practitioners' perceptions of educational and treatment issues affecting access to care for children with health care need. J Dent Educ 2004;68(1)23-28.
15. 2001 Surgeon General's Conference on Health Disparities and Mental Retardation Available at: http://www.surgeongeneral.gov/topics/mentalretardation/ Accessed June 8, 2010.
16. U.S. Department of Health and Human Services. The National Survey of Children with Special Health Care Needs, Chart book, 2005-2006. Rockville, MD: U.S. Department of Health and Human Services, 2007. p25.
17. White PH. Access to Health Care: Health Insurance Considerations for Young Adults With Special Health Care Needs/Disabilities. Pediatrics 2002;110:1328-35.
18. Dao LP, Zwetchkenbaum S, Inglehart MR. General dentists and special needs patients: does dental education matter. J Dent Educ 2005;69:1107-15.
19. Waldman HB, Perlman SP. California community residential facilities for individuals with intellectual and developmental disabilities. J Cal Dent Assoc 2006;34:235-238.
20. Lewis C, Robertson AS, Phelps S. Unmet dental care needs among children with special health care needs: implications for the medical home. Pediatrics 2005;116:e426-e31.
21. Ngui EM, Flores G. Unmet needs for specialty, dental, mental, and allied health care among children with special health care needs: are there racial/ethnic disparities? J Health Care for Poor Underserved 2007;18:931-49.
22. Commission on Dental Accreditation. Accreditation Standard 2-26 for dental education programs. Adopted July 30, 2004.
23. Christensen GJ. Dealing with the increasing need for continuing education. JADA 2007;138(3):387-90.
24. American Dental Association. Continuing education requirements of state dental boards for dentists and auxiliaries. Available at: "http://www.ada.org/prof/prac/licensure/continuing_ed.pdf" Accessed May 14, 2010.
25. 2009 ADA Annual Session. Continuing Education Course Listing. Available at: http://www.softconference.com/ada/sessionDetail.asp?SID=143911 Accessed September 21, 2009.
26. Department of Health and Human Services. Oral Health in America: A Report of the Surgeon General. Rockville, MD: National Institutes of Health, 2000.
27. Crozier S. Dental clinic touches hearts. ADA News January 17, 2011. Available at: http:www.ada.org/news/5229.aspx Accessed February 4, 2011.

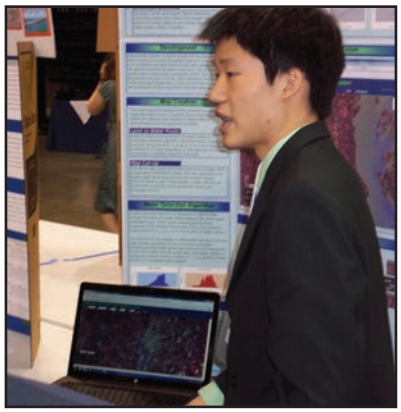
ODU Hosts 2011 Science Talent Awards Program

By: Timothy E. Russell, D.D.S.



Dr. Sharon Colvin interviews contestants

Dr. Jackson Payne judges entry



Darwin Hanchin Li, Malbon Prize Winner

The Virginia State Science and Engineering Fair is the central competition for the VDA's Science Talent Awards Program. At this year's awards ceremony held on April 2 at Old Dominion University in Norfolk, VDA President Dr. Michael A. Abbott presented our category awards. Dr. Abbott's presentation projected a high level of professionalism and was enthusiastically received by the assembly.

Dr. Abbott presented each of our twenty winners with cash awards of $100, certificated of merit and career info. Dr. Jackson Payne presented our annual "Dr. Bennett A. Malbon Prize". The prize memorializes Dr. Malbon's contributions to dentistry, dental education, and his community.

The Malbon Prize is awarded to the individual VSTAP winner who demonstrates excellence in science, research, and community service. This year's Prize was presented to Darwin Hanchin Li of Fairfax in the category of Environmental Management. His project's title is "Remote Sensing-Based Water Quality Monitoring System for the Chesapeake Bay".

Mr. Li received $1,500 in cash, a handsome plaque, and a copy of Sam Kean's "The Disappearing Spoon". We would like to thank the following VDA members who made the trip and represented the Association as judges at the State completion:

Dr. Jackson Payne	Dr. John Marino
Dr. Leah Luck	Dr. Avi Gibberman
Dr. William Burston	Dr. Tim Russell
Dr. Leonard Jackson	Dr. Clay Weisberg
Dr. Sharon Colvin	Dr. Jon Piche'

In addition to the state competition the VDA participated in all eleven Regional fairs. We gave awards to 220 projects across the state. Cash awards totaling $1,100 were given to eleven Grand Prize winners along with special certificates of merit.

Finally I wish to express my gratitude to all of you, my colleagues for your generous and steadfast support as we continue to advance our case and "Sponsor the Future" throughout the Commonwealth.

The 2012 VSSEF will be held Saturday, April 7 at Old Dominion University. You are all invited to join us for what will prove to be another exhausting yet exhilarating day!

PathologyPuzzler

with Dr. John Svirsky

L-R: Dr. Bryan Trump (as a senior dental student) rotating with Drs. Svirsky and Burns.

This case was developed by Dr. Bryan Trump as a part of the ADEA Student Mentorship in Academic Dentistry Program. He is a 2011 graduate of the VCU School of Dentistry and will begin a three-yr Oral & Maxillofacial Pathology Residency at Baylor College of Dentistry in Dallas, Texas.

A 69 year old African-American female presented to the Virginia Commonwealth University School of Dentistry with a chief complaint of "red and very painful lips" (Figure 1). The patient had been dealing with the condition for over three years. She had received treatment from various medical professionals. At the time of her appointment, she was taking Nystatin ointment for treatment of the condition.

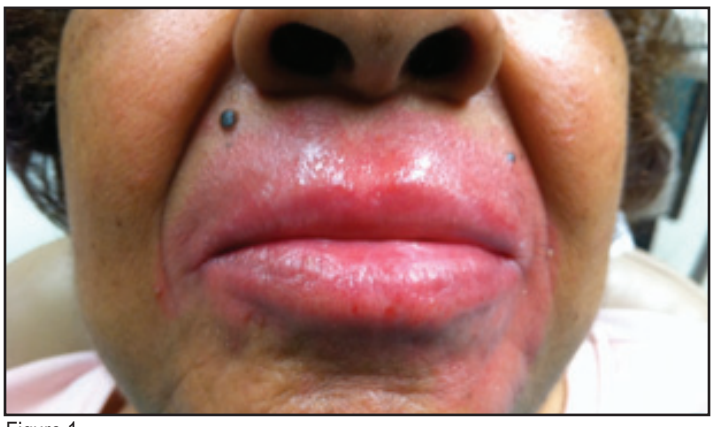


Figure 1

A differential diagnosis would include which of the following?

- Allergic dermatitis (perioral dermatitis)
- Cheilocandidiasis
- Angular cheilitis (perleche)
- Systemic lupus erythematosus
- Lichen planus
- Actinic Cheilitis
- Cheilitis granulomatosa

Continued on page 37

Periodontic Abstracts

Morozumi T, Kubota T, et al. Effects of irrigation with an antiseptic and oral administration of azithromycin on bacteremia caused by scaling and root planing. J Periodontol 2010;81(11):1555-1563.

AIM: To investigate the prevalence of bacteremia caused by quadrant scaling and root planing (SRP) and to evaluate the effectiveness of two methods, subgingival irrigation with an essential oil-containing antiseptic (EO) and azithromycin (AZM), on bacteremia.

METHODS: Thirty subjects with generalized moderate to severe periodontitis and three or more teeth with probing depths (PD) of 5mm or greater in each quadrant were selected and randomly assigned to one of three groups, the EO group, AZM group or the control group. The quadrant with the most severe periodontal condition was chosen for treatment based on the probing depths at six sites per tooth (mesio-buccal, buccal, disto-buccal, mesio-lingual, lingual and disto-lingual), clinical attachment levels (CAL), and bleeding on probing (BOP). Subgingival plaque and peripheral blood samples were collected at baseline and again at the time of SRP one week later. In addition, the EO group had quadrant subgingival irrigation with 100 ml of EO for 10 minutes at baseline and 10 minutes prior to initiating SRP. This group also rinsed four times a day for 20 seconds with 20 ml of EO during the week prior to SRP. The AZM group had orally administered AZM 500 mg once a day beginning three days prior to SRP. Quantitative analysis using the polymerase chain reaction (PCR) Invader method was employed.

RESULTS: The results showed that the total incidence of bacteremia after SRP was 60% (18/30). The frequency of bacteremia was 90% (9/10), 70% (7/10) and 20% (2/10) for the control, EO and AZM groups respectively. The incidence rate of bacteremia for the AZM group was significantly lower than that of the control group. Counts of total bacteria studied, as well as the levels of two periodontal pathogens, were significantly decreased compared to baseline after one week in the EO group. However, the AZM group had significantly greater reductions in counts of all species studied after one week compared to baseline. Comparing between groups, the counts of all the species studied after one week in the AZM group were significantly lower than the other two groups.

CONCLUSION: Quadrant SRP frequently induced bacteremia and the pretreatment administration of AZM reduced the incidence of bacteremia greater than EO irrigation along with SRP or SRP alone.

Stephanie Chambers, DDS, 1st Year Resident, VCU Graduate Periodontics

Ryu J-I, Oh K, et al. Health behaviors, periodontal conditions, and periodontal pathogens in spontaneous preterm birth: A case-control study in Korea. J Periodontol 2010;81(6): 855-863.

AIM: To evaluate whether periodontal conditions, dental health behaviors, or periodontal pathogens are risk factors for PTB (preterm birth) among Korean mothers.

METHODS: This study is a hospital-based case control study, including mothers who gave birth between November 2007 and July 2009 at the obstetrics clinic of a general hospital in Seoul, Korea. Cases included mothers with a single birth and spontaneous PTB, excluding those mothers with a systemic condition. The controls were matched to the case group by maternal age (within three years) and delivery mode (vaginal versus Caesarean section). Clinical examinations including demographic and health information, an oral examination, microbacterial examinations, and sampling of gingival crevicular fluid (GCF) and subgingival bacteria were conducted. Oral examinations were conducted two to five days after delivery. Periodontitis was defined as at least two teeth showing clinical periodontal loss greater than 3.5 mm, and to have gingivitis when at least 25% of sites showed bleeding on probing (BOP). Subgingival biofilm and GCF were sampled with two sterilized paper-points. Statistical analysis included chi-square, Mann-Whitney U test, and multivariable logistic regression.

RESULTS: No significant differences were found in demographic and obstetric characteristics. In addition, none of the oral health factors were significantly different between the case and control groups. Among the health information before pregnancy, scaling within the last 12 months was the only variable that showed a significant difference between the case and the control groups. Scaling during pregnancy was not significant between case and control groups. Among the microbial factors, only P. gingivalis showed a potential difference between the pre-term delivery and low birth weight (PLBW) and normal range birth weight groups.

CONCLUSION: Only scaling within 12 months prior to pregnancy and P. gingivalis showed a difference between the PTB group and the control group, but clinical periodontal conditions showed no association with PTB.

Bottom Line: Scaling within 12 months before pregnancy and P. gingivalis showed differences between the PTB and control groups.

Sayward Edwards Duggan, DDS, 3rd Year Resident, VCU Graduate Periodontics

Santamaria MP, Ambrosano GMB, et al. The influence of local anatomy on the outcome of treatment of gingival recession associated with non-carious cervical lesions. J Periodontol 2010;81(7):1027-2034.

AIM: To investigate the influence of anatomic factors on the amount of gingival recession reduction and gain of clinical attachment.

METHODS: Seventy-eight mucogingival defects (Miller Class I gingival recession associated with a non-carious cervical lesion in maxillary canines or premolars) were treated as follows: 19 received coronally advanced flap (CAF), 19 received CAF plus resin-modified glass ionomer restoration (CAF + R), 20 received connective tissue graft (CTG), and 20 received CTG plus resin-modified glass ionomer (CTG + R). Plaque index, bleeding on probing, probing depth, relative gingival recession (RGR; gingival margin to incisal edge of tooth), and clinical attachment level (CAL) were measured at baseline and at 45 days and 2, 3, and 6 months following surgery. Other parameters measured at baseline included non-carious cervical lesion height (CLH), width (CLW), and depth (CLD), keratinized tissue width (KTW) and thickness (KTT), adjacent papillae width (PW) and height (PH), bone level (BL), and post-surgical position of the gingival margin (PGM). Post-surgical maintenance included professional plaque control and oral hygiene instructions weekly during the first month and monthly during the following six months. Multiple linear regression analysis was performed to assess the influence of the local anatomic factors listed above on the reduction of RGR (ΔRGR) and clinical attachment gain (ΔCAL).

RESULTS: 1) KTW was weakly associated with ΔRGR within the overall CAF group. 2) CLH and CLD were moderately associated with ΔRGR within the overall

CAF group. 3) BL was significantly associated with ΔCAL within the overall CAF group. 4) CLH and BL were significantly associated with ΔRGR within the overall CTG group. 5) CLH was significantly associated with ΔRGR within the CTG + R group. 6) BL was significantly associated with ΔCAL within the overall CTG group.

CONCLUSION: Local anatomic factors, such as KTW, CLH, CLD, and BL may have an effect on recession defect coverage after surgical therapy.

Justin Hardison, DMD, 2nd Year Resident, VCU Graduate Periodontics

McGuire MK, Scheyer ET. Xenogeneic collagen matrix with coronally advanced flap compared to connective tissue with coronally advanced flap for the treatment of dehiscence-type recession defects. J Periodontol 2010;81(8):1108-1117.

AIM: To investigate if a xenogeneic collagen matrix (CM) with coronally advanced flap (CAF) can be as effective as connective tissue graft (CTG) with CAF in the treatment of recession defects.

METHODS: Twenty-five subjects with bilateral dehiscence-type defects (Maxillary and Mandibular) of at least 3mm deep and wide were treated with either CM+CAF (test) or a CTG+CAF (control). Outcome variables were recession depth at six months, clinical attachment level (CAL), probing depth (PD), keratinized gingiva (KG) width, percent root coverage, recession width, color and texture, subject esthetic satisfaction, and subject pain and discomfort. Surgical treatment involved: root surface modification, partial thickness flaps and root conditioning. Post operative care included Doxycycline 100mg bid x 10 days and Chlorhexidine 0.2%.

RESULTS: Recession depth change from baseline to six months was statistically significant between test and control with an average of 2.62mm gained at CM+CAF sites and 3.10mm at CTG+CAF sites. At one year percent root coverage was 99.3% for CTG+CAF and 83.5% for CM+CAF. No significant differences were seen between test and control for PD, CAL, KG width, color, texture match, subject assessment of esthetics and pain/discomfort. When maxillary defects were only considered root coverage percent was 99.2% for CTG+CAF and 91.1% for CM+CAF.

CONCLUSION: CM+CAF may serve as an alternative to CTG+CAF in the treatment of dehiscence-type recession defects.

Corin Marantz, DDS, 2nd Year Resident, VCU Graduate Periodontics

Griffiths GS, Ayob R, et al. Amoxicillin and metronidazole as an adjunctive treatment in generalized aggressive periodontitis at initial therapy or re-treatment: a randomized controlled clinical trial. J Clin Perio 2011; 38(1): 43-49

AIM: The aim of this study was to assess the outcome of crossing over the treatments of initial therapy with and without systemic antibiotics, for groups in a previous study who either had, or had not, received systemic antibiotics.

METHODS: Two groups of 19 subjects each, all with a diagnosis of generalized aggressive periodontitis and devoid of any confounding systemic factors, had completed a randomized clinical trial (RCT) to assess clinical outcomes of probing depth (PD), recession (R) and clinical attachment level (CAL) following scaling and root planing (Sc/RP) with or without a regimen of amoxicillin 500 mg three times daily for seven days and metronidazole 500 mg three times daily for seven days. Six months after the original study began, this study commenced, with a second round of Sc/RP being performed, though this time the placebo group became the test group, and vice versa. Clinical parameters were measured at the beginning of this stage of the study, and two months later (eight months after the beginning of the original study). The primary outcome was PD reduction at sites initially measuring at least 7mm, with secondary outcomes being changes in PD and CAL at different PD categories, percentage of sites converting between PD categories, instrumentation time, and any complications/adverse effects of the medications.

RESULTS: The group which in the first stage of the study had not been given antibiotics showed its largest PD reduction two months after receiving antibiotics, approximately 2.8mm. That said, at this same time point the other group, which got antibiotics initially but became the placebo group in the second phase of the study, still at 2 months after the second phase began had a PD reduction of 0.9mm more than the other group. This change was significant in pockets equal to or greater than 7mm, but was not in pockets measuring less. Over the entire length of the study, a significantly higher percentage of pockets in the group that got antibiotics originally (83%) converted from greater than 5 to less than 4mm, while only 67% of those in the other group made this conversion. There was a trend for similar conversions between the two groups in lesser pocket depth categories as well, but these differences were not statistically significant. There was a high incidence of adverse events at 42%, but these were mostly considered minor, with the exception of one moderate bout of nausea and one severe rash.

CONCLUSION: While systemic antibiotics will exert a positive effect on initial therapy in aggressive periodontitis patients at any point, their best use is at the outset of therapy.

Bottom Line: Use systemic antibiotics as early as possible in the treatment of aggressive periodontitis

Sam Malkinson, DMD, 2nd year resident, VCU Graduate Periodontics

M, Jacob Steiger J, Neely AL, Shah M, Bhola M. Treatment of Class II Molar Furcation Involvement: Meta-Analyses of Reentry Results. J Periodontol 2011; 82 (3):413-428.

AIM: To investigate the effectiveness of various methods for the treatment of Class II furcation involvement by clinical improvement and bone regeneration based on reentry results

METHODS: Inclusion criteria: 1)human molar teeth with Class II furcation involvement; 2)randomized controlled clinical trials with greater than six months of follow up by surgical reentry; 3)pretreatment and post-treatment vertical probing depth (PD), vertical clinical attachment level (CAL), horizontal bone level, and vertical bone level measurements or changes.

RESULTS: Thirteen studies were compared.

- Five studies compared resorbable versus non-resorbable membranes: significant difference in the change in vertical bone level with the use of resorbable and non-resorbable membranes
- Five studies compared non-resorbable membrane to open flap debridement: significantly greater reduction in vertical probing depth (VPD), significant gain in vertical clinical attachment level (VCAL), significantly greater horizontal bone level (HBL) increase, significantly greater vertical bone level (VBL) increase with non-resorbable membrane versus open flap debridement.

Three studies compared resorbable membrane to open flap debridement: significantly greater reduction in VPD, significantly greater gain in VCAL, significantly greater increase in HBL, significantly greater increase in VBL.

CONCLUSION: In Class II furcation defects:

- Use of resorbable membranes was significantly better than non-resorbable membranes
- Guided tissue regeneration (GTR) using resorbable or non-resorbable membranes produced better results than open flap debridement
- The addition of allograft/xenograft to a resorbable membrane enhanced VPD reduction, CAL gain and HBL increase compared to resorbable membrane alone
- GTR using a non-resorbable membrane and allograft resulted in improved bone level gains compared to non-resorbable membrane alone
- Tooth and patient factors influence the outcome of regeneration and these factors should be addressed presurgically (cervical enamel projections, bifurcation ridges, enamel pearls, smoking, plaque index)

.

Jason Streem, DDS, 3rd Year Resident, VCU Graduate Periodontics

Paolantonio M, Femminella B, et al. Autogenous periosteal barrier membranes and bone grafts in the treatment of periodontal intrabony defects of single-rooted teeth: a 12-month reentry randomized controlled clinical trial. J Periodontol 2010; 81(11):1587-1595.

AIM: To evaluate the effectiveness of autogenous periosteal barrier membranes and autogenous bone chips in treating intrabony defects.

METHODS: Forty-two patients (20 males, 22 females), ages 38 to 64 years old, all with moderate to severe chronic periodontitis were studied. Non-surgical therapy was performed under local anesthesia. All were non-smokers with no antibiotic therapy in previous six months and no periodontal therapy within the past two years. The residual probing depth (PD) had to be greater than 6mm with bleeding on probing (BOP). The subjects were then divided into three groups: 1) Open-flap debridement (OFD) without barrier membrane or filler 2) OFD with a collagen membrane 3) OFD with periosteal membrane and autogenous bone chips as a filler material.

RESULTS: One year follow-up measurements were compared to baseline within each group and showed statistically significant changes. In the guided tissue regeneration (GTR), autogenous bone chips (aCPRT), and OFD groups, PD reductions were 5.2, 4.4, and 2.9 mm respectively. Clinical attachment level (CAL) gains were 3.2, 3.9, and 1.6mm. Defect Bone Level (DBL) gains were 2.4, 3.1, and 1.5mm respectively. In the aCPRT group, gingival recession (GR) increase was smaller (0.5mm) when compared to the GTR (2.0mm). aCPRT experienced greater DBL gain (2.4mm) when compared to the GTR (2.4mm).

CONCLUSION: When comparing OFD, GTR and aCPRT, both the GTR and aCPRT procedures resulted in additional clinical benefits over OFD alone. When comparisons of GTR and aCPRT were made, aCRPT experienced less GR and better defect bone-level improvement than the GTR procedure.

Daniel Noorthoek, DMD, 1st Year Resident, VCU Graduate Periodontics

Chambrone L, Chambrone LA, et al. Effects of occlusal overload on peri-implant tissue health: A systematic review of animal-model studies. J Periodontol 2010;81(10):1367-1378.

AIM: The aim of this study was to perform a systematic review of the effect of occlusal overload on peri-implant tissue health from the existing literature.

METHODS: Search conducted by two independent reviewers of MEDLINE, EMBASE, and LILACS databases. Randomized and non-randomized controlled trials were included but studies evaluating splinted implants were excluded. Primary outcome measures: probing depth (PD), clinical attachment level (CAL), plaque index (PI), gingival index (GI), bleeding on probing (BOP), distance of implant shoulder to gingival margin, radiographic/histologic data regarding implant shoulder to bone distance (BID) and bone density(BD).

RESULTS: Of 347 potential articles only two studies were considered appropriate, neither were randomized controlled trials. Both were split-mouth design, animal (canine) models, evaluating a total of 80 implants (surfaces included machined, sand blasted/acid etched (SLA), and titanium plasma sprayed (TPS). Implant dimensions were 4.1x8mm and 3.75x10mm. Implants were loaded at three and six months post-placement. Study characteristics were too variable for metanalyses. In the presence of plaque control, there was a lack of association between occlusal overload and peri-implant tissue loss. Positive correlation was noted between increased plaque index with a significant increase in PD and BID. In absence of inflammation, occlusal overload may lead to increase of bone to implant contact and bone density. No prosthetic complications or implant fractures were noted.

CONCLUSION: The review was based on limited information and no randomized controlled trials. The two studies reviewed suggest that occlusal overload may result in peri-implant tissue breakdown when in the presence of poor plaque control or inflammation. In the absence of inflammation, occlusal overload did not negatively affect osseointegration.

Bottom Line: Occlusal overload in combination with plaque induced inflammation may result in peri-implant tissue breakdown.

Rafael K. Rodriguez, DMD, 3rd Year Resident, VCU Graduate Periodontics

Continued from page 33

PathologyPuzzler
with Dr. John Svirsky

Differential diagnoses to be considered include a, b, c.

The most common presentation of bacterial or fungal infections of the lips is angular cheilitis. Infection of the entire lip is very unusual. Most diffuse cases represent a secondary candidal infection in areas of low-grade trauma of the vermilion border of the lip. The involvement of the angles of the mouth is characterized by erythema, fissuring and scaling. Infrequently, the candidal infection more extensively involves the perioral skin, usually secondary to actions that keep the skin moist, creating a clinical pattern known as cheilocandidiasis. Perioral dermatitis refers to a unique inflammatory skin disease that involves the circumoral area. Although the exact mechanism is uncertain, many investigators believe the process arises from an idiosyncratic response to a variety of exogenous substances; tartar-control toothpaste, bubble gum, moisturizers, night creams, and other cosmetic products. 1 Nystatin ointment, when taken alone, is irritating and can worsen the condition. This correlates to the patient's complaint that her symptoms have persisted for over four months while using the anti-fungal ointment. Lidex was prescribed and after two weeks, the redness and pain were resolved (figure 2).

Systemic lupus erythematosus (SLE) is a serious multisystem disease with a variety of cutaneous and oral manifestations. Common findings include fever, weight loss, arthritis, fatigue, and general malaise. The classic "butterfly rash" over the nose is typical of this condition.

Lichen planus is a relatively common, chronic dermatologic disease that often affects the oral mucosa. The skin lesions of lichen planus have been classically described as purple, pruritic, polygonal papules. A reticular pattern is usually evident on the lips, not redness.

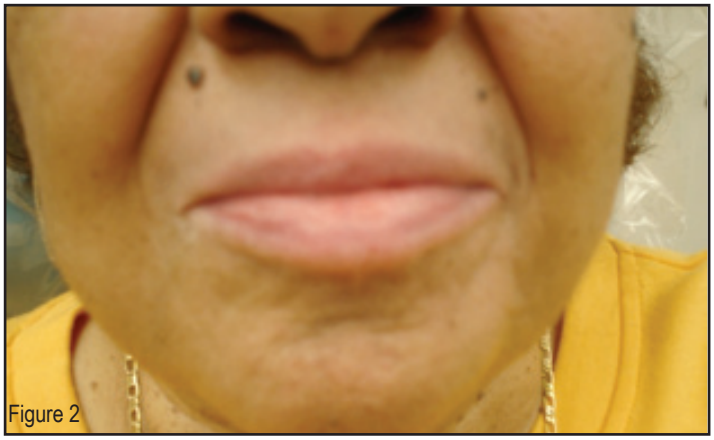


Figure 2

Actinic cheilitis is a common premalignant alteration of the lower lip vermillion that results from long-term or excessive sun exposure.

Cheilitis granulomatosa is a clinical presentation of orafacial granulomatosis in which the lips alone are involved. The labial tissues demonstrate a nontender, persistent swelling that may involve one or both lips.

Therefore, the correct diagnosis is "a", perioral dermatits.

References:

1. Neville, et al. 2002. Oral & Maxillofacial Pathology, 2nd Ed. W.B. Saunders Company, Philadelphia.

DELTA DENTAL'S Smart Smiles®

We're turning frowns upside down

Delta Dental's Smart Smiles® public outreach program reaches thousands of children and adults across Virginia every year. Through oral health research, education and access to care for the underserved, Smart Smiles helps support Delta Dental of Virginia's mission to improve the oral health of all Virginians.

DELTA DENTAL'S Smart Smiles® *In School*

Oral health education – through programs such as free, on-loan education kits to public schools, Radio Disney educational partnerships and support of oral health education exhibits in major area museums.

DELTA DENTAL'S Smart Smiles® *At the Dentist*

Access to oral health care – providing much needed oral health care and education to children who lack dental insurance or are eligible for Medicaid and FAMIS, through community partners such as Boys & Girls Clubs.

DELTA DENTAL'S Smart Smiles® *In the Community*

Community support – providing financial and volunteer support to charitable and philanthropic initiatives designed to improve oral health and enhance quality of life in communities throughout Virginia, including Mission of Mercy projects, Give Kids A Smile®, grants to Virginia's Free Clinics and support of Virginia's Dental and Medical schools.

Because everyone deserves a healthy smile

DELTA DENTAL®

800.533.4137 ext. 9
deltadentalva.com
(Community Outreach)

The Age One Dental Visit: An Opportunity that Can't Be Missed

By: Susan Pharr, RDH, MPH and Elizabeth Barrett, DMD, MSPH

(L) Ms. Pharr (R) Dr. Barrett

Background

The American Dental Association (ADA), American Academy of Pediatric Dentistry (AAPD), and American Association of Pediatrics (AAP) recommend that all children have their first dental visit within six months of the eruption of their first tooth or by age one regardless of risk of future disease.[1,2,3] In spite of this recommendation, many physician and dentist offices advise parents to wait until age three for the first visit. By age three, the opportunity has been missed for effective early preventive measures, including oral assessment, parental education, and fluoride varnish application when appropriate.

The purpose of this article is to explain how to provide the age one dental visit. We hope to convince you to give it a try in your office, and we are available to come to your office to provide training if that would be helpful (see contact information at end of article).

What is the Age One Dental Visit?

The age one dental visit establishes a relationship between the dentist and the parent and child, thereby providing a dental home for the child. The three components to this visit are:

1. Assess the risk of the child for developing early childhood caries through surveying the parent and doing an oral screening.

2. Provide tailored educational messages to the parent regarding disease prevention.

3. Provide preventive interventions and treatment referrals as needed.[1,3]

Oral Health Risk Assessment

In the practice of dentistry and dental hygiene, providing a risk assessment is considered a critical component for treatment planning based on the individual's preventive needs. Assessing risk of decay in a one-year-old includes performing an oral screening and asking the parent about the child's fluoride exposure, daily oral care, feeding practices, intake of dietary sugars, general health considerations and parents' and siblings' dental history.[1] The identified risk factors (Table 1) determine the preventive treatment plan and guide what information is provided to the parent.

There are several widely used risk assessment tools available online, or you may choose to develop your own tool or method.

- AAPD's Caries Risk Assessment Tool (CAT) www.aapd.org
- ADA's Caries Risk Assessment www.ada.org
- Virginia Department of Health's (VDH) Oral Health Risk Assessment www.vahealth.org/dental

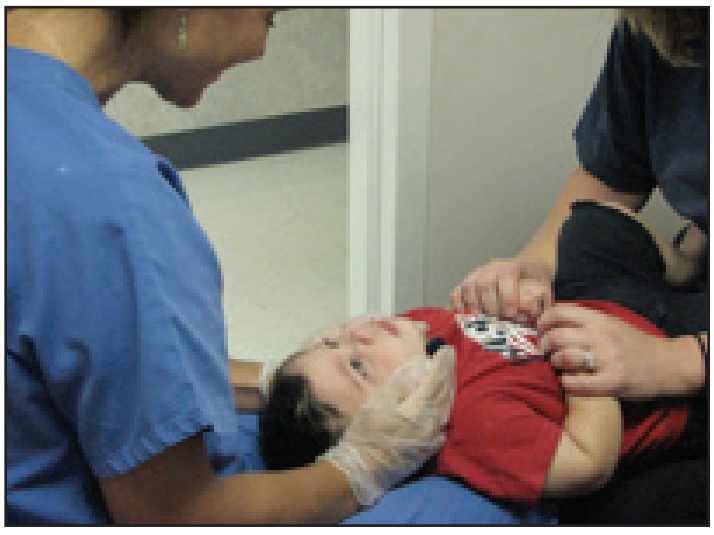
After surveying the parent regarding risk factors, you will perform an oral screening. This does not require the typical setting of a dental operatory but rather is ideally done in the 'knee-to-knee' position with the parent as shown here:

Table 1: Risk Factors to Consider

Individual-Based	Population-Based
History of decay in child, parent, siblings	Low income and minority populations
Frequent dietary sugar intake of parent or child	Children with special health care needs
Insufficient fluoride exposure (systemic and topical)	
Poor oral hygiene of parent or child	
Presence of demineralized enamel	

Anticipatory Guidance for Parents

Once the risk assessment and screening are complete, recommendations are made to the parent about controlling the risk factors identified for the child. Parents of infants and toddlers should be advised about oral hygiene, diet, and fluorides with the message tailored to the particular child and family, as opposed to a 'one size fits all' approach. The importance of this invaluable opportunity to inform the family cannot be overstated.



Knee-to-knee position

Oral hygiene

• It is extremely important that the parent practice good daily oral hygiene to reduce the amount of cariogenic organisms transmitted to the child.

• Parents should be instructed to wipe or brush the baby's teeth twice daily as soon as they erupt to reduce bacterial colonization.

• Toothpaste use for infants and toddlers is recommended as follows:

• Children under 2 years who are at high risk for caries development should use a 'rice-grain' (smear) amount of fluoride toothpaste.[4] This is a relatively new recommendation, based on current knowledge confirming that the benefits of daily exposure to low levels of fluoride outweigh the risk of developing very mild or mild fluorosis.
• Children who are not at high risk may use non-fluoride toothpaste until they are developmentally able to spit out the toothpaste, usually around age 2 or 3.

Diet/feeding practices

• Mothers should be advised of the cariogenicity of carbohydrate foods and liquids and to reduce sugar intake because of the impact on the bacterial population in her mouth on her baby.

• The baby should not be put to bed with the bottle unless it contains water only.

• Training cups with juice or milk should be used at mealtime only.

• Saliva-sharing behaviors should be avoided (sharing of utensils, cups, etc.).

Fluoride

• Systemic and topical fluoride exposure should be assessed and adjusted to appropriate levels that will minimize the risk of disease and maximize protection. (Note: The AAPD cautions that decisions concerning the administration of additional fluorides should be based on the unique needs of the patient.[5])

Fluoride Varnish Application

Based on the risk level of the patient, you may recommend an application of fluoride varnish, the only topical fluoride that can be safely and effectively applied to the teeth of young children. The varnish is applied with broad strokes of the application brush or with your gloved finger to all surfaces of the teeth. To increase your comfort level, it may be helpful to 'practice' on babies who have anterior teeth only, as these teeth are easily accessible. The advantages of fluoride varnish are:

• The teeth do not have to be polished or dried prior to application.

• The high concentration and immediate adherence allows for a very small amount to be used. For children under 3 years, the pedo 0.25 ml. unit-dosed packaging is very convenient and is enough varnish for 20 primary teeth.

• The application is extremely quick, ranging from a few seconds to a minute, depending on the age of the child.

• Fluoride varnish can be applied as frequently as every three months, depending on the risk for developing decay. However, there is no harm in using it more frequently. For example if a child has received varnish through a program such as Early Head Start or WIC, it is permissible to provide it again in your office.

Billing Information

The oral evaluation and topical fluoride varnish application procedures are reimbursed from public (Medicaid) and most private insurance plans.

CDT codes for insurance filing:

D0145 – Oral evaluation of a patient less than three years of age and counseling with a primary caregiver
D1206 – Topical fluoride varnish – therapeutic application for moderate to high caries risk patients

Summary

The dental profession has been a long-standing forerunner in preventive health strategies through comprehensive oral evaluations, patient education, and the use of appropriate topical fluorides. Expanding the provision of these services to the youngest of our patients is necessary to prevent early childhood caries and educate parents with timely information. To do this, we must provide an oral health risk assessment and prevention strategies at the earliest possible opportunity, the age one dental visit.

Additional resources:

• AAPD's Head Start Dental Home Initiative Videos (www.aapd.org/headstart)

• First Dental Visit by Age One (Arizona Department of Health Services, www.azdhs.gov)
• Virginia Department of Health (www.vahealth.org/dental/maternalandearlychildhood)

For 'in office' or local dental society trainings:
Susan Pharr, RDH, MPH
Early Child Oral Health Coordinator
Dental Health Program
Virginia Department of Health
Susan.Pharr@vdh.virginia.gov
804-864-7782

References:

1. American Academy of Pediatric Dentistry. Policy on the Dental Home. Pediatr Dent. 2004;26(7);18-9. Available at http://www.aapd.org/media/policies_guidelines/p_dentalhome.pdf.
2. American Dental Association. ADA Statement on Early Childhood Caries; 2004.
   Available at http://www.ada.org/2057.aspx.
3. American Academy of Pediatrics Section on Pediatric Dentistry. Oral Health Risk Assessment Timing and Establishment of the Dental Home. Pediatrics. 2003;111:1113–6.
   Available at http://aappolicy.aappublications.org/cgi/content/full/pediatrics;111/5/1113.
4. Maternal Child Health Bureau Expert Panel. Topical Fluoride Recommendations for High Risk Children; 2009. www.mchoralhealth.org/alert/2009/ohalert0309.html.
5. American Academy of Pediatric Dentistry. Guideline on Fluoride Therapy. Council on
   Clinical Affairs. 2008.
   Available at http://www.aapd.org/media/policies_guidelines/g_fluoridetherapy.pdf.

Editor's Note: Dr. Elizabeth Barrett is Oral Health Promotion Unit Manager for the Virginia Department of Health

Oops, Pew Did It Again!

By: Dr. Ted Corcoran - President, Northern Virginia Dental Society

The Pew Foundation recently released their annual report card on children's dental health. Once again Virginia was given a grade of "C". When results were leaked in May, Virginia's rate of Medicaid participation compared to Alaska's in an unflattering way. I had reservations regarding the methodology used. My understanding is that Alaska, thanks to oil revenues, is a state with minimal or no state taxes (there is no state income or sales tax) and that, instead of paying taxes, citizens receive annual payments from the state based on their years of residency. As a result of their fiscal health, the Medicaid reimbursement rates are far higher than here in Virginia and, in fact, higher than most private insurance plans. Some fee examples would be: PFM crown - $820, two-surface Resin Restoration - $178, Surgical Extraction - $245. This would easily explain Alaska's 50% participation rate with dentists seeing over 100 Medicaid patients annually.

Now that the report is out, an examination of the benchmarks and conclusions does nothing to allay my concerns. The devil is in the details. All eight benchmarks are "policy indicators" i.e., laws passed. Actual dental health of children is measured in only one area. Despite Virginia's "C" grade, our rate of untreated decay in third-grade students of 15.4% ranked 3rd best nationally, trailing only New Hampshire and Washington State. Our rate of third-graders having sealants, 49.4%, was 13th. Also of concern is that two of the eight benchmarks were based on non-dentists' ability to provide dental care. The first, permitting hygienists to apply sealants without an exam or supervision by a dentist has been debated by the House of Delegates and the only question seems to be how best to apply this concept. The second, licensing of midlevel providers, is at best premature. Only Alaska met this "benchmark" and I am concerned that licensing of DHATs is now considered standard of care in dental public health. There is something inherently wrong when a grading system that rates a state with the least amount of untreated caries with a grade of "C". The grade would be have been raised to a "B" if we allowed hygienists to practice independently and we would received an "A" if we permitted community college graduates to perform cavity preps, fillings and extractions. What is not clear is why states that do permit these practices seem to have poorer outcomes.

I realize that perception is reality and that reports like this present our profession in an unfavorable light. There is much more we can do and progress is being made. This is evidenced in Pew's own data where Medicaid utilization in Virginia has more than doubled in the last ten years. I have difficulty conceding the moral high ground to groups that publicize reports that compare apples to oranges, as in the case of Virginia versus Alaska Medicaid participation, or use selective data to draw their conclusions. All seven of the "A" states had higher rates of untreated decay than Virginia and only two had a higher rate of sealants. Amazingly, "A" rated Maryland had an untreated decay rate of 25.9% and a sealant rate of 23.7% compared to "C" rated Virginia at 15.4% and 49.4% respectively. Apparently Maryland had better laws on the books. This groupthink is not exclusive to Pew. On a recent visit to Northern Virginia, VDA Executive Director Dr. Terry Dickinson shared that he had recently met with a group from the University of Virginia who had been awarded a grant of $750,000 to investigate the possibility of building a dental school in Wise, Virginia on the basis that if you build it, dentists will come. To those not familiar with access to dental care, such an idea might seem reasonable but we are in a climate where we have to change the dental practice act to make it easier for VCU to attract faculty to Richmond. Wise would be an even tougher sell but serious money is available to pursue ideas like this. Since Pew has invoked DHATs as a standard, using as a basis the New Zealand dental nurse model, I would question the premise that the New Zealand experience is a success. As we had noted in a previous newsletter, just this year the New Zealand Herald showed that New Zealand children have one of the highest rates of decayed, filled and missing (DFM) teeth in the industrialized world. Although the United States is perceived to have an access to care problem, the DFM rate here is far lower. In this era of evidence based practice perhaps it is time that we measure results instead of intentions and performance rather than policy.

At some point, we will have to sit down with such groups to find some common ground. However, they seem to be intolerant to alternative thinking while claiming that dentists are unwilling to think out of the box. I fear that if we are too passive and allow their premises to be accepted as fact, the game will be played deep in our end of the field with an end product of onerous regulation that will ultimately result in less care, of lower quality, delivered by practitioners with questionable credentials. And after the first wave of intervention fails, the solution will be even more of the same. Pew is not alone in its attempt to reshape dental care in a more centralized form. A recent column reminded me that tucked into crevices of Obama Care is the statement "The Secretary shall develop oral healthcare components that shall include tooth-level surveillance." No one has any idea what this means, but some unelected, unaccountable bureaucrat will let us know later and will cite studies like Pew as the rationale for whatever they decide is their current vision for oral healthcare delivery. This will be a long, arduous journey that will test our unity and our perseverance on multiple fronts. It's a battle we can't afford to lose; our patients are counting on us.

Editor's Note: this column appeared previously in the May 2011 edition of "NOVA News", the newsletter of the Northern Virginia Dental Society.

Dental Direct Reaches out to Human Resource Professionals

By: Elise Rupinski, VDA Director of Marketing & Programs

The VDA's Direct Reimbursement Committee is pleased to be working with the Richmond Society of Human Resource Managers (RSHRM) in 2011. In partnering with RSHRM, the committee is promoting Dental Direct Reimbursement and Assignment dental plans to employer groups. Dental Direct has worked with the Virginia Society of Human Resource Managers in the past and also local chapters in Hampton Roads and the Roanoke Valley. The RSHRM organization represents over 1200 human resource professionals in Central Virginia.

By working with RSHRM, Dental Direct educates benefits decision makers about the dental benefit plan that has been recommended by the American Dental Association and the Virginia Dental Association since 1996. Dental Direct is a self-funded benefit employers can provide to their employees as an alternative to a traditional insured dental plan. Dental Direct plans offer freedom of choice to visit any dental provider and preserve the dentist-patient relationship by eliminating pre-authorizations and procedure exclusions (only cosmetic procedures are excluded). In addition to providing employees with a quality dental benefit, employers also appreciate the ability to design a Dental Direct plan that will fit their budgetary needs. Often, employers will see a cost savings with a Dental Direct plan when they compare to a fully insured plan. The benefits of Dental Direct are being communicated to the members of RSHRM through meetings, marketing materials and articles that will appear in their publications throughout the year.

The DR Committee is grateful for the support of the VDA Membership as they work to promote Dental Direct Reimbursement and Assignment plans to Virginia employers. Dental Direct plans are fee-for-service and have no networks to join and no fee schedules to agree to. In 2010 alone, Dental Direct plans in Virginia had over $1.6Million in submitted claims which represent non-discounted claims reimbursed to Virginia dental providers. To learn more about Dental Direct plans and how your office can help educate employers about the Dental Direct alternative, please visit www.VADentalDirect.com.

Say Yes!
To Dental Direct.

DENTAL DIRECT
VDA
Virginia Dental Association

The VDA's Direct Reimbursement Committee invites you to visit their website dedicated to Dental Direct Reimbursement and Assignment dental plans at:

www.VADentalDirect.com

The comprehensive web home for Dental Direct plans in VA makes DR and DA easier to research online.

On the site, information is available for dental offices, employers, employees and brokers.

Links to resources, articles and other sites about DR plans are all available at www.VADentalDirect.com.

NEWS

Up to date news about Dental Direct in Virginia is easy to access at the site!

Dental Direct Reimbursement and Assignment plans are dollar-based dental benefits that employers can offer to their employees as a dental benefit. The Dental Direct website has great resources available for your office. Check out the Frequently Asked Questions section to get a better understanding about Dental Direct and what it can mean for your office. If you or anyone at your office would like more information about Dental Direct, please contact Elise at the VDA - rupinski@vadental.org; 804-523-2184.

Dental Ethics – History Repeats Itself

By: Dr. William J. Bennett - Vice-Chair, Ethics and Judicial Affairs Committee

Times change, views are altered, the unaccepted becomes the accepted and history can be repeated. This is not all bad but where do professionalism, patient care, legal limits and ethics stand in this scenario? Is the axiom of doing no harm to patients and offering all reasonable options no longer the standard? Does putting yourself above colleagues for self-promotion become an acceptable means to gain patients? Is profit now the main objective of patient treatments? Is enticement of patients with free second opinions nothing more than an attempt to discredit a colleague to gain a patient? Is paying patients for referrals okay? Should corporate names, promotions or patient testimonials that are misleading be viewed today as acceptable? Is personal opinion now viewed as credible research and treatment protocol? Do mail order and unconventional professional titles mean competency? Do you see over treatment and excessive fees presented to patients as the only option? Where do practice, individual promotion and profit motive go past the line of professional ethical acceptability? Again, as in the 1930s, is the public entering a "patient beware" world of healthcare with limitless self and practice promotional claims? Are Painless Parker promotions and snake oil salesmen again on the horizon in the dental health profession? This evolving situation raises concerns. Is it of concern to you or your patients?

As dental health care professionals our only assets are public image and trust. We have been ranked at the top but our status is not being maintained. What can be done? We are self-regulated as a profession, at least for today. That is a great professional obligation and commitment to society at large. It is the essence of being recognized as a true profession. If it is not taken seriously it can and will be removed. Can you envision being regulated by individuals with possibly little or no knowledge of dental procedures or practice? Regulating our profession and maintaining a high standard for dental care needs to be a major priority for us or our self-regulation will be lost to others.

Today, as always, there are legal and ethical parameters involved in acceptable patient care and professional conduct. The legal limits set by Dental Boards do not always reflect the same level of conduct required by honorable organizations such as the American Dental Association [ADA] and other significant professional groups. As a licensed dentist in Virginia we are bound by the Dental Laws of the Commonwealth of Virginia. Those legal statues are regulated by the Virginia Board of Dentistry. The dental statues can be found on the BOD website at www.dhp.virginia.gov/dentistry. As a licensed dentist in Virginia you are required to uphold the statues of the Commonwealth. The Board of Dentistry is charged with the protection of the public and enforcement of all legally binding regulations.

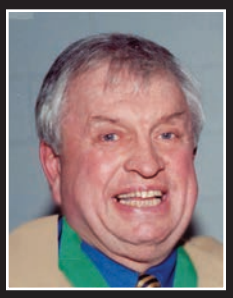
As a member of the ADA, VDA, and your constituent society you are bound as a member to abide by the Code of Ethics and Professional Conduct of the ADA. The ADA Code and Conduct documents and other guidelines in that regard can be located on the ADA website www.ada.org. After entering the main site, click on the left side link ADA Positions, Policies & Statements. On the now opened page click on the left hand link to ADA Principles of Ethics and Professional Conduct. Other Ethical topics can also be found in the left hand link ADA Ethics Resources on this same page.

As a licensed dentist in Virginia and a member of the ADA you are expected by Virginia law and ADA professionalism to know and abide by established Code requirements and Virginia laws. Not doing such is unacceptable legal or professional behavior. Being legally acceptable does not reflect that those actions are also ethically correct or in accordance with ADA guidelines. This distinction should be understood and considered in all promotional material.

Your local constituent society, the VDA and the ADA are responsible for the education of and enforcement of the ADA Code of Ethics and Conduct. The internet and numerous means of promotion are now available and have become acceptable. This change has occurred in recent years. However, misleading and unscientifically based material is still not acceptable in respectable dental organizations such as the ADA and others. There is concern for maintaining the high level of respect and trust our profession holds with the public and other health care communities. There are many influences that today enter into patient care and practice management. The ADA Code requires we adhere to the highest standards in professionalism, leadership, ethics and patient care.

The VDA is renewing its efforts to assure the best care and professional conduct for the patients we serve here in Virginia. Please take the necessary time to review the Virginia Laws of Dental Practice and our ADA Code of Ethics and Conduct. It is our obligation, as a self-regulated profession and members of the ADA, which is an honored and trusted dental organization, to do so. It is also our obligation to assure that we maintain these ADA and Virginia standards by our own actions and that of others. If we don't, someone else will.

Awards & Recognition



Dr. Harry Simpson honored by Gloucester Boys & Girls Club

May 10, 2011 - More than 60 people, including family, friends and Gloucester Boys & Girls Club officials, gathered for the recognition ceremony naming the Gloucester Boys & Girls club after Dr. Simpson. Dr. Simpson has been a lifelong participant and supporter of the organization.

Richmond Endodontist Honored by American Association of Endodontists

James R. Lance, D.D.S., received the Spirit of Service Lifetime Dental Community Award from the American Association of Endodontists during its recent Annual Session in San Antonio, Texas.

Dr. Lance, a retired endodontist living in Richmond, Va., dedicates much of his time and resources to treating the underserved in his community. Most recently, he participated in the Virginia Dental Association's Mission of Mercy, which donates its time and resources to provide free dental care. He personally provided endodontic services at 21 MOM projects, completing more than 400 root canal procedures and mentoring endodontic residents to do the same. Dr. Lance donated the vast majority of the endodontic instruments for the projects in which he participated.

Dr. Carol Pratt Named Robert Wood Johnson Fellow

May 5, 2011 – Carole Pratt, DDS, from Pulaski, Va., has been named one of five Health Policy Fellows with the Robert Wood Johnson Foundation (RWJF) for 2011-12. Pratt begins her one-year term in September 2011. The Health Policy Fellows program is a minimum of one-year residential experience in Washington, D.C. that gives exceptional mid-career health professionals and scientists an opportunity to actively participate in health policy processes at the federal level and gain exclusive, hands-on policy experience. Pratt practiced general dentistry in southwest Virginia for 32 years, during which time she served four terms as chair of Virginia's Board of Health and was vice chair of the Department of Medical Assistance Services. In 2009, she was named a Fellow of the National Rural Health Association and currently serves as a board member of the Virginia Oral Health Coalition.

(L) Dr. Bruce Hutchison, (R) Brian Sodergren

Dr. Bruce Hutchison recognized by American Dental Association

Dr. Bruce Hutchison was recognized by the ADA for the work he did with the fundraiser for Virginia Senator Dick Saslaw in 2010. He was presented his award during the ADA Washington Leadership Conference in Washington, D.C. on May 11, 2011 by Brian Sodergren, ADA Manager, Grassroots Education.

Recruiting New Members:
The Use of Social Media

By: Dr. Alan Bream, Chair, Membership Committee

Membership is an area where we all have the ability to make a positive impact. Invite a colleague with you to a meeting or arrange a get together with a new dentist in your component to discuss the benefits and importance of membership.

The business of dentistry has been affected by the "Great Recession". Office budgets are tight making ADA/VDA membership a tough choice. Recent dental school graduates get free or discounted membership for their first five years in practice. Existing members are eligible for financial assistance through the VDA. Ask your component officers to help make arrangements through the VDA.

In component VII we are trying a somewhat different approach. Dr. Danielle Ryan is putting together a Facebook® page. We will use this resource to inform the public of the contributions that dentistry provides to their community. Facebook will allow contributions from dentists, staff, clinics, and dental offices. If you provide free care in your office, at a free clinic, MOM project, or missionary work we want you to post your activities. Post any civic or voluntary work you (or your staff) contribute to your community. My vision is to have the public excited enough about the VDA that they will ask their dentist if they are members of the VDA.

This Facebook page will be monitored daily so that inappropriate material, information, or content can be deleted. Participation is a vital part of creating a successful Facebook page so I hope you will sign up as a "friend".

.

I have applied for a grant from the ADA to help with membership activities. Geography isolates our members into several clusters. In an effort to reach more members I would like to add two half-day educational meetings each year, which will rotate their location within the component.

Virginia Dental Association
Governance Meeting

September 16-18, 2011
Fredericksburg, VA

The 2011 Virginia Dental Association Governance Meeting will be held September 17-18. Per the direction of the 2010 House of Delegates, this will be the first year of the one and a half day meeting.

Looking at the schedule you will see that Saturday is a full day beginning with the opening sessions followed by the reference committee meetings and the Annual Business Meeting in the afternoon.

The VDA Fellows will hold their annual meeting during a lunch at noon on Saturday.

The reception and Awards Banquet Saturday evening give an opportunity to socialize with your colleagues and recognize the individuals being honored for their contributions to and leadership in the VDA.

Sunday morning the component caucuses will meet followed by the second meeting of the House.

Please remember that these meetings are open to all members. This is an opportunity to see how your VDA is responding to the challenges of access to care, workforce issues, governmental intrusion and a whole host of related matters. You may find that you would like to join the process and help your profession.

The House promises to be engaging and meaningful for the working of the VDA. There should be many issues that need to be resolved. Fortunately we should have the time to talk about, reflect upon and then act to help our profession. Your participation and deliberations are vital to the member driven VDA.

See you there,
David C. Anderson, D.D.S.
Speaker of the House

HOTEL RESERVATION INFORMATION

Fredericksburg Hospitality House Hotel and Conference Center
2801 Plank Rd.
Fredericksburg, VA 22401

ROOMS ARE AVAILABLE UNDER THE VDA ROOM BLOCK FOR THE NIGHTS OF SEPTEMBER 15th – 17th

ROOM RATE: $ 89.00 Single/Double
$300.00 Suite
(Price does not reflect the local room tax.)

RESERVATIONS MUST BE MADE BY AUGUST 16, 2011
(Any reservation received after this date will be accepted on a space and rate availability basis.)

CALL: 540-786-8321 (Direct)
800-682-1049
(Be sure to ask for the VDA Governance Meeting block rate)

ONLINE: Use hotel reservation link provided on the reservation form in the Governance Meeting information on the VDA website.

2011 VDA GOVERNANCE MEETING SCHEDULE

Friday, September 16, 2011

12:00pm	Board of Directors

Saturday, Sept. 17th

7:00am-8:00am	Breakfast
7:00am-1:30pm	Election of Officers
7:15am-8:00am	HOD Registration
8:00am-9:30am	Opening Sessions
10:00am-11:00pm	RC 1000
11:15am-12:15pm	RC 2000
12:15pm	Lunch (On Your Own)
12:15pm	Fellows Lunch
2:00pm-3:00pm	Annual Business Meeting
3:15pm	VDSC
3:15pm	C & B Committee
4:45pm,	16th District
6:00pm/6:30pm	Reception/Award Banquet

Sunday, Sept. 18th

6:30am-7:30am	Breakfast
7:00am-8:00am	Caucus Meetings
7:45am-8:30am	HOD Registration
8:30am-11:00am	House of Delegates
11:15am-12:30pm	Board of Directors

Membership

VDA AWARDS BANQUET

When: Saturday, September 17, 2011
6:00PM Reception 6:30PM Dinner

Where: Fredericksburg Hospitality House Hotel and Conference Center
2801 Plank Rd. Fredericksburg, VA 22401

Cost: $20.00 – House of Delegate Members/Board of Directors
$50.00 – All other guests

TICKET SALES DEADLINE: SEPTEMBER 2, 2011 – NO ONSITE SALES

To attend, please fill out the following and mail or fax to the VDA Central Office.

Name: _____ Number attending: _____

Amount enclosed: _____

Payment: Check payable to VDA

Credit Card # _____ Expiration Date: _____
MasterCard or Visa Only

Print Name:_____ Signature: _____
(As it appears on card) (Signature indicates approval for charges to your account and payment under the credit card issuer's agreement.)

Card Billing Address: _____

Please mail or fax to:
Virginia Dental Association
3460 Mayland Ct, #110 Henrico, VA 23233
Fax: 804-288-1880

Awards Banquet

VDA MEMBER VOTING OPTIONS

There are three methods of voting available:

1. Written Absentee Ballot:
   - Absentee ballots may be requested from the VDA Central office beginning 30 days prior to the election (August 17th). An Absentee Ballot Request Form will be in the July, August, September edition of the Journal.
   - An absentee ballot will be mailed to the member and must be returned to the Central Office no later than 12:00 noon two business days prior to the start of the Governance Meeting (Wednesday, September 15th) in the envelopes provided.
2. Online Voting:
   - A secure Member Voting Module will be available on the VDA website (www.vadental.org) beginning August 17th.
   - Members will use selected identifiers to login and protect the security of the vote and the privacy of the member.
   - Online voting will be available until 12:00 noon September 17, 2011.
3. In Person:
   - Computers will be available for member voting at the Governance Meeting.
   - Voting on site is also done through the secure Member Voting Module on the VDA website.

It is not possible for a member to vote more than once.

In the event of a runoff election, elections will take place at the Annual Business Meeting which will be held at 2:00pm Saturday, September 17, 2011.

VDA FELLOWS LUNCH

When: Saturday, September 17, 2011
12:15pm-1:45pm

Where: Fredericksburg Hospitality House Hotel and Conference Center
2801 Plank Rd. Fredericksburg, VA 22401

Cost: $26.00

TO ATTEND PLEASE COMPLETE THE FOLLOWING AND MAIL OR FAX TO THE VDA CENTRAL OFFICE BY SEPTEMBER 2, 2011. NO ONSITE TICKET SALES.

To attend, please fill out the following and mail or fax to the VDA Central Office.

Name: _____ Number attending: _____

Amount enclosed: _____ Payment: Check payable to VDA

Credit Card # _____ Expiration Date: _____
MasterCard or Visa Only

Print Name:_____ Signature: _____
(As it appears on card) (Signature indicates approval for charges to your account and payment under the credit card issuer's agreement.)

Card Billing Address: _____

Please mail or fax to: Virginia Dental Association
3460 Mayland Ct, #110 Henrico, VA 23233
Fax: 804-288-1880

Fellows Lunch

VDA Governance Meeting Absentee Ballot Request

Please send an absentee ballot to:

Name: _____

Address: _____

_____

Phone: _____ - _____ - _____

Absentee ballots will be available August 17, 2011 from the VDA Central Office and must be returned no later than Noon on Wednesday, September 15, 2011.

Send you absentee ballot request to the VDA Cenral Office at the address below:

VDA - Attention Bonnie Anderson
3460 Mayland Ct, #110
Henrico, VA 23233

VDA Membership Directory Request Form

Please send a membership directory to:

Name: _____

Address: _____

_____

Phone: _____ - _____ - _____

Please allow 7-10 business days to receive your directory

Send you membership directory request to the VDA Cenral Office at the address below:

VDA - Attention Leslie Pinkston
3460 Mayland Ct, #110
Henrico, VA 23233

Virginia Dental Association
Board of Directors
Actions in Brief
April 28, 2011

I. Item that requires action by the House of Delegates:

A. The following was approved as VDA policy: (Anyone wishing to use the VDA logo would need to contact the VDA and sign the following agreement.)

1. VDA Logo Usage Policy

The logo of the Virginia Dental Association (VDA) represents an important element of our Association's identity. Members in good standing may use the logo to identify themselves as members of the VDA. Use of the VDA logo by members demonstrates pride in Association membership and helps to identify the VDA to patients and the public.

The Virginia Dental Association will license use of its logo to any member who agrees to and satisfies the terms of the License Agreement set forth below. PLEASE READ THE AGREEMENT CAREFULLY. If you agree to its terms, please indicate your acceptance by signing where indicated at the end of the Agreement.

Agreement for Licensing Of VDA Logo to Members

In consideration for a limited license from the Virginia Dental Association ("VDA") to use its logo in accordance with the terms and conditions set forth below, I hereby agree as follows: I recognize that the attached logo is the sole and exclusive property of the VDA. By using the VDA logo, I acquire no rights in that logo other than as set forth in this license.

I will use the VDA logo only as long as I remain a member in good standing of the VDA. I will not make any use of the logo without clearly and conspicuously indicating a category of my membership in VDA, e.g. Active Member, Associate Member. I will immediately cease using the logo if I cease being a member of the Association, and I will immediately make the appropriate modification in my use of the logo if my membership category changes.

I recognize that the VDA may revoke my license to use the logo at any time and for any reason. I hereby waive any and all rights that I may have to contest revocation by the VDA of my right to use the VDA logo.

I will not revise or alter the VDA logo as set forth below in any way. I will always use the logo as it currently appears, except in terms of color and size. I may use the logo only on my stationery, business cards, in telephone directory listings, and on my website. The logo may not appear on any educational advertising or marketing materials. This includes any correspondence on letterhead related to such events.

Notwithstanding the foregoing, I may not use the VDA logo in any manner that, in the sole discretion of the VDA, discredits the VDA; is false or misleading; violates the rights of others; or violates any law, regulation or other public policy. I will not make any claim that states or implies endorsement, approval, sponsorship, or certification of me or my practice by the VDA. I will immediately cease using the VDA logo if I am convicted of a felony; am found to have a substance abuse problem; have my dental or Controlled Substances Act license revoked, suspended, or restricted; or have disciplinary proceedings instituted against me by the VDA, any licensure authority, or similar institution.

If requested by the VDA, I shall give the VDA samples of my use of the VDA logo. I agree to forfeit any and all right to use the logo if the VDA, in its sole discretion, determines that my use of the logo is not in strict accordance with the terms and conditions of this license.

I agree that use of this logo does not imply, or suggest in any way, endorsement by the VDA. I will direct any questions concerning the use of the VDA logo or the terms and conditions of this license to the VDA Membership Director at (804) 288-5750.

Read and agreed to:

_____

Signature

_____

Print Name

Actions in Brief Continued

II. The following is reported as information only:

A. The following resolution was approved:

1. Background: The attendees of the November 12-13, 2010 VDA Leadership Conference developed a number of challenges for the next one to five years.

Resolution:A task force, chaired by the VDA president elect, will be appointed by the VDA president to insure that the challenges are met.

The task force is to: (1) finalize a strategic plan for the VDA based upon the VDA adaptive challenges (November 2010) and (2) delineate a means for long-term implementation and evaluation of the strategic plan.

Welcome New Members!

July 2011

NORTHERN VIRGINIA DENTAL SOCIETY

• Dr. Robert Cheron graduated from the University of Pennsylvania in 2003. He attended the Universtiy of CA, SF, where he completed his Certificate in Endodontics /MS in 2007. Dr. Cheron is practicing in Arlington.

• Dr. Ahmed Ezzeldin graduated from the New York University College of Dentistry in 2009. He continued at the Woodhull Hospital in Brooklyn to complete his GPR 2010. Dr. Ezzeldin is currently practicing in Alexandria with Telegraph Dentists.

• Dr. Anthony Hoang graduated from Temple University in 1998. He is currently practicing in Burke.

• Dr. Gretchen Jungerman graduated from the University of Florida in 1998. She received her Certificate in Endodontics in 2008. Dr. Jungerman is currently practicing in Falls Church.

• Dr. Thomas Lin graduated from Boston University in 2006. He continued to the University of Pennsylvania where he completed his specialization in periodontics in 2009. Dr. Lin is currently practicing in Lorton.

• Dr. Audrey Maiurano graduated from VCU School of Dentistry in 2010.Dr. Maiurano is currently practicing in Fairfax.

• Dr. Tamesha Morris graduated from VCU School of Dentistry in 2003. Dr. Morris is currently practicing in Dumfries.

• Dr. Sassan Nadjmi graduated from Tufts Dental School in 2000. He completed his Certificate in Prosthodontics in 2007. Dr. Nadjmi is currently practicing in Falls Church.

• Dr. Sara Shambayati graduated from Case Western University in 1999. She received her Certificate in Endodontics in 2003. Dr. Shambayati is currently practicing in Arlington with Dr. Shojaei.

• Dr. Joshua Swanson graduated from University of Louisville in 2008. He is currently practicing in King George.

• Dr. Kambiz Tavakkoli graduated from Temple University in 1998. He is currently practicing in Woodbridge.

• Dr. Mady Zeyad graduated from the University of Illinois at Chicago in 2006. He is currently practicing with Dr. James Green in Alexandria.

PIEDMONT DENTAL SOCIETY

• Dr. Michelle Anderson graduated from Tufts School of Dentistry in 2007, and completed her Certificate in Pediatric Dentistry in 2009. Dr. Anderson is practicing in Roanoke.

RICHMOND DENTAL SOCIETY

• Dr. Neil Agnihotri graduated from the University of Medicine and Dentistry of New Jersey in 2003. He completed his specialization in Oral and Maxillofacial Surgery in 2009. Dr. Agnihotri is currently practicing with Drs. Niamtu, Alexander, Keeney, Harris, Metzger, and Dymon, PC. in Glen Allen.

• Dr. Elizabeth Bortell graduated from Howard University in 1999. She completed her certificate in pediatric dentistry in 2001. Dr. Bortell is currently practicing at the Children's Hospital of Richmond.

• Dr. Thomas Vahdani graduated from the University of Southern CA in 2003. Dr. Vahdani will be joining VCU school of Dentistry as Assistant Professor full-time and practicing in Faculty Practice.

• Dr. Andrew Zima graduated from the VCU School of Dentistry in 2008. He completed his specialization in Pediatric Dentistry in 2010. Dr. Zima is currently practicing with Hanover Pediatric Dentistry in Mechanicsville.

SOUTHSIDE DENTAL SOCIETY

• Dr. Erika Crawford graduated from VCU School of Dentistry in 2010. She is currently practicing in Colonial Heights.

Spotlight on New Members:

Dr. Joseph Bernier-Rodriguez

What Dental School did you attend? VCU School of Dentistry Class of 2002. In 2008 I received my Certificate of Endodontics. I am currently practicing at Meares & Bemier Endodontics in VA Beach.

What High School did you attend? Lake Braddock Secondary School, Burke, VA

What are your hobbies? Scuba Diving, Travelling, Spending time with my family

Favorite movie (or book)? Books written by Dan Brown

Why did you join the VDA? My father practiced Endodontics for over 20 years in Northern Virginia and was active in organized dentistry. I feel an obligation to give back to the profession that has provided so much for my family.

In Memory Of...

Name	Component	City	Date
Dr. William H. Higinbotham, Jr.	Tidewater Dental Association	Suffolk	May 30, 2011
Dr. John D. Rice	Southside Dental Society	Sutherland	April 22, 2011
Dr. David G. Shannon	Richmond Dental Society	Richmond	October 1, 2010
Dr. Julian P Todd, Jr.	Richmond Dental Society	Richmond	April 22, 2011
Dr. Emerson Cornett Gambill,Sr.	Shenandoah Valley Dental Association	Harrisonburg	February 1, 2011
Dr. Douglas C Wendt	Northern Virginia Dental Society	Reston	March 17, 2011
Dr. Albert G Paulsen	Northern Virginia Dental Society	Falls Church	February 10, 2011

Corpulent Canine

Fat Dogs Don't Hunt

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

Dentists have had it pretty good over the years. Compared to our physician counterparts, we have had much less interference from insurance companies, have maintained a good deal of independence, regulators have been held at bay- for the most part- and most patients still go to the dentist they choose instead of the one the insurance company tells them to go to. We are FAT DOGS. Life is good so it's easy to assume that it will always be good. But have we forgotten how to hunt?

Bleaching kiosks in the malls. Insurance companies devising new ways to delay and deny claims. Insurance maximums. Lists of insurance dentists. Advanced Dental hygiene Practitioner (ADHP) being pushed by the hygiene association where a hygienist with "a little more training" can do restorative procedures, perform a dental diagnosis, and perform many other "dentist only" tasks - without the direct supervision of a dentist. Dental hygienists have their own Board, and they are no longer regulated by the Board of Dentistry. DHATs - community college educated persons who can perform restorative procedures and extractions. Dentists just over the border providing dental care at drastically reduced rates with no malpractice worries, no regulation, and no recourse. Patients having their dentures made by a lab technician- with absolutely no input from the dentist.

"This could never happen here" the FAT DOG says. Well, all of this is happening NOW in the United States.

Thomas Jefferson said "America is not a government of the majority. It is a government of the majority who participate." You can bet all those groups listed before are speaking with their legislators telling them you don't really have to be a dentists to do all these "simple" procedures. They can do it for less - but maintain the same quality of care. Do you believe that?

Get involved. Prevent our great profession from eroding away. Pay your VADPAC dues, move your contribution up to Governor's Club or Apollonia levels. Learn how to hunt again. PARTICIPATE.

VADPAC UPDATE

Component	# of Members Contributing to Date	2011 VADPAC Goal	Amount Contributed to Date	Per Capita Contribution	Amount Needed to Reach Goal
1	167	$44,000	**$40,460**	$242	$3,540
2	113	$25,000	**$27,376**	$242	$0
3	51	$12,500	**$12,600**	$247	$57
4	232	$60,500	**$65,027**	$280	$0
5	112	$28,100	**$26,701**	$242	$1,399
6	89	$23,000	**$26,368**	$296	$0
7	105	$30,000	**$26,316**	$251	$3,684
8	479	$132,000	**$129,323**	$270	$2,677
TOTAL	1,348	$355,100	**$354,171**	$259	**$929**

Total Contributions: $354,171

Goal: $355,100

WE NEED CONTRIBUTIONS TO RAISE $5,539!

Time and again, we have encouraged dentists across Virginia to develop good working relationships with legislators. After all, it's the only way to make sure that your voice is heard in Richmond.

Effective working relationships depend on personal knowledge and your willingness to serve as a sounding board when legislation affecting your profession is being considered by the General Assembly. There are other important considerations in building effective political relationships, including providing campaign assistance for legislators and candidates running for the House and Senate.

Every year, VADPAC participates vigorously in the political process to make sure that dentistry's voice is heard and to ensure that the interests of your patients are foremost in the General Assembly's eyes.

VADPAC can play this role only with your support. Whether you like the political process or not, the hard facts of the matter are that effective political relationships involve campaign assistance for legislators and candidates who support the work of the VDA.

Realizing these facts, it's hard to believe that any dentist in the Commonwealth would not contribute to VADPAC. Unfortunately, however, only 50% of VDA members contribute each year. This means that 50% of the membership is carrying the weight of all Virginia dentists.

Our political action efforts, including the important contributions made to these efforts by VADPAC, have been very productive.

Can you imagine how much more successful the VDA would be if every dentist contributed? For members who think that their money is used to support party politics, this is NOT the case.

VADPAC is not affiliated with a particular political party. VADPAC supports legislators regardless of their political affiliations and without regard to their positions on issues other than those affecting the dental profession and dental patients. The criteria used by VADPAC in making campaign contributions to incumbent legislators are based solely on a legislator's history of support for dentistry and our patients. For candidates, the criteria involves taking the first step, the first of several, in building an effective working relationship.

Bottom Line: Your VADPAC dollars allow the VDA position to be heard by the people who make the laws in the Commonwealth: the statues directly affecting you and your patients. Please contribute today!

Fundraiser for Delegate Cox

VDA Hosts Fundraising Event for House Majority & Minority Leaders, Kirk Cox & Ward Armstrong: Both Friends of Dentistry

By: Laura Givens, VDA - Director -Legislative and Public Policy

Thanks to the dynamic leadership of Dr. Sam Galstan, the VDA hosted a very successful fundraiser for Delegate Kirk Cox on April 19th at the Swift Creek Mill Theatre in Colonial Heights. The event was attended by 40 VDA members, friends and guests. Delegate Cox represents the 66th district and has provided a consistently high level of leadership during his legislative tenure; witness his selection as the House of Delegates Majority Leader. Delegate Cox has been a friend of dentistry and supported VDA efforts on behalf of our profession and patients for many years. As Majority Leader and a Budget Conferee, he has a keen understanding of how legislation and the Budget impact dentistry. This event was a great opportunity for VDA members to thank him for his ongoing support.

Dr. Craig Dietrich led the charge for another successful VDA House leadership event recently: this time for Martinsville's favorite son, Delegate Ward Armstrong.

The Chatmoss Country Club was the site on May 11th as dentists and their guests from the area gathered to express their appreciation for Armstrong, the House Minority Floor Leader, and a longtime supporter of dentistry.

Fundraiser for Delegate Arnstrong

VDA Action Team Leaders Present Important Agenda to Virginia's Federal Leaders at ADA Washington Leadership Conference

By: Laura Givens, VDA - Director -Legislative and Public Policy

Hundreds of dentists, state dental association lobbyists and staff members gathered at the Hyatt Regency in Washington, DC May 9-11th for the Annual ADA Washington Leadership Conference. Conference attendees were briefed on the key issues to be discussed during their Capitol Hill visits and also heard from several Congressmen and political commentators.

Among the speakers at the conference was freshman Congressman Dr. Paul Gosar (R-AZ), an ADA member dentist. Strong support from Gosar's ADA colleagues helped him win the seat last fall: certainly a victory to have another dentist elected to the Congress during this time of great change in health care.

Dr. Bruce Hutchison (L) was recognized by the ADA for the work he did with the fundraiser for Virginia Senator Dick Saslaw in 2010. He was presented his award during the ADA Washington Leadership Conference in Washington, D.C. on May 11, 2011 by Brian Sodergren, ADA Manager, Grassroots Education.

Representative Gosar (R-AZ) is wasting no time adding his voice to the Health care debate in Washington; note the discussion below about his legislation, HR1150.

The issues at the forefront of Congressional lobbying this year are:

- **Breaking Barriers to Oral Health Act of 2011: HR1666**
  A bill designed to help oral health providers at the state and local levels form public-private partnerships to improve oral health education and dental disease prevention and reduce barriers to oral health care. The bill also offers support for local and state programs that provide free dental services. At a time of fiscal constraints, HR1666 recognizes that limited federal resources should be targeted closer to the patient.

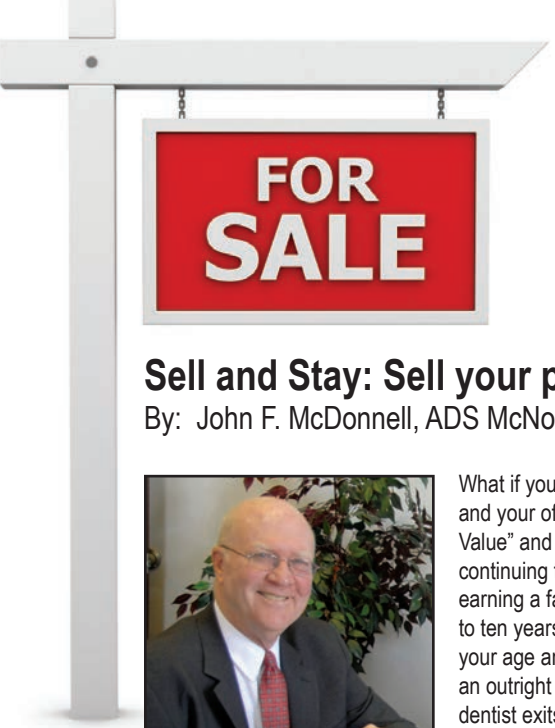
- **Patients' Freedom to Choose Act: HR605/S312**
  These bills repeal sections 9005 and 10902 of the Patient Protection and Affordable Care Act (PPACA) and section 1403 of the Health Care and Education Reconciliation Act of 2010. These bills represent a common sense way to allow consumers to decide how they will set aside funds to pay out-of-pocket health care costs. The PPACA's treatment of FSAs runs counter to our interests of making health care more affordable. These bills correct that, restoring to consumers a greater degree of control over their health care expenses. If out-of-pocket costs for traditional medical insurance exceed the newly established $2,500 annual limit, consumers will be faced with hard decisions about the affordability of additional health care costs like vision and dental care. Hundreds of thousands of Americans (many of whom have middle-class incomes) rely on medical FSAs to cover these rising out-of-pocket health care costs.

- **The Competitive Insurance Reform Act of 2011: HR1150**
  The McCarran-Ferguson Act adversely affects the public by exempting insurers from some federal antitrust laws. This bill was introduced by Rep. Paul Gosar (R-AZ), a fellow dentist, and would repeal this unfair exemption. Application of the federal antitrust laws to the business of health insurance should produce consumer protections and enhanced competition.

The VDA would like to thank all Action Team Leaders who were able to attend and meet with their Representative and Senators. The Action Team Leaders participating were: Dr. David Anderson, Dr. H.J. Barrett, Dr. Mark Crabtree, Dr. Wally Huff, Dr. Bruce Hutchison, Dr. Rod Klima, Dr. Ron Tankersley, Dr. Don Trawick and Dr. Gus Vlahos. The Action Team Leaders and VDA Legislative Committee will continue to monitor the issues at hand and communicate with the Washington delegation as necessary.

All members are encouraged to participate in legislative and grassroots events like the ADA WLC, as well as the VDA Day on the Hill in Richmond and by attending local fundraisers for incumbents and candidates in your respective districts.

Save the Date for the VDA Day on the Hill: January 20, 2012. Please contact Laura Givens at givens@vadental.org or 804-523-2185 with questions on upcoming events and/or contributing to the Virginia Dental Political Action Committee (VADPAC).



Sell and Stay: Sell your practice now, stay on after the sale

By: John F. McDonnell, ADS McNor Group

What if you could sell your practice and your office space at "Fair Market Value" and stay on after the sale, continuing to enjoy dentistry and earning a fair compensation for two to ten years (or more) depending on your age and exit timetable? Although an outright sale, when the selling dentist exits the practice immediately or within three to six months, is still the most popular exit strategy, selling and staying on after the sale is becoming a good option for sellers.

REASONS TO SELL AND STAY

When we interview dentists who are preparing their exit strategy, the common theme is they still enjoy performing dentistry and communicating with the patients, but do not like running the business, dealing with insurance companies and handling staff issues.

Some of the reasons that dentists are choosing to sell and stay on after the sale are:

1. They are tired of being a business owner 24/7 – 365 days a year.
2. They have peace of mind completing their exit strategy while still practicing dentistry.
3. We are finding dentists in their thirties, forties, and fifties who have a large debt service and high monthly payment to the bank. They have good practices but, due to the high debt, find it very stressful and their earnings are not as high as they want.
4. Some dentists from ages 50 to 70 do not want to sign another long term lease that commits them to a space longer then they want.
5. Owners with a full time associate realize that they can switch roles with the associate and stay on after the sale.
6. Baby boomers have set a goal of selling their practices after reaching age 55. The strategy allows them to sell, but continue earning income and increase savings to offset losses they have had due to the economic downturn in recent years.

EXAMPLES OF SELLING AND STAYING

Dr. "A" had a very successful solo practice. She was ready to plan her exit strategy but wanted to continue to work her normal four-day work schedule for two or more years, and then cut back her days until she would exit all together within four to five years. She sold her practice for the "Fair Market Value" plus her accounts receivables and now earns a good income. Almost immediately, she had peace of mind of knowing that her exit strategy had been implemented.

Dr. "B", 42, was faced with signing a new seven-year lease in his 2000 square foot, six operatory office space. Having purchased new equipment and renovating the office a few years ago, he was stressed by the $400,000 bank loan affecting his compensation. He sold the practice, paid off the loan completely, and still had money left over from the sale. He is now in a position to earn as much or more from the practice as an associate.

Dr. "C" had an excellent practice with a full time associate. Both the owner and the associate were in their sixties. Dr. "C" wanted to plan for his exit from the practice within five years. As his associate was leaving and moving out of the state, Dr. "C" discovered that he could sell the practice at its peak performance and value and stay on after the sale for five years. He was able to continue to work on the same patients and the new owner treated the patients of the associate who left the area.

WHO ARE THE BUYERS?

1. Dentists who see the opportunities in dentistry and choose to own multiple practices. They are able to keep the selling dentist and take charge of all of the business aspects of the practice including responsibility for future practice growth. .

2. Dentists in a dead-end associate (employee) job who are willing to buy a practice now, and wait for it to grow so that they can have their own practice. They may continue to work a part time job as they grow the practice.

HOW TO EXPLORE THE SELL AND STAY STRATEGY

1. Choose a transition organization that specializes in practice transitions and does not have other products and services to sell you like dental equipment, financial planning and practice management.

2. Have your practice valued by a qualified transition specialty organization that is experienced in this area.

3. Decide what you want to do and what your timetable is. Plan your transition now and how long you want to stay after the sale.

For a dentist who loves performing dentistry and communicating with patients, and who is ready to implement a successful exit strategy, selling the practice and staying is an excellent alternative.

Editor's Note: John F. McDonnell is founder and former President of ADS McNor Group. He may be reached at (888) 273-1014, ext. 103 or johnfm@adstransitions.com.

Classified Advertisements

Job Opportunities

Two Dentists Needed, Orange County, VA

Piedmont Regional Dental Clinic (nonprofit) seeks staff dentists. 70% of patients are children under 18. Pedodontics in a fast paced environment required. No practice management responsibilities. Full job description: http://www/vaprdc.org/Jobs/index.php

Family Dental of VA desires motivated, quality oriented General Dentists to work in our busy practices in **Hampton & Richmond, Virginia**.

At ***Family Dental of VA*** we focus on providing the entire family superior quality general dentistry, in a modern technologically advanced setting with experienced support staff.

Because we understand the tremendous value of our Associate Dentists, we make sure that their compensation package is ranked amongst the best.

Our competitive compensation package includes:

1. Average earning potential of $200,000 to $350,000 per annum

2. Malpractice insurance

3. Health insurance

4. Paid vacation*

5. Visa/permanent residency sponsorship

6. Relocation assistance*

7. Sign-on bonus*

*Certain locations

For more information, please contact:
Chyrisse Patterson
Director, Human Resources
312-274-4520 office
312-944-9499 fax
cjpatterson@kosservices.com

Miscellaneous

NEW OWNER REPRESENTATION:
Our family and organization has represented over 1000 new owners over the last 65 years in the mid-Atlantic area that have purchased, started or became partners in a dental practice. Ownership is a decision that is too important to make without a qualified facilitator. We can get the new owner 100% financing plus working capital. Call us for a FREE CONSULTATION and allow us to send you a list of our references. THE MCNOR GROUP, 888-273-1014 x 103 or johnf@mcnorgroup.com, www.mcnorgroup.com

SELLERS WANTED
We have qualified buyers with 100% funding approval that want to buy a practice in Virginia. The baby boomers are starting to sell and this is a great time to transition your practice. We get excellent prices and sell the practice in a timely, healthy manner. THE MCNOR GROUP, 888-273-1014 x 103 or johnf@mcnorgroup.com, www.mcnorgroup.com

WANTED
Your gently used Cavitrons, Curing Lights, Amalgamators. Please contact Barbara Rollins at the VDA rollins@vadental.org or 804-288-5750 Thank You!

Interim Professional Service:
Maternity Leave, Vacations, Illness, Disability, Part-Time Associates. Maintain Production & Patient Access. Also, Interim Job Opportunities. Forest Irons & Associates 800-433-2603 www.forestirons.com DENTISTS HELPING DENTISTS SINCE 1984

PRACTICE VALUATION APPRAISAL
We are the only transition consulting company in the area that has a Certified Valuation Analyst CVA as a principal that focuses exclusively on the transition of DENTAL PRACTICES. Please see the article by CVA Karen Norris on page 82 of the April 07 issue of Dental Economics on this subject or call or email us for a FREE CONSULTATION and a copy of the article. If you are selling, buying, creating a partnership or just want to find out the current value of your practice contact THE MCNOR GROUP, 888-273-1014 x 103 or johnf@mcnorgroup.com, www.mcnorgroup.com

Practices For Sale/Lease

PARTNERSHIPS OR DELAYED SALES
We have many satisfied clients with associates in your area that we have helped to either buy-in, buy-out or conduct a delayed sale with the current associate. Without a quality valuation and plan up front these transactions normally fail. Call or email us to arrange a FREE CONSULTATION to find out if you are a candidate for this service. The result is higher income and a higher practice value for the seller and a clear financially positive path for the associate. THE MCNOR GROUP, 888-273-1014 X 103 or johnf@mcnorgroup.com, www.mcnorgroup.com.

PRACTICE BUYERS WANTED
For great practices in the Virginia area. We have many practices available for sale in the Virginia area. Are you tired of being an employee in a dead end job? Call us for a FREE CONSULTATION to find out about these opportunities. THE MCNOR GROUP, 888-273-1014 x 103 or johnf@mcnorgroup.com, www.mcnorgroup.com

Classified advertising rates are $60 for up to 30 words. Additional words are .25 each. It will remain in the Journal for one issue unless renewed. All advertisements must be prepaid and cannot be accepted by phone. Faxed advertisements (804-288-1880)must include credit card information. Checks should be payable to the Virginia Dental Association. The closing date for all copy will be the 1st of December, March, June, and September. After the deadline closes, the Journal cannot cancel previously ordered ads. The deadline is firm. As a membership service, ads are restricted to VDA and ADA members unless employment or continuing education related. Advertising copy must be typewritten in a Word document and either mailed (in the form of a disc) or emailed to the following address: Journal and Website Classified Department, Virginia Dental Association, P.O. Box 3095, Henrico, VA 23228 or emailed to jacobs@vadental.org. The Virginia Dental Association reserves the right to edit copy or reject any classified ad and does not assume liability for the contents of classified advertising.

It is estimated that over 30% of dental restorations go to off shore laboratories!

Are you and your patients informed of where your restorations are made?

Baran Dental Laboratory

"Keeping jobs here in America!"

Come Visit Your Case With Us!

703.961.0116/800.941.4291

Baran Dental Laboratory

The Choice for Crowns, Bridges & Implants

4433-E Brookfield Corporate Drive, Chantilly, Virginia 20151

703.961.0116/800.941.4291

& Milling Center

Ceramic Crowns starting as low as $135.

PFM Crowns starting as low as $140.

Patient Specific Custom Designed Restorations:

Proudly Crafted Here in America!

Virginia Dental Journal

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

VISIT US ONLINE AT WWW.VADENTAL.ORG

VDA SERVICES

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

VDA Services Endorsed Vendors

Peer Reviewed • Members Only Benefits • Supporting the VDA

By using the vendors below you are able to access member benefits and support your Association simply by purchasing the products and services you are likely already using. By choosing the VDA Services vendors you are providing a valuable source of non-dues revenue that is used to support the MOM Projects, the Virginia Meeting, the 8 local component dental societies and continuing education programs across the Commonwealth.

Bank of America

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

Banc of America Practice Solutions™
A subsidiary of Bank of America

MEDICAL PROTECTIVE
Strength. Defense. Solutions. Since 1899.
a Berkshire Hathaway Company

MDE
DENTAL OFFICE EFFICIENCY EVOLVED.

PROSITES
Website Design and Internet Marketing

CareCredit
Patient Payment Plans

PAYCHEX

VDA SERVICES GLOVES

GreenFlag
PROFIT RECOVERY
BY TRANSWORLD SYSTEMS

Hand Craft
LINEN SERVICE

SolmeteX®

WorldPay™

For more information, contact Elise at the VDA — 804-523-2184 or visit www.vadental.org.