Volume 88, Number 2 • April, May & June 2011

VDA Virginia Dental Association Journal

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April, May & June 2011

HEADLINES & ARTICLES

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The VDA staff is scheduled to move into their new offices on Monday, April 25th. The office will be closed on April 25th for this move.

Please make a note of our new contact information (effective April 25th)

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Message from the Editor

Dr. Richard F. Roadcap

Researchers at the University of Southern California calculated that if all of the world's data were stored on compact discs, the stack would reach beyond the moon[1] (assuming the CDs are in jewel cases). I'm sure dental continuing education would contribute a few feet to the height. CE, at least for dentists, has evolved into an industry of its own and become a full time pursuit for many well-known speakers. It consumes many of our discretionary dollars and countless hours of unallocated time. I've always considered it to be one of four pillars of a dental career, as it shapes our professional life and our identity as practicing dentists.

Technology has changed the face of CE, as it has for nearly everything else in the last fifteen or twenty years. The darkened hotel conference room has given way to many other forms of professional education. Live patient demonstrations, hands on learning, online courses, webinars, podcasts, and now apps for the ubiquitous "smart phones" are supplanting the 2:00 p.m. nap at the Hyatt. Courses range in length from a week at an exotic resort to an hour at the local army base. Fees can be insanely expensive or the price of dinner, with the course for free. As in everything else, you don't always "get what you pay for". Some of the most memorable, provocative, and habit-changing classes have been a half day or less. I don't know if that's due to an avoidance of information overload, or our ability to absorb knowledge in brief, intense bursts of understanding. I recall, in particular, a Friday afternoon lecture by Dr. Stanley Malamed on the subject of local anesthesia. At the time I had been in practice about ten years and felt supremely confident in my knowledge of the subject. In two or three hours he convinced me I knew almost nothing (he was correct) and forever changed my dental school-flavored perspective. Would a class lasting one (or two) days have had the same impact?

How much CE is enough? Some colleagues have an insatiable appetite for courses, others get by. Nearly all states have a mandatory requirement for continuing education, with the national average being about twenty credit hours.[2] (Virginia requires fifteen.) There are varying standards from state to state on subject matter – some don't give credit for practice management courses – and the number of hours from online courses allowed varies among the states. Mandatory training in Virginia includes OSHA (annually) and CPR (every two years). There's never a point where a doctor can have too much CE. The challenge lies in allocating our time to gain a wide exposure to a number of topics so that no aspect of our practice goes begging. Without a plan the tendency is to gravitate to the familiar subjects, and subjects that are unfamiliar (or uncomfortable, such as risk management) are left to languish.

Even with the many formats available, the CE lecture continues to dominate the market.[3] There are many reasons for this: economies of scale inherent in large meetings; difficulty in updating digital material; costs involved with live patient and hands-on learning; and general inertia and resistance to change. Another reason (and not necessarily a bad one) for the lecture format to prosper well into the 21st century is the opportunity for socializing, networking and camaraderie that exists in meeting halls. There are few chances to renew acquaintances at a webinar. It would seem online courses would be the next frontier in learning, but many web classes can be described in one word: boring. In addition, online CE may extend over several days and involve night and weekend study, further diminishing its appeal.

The Virginia Meeting offers VDA members first class CE with only a modest outlay of time and money. The speakers and their subjects have been "vetted" (to use a trendy term) by the Council on Sessions to insure they are both valuable and interesting. One weekend can fulfill the Board's annual requirements. Many members will of course accumulate credits far beyond the minimum as they pursue professional and personal excellence in the practice of dentistry. What were the other three "pillars" of a dental career? Those are subjects for another time and place. For now each of us only wants to serve our patients to the best of our abilities. The real "cost" of dental CE is not money or time away from the office. The sacrifice lies in our free time, which can never be replaced. To be valuable professional education beyond formal training must never waste our, or our family's, personal time.

1 Martin Hilbert and Priscilla Lopez, "The World's Technological Capacity to Store, Communicate and Compute Information", *Science*, February 10, 2011, http://www.sciencemag.org/content/early/2011/02/09/science.1200970

2 Schleyer, T. , Dodell, D. Continuing dental education requirements for licensure in the United States. JADA 2005;136 (10), 1450-1456

3 Christensen, G. J. Continuing Education: The good, the bad, and the ugly. JADA 2004; 135 (7): 921-924

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Message from the President

Dr. Michael Abbott

As I returned home from the 50th Missions of Mercy (M.O.M.) which was held last weekend (February 19th and 20th) in Gloucester, I am reminded again how thankful we all must be to be in this profession at this time. It was just a short while ago that the Virginia Dental Association Foundation started these outreach programs in Wise County. Here we are 11 years and over 40,000 patients later having the 50th M.O.M. within this State.

Overall, I had a great feeling about my service and my ability to help even just a few fellow humans. The experience left me both humbled and overwhelmed by the need for dental care in our State. I went back to my practice and told all who would listen about my experience and how enjoyable the hard work had been. How lucky we are to be in a profession where we can have such an impact on your fellow man and women. How we can affect their self-esteem and alleviate their pain and infection.

If you have not volunteered at one of these projects, I would encourage you to participate. To most people, a volunteer is someone who contributes time to help others with no expectation of payment or material benefits to himself or herself. However, this does not mean that volunteer work is of no consequence to the volunteer. Research has shown there are many benefits to the volunteer such as increased self-esteem, increased self-sufficiency and reduced stress just to name a few. Another benefit I personally find in the volunteering experience is a sense of connection to the larger dental community. The opportunity to see old friends and to make new ones provides a sense of community beyond my component.

As time has gone on, my M.O.M. experience has evolved and now includes a mission of mentoring dental students. There are always a significant number of dental students participating in the M.O.M. projects, not only in the oral surgery treatment area, but in all areas of dental treatment. I enjoy not only teaching, but also interacting with these young people. The dental students are very generous to give of their precious free time to volunteer at these projects. I have heard many stories about their returning to Richmond for tests, lab work and 8:00 am lectures. I find it gratifying to assist their educational experience and I encourage their continued participation with the VDA. I have found the opportunity to pass down knowledge to the dental students gives me a deeper satisfaction in my volunteer experience.

I hope my reflections on my personal volunteering experience will encourage you to participate, if you have not already. I know you will find many benefits from the meaningful experience of helping other individuals around our state. Through my work at the M.O.M. projects, I have come to believe, as have many other volunteers, our profession must always be in the service of others to be truly rewarding.

I hope to see all of you at the 2011 Virginia Meeting at the Williamsburg Lodge in June.

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Letter to the Editor

Do You Speak Fear or Comfort? Words Speak As Loud As Action

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

The initial approach to a new patient can make a profound impact on the success of a dental practice. Some physicians and dentists go into the reception area and shake hands and introduce themselves to a new patient and others wait until the patient is in the operatory. From then on what you say and how you say it in the operatory can make the difference between a cooperative patient with complete confidence in you, or a dissatisfied patient. Frequently the initial comments by the doctor to the patient can ignite a warm relationship of trust and confidence. Sometimes "a slip of the tongue" can induce fear, apprehension and distrust between the dentist and patient. The doctor and patient instantly recognise their mutual discomfort and the patient's departure is permanent.

In communicating with a patient, the doctor must be honest, empathetic, and accentuate the positive aspects of the patient's needs. The dentist must be knowledgeable, confident and a good listener.

However, doctors must not get discouraged when the patient rejects professional recommendations since there is a diversity of patients with different cultures, personalities, economic status, age, education, and intelligence.

Some suggestions with reference to new patients and the initial dentist's comments after reviewing the medical history and completing a clinical and radiographic examination of the patient are presented.

Case 1 - 39 year old female - High School Teacher
Medical History - Hay fever, mild hypertension

Chief Complaint - Bleeding gums when brushing teeth

Dental Findings - Scattered 3-4mm pockets, mild generalized gingivitis

Doctors Initial Comment - "It appears to me that you are a healthy person and I expect you will live a long life. I would like the opportunity to give you a healthy mouth and pleasant appearance that you will have for many years.. Your dental problems are easily treatable without discomfort.

Case 2 - 46 year old female - Housewife
Medical History - Ovarian carcinomas with lung metastasis, extreme weight loss recently, depressed

Chief Complaint - Loose teeth, difficulty chewing food

Dental Findings - Moderate to severe periodontal disease with gingival hypertrophy generalized

Doctors Initial Comment - "As you probably know, medicine and other scientists are making remarkable progression treating malignant disease. Almost every dental and medical journal reports new treatments and long lives for cancer patients. You will probably be another person who benefits from these new forms of therapy. We can help your mouth by treating your gums and loose teeth to enable you to chew your food properly for many years ahead and enjoy it."

Case 3 - 68 year old male - Electrician
Medical History - Benign prostate hypertrophy, pipe smoker for 25 years, cataracts both eyes, sore tongue

Chief Complaint - Painful tongue for two years with difficulty talking and eating worse past three months

Dental Findings - Raised mass, indurated, bleeds on palpation, measures 2 cm x 1.5 cm on right ventral surface on anterior 1/3 of tongue. Chipped mandibular anterior teeth with missing maxillary right cuspid. Minimal periodontal disease - large carious lesions on maxillary right 2st and 2nd molars

Doctors Initial Comment - "I can see why talking and eating might be a problem with that sore under your tongue. Our profession can have you eating and talking without discomfort. We will need to remove a small piece of that sore to find out what it is and then give you a healthy mouth. The chipped front teeth can be restored and the missing front upper tooth replaced. You have two large cavities on your 2 back upper teeth which we can restore at one visit. With your cooperation we will put your mouth in good health and even Improve your appearance, if you dispose of your pipe."

Case 4 – 26 year old male – College Student – Candidate for Ph.D
Medical History – Type 2 diabetes (controlled by diet and exercise); ear infections, tonsillitis, and impacted teeth surgery

Chief Complaint – Right side ear ache, bad taste, pain posterior of lower right jaw, two weeks duration

Dental Findings – Acute pericoronitis with white exudates surrounding a mesio-angular impacted mandibular right 3" molar, mild generalized gingivitis. End to end anterior bite

Doctor's Initial Comment – "I see your problem and will relieve you of your pain within this day. You will sleep soundly tonight. This pain is a result of a wisdom tooth which did not have enough room in your jaw to come in properly and the surrounding tissue is inflamed and infected. I will prescribe an antibiotic and some pain medication which in a few hours will have you comfortable. In a few days, when the infection is controlled, I will remove the wisdom tooth and you should never have this problem again. Our hygienist will clean your teeth after you are healed and don't be surprised if your blood sugar begins to look more normal after I make your mouth healthy."

Case 5 – 52 year old female – reporter on big city newspaper
Medical History – Heavy cigarette smoker (2+ packs/day) for past 15 years, social alcohol. Migraine headaches, hypertension, anxiety, bruxism

Chief Complaint – Pain along gum line posterior upper and lower teeth when drinking cold liquids and mouth breathing in cold winters. "Ugly" front teeth

Dental Findings – Flat occlusal surfaces on all molars and 2nd biscuspids. Gingival re-cession and exposed cementum mandibular posterior teeth – buccal surfaces. Nicotine stomatitis posterior hard palate. Brown discoloration anterior teeth. Extensive subgingival calculus mandibular anterior teeth. Missing mandibular right 2nd molar

Doctor's Initial Comment – "I have good news for you! After examining your mouth and seeing your radiographs, you have absolutely no evidence of any malignancy. I am glad you came in today so we can treat you so that you are not a high risk mouth or pharyngeal cancer and lung disease. If you will cooperate, the smoking habit can be eliminated and this alone will add years to your life. When you have conquered this bad habit you might be surprised how good you will feel and as another benefit watch your blood pressure come down. The pain along your gum lines when you drink cold liquids is easily treated with a special toothpaste and some medicine which we will apply. Our dental hygienist will remove the cigarette stains from your teeth and remove the debris under your gums caused by the smoking. Your oral health and your general health will improve significantly if you allow me to help you. I am confident you will be a happier person as well as an attractive woman."

If the doctor is honest, pragmatic, well informed and confident, he or she will have an office reception room occupied by many patients who are cooperative, faithful, appreciative and serve as practice builders for many years to come. ■

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Letter to the Editor

Stupid is as Stupid Does

Henry Botuck, DDS

Hundreds of veterans will be offered free screenings for HIV, Hepatitis B, and Hepatitis C, because for eighteen years a Veterans Administration dentist in Dayton, Ohio failed to change his gloves between patients. At another VA facility it was found that dental instruments were not properly cleaned prior to sterilization. Hundreds will be tested at that facility also.

This prompts me to bring up an area of infection control that has been ignored for years. It may not be as egregious, but it is insidious. If you are following CDC guidelines, you are using a biologic indicator (spore test) at least weekly to check if your sterilizer is working properly. Each week the test comes back negative; except one time, when you get a call that your sterilizer failed the spore test. It does happen.

Now what? You mailed the test on Monday morning. The testing company received it on Wednesday, and called you on Thursday afternoon to tell you the bad news. You sterilized multiple loads from the time you mailed the spore test to the time you got the call. This puts all of those instruments in question as to their sterility, many of which you have already used again. Think about it. If you went to the hospital for surgery would you be satisfied if the surgeon assured you that the instruments he was going to use were probably sterile? What bothers me is that dentistry has not kept up with the latest technology in this area.

Was the cause of the failed spore test because the autoclave needed repair, or was it due to operator error? According to the CDC, eighty five percent of the time it is operator error. For example, the operator didn't wait for the sterilizer to warm up sufficiently, or the operator overloaded the chamber. This would mean that it wasn't the sterilizer itself that was the problem, only that this one particular load was not sterilized properly. But fifteen percent of the time it is the sterilizer. So, how do you differentiate, and would you know what to do? I won't discuss that issue here because that is not my main point.

My point is that this scenario and this worry could have been avoided completely. Dentists have been assuming that all sterilizer loads between spore tests were sterile. But, because of operator error, we know that this is not necessarily true, and we have ignored this inconvenient fact.

But there are chemical indicators that can give us the information that we need to make sure that all of the necessary parameters of enough heat, enough steam saturation, and enough time have been met. The Association for the Advancement of Medical Instrumentation (AAMI) has defined six categories of chemical indicators. Most of your inexpensive pouches have a built in class 1 indicator that shows the presence of heat or moisture. It merely differentiates between autoclaved, and non-autoclaved, instruments. It does NOT show sterility.

Some newer pouches have built in class 4 indicators. These show two of the three parameters to insure sterility: either enough steam and proper time, or enough steam and proper temperature. They cost a little more, but not a lot. However, in order to show that all of the parameters needed for sterility were present, you need a class 5 "Integrated Indicator". This is FDA approved and shows if time, temperature, and steam saturation all were present when that load was sterilized. By placing a class 5 "Integrated Indicator" in the center of your load of pouches you would know instantly if all of the parameters needed for sterilization were present. You would not need to assume anything about loads between spore tests. You would know.

And if a load fails, you can re-package, re-sterilize, and know in half an hour if it was the sterilizer or the operator that was to blame. The cost for safety and peace of mind is about fifty cents per load. Well worth the investment. I hope that the supply houses get a groundswell of orders for class 5 Integrated Chemical Indicators. Our patients deserve it.

Although this chemical indicator has a documented performance equivalent to a biological indicator, the CDC still insists that the spore test be done at least weekly and with all loads that contain implants.

Prescription Drug Monitoring Program

By: Michael J. Link, DDS

If you have been in practice for more than one year, you have probably run into a situation that made you feel uneasy and wonder, is this patient truly in pain or just seeking narcotics? As practitioners, we are faced with this situation on a daily basis. In dental School, we are taught the basics on how to diagnose a patient in true dental pain versus a patient seeking drugs. Do any of the following scenarios sound familiar to you? A patient asks for a specific drug by name? A patient pages you over a holiday or over a weekend and tells you they saw you or one of your partners roughly three to six months ago but can only give you a vague description of what procedures you did on them? A patient suddenly hangs up on you when you are trying to confirm their patient status by remote access to your office computer? A new patient schedules an appointment and you diagnose an abscessed tooth; you prescribe antibiotics for the abscess and narcotics for the pain; you reappoint the patient for a follow up visit for an extraction or root canal therapy and the patient breaks their next appointment? Any of these scenarios could provide clues that a patient is seeking narcotics.

During my father's generation of dentistry, he would often call the pharmacist to gain any insight on a patient's prescription history. He wanted to know if the patient had a record of abusing prescription pain medication. This method today is still a valid means to finding out more information concerning your patients, however, what if the drug seeker uses different pharmacies to fill their prescriptions? Since 2005, there is another, more precise, way to find out if your patient is a drug seeker; it is called the Prescription Monitoring Program (PMP) (1).

Background information on the establishment of the Prescription Monitoring Program.

In 2001, the need for a prescription monitoring program became evident with the increased number of deaths attributed to oxycodone abuse that were reported in southwest Virginia (2). In 2002, Senator William Wampler and Delegate Terry Kilgore sponsored legislation to the General Assembly to amend the Code of Virginia to implement a pilot program called the "prescription monitoring program". This program applied to only Schedule II controlled substances that were dispensed in Southwest Virginia (3). This was a 2 year pilot program and the Department of Health Professions (DHP) was required to secure federal or other funding to cover the costs for implementation of this program (4). In April 2003, DHP was awarded a federal grant through the Harold Rogers Prescription Drug Monitoring Program to implement and support initial operations of the program (5). The pilot program began in September 2003 and involved the collection of prescription data for Schedule II drugs and the maintenance of that data in a central database (6). While the pilot program was a great start, there were several concerns about its implementation. What about Prescription drug abuse in other areas outside southwest Virginia? Also, the doctor shoppers knew where the line was drawn for this pilot program, therefore, they were able to go outside the boundaries of the program to obtain narcotics. Furthermore, this pilot program did not cover Schedule III and IV drugs, which were often abused in combination with other legal and illegal narcotics, not just Schedule II (7). In 2005, the Code was amended. The prescription monitoring program was administered statewide and went into effect for all Schedule II, III, and IV, not just Schedule II narcotics (8).

The new provisions for the statewide Prescription Monitoring Program (PMP) are found in sections 54.1-2519 through 54.1-2526 and in section 54.1-3434.1 of the Code of Virginia (9). If you want some nighttime reading to help you sleep, please read these sections of the Code. Seriously, please read these provisions very carefully and understand how the Program works and all of the ramifications of violating these statutes.

How the Program works

How the Program works is simple. You need to fill out, sign and send in the registration form. The form is available on-line at www.pmp.dhp.virginia.gov. Select "new user", fill out the registration material and then print for signing. You will be notified by e-mail when you are accepted into the program. If you prefer, you can request registration material by calling (804) 367-4566 or email them directly at: pmp@dhp.virginia.gov. Once you are registered, you will be able to access the state-wide prescription data base (10).

How long does it take to query a name?

Literally, it will take less than a minute to get a response from the data base containing a report of the patient's drug history.

Statute requirements

The statute spells out the specifics of the prescription monitoring program, but a quick summary regarding the program is as follows: You cannot send the Prescription Monitoring Program report as part of the patient's record to anyone, including another Dentist or the patient! You can only verbally discuss the (PMP) report with another dentist and with the patient. So the $64.00 question is what happens if you accidently send the (PMP) report to another dentist or give a copy to the patient? The Board of Dentistry will initiate an investigation. The Statutes provide the respective Boards with the authority to be very punitive for violating any section of these Codes. Each violation can cost up to $5,000 in monetary penalties in addition, you could be charged with a Class I misdemeanor (11).

On a personal note, I have used this program for the past nine months. On one occasion, I found out about a patient in my chair who was trying to obtain more narcotics from me. I was concerned because the patient never followed up with any of the treatment options that I had outlined and presented to him. I queried his name and obtained the (PMP) report from the state data base. In this report, it listed all of the prescribers from whom he had obtained narcotics in the past year. Not only was my name on the report from his previous visit, but, two other local dentists, two oral surgeons and several physicians' names were also on the report. Needless to say, the conversation with this patient was an interesting one and not to the patient's satisfaction! What I found to be particularly interesting in this report and other reports that I have queried from the data base was physicians tend to write for much larger quantities of narcotics than dentists.

In conclusion, the fines associated with violating any sections of the statute are enormous, but the positives of this program far outweigh the negatives. To be able to find out the drug history on a questionable patient is truly an incredible achievement. I believe the Prescription Monitoring Program to be one of the best tools that has been created for all dentists in the modern era. It will enable you to find out the true drug history of your patient. This in turn will help you improve your responsibilities when writing narcotic prescriptions.

References

(1), (2), (3), (4), (5), (6), (7), (8), (9), (10), and (11)
Prescription Monitoring Program Survey August 2004, by Kirsten Barrett, PHD: Virginia Commonwealth University, Appendix A (Draft of Proposed Legislation), B (Survey of the Prescription Monitoring Program), C (Model Policy for the use of Controlled Substances for the treatment of Pain), D (Fact Sheets from the National Drug Control Strategy 2004) and E (State of Nevada Prescription Controlled Substance Abuse Prevention Task Force 1997-2003).
Jackie Burgess: Department of Health Professions; personal communication
Code sections: 54.1-2401, 54.1-2519 – 54.1-2526, and 54.1-3434.1 of the Code of Virginia.
Sandra Reen: Executive Director of the Virginia Board of Dentistry; personal communication

Legislative Report, 2011

By: Chuck Duvall & Denny Gallagher, VDA Lobbyists

Well, they finally left town, a day late due to Budget negotiations that could not be concluded by the regularly scheduled departure date, which was February 26.

During its 47 days in Richmond, the General Assembly considered some 1882 bills and 810 resolutions and concluded by passing 1599 pieces of legislation.

As is usually the case, the Budget received the major focus of legislators' attention. Though the economy, at least as it relates to state revenues, is showing some signs of improvement, Virginia still had limited revenues with which to work as House and Senate Budget Conferees fine-tuned last year's $78 billion biennial Budget.

We have outlined below some of the major issues that were of importance to the VDA at this year's session:

MEDICAID:

During the 2010 General Assembly, the adopted Budget cut dental Medicaid services providers 3% effective July 1, 2010; another 4% reduction was scheduled to take place this July 1.

The Budget just adopted by the General Assembly and sent to the Governor for approval, however, eliminates the 4% cut for dentists scheduled for July 1. That equates to $4.7 million reinstated.

The Budget just adopted also eliminates the 4% cut for inpatient hospitals, physicians and other health care providers.

As you may recall, the VDA had asked that language be added to the Budget in case the cuts scheduled for July 1 could not be avoided. The VDA's language asked that DMAS work with its Dental Advisory Committee to ensure that children would continue to receive basic dental care while reducing other services to meet necessary funding reductions. The stated aim of the VDA's proposed language was to avoid the across-the-board cuts (totaling 3%) in the Smiles for Children program that occurred in July, 2010.

Fortunately, with the adoption of the Budget just described, the VDA's language was not needed.

SUBSTANCE ABUSE/CONTINUING EDUCATION:

There were a multitude of bills dealing with substance abuse as well as legislation aimed at mandating substance abuse programs as part of dentists' continuing education requirements.

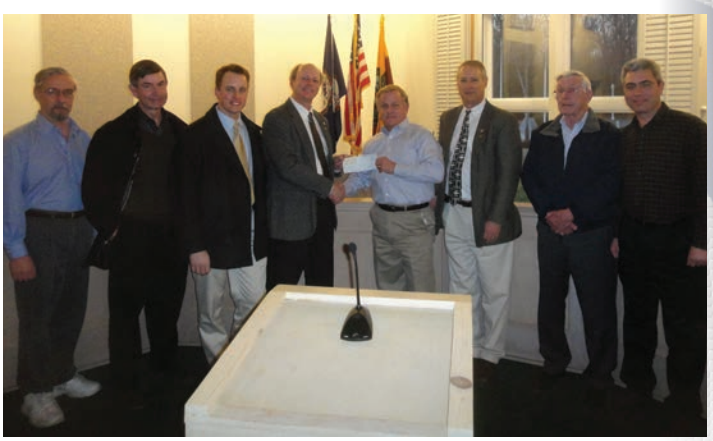
Those measures were either tabled or withdrawn. In their place, the VDA agreed to work with a provider coalition to bring substance abuse prevention education to all health care providers in Southwest Virginia. The coalition will partner with OneCare of Southwest Virginia, a nonprofit organization committed to decreasing the abuse and misuse of prescription and nonprescription drugs.

Those of you practicing in Southwest Virginia and dentists participating in the M.O.M. projects in Wise and other parts of Southwest Virginia know that substance abuse involving both prescription drugs and nonprescription drugs is a growing problem. We hope that this education program will help everyone to address these problems more effectively.

DENTAL HYGIENE:

At the request of the VDA, Senator Phillip Puckett (D-Tazewell) introduced SB 1014 to extend a protocol authorized by the 2010 General Assembly. This protocol allows dental hygienists employed by the Virginia Department of Health to provide educational and preventative dental care in localities selected by the Department.

Last year's legislation established pilot programs, but time constraints were such that a progress report could not be prepared. This bill allows additional time to produce such a report. Senator Puckett's legislation passed and awaits the Governor's signature.



Gordon Helsel pictured fourth from right. The newest member of the Virginia House of Delegates receives a VADPAC contribution check from Poquoson area dentists. Helsel was elected to represent the 91st district, which includes the city of Poquoson, part of the city of Hampton, and part of York county.

CONSCIOUS SEDATION:

At the request of the Board of Dentistry, Senator Fred Quayle (R-Suffolk) introduced SB 1146. This legislation requires dentists who use conscious sedation or anesthesia in a dental office to obtain either a conscious/moderate sedation permit or a deep sedation/general anesthesia permit issued by the Board of Dentistry. This legislation also requires the Board of Dentistry to promulgate implementing regulations within 280 days of the bill's enactment.

The VDA worked with the Board to exclude from the bill general dentists who do not use any of these forms of sedation. Language was also added to the bill at the VDA's request such that oral surgeons currently holding a permit are not required to submit to the permitting process.

VCU DENTAL SCHOOL:

The VCU Dental School asked that Delegate John O'Bannon (R-Henrico) and Senator Donald McEachin (D-Henrico) introduce bills to change licensing requirements for dental and dental hygiene faculty members.

Following the introduction of these measures and after consultation with the VDA, the dental school asked that they be stricken. This action should enable the dental school and the VDA to develop 2012 legislation that more precisely describes the school's objectives.

This legislation will be a priority for the VDA at next year's session.

MEDICAL MALPRACTICE:

HB 1459, patroned by the House Courts of Justice Committee Chair Delegate Dave Albo (R-Springfield) and SB 771, patroned by Senate Majority Floor Leader Richard Saslaw (D-Fairfax), changes the current medical malpractice cap of $2 million by increasing the cap $50,000 annually effective July 1, 2012 and continuing through June 30, 2032.

HEALTH DEPARTMENT:

Delegate Bud Phillips (D-Castlewood) introduced legislation directing state health officials, including the Department of Health and the Commissioner, to develop and provide ". . . a comprehensive program of preventative, curative, and restorative dental and oral health services for children . . ." statewide.

While this legislation (HB 2175) was killed, Budget language was approved that requires the Commissioner of Health to identify and develop options to expand

dental services to underserved areas of Virginia.

SOUTHWEST VIRGINIA DENTAL CLINIC:
As you may recall, the VDA worked with the General Assembly in 2008 to authorize $5 million in capital bonds to build a dental clinic in Southwest Virginia. The clinic was to be a cooperative effort between the University of Virginia's College at Wise and the VCU School of Dentistry to train dentists and dental hygiene students and to provide care for underserved residents in the area.

Even though bonding authority was provided for the clinic in 2008, no action has occurred regarding its construction. Consequently, language was included by the House of Delegates in its version of the Budget to eliminate the bonding authority.

As part of the final Budget compromise, however, the $5 million bonding authority remains in place.

WHAT'S NEXT?
The Governor has 30 days from the adjournment of the session (February 27) to review all measures approved by the legislature and sign, veto or amend them.

The legislature will review the Governor's recommendations and take appropriate action during a one-day Reconvened Session scheduled for April 6, 2011.

All legislation passed by the General Assembly and approved by the Governor takes effect on July 1 unless otherwise noted.

REDISTRICTING:
Preceding the Reconvened Session, the legislature will convene on April 4th to begin the once every decade redistricting of House, Senate and Congressional districts.

Since the 2001 redistricting, Virginia's population has grown from 7,078,515 (2000) to 8,001,024 (2010). Rural districts have lost population and urban areas, particularly in Northern Virginia, have gained population. We will see a shift of additional General Assembly seats – both House and Senate – to Northern Virginia.

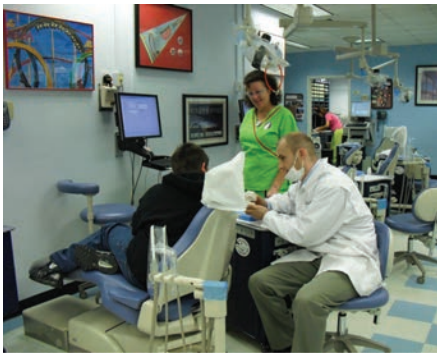
VADPAC:
With redistricting as a backdrop to this fall's House and Senate elections, it is more important than ever that we have an active participation in VADPAC this year.

Active PAC participation coupled with your individual participation, both in terms of involvement in campaigns and contacts with legislators on key issues impacting your patients, will make all the difference as we continue to get the VDA message in front of our elected officials.

Thank you for your continued participation. If you have any questions, please feel free to call Laura Givens, Director of Legislative and Public Policy at the VDA office (804/288-5750).

The VCU School of Dentistry Craniofacial Team

By: Bhavna Shroff, DDS, MDentSc., MPA
Professor and Graduate Program Director - VCU School of Dentistry, Department of Orthodontics



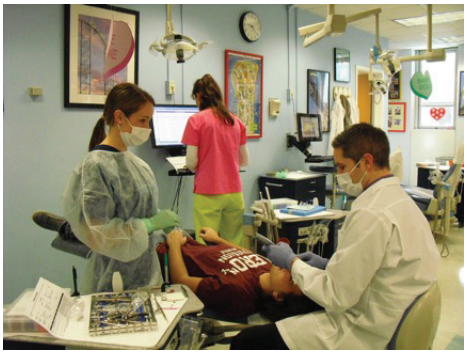
VCU Orthodontic Clinic: Dr. Shoff, a first year orthodontic resident, is discussing treatment with his patient while Julie , his assistant, is updating the patient information

The VCU School of Dentistry (SOD) Department of Orthodontics (VCU Orthodontics) plays a critical role in providing orthodontic services and comprehensive dental care to patients with craniofacial deformities in central Virginia. The majority of the patients with craniofacial deformities treated at VCU Orthodontics present with a cleft lip and/or palate, a congenital facial deformity that affects one out of every 700 to 750 infants born in the United States.1 The VCU Orthodontic clinic also offers treatment to patients with various other craniofacial deformities including but not limited to, craniosynostosis, Pierre Robin syndrome and Ectodermal Dysplasia.

The treatment of cleft lip and palate patients requires a multidisciplinary team approach and usually extends into the adolescent years. 1, 2 Care provided to cleft lip and palate patients is a multistage process that needs to be carefully coordinated between the various medical and dental specialties. The efficient coordination of such therapeutic effort assures a successful outcome of treatment for these patients, allowing them to enjoy a fulfilling life and active participation in society. The American Cleft Palate and Craniofacial Association adopted the criteria necessary to provide quality multidisciplinary oral care to patients with such facial deformities in 1993. The multidisciplinary approach to care has proven very beneficial to patients over the years, providing better communication and understanding of treatment to patients and their family. 1,3

The Virginia Commonwealth University Medical Center has an active craniofacial team that includes medical and dental specialty providers. Among the specialties represented are: Plastic Surgery, Neurosurgery, Oral and Maxillofacial Surgery, Orthodontics, Pediatric Dentistry, Ophthalmology, Otolaryngology, Speech Pathology, Psychology and Social Work.

Families start to interact with the entire team as early as a few weeks after their baby is born and the first stage of the facial rehabilitation includes the surgical closure of the lip (as early as it is safe to achieve surgically) and then the surgical closure of the palate, typically within the first year. Families meet with providers on the dental team from their very first appointment at the craniofacial team. An orthodontist (Dr. Bhavna Shroff), a pediatric dentist (Dr. Frank Farrington) and an oral and maxillofacial surgeon (Dr. Omar Abubaker) discuss with the families the timing of future dental care needed by their child and the sequence of that treatment. The dental team meets with families yearly thereafter to attend to their needs and answer their concerns.



Dr. Johnson and 2nd year student, Julia Niculescu delivering orthodontic care to one of their patients.

One of the unique features of the VCU Craniofacial Team is the dental team that provides full maxillofacial rehabilitation for these patients. A majority of patients seen at the VCU Craniofacial Team receive their pediatric dentistry care through the department of Pediatric Dentistry at the VCU SOD. The department of Orthodontics provides Orthodontic care to craniofacial patients once a month, on a Friday morning. An average of about 40 active patients are currently under the care of the VCU department of Orthodontics. The dental team that provides this care includes an orthodontist (Dr. Steven J. Lindauer), a maxillofacial prosthodontist (Dr. Harlan Schufeldt) and an oral and maxillofacial surgeon (Dr. Omar Abubabker). Patients are referred from the VCU Craniofacial Team directly to the department of Orthodontics and screened by Dr. Shroff at the patient's convenience. Typically, patients with cleft lip and palate will need a first phase of treatment around the age of 7-9 that includes the alignment of their front maxillary teeth and the expansion of their palate in preparation for alveolar bone grafting. This phase usually takes nine to twelve months and patients are placed in retention after the bone graft until their permanent dentition erupts. Patients are then ready for a second phase of orthodontic therapy, which in some cases may be combined with orthognathic surgery. The treatment planning of cleft lip and palate patients is achieved with the input of the orthodontist, the prosthodontist and the oral and maxillofacial surgeon. This comprehensive approach offers true multidisciplinary and coordinated care to our patients and is of great benefit to them.

L-R: Drs. Shroff, Schufeldt and Lindauer

For the orthodontic faculty, residents, and other team members involved in care delivery, as well as for the patients themselves, this treatment is a very rewarding experience. These patients present with severe malalignment of teeth and/or skeletal discrepancies that are challenging to treat but also result in dramatic functional and esthetic improvements.

The care provided by the VCU Craniofacial Team is not limited to patients with cleft lip and palate, and the team is also available for patients presenting any other types of craniofacial deformities. Further information about the craniofacial team can be obtained at www.craniofacial.vcu.edu or by calling Ruth Trivelpiece who coordinates the VCU Craniofacial Team at (804) 828-3042 or Dr. Bhavna Shroff at (804) 828-9326

References:
1. Strauss, RP. Cleft Palate and Craniofacial Teams in the United States and Canada: A National Survey of Team Organization and Standards of Care. Craniofacial Journal, November 1998, Vol. 35 No. 6.
2. Ronald P. Strauss (1999) The Organization and Delivery of Craniofacial Health Services: The State of the Art. The Cleft Palate-Craniofacial Journal: Vol. 36, No. 3, pp. 189-195.
3. American Cleft Palate–Craniofacial Association (ACPA). Parameters for evaluation and treatment of patients with cleft lip/palate or other Craniofacial anomalies. Cleft Palate Craniofac J. 1993;30(suppl): S1–S16.

Orthodontic Residency Program

The Department of Orthodontics at the VCU School of Dentistry has a nationally acclaimed two-year orthodontic residency program that has attracted students from VCU and many other schools in the US. The residency program offers four full time positions every year and the department's selection process strictly adheres to the principle of the Postdoctoral Dental Matching Program.

The VCU Orthodontic residency program is designed in a unique fashion to simulate a private practice environment for residents from the first day of the residency program. The practice is organized in teams of two residents and one assistant and each team functions as a miniature private practice. Each individual team manages patients' records, treatment and follow-up appointments. All appointments, records and charts are electronic and the clinic is essentially paperless. Besides a busy clinical schedule, orthodontic residents

have a rigorous didactic program that includes graduate level courses and an ambitious research agenda leading to the defense of a Master's thesis, a requirement for the Master's degree of Science in Dentistry. Residents are exposed to a wide spectrum of clinical experiences including, but not limited to, treatment of patients in the mixed dentition, comprehensive treatment, treatment involving growth modification, orthognathic surgery and multidisciplinary treatment involving restorative dentistry, periodontics, prosthodontics and pediatric dentistry. Residents also play a very active role in treating patients with craniofacial deformities.

Every year the number of applicants has been above 200 until recently when the number of applicants decreased to less than 200 per year (Figure 1). It has been speculated that the drop in the number of applications might be due to a decrease in the number of foreign applicants, the amount of current debt incurred by dental students in the United States and the economic recession that started in 2008. Typically, after evaluating all the applications, the selection committee invites between 25-30 prospective students for a two-day interview process. The interviewees meet with the full time faculty members, two part-time faculty members, three alumni of the program, the assistant dean of admissions of the dental school and the first year residents in four separate interviews and also attend a formal presentation of the department followed by a campus tour. The interviewees also get an opportunity to observe patient care in the clinic under the supervision of Dr. Peter Wendell, a part-time faculty member in the department of Orthodontics. On the evening of the first interview day, the department organizes a social event to give interviewees, faculty and residents an opportunity to interact in a more relaxed setting. The selection committee includes the full time faculty, the part time faculty, the alumni involved in the interview process, the assistant dean for admission and the residents. The final deliberation and vote takes place on the afternoon of the second day and the process is fair, transparent and confidential. The list of candidates is then submitted to MATCH, the Postdoctoral Dental Matching Program. Results of the MATCH are usually official on the first Wednesday of December. Fig. 2 shows the distribution of Virginia students versus out of state students admitted to the program for the past 10 years.

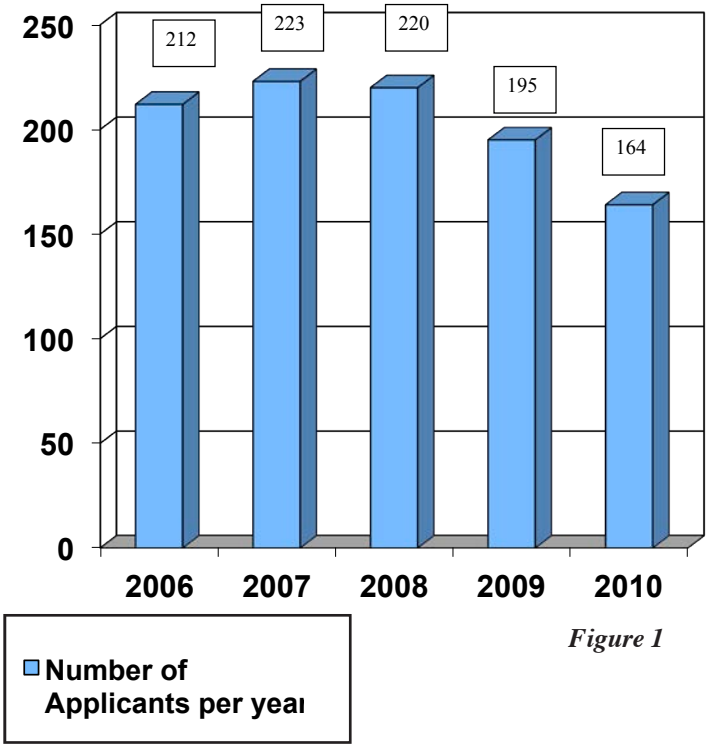


Figure 1

The Externship Program

The externship program is a very unique program that is offered by the department of Orthodontics at the VCU School of Dentistry. The program offers an opportunity for dental students in the United States and Canada who are considering orthodontics as a career to spend up to one week in the department of Orthodontics. The goal of the program is to offer these students a didactic and clinical exposure to an orthodontic residency program that is modeled after a private practice. Students attend seminars and lectures and they observe and assist in the clinic during the time of their visit.

The externship program was formalized about six years ago and has enjoyed tremendous popularity. There is no fee for attending this program. Students find instructions on how to apply on the website of the department of Orthodontics at http://www.dentistry.vcu.edu/ortho/postgraduate/externship.html. Students apply by emailing a letter of intent, a curriculum vitae and proof of liability insurance obtained from their dental school to Dr. Bhavna Shroff who sets up their visit. Ms. Darlene Johnson, the department's executive administrative assistant, provides information about housing and the Richmond area and we host an average of about 40 students every year between March 1 and September 1.

Most students visiting are interested in pursuing a career in orthodontics and the externship program gives them an excellent appreciation for the scope of VCU's Orthodontic residency program. It has provided the department of Orthodontics an opportunity to become better known by students at most US and Canadian schools and this program has provided excellent public relations with other dental schools. The majority of students who participate in the externship program also apply to the residency program.

The externship program has been an excellent way to introduce the VCU Orthodontic residency program to dental students in the United States and Canada, extending its reputation outside of the VCU community. We would like to expand the program to include foreign students as well but this has been made logistically more difficult because of requirements such as insurance and entry visas. We hope that we will be able to resolve these challenges in the near future and be in a position to welcome dental students from abroad. We plan to continue to offer this program for the coming years to students in the United States and Canada as it has become one of the most popular orthodontic externship programs in the United States.

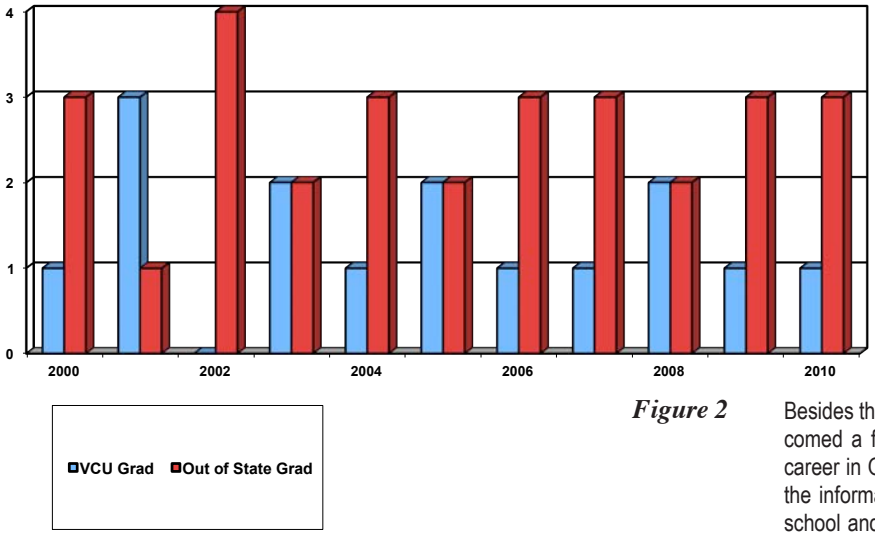


Figure 2

Dr. Omar Abubaker (R) consults with his resident, Dr. Ammar Sarraf

Besides the externship program, the VCU department of Orthodontics has also welcomed a few college and high school students who show interest in pursuing a career in Orthodontics. Students usually contact Dr. Bhavna Shroff after searching the information available on the website and she arranges a one-day visit of the school and the department for them. Students have shown much enthusiasm and this positive experience has allowed them to solidify their interest in Orthodontics as a career choice. ■

When Two Equals Four

By: Dr. Gilda P. Ferguson, Assistant Professor
VCU School of Dentistry, Department of General Practice

Many dental students gain no experience in four-handed dentistry while in school. Often a student will avoid using an assistant simply because of the unfamiliarity of a new experience or fear of failure.

In order to provide that experience and demonstrate the value of a good assistant, the Private Practice Simulation Clinic (PPSC) was conceived and preparations were swiftly begun for an opening date of August, 2010. The goal was to place dental assistants and senior dental students in an environment that simulates private practice. Emphasis would be placed on teamwork, efficiency and utilization of dental assistants.

The clinic is a rotation included in DENS752, a course directed by Dr. Jim Burns and Dr. Fred Certosimo, with each senior student rotating through the clinic twice a year.

First, we chose a physical location. A small, stand alone clinic located on the first floor of the Woods Building was selected. Currently there are eight chairs, two x-ray heads, a sterilization area, a small conference room, a small waiting area, and an area for the patient care coordinator and the office manager. This self-contained clinic would allow the student to not only experience four-handed dentistry, but also to experience, to some degree, what a week in a private practice can be like.

I was asked to oversee the clinic. Support staff would include Hazel Luton, a well known VCU staff member, as the office manager. Ms. Luton and I have known each other for years – she was my assistant for state boards. Linda Bartlett, an experienced patient care coordinator, was selected as the new clinic's PCC. Six dental assistants complete the staff roster. Each assistant works solely with one of six senior dental students for the week of the rotation. Two to three senior dental hygiene students are also assigned to the clinic several periods per week. Second year dental students also rotate through the clinic on a limited basis. Once they have passed their competency, the D2s are allowed to administer local anesthesia. They also assist with data gathering and recording, or they may observe.

Once the staff was in place, other issues had to be addressed.
It was determined that the clinic would need to obtain its own patients through screening. Those patients would stay with the clinic as in a private practice, and not be assigned to an individual student. Since acquiring patients for the clinic became a necessity, screening was begun over the summer of 2010. To maintain a sufficient patient population, screening continues for most clinic sessions.

The screening patient population is important for the clinic. If a student's assigned patient does not show up, or cancels, students can then work with a screening patient to assess needs. Consults with specialty faculty are requested as needed. Complex cases are referred to Advanced Education in General Dentistry (AEGD), or to the appropriate graduate clinic. If, however, that screening patient is accepted for the PPSC, the student has the opportunity to begin treatment of that patient immediately if the patient so desires. Senior dental students can elect to have a hygiene student begin collecting data, and perform hygiene duties, or they may do so themselves.

Emergency patients are also seen, and appropriate treatment is begun.

Students are also allowed to appoint their own assigned patients needing quadrant dentistry into the clinic in order to take advantage of the dental assistant's help.

Procedures performed in the clinic are essentially the same as in the student's home clinic. Senior students can perform crown and bridge, restorative, some endodontics, and limited periodontics.

Under the guidance of the Orthodontic Department, certain Invisalign® patients are accepted. Any procedure begun in PPSC must be completed there. Ms. Bartlett is a genius when it comes to arranging accommodations for the student to finish treatment.

For the week-long rotation, the senior dental students are assigned to one assistant who acts not only as an assistant, but as an instructor in the art of four-handed dentistry. The assistant guides them in correct instrument transfer, and urges the student to develop proper posture.
At the end of the last rotation session, students are asked to write a One Minute Paper anonymously which gives us feedback on the experiences they have had in the clinic. Student reactions have ranged from "I didn't realize how much I could accomplish with a dental assistant", "How can I live without an assistant now?", and "Wow! This is fantastic! When can I come back?" We have had very few negative comments.

On a personal note, I have found establishing a clinic such as this to be a challenge. Moving into the clinic, and setting up supplies and equipment – as well as telephones and computers - could have been a nightmare without the help and dedication of Hazel Luton, Linda Bartlett, and the original five dental assistants. With the help of all eight of us, the operatories were cleaned and stocked, the front desk area was made functional for Ms. Bartlett and Ms. Luton, and we were ready.

During the time my magnificent seven were working on clinic logistics, I was madly screening, attempting to create a large enough patient population to sustain clinic requirements for the first month or so. My chief worry was the students seeing brand new patients, and having to gather data and treatment plan each of these individuals. This meant little operative dentistry would be taking place with the first group of students when the semester started.
That changed quickly, and students were able to begin operative procedures. Students became competitive, vying to see who could do the most surfaces efficiently and competently. The record is now 13 surfaces in one morning session, proving to the students that a good assistant is worth her weight in gold. One of the most rewarding moments for me is when I watch a student who is tentative and slow become more confident and efficient by the end of the rotation.

That moment, and the positive feedback, are what makes all the hard work worth every minute put into establishing this clinic.

VDA and VCU School of Dentistry to Partner on Dental Education Licensure Issues

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

The VDA Board of Directors and the VCU School of Dentistry will together prepare legislation for the 2012 General Assembly that will enhance the school's ability to recruit specialized faculty members and expand both training and continuing education opportunities. Previously, the school appointed a faculty committee to review the current Virginia dental licensure code and regulations solely related to activities of the School of Dentistry and dental education programs. The committee concluded that based on restrictions within the licensure code, the school was missing faculty recruitment and resident, fellowship, and continuing education opportunities compared with peer schools in other states.

The school approached the Virginia Board of Dentistry for assistance in drafting revisions to current laws that impact faculty and resident licensure and continuing education. The result was a bill introduced in the 2011 General Assembly as HB1642/SB1311. The VDA Board of Directors requested more time to work with VCU to lend support for the new legislation. At its January legislative meetings, the VDA Dental Practice Regulations Committee, Legislative Committee, and the Board of Directors discussed the draft legislation and the following Board resolution was adopted.

University Connections

Resolution: The VDA Legislative Committee supports in concept the ideas included in HB1642 and SB1311. We feel that this legislation needs to be fully vetted through the VDA process and be a VDA legislative initiative in the 2012 General Assembly session. This process would include the Board of Directors appointing a task force to work with the Dean of the VCU School of Dentistry to develop legislation incorporating the ideals encompassed in HB1642 and SB1311.

The areas addressed in HB1642/SB1311 affect only dental licensure issues related to dental educational institutions such as the VCU School of Dentistry and do not affect who is permitted to practice dentistry in private offices. VDA President Dr. Michael Abbott has appointed former VDA President Dr. Gus Vlahos to chair the task force.

Read on for more information on: Challenges in Faculty Recruitment and Retention in Dental Education

One of the major challenges as the new dean of our dental school is recruiting and retaining a faculty with the special expertise needed to deliver quality education and contribute to the art and science of dentistry. There are three main challenges we must solve to maintain the faculty: student debt, lack of interest in academic dentistry careers, and lack of national licensure processes to permit mobility of faculty members.

If you are a young dentist, you likely have substantial debt which you incurred while obtaining your education. If you are a more experienced dentist, you likely have heard that new students are leaving dental school with an average debt of $200,000. Students who have completed an accredited advanced dental education program after dental school (specialty training, AEGD, or GPR) have even higher debt. Salaries for dental faculty have always lagged private practice and at the VCU School of Dentistry dental faculty salaries are 60% to 75% of what dentists with comparable training and experience are earning in private practice. Needless to say, recruiting and retaining new dentists into teaching is virtually impossible. If it were not for the opportunity to generate clinical revenue by seeing private patients, the situation would be even worse. The salary percentages above include all sources of income for dental faculty including university salary, faculty practice salary, and other earnings from sources such as teaching continuing education courses or consulting.

For the few dentists who can manage to live and pay back student indebtedness with the earnings of a dental faculty member, the interest in an academic career is rare to find. Our society does not place a high value on teachers, whether in the K-12 or higher education setting. Dental students will often proclaim how influential a particular faculty member was in their becoming a dentist, yet when you ask them if they would consider an academic career, there is little interest. Becoming an excellent dental faculty member is a career endeavor that may not be fully appreciated by those outside of the academic environment. First, you must be a dentist with the appropriate knowledge and skills. In addition, you must be willing and able to serve as a mentor, possess excellent communication skills (oral and written), be able to organize information and data, understand statistical methods, be both a team player and an individual achiever, possess the ability to question existing knowledge and to try new ways, be adept at separating hype from true progress by virtue of acquired expertise, learn and use instructional technology effectively, and be able to function successfully in a large institution.

When dental schools seek to hire a new faculty member, they use a formal search process. All universities use a search process for hiring full-time faculty members and this process is governed by university policy and laws. Faculty searches are conducted on a national and international level to seek the most qualified applicants. Since dental faculty must be licensed in Virginia to legally perform the scope of their duties to teach, perform dental procedures, and complete research that involves live patients, the dental school cannot hire anyone who does not qualify for a dental license under current Virginia law. Dentistry lacks a national licensure process and this has created difficulty for our dental school to hire the best applicants with the skills described above. The nature of the current licensure laws put the VCU School of Dentistry at a competitive disadvantage with schools in states that have more flexible dental licensure laws governing restricted dental licenses for dental school faculty members.

During recent faculty searches, your school could not hire several highly qualified candidates because they did not qualify for licensure by credentials or for the faculty license provision. The Department of Oral & Maxillofacial Surgery could not interview ABOMS board-certified or board-eligible candidates because they could only qualify for a Virginia dental license if they completed a board-approved licensure examination such as the one offered by the Southern Regional Testing Agency (SRTA). Since these surgeons have not been practicing general dentistry for many years and had other faculty options, they declined to consider taking another dental licensure examination. These candidates also could not qualify for the dental faculty license that provides a restricted license to function only within the dental school because their original dental degree was from a foreign country. The Department of General Practice had to decline to interview candidates trained in operative dentistry and dental materials because their original dental degree was from a foreign country and would not qualify them for any form of a Virginia dental license including the limited faculty license. The reality is that virtually 100% of top faculty candidates who have completed advanced degrees in operative dentistry and dental materials at training programs at dental schools such as the University of Iowa, Indiana University, and the University of North Carolina have foreign dental degrees. These are the dentists who have studied to be experts in adhesion, composites, CAD/CAM, and ceramics yet they cannot be hired onto the VCU School of Dentistry faculty.

The education of tomorrow's dentists is at the core of our mission here at the VCU School of Dentistry. Yet without highly qualified and committed dental faculty to lead and provide that education, we cannot pursue, let alone achieve, our stated mission. To recap, there are three main roadblocks standing between us and the recruitment and retention of faculty: salaries, interest, and licensure. The means for addressing the challenges of interest and licensure are closely linked. Although Americans may not value a career in education, many foreign trained dentists hold a career in academia in high regard. Many of these highly motivated foreign trained dentists are also leading experts in their fields with extensive US post-graduate training. By modifying Virginia's dental licensure code for academic faculty practitioners, we will open up an entirely new population of faculty candidates who possess unique clinical and scientific expertise and the commitment to academics that will enhance and add value to our programs. This will not resolve all of the challenges of faculty recruitment, but it represents an important step forward to keep our school competitive for the most talented candidates. If we prevail in our efforts, I am certain that it will be my pleasure as Dean to announce many successful faculty recruitment searches in the coming years. ■

Strengthening the Backbone of our Financial Systems

By: Lisa Philp, RDH, CMC - President, Transitions Group

There are forty-four systems at work in every practice that keep the practice running smoothly on a daily basis. Some of the most important are the five or six financial management systems. The financial management systems are the ones that contribute to the revenue engine of the practice and include financial arrangements, insurance claims management, pre-determination management, treatment planning and accounts receivable. But the backbone of the financial management systems is the written financial policy. Unfortunately, many practices that have a financial policy may not be including the right options, the right level of detail and using the policy in the right way to enhance patient communication. Without a written financial policy and team collaboration and understanding of the different options patients have to pay for their dentistry, it is challenging to achieve patient clarity regarding your payment expectations and the case acceptance that's possible. But, when there is a consistent policy that everyone can communicate, there is less stress, less leniency, and less chaos. Let's take a look at what an effective financial policy should include and how it should be used.

An Effective Financial Policy Should Be Specific

In basic terms, a financial policy is a list of the different ways patients can pay for care, clearly communicating payment options and responsibilities. But to maximize patient understanding, clarity and case acceptance, the financial policy should be very specific. First, your financial policy should list all payment options available. One of the biggest benefits of a written financial policy is it immediately shows patients all their choices and makes it easy for them to see you have a solution that will serve their needs. The more time they have to focus on cost, the harder it will be for you to address their concerns. So, you would list cash and checks and include an accounting reduction for prepayment if allowed by your state law. You would also list all the major consumer credit cards you accept such as Visa, MasterCard, Discover and American Express. If you allow payment by appointment, be sure to provide detail on payment expectations and your cancellation policy. Also remember to list all of your patient financing programs along with the specific plans available.

An Effective Financial Policy Should Be Used

A financial policy cannot do its job as one of the most important financial systems within the practice if it's left to languish in a drawer. Again, the sooner you communicate to patients you have financial solutions that help them get the dental care they need, the more they will regard you as their oral health advocate and have greater satisfaction with your practice. So, put a copy of your financial policy in your new patient welcome kits and post one in your office. The only place I recommend not posting your financial policy is on your website. I believe the money conversation should only take place when there is a relationship built on trust. We do not have a relationship with patients until they call our office, not when they are seeking information on our site. What you should include on your website, though, is a statement of your commitment to finding both clinical and financial solutions that enable patients to enjoy oral health.

Most importantly, when the treatment plan is created and the patient is taken to a private environment to sit down and discuss the investment that's associated with the recommended dentistry, it's our obligation to inform before we perform. One of the top three breakdowns in patient relationships is improper explanation of fees when the patient is in an upright and coherent state. So one of the best ways we can ensure patient understanding is using a written financial policy during the treatment and fee discussions. This allows patients to both hear and read their payment choices, enhancing learning and information retention. Remember, 85% of adult learning is done visually.

An Effective Financial Policy Should Include a Patient Payment Agreement Form

Once the patient has committed to the dentistry and has chosen his or her preferred payment option, documenting the conversation with a patient payment agreement form is critical. This form ensures the patient understands what he or she is agreeing to and is meant to protect both the patient and the practice. The patient payment agreement form should detail the payment option chosen and the patient's payment responsibilities including amounts and the dates payment is expected. Patients should sign the agreement form and keep a copy for their records. The other copy should be filed in their patient file. In the unlikely event that a patient is reluctant to sign the patient payment agreement form, the practice should not move forward with care. One of my favorite phrases in dentistry is, "we will wait with you."

"Mrs. Jones, I understand there are times when saying 'Yes' is just not possible. If anything changes in your life before we see you again, please don't hesitate to call. We are happy to wait with you until the time for care is right."

An Effective Financial Policy Should Benefit the Patient and Practice

There are many ways a written financial policy benefits your patients and practice. First, there is more clarity in communication, so patients are happier. There are fewer unanswered questions. Patients don't have to try to "remember" what you said and what they committed to after they've left the practice because they have it in writing. Second, a financial policy demonstrates to patients that you are committed to finding a way for them to get the care they need. For your practice, a financial policy will make dentistry affordable, increasing case acceptance. You will also have more consistency, fewer "special cases" where patients are allowed to pay in a manner that is not beneficial to the practice because they are "friends" of one of the team members or because of their particular circumstances. You'll also find you'll have lower accounts receivable. If you currently do not have a written financial policy and patient payment agreement form, it should be at the top of your "to do" list. Get the team involved and pay attention to detail. There are some great resources available to help you. For example, CareCredit has a customized financial policy and patient payment agreement form available to practices that offer their program (for information go to carecredit.com/financialpolicy).

Your financial policy is the backbone of your financial systems. When you and your team create and use a strong financial policy you not only keep your practice healthy, but keep your patients happy and healthy.

Author bio: As CEO of Transitions Group, Ms. Philp works with dentists and their teams on a daily basis, solving problems and streamlining systems and processes within the practice. Lisa Philp is a certified effectiveness trainer, certified facilitator in Integrity Selling and a Certified Management Consultant. Ms. Philp is an authentic and engaging speaker and author who shares her passion for dentistry and practical, real-life solutions.

Disclaimer: the opinions expressed in this article are those of the author and not necessarily the views or opinions of CareCredit, this publication or the association.

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Virginia Dental Association

VDA Service Milestones

The Virginia Dental Association is fortunate to have a staff of dedicated employees. It's hard to believe but the VDA's nine employees have over ninety years of combined service to our Association.

We would like to take time out to thank all of our staff for their dedication, loyalty and commitment to the VDA. Two of our staffers are celebrating some huge service milestones. Linda Gilliam, our Director of Finance, is celebrating twenty years with us and Bonnie Anderson, our Director of Administrative Services, has served fifteen years. Without our staff we wouldn't be where we are today as an Association.

Please be sure to express your appreciation to our staffers during your daily interactions with them.

Accounting for Twenty Years!

By: Linda Gilliam, VDA Director of Finance

When I was asked to give my accounting of twenty years of service to the association I thought about the association and its value. In accounting terminology, retained earnings and losses is a way to measure a business's monetary worth. That's pretty easy. But how does one measure twenty years of service? Is there a formula to determine the value of commitment and loyalty to an organization?

When I first started with the VDA there were only two full-time employees. Pat Watkins was the Executive Director and Betty Lou Witten the bookkeeper/membership/secretary of seventeen years. Hers were the shoes I would attempt to step into. I was immediately amazed by the amount of work that they, along with some very dear part-time ladies, were able to accomplish.

Mrs. Watkins's dedication was especially impressive. The VDA didn't have a lobbyist on contract in those days. When the General Assembly was in session, Mrs. Watkins faithfully joined the doctors on the "hill". Together they represented the Association on any dental health issues that were pertinent at the time. This she continued until she retired in 1994.

There were no computers when I started working at the VDA. The membership payment records were kept on 3 x 5 index cards and handwritten when dues payments were made. The accounting was done by hand and kept in "big, heavy ledgers". Financial reports and meeting minutes were typed on the "big IBM word processor". One would think the first order of business would be to buy a computer, but change in those days came slowly.

After much persuasion from some of the dentists, it was decided that the VDA would purchase its first computer in 1992. It was purchased with the understanding that I would share it with the secretarial staff that had recently been hired. We worked out a system where I could use the computer in the morning to post membership payments and interface with the ADA to transfer the files and in the afternoon the secretary would use it for word processing. Finally, we had moved into the 21st Century!

Of course we still only had two phone lines. This was challenging since one line had to be used as a modem, while the other needed to stay open for calls. I vividly remember using the modem one day when Mrs. Watkins needed to use the phone. The other line was in use, so she came to the steps and called up the stair well "Linda, are you playing on that computer again". I can only laugh now in looking back.

In 1995, William Zepp was hired as director as well as several new staff members. It was at this time that I believe true growth began for the VDA. The membership and leaders were ready to branch out. This would be realized through the formation of the Virginia Dental Association Foundation, which would soon implement the Donated Dental Services program. This program would allow many individuals access to dental services that had no other means of obtaining dental assistance. Today the continued success of this program is due to the loyal member dentists

who volunteer their time and resources to meet the needs of the underserved. At the same time, the for-profit arm of the VDA, Virginia Dental Services Corporation was formed to help provide funding for the VDA Foundation, speakers at the VDA Annual Meeting, and many other programs that arose out of our growth. The VDSC is profitable because of the many members that participate in its programs and use the services of endorsed vendors.

The Dental Direct Program was also implemented during this time. It allowed many businesses, which had previously been unable, to offer dental benefits to their employees.

Oh, and did I mention we now had a new phone system to accommodate the additional eight staff members' needs as well as computers? Yes, I said computers in the plural! We had email! At last the membership and financial records were computerized.

In 1999, Dr. Terry Dickinson came to the VDA to take over as the new director. Soon after his arrival, Sister Bernie Kenny, who was then the director for the Health Wagon, called from Southwest Virginia to speak with him about her concerns of the plight of so many individuals in the southernmost part of our state. Through her efforts (to bring this need to the dental association's membership) an awareness of the critical need for access to care in the rural areas of our state was realized. This would be the start of the Missions of Mercy Projects in Wise, Virginia. Since then these projects have grown to include six in our state with many other states developing their own MOM and DAD programs. The success of MOM is due to the many hours of volunteer work by dentists, hygienists, assistants and students.

As we grew, so did our need for space. Overcrowding at our location on Monument Avenue was evident with staff working in the conference room, mailroom and storage rooms. We were bursting at the seams! A new building was purchased to accommodate the needs of the Association and in March of 2001, we moved into our building on Staples Mill Road.

We settled in and it was business as usual until 9/11 which changed the hearts and lives of all of us forever. Our annual meeting was scheduled for that very same week and so for the second time in history (I am told) we cancelled the annual meeting. The first time was in the late 1800's when there was a smallpox epidemic. Many of those who had registered for the meeting donated their registration fees to a scholarship fund the association set up to help with education of the children of those lost in the World Trade Building.

In 2005, Hurricane Katrina hit the Gulf Coast and once again in February 2006 the VDA membership stepped up and a group of approximately 485 volunteers traveled to New Orleans to answer the call to care for the dental needs of those who had suffered and lost so much.

When our building was struck by lightning last July we were all there to witness the aftermath of destruction. It was overwhelming to see our building gone, years of records, equipment, supplies, and irreplaceable memorabilia destroyed.

Even in the midst of all of this I knew that the heart of our organization was still intact. After all it wasn't the new technology, equipment or offices that made the difference. The real worth of this organization is its membership and their commitment to caring. Each member, volunteer and employee has contributed to its growth and left an indelible footprint for others to follow. And so in concluding I would say that the value of commitment and loyalty to an organization is measured by "caring to be a small part of a greater mission". For me the time has been well spent. ■

Fifteen Years of Change

By: Bonnie Anderson, VDA Director of Administrative Services

First of all I must say it does not seem like fifteen years. It was suggested that we write about the changes in the VDA during the time we have been here and of course, there have been many.

One of the obvious changes is in technology. Not too long after I started we were introduced to e-mail. My first reaction was "oh my gosh, how am I going to do this!" However, I adjusted quite well and now couldn't work without it.

Another technology change is in our computers. We used to take a standard desktop computer and monitor, etc. to all our meetings. Not only was it heavy and cumbersome to transport (it was not unusual to return with bruised arms from my encounter with the equipment), but each staff member had to wait her turn to type committee reports making this a long slow process. Now a laptop, in a docking station, is the computer we work on every day and when we need to be mobile we just pick it up and are on our way.

The VDA's role in access to care has grown tremendously since 1996 beginning with the DDS program. Today so many lives are being changed by the Missions of Mercy projects around the state, as well as Give Kids a Smile.

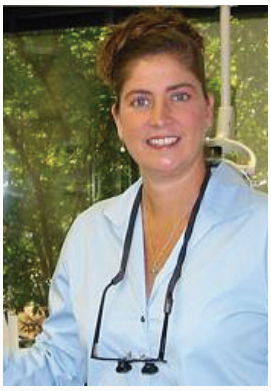
The growth of the VDA made it necessary to sell the building on Monument Avenue and move into the larger space on Staples Mill Road. A lot of "stuff" had accumulated during the time there that needed to be sorted through and a lot to be moved. I remember thinking that I was so glad I would not have to do that again. I would never have dreamed that I would be with the VDA through another move, but the lightning strike July 29, 2010 put us into the moving mode. We have been in two temporary locations since that time and are looking forward to the move to our new permanent location. Of course, we are minus the "stuff" so our upcoming move will be a little different.

One constant in working for the VDA is the many good people I have had the pleasure of working with. I am blessed to work with staff members that feel like family. I truly enjoy working with the members of the VDA and can honestly say that I have never worked anywhere where I was thanked for what I do, like the staff is here.

Everyone is asked the question - where do you work? For the last 15 years I have answered with great pride "the Virginia Dental Association".

Extraoral

By: Dr. Elizabeth M. Wilson



Finding Thalhimers - One woman's obsessive quest for the true story of her family and their beloved department store.

By: Elizabeth Thalhimer Smartt

ISBN-978-0-9827019-1-1, $25.00
Publisher: Dementi Milestone Publishing, 2010, Manakin-Sabot, VA

Note: Gentlemen, it is not Ladies' Night here at "Extraoral", so please stay, crinkle the Journal a bit and read on...this charming book *Finding Thalhimers* isn't so much about fashion as it is about history. Elizabeth Thalhimer Smartt is the author and she has crafted a richly detailed tribute to her famous-in-Richmond family.

Richmond certainly is a city rife with history... we see it at every turn. Monument Avenue alone is a sort of CliffsNotes® come to life along the street. Having been born and raised here, I'm proud of our city. I am fortunate to "have fond memories of my youth here in Richmond; field trips to our many museums, tours of old homes and much more. History is simply part of our culture here and across our state. Perhaps this influenced my own fascination with all kinds of history. Thalhimers, in my mind, is another gem of a memory. Along with recalling Miller & Rhoads, the Tea Room and of course Santa, I am, as they say transported to my youth, holding my Mom's hand, hearing my little patent leathers snap across marble floors. I marveled at the glass cases, the fashion models, even the escalators.

So I was recently delighted when perusing a bookstore, I came across this book. Luckily, it turned out to be a couldn't-put-it-down book...I started it on a Friday evening and finished the next afternoon. For anyone not familiar, Thalhimers was really just a department store located downtown. Yet from the prologue (written beautifully by John Stewart Bryan, III): "What began as a small shop in Richmond's Shockoe Bottom in 1842 grew...". He says: "Clearly...the combination of those blocks, bounded on the north by Broad Street, the south by Grace, the east and west by Seventh and Fifth Streets, defined the city of Richmond in the mind of many residents and visitors alike in the half century between the end of World War II and the decade of the 1990's." When I was a little girl, we dressed up to go shopping. It was special.

Ms. Smartt opens her book by inviting curiosity about her family's history. We, too, become curious. How did those marble floors end up there? The road she uncovers is indeed compelling. She unwinds her family's genealogy all the way back to a small corner of Germany, to the first Thalhimer allowed their own surname. We meet each Thalhimer along with their wives and children. We travel with them from Germany to Neuland (or America) and see their lives unfold. The research done here is exemplary; the storytelling absorbing. Ms. Smartt delivers a compassionate yet honest portrait of her ancestors, happy accidents and all.

She adroitly mixes in today's family as well. Her father searching for all the "family cousins" is endearing, even if at one time he finds it "amazing how a whole bunch of the family tree can just snap off". Turns out during this particular chapter, out of five brothers, all with many children, one of the brothers' own five children subsequently had no surviving children!

An additional feature of the book I enjoyed were the photos. Ms. Smartt includes on almost all the pages pictures she has collected that add definition and heart to her story. This method appealed much more to me than the usual photos or portraits you might find all stashed together in a few pages. Perhaps because she had an abundance to choose from, they complemented and truly animated her narrative. I feel like I could have known some of these folks.

Eventually...well, no, I won't spoil the whole thing. Pick it up if you like. Plan on mentioning it to patients, and to hearing reaction from any who may have read it. A real treat for Richmonders and all Virginians.

Editor's Note: Dr. Elizabeth Wilson has been a practicing dentist in Richmond since 2011. She is a delegate of the VDA, a member of the Board of Directors for the Richmond Dental Society and is adjunct faculty at VCU School of Dentistry. Email her: e.wilson45@verizon.net.

Give Kids A Smile 2011

By: Samuel W. Galstan, DDS

Each year on the first Friday in February, thousands of the nation's dentists and dental team members provide free oral health care services to children from low-income families across the country.

The ADA's Give Kids A Smile!® program enhances the oral health of large numbers of needy children. Give Kids A Smile! activities also highlight for policy makers the ongoing challenges that low-income families face in finding dental care.

GKAS is a three tiered program with local, state and national emphasis. The ADA started this program in 2002, using the Greater St. Louis Dental Association's program as a template.

Each program is designed differently: some educate, some screen, some provide treatment, and others ensure a child has a dental home as long as they need one. Since each program is developed and carried out by different communities in different settings, each one is tailored to their individual situation, and therefore there is no "cook book" program. Successful programs are able to combine partners, resources and expertise with shareholders and stakeholders in community programs, piggybacking with existing programs or growing on past successes. While there may be several key players in local programs, we always stress that if we able to get a number of people working together we can accomplish things as a group that we are not able to as individuals. Likewise, we can then each take on manageable amounts of extra work and not be overwhelmed in the process. As the old saying goes: "How do you eat an elephant? One bite at a time." If you have an existing program, reach out to dental society members, colleagues and friends and ask them to help. Don't forget – dentists are not the only ones who are great community partners. Also consider local school systems, health departments, community foundations, hospitals, Boys and Girls clubs, community organizations, civic organizations, and churches. All of these groups have an interest in seeing that the underserved in their areas receive dental care, and they are often willing to help make your program a success. Don't think that you have to do it alone. It is important to bring our younger members on board to maintain continuity in our programs, so that one person isn't doing all the work and quits because he or she is "burned out".

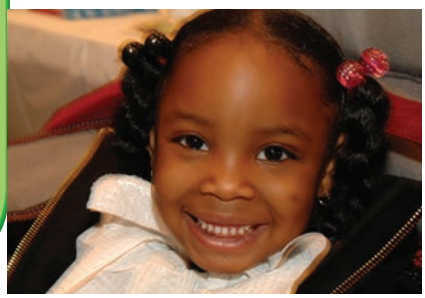
This year, 42 Give Kids A Smile! day events were planned across the State of Virginia. The results are still coming in and, as many programs are ongoing throughout the year, we won't know how much donated dental care was provided until the year is over. To date, we know that $282,951 in care was given to over 3400 children! Thanks to the more than 430 volunteers who participated this year!

Give Kids a Smile! is one of three main outreach projects that the VDA has developed for underserved Virginians. The elected officials, policy makers, and the general public are aware that the VDA and the dentists in Virginia are making a major effort to deal with the access to dental care issue facing the underserved in Virginia. You can go into any office on Capitol Hill in Richmond, and the staff member will have heard about the VDA and our outreach projects. This is important because the VDA is included in many of the discussions that involve dentistry in Virginia. Often, state dental associations are not consulted in similar situations in other states because they do not have the programs or the relationships the VDA has.

These three projects have given the VDA credibility, and have solidified the VDA as the voice of oral health literacy in Virginia. Dentists in Virginia have a long history of providing dental health care to Virginians. While the Missions of Mercy project certainly gains the most attention, GKAS and DDS provide valuable services in ways that the MOM project cannot.

Thank you to everyone who helps in the important outreach activities that the VDA does to decrease barriers to all Virginians receiving dental care. We know you are busy and recent downturns in the economy have made it difficult on many Virginia dentists. Remember that these projects yield profound dividends for both patients and dentists in Virginia. Offer to help in any way that you can. If you or your office help with GKAS, THANK YOU! If you don't presently volunteer, please consider helping in the future. We need your help. If you have questions or need assistance, please contact me or Kate Hanger at the VDA.

We have more Give Kids A Smile! photos then we could ever print! Follow the link below to view all of our photos. Thanks to the many volunteers that keep Virginia's kids smiling.



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Dr. Brenda Young
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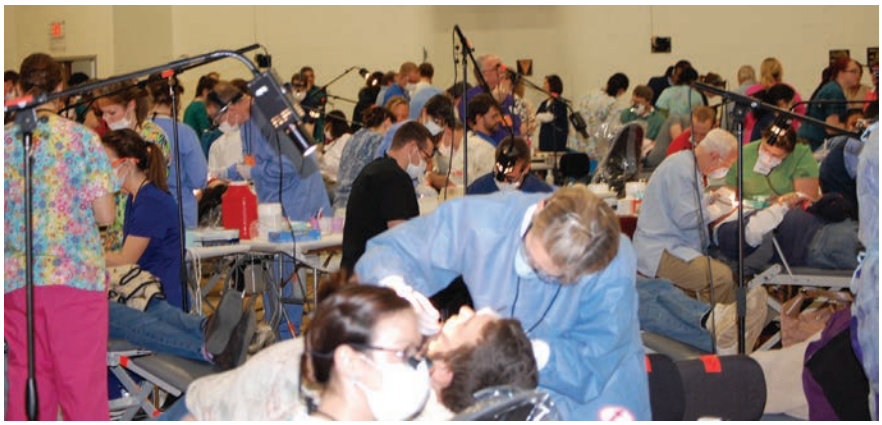
Middle Peninsula/Northern Neck M.O.M. Project 2011

By: Mrs. Phyllis Harris



Typical M.O.M. scene, everyone is working diligently to see as many patients as possiible in a day and a half.

What a difference a year makes! The blessing of beautiful weather and an additional half day for our second Missions of Mercy project at Gloucester High School helped make the weekend of February 19 and 20 a great success.

Our MOM project began with a pre-registration call-in on February 11. We advertised in local newspapers, radio and in local free clinics the time, date, and phone number for this call-in in order to get 150 random patients to pre-register on Friday afternoon. All other patients would be on a first-come, first-serve basis Saturday morning, with the doors opening at 7:00 a.m. With three phone lines ringing non-stop, we obtained our quota in just two hours.

On our Project weekend again this year, the Abingdon Ruritan Club provided an outstanding dinner for almost 300 volunteers after an afternoon of setting up, triaging, and getting ready for the Day One. The evening's excitement built when it came time to draw tickets for the four items being raffled: an i-Pad®, two nights at the Kingsmill Marriott, half of the 50/50 drawing, and a handmade custom fishing rod. Then, on Saturday night, dental students were fed a pasta extravaganza by Abingdon Episcopal Church members.

Pharmacist Becky Rose gets a delicious breakfast from servers Rod Taylor, DAvid Dea, Don Rainey, & Karen Ward, Olivia's co-owner.

Saturday and Sunday morning both began with a delicious breakfast at 5:30 a.m. cooked by Jessica's Sweet Shop and Olivia's in the Village, respectively. Homemade sweet rolls, hash browns, scrambled eggs, sausage, and fresh fruit gave volunteers a hearty start to a long day of hard work and repairing the smiles of those they came to serve. Many restaurants and eateries donated food to help feed our over 500 volunteers throughout the weekend—Chick-Fil-A, Arby's, Ruby Tuesdays, Applebee's, Kentucky Fried Chicken, Taco Bell, Subway, Rosemary & Wine, as well as local churches and individuals. We are so fortunate to live in such a giving community.

We offered free flu shots again this year and added free sight and hearing testing. The Lions Club was on hand for vision testing and to provide glasses to those who needed them.

Dentures were new to our MOM Project this year! We welcomed Dr. Stephen Alouf and staff from Salem, who utilized the new Larell denture technique. What an amazing process to observe! The dentures are premade and then adjusted to fit each patient, therefore making delivery much quicker. Dr. Alouf and staff were able to deliver 38 dentures in one and a half days. What a fantastic process for free clinics to offer their edentulous patients. There are also 21 sets of dentures that are in the process of being fabricated to be delivered traditionally by local dentists.

The totals for the weekend were outstanding! There were 779 patients seen, 685 prescriptions filled (all donated by Gloucester Pharmacy—thank you Keith Hodges and staff – the staff volunteered to open on Sunday), 788 routine extractions, 353 surgical extractions, 17 root canals, 1,034 restorations, 286 cleanings, 186 fluoride varnishes and $620,565 in total donated dental services! That's $797 of donated dental services per patient!

We were grateful to have Cliff and Mary Ann Demars this year, who worked tirelessly making name tags and scanning our volunteers in and out. This technology made such a difference in registration time and in providing statistics on volunteer hours.

Our thanks to the Gloucester County School System, who again provided us with an excellent facility and were so wonderful to work with throughout the entire project; to the custodial staff at GHS were a tremendous asset; to the VDA, specifically Dr. Terry Dickinson for his vision and Robbie Schureman and Barbara Rollins for their leadership.

Our unending thanks to the many volunteers from all over Virginia, North Carolina, and Maryland! The 2011 MPNN MOM would have never been possible without the organization skills, hard work, and watchful eye of Kelly Cooper, my husband's (Dr. Chuck Harris) right-hand. Many thanks also to the remainder of Chuck's staff for all they have done throughout the year to bring this project to fruition. And to our community volunteers, thank you again for reminding us that the Middle Peninsula is the most wonderful place to live!

Missions of Mercy

Gloucester M.O.M at a glance...

Patients treated:	**779**
Value of care:	**$566,000**
Volunteers:	**600+**

A special thank you goes out to the two denture teams, Dr. Steven Alouf and Greg Gray (Southern Gray Dental Lab, Fredericksburg) and Dr. Phillip Render and Lewis Bowles (Service Dental Lab, Lynchburg) who fabricated 46 complete dentures in addition to 4 partial dentures and several repairs and adjustments. An amazing accomplishment in 1 1/2 days!!

M.O.M. has provided 1.280 Gloucester area residents with dental care valued at over $890,000 through the 2010 and 2011 projects!

THANK YOU!

A BIG THANK YOU TO ALL THE 2011 GLOUCESTER M.O.M PROJECT VOLUNTEERS!

Dr. Mike Abbott
Dr. Ana Maya Adkins
Molly Adler
John Aiken
Jill Aikilani
Myrna Alderman
Clint Alexander
Dr. Tawfiq Alkilani
Dr. Sarah Allen
Dr. Steven Alouf
Dr. Fahad Alsaad
Safiya Alsogair
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Julie Delusa
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Dr. Harold Demsko
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Dora Dye
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Dr. Peter Zullo

Outreach

The **Virginia Dental Association** and **VDA Services** are pleased to invite you to join:

John A. Svirsky, D.D.S., M.Ed. for a Continuing Education Vacation

Western Mediterranean Cruise

The Epicurean's Guide to Europe Continues...Another Oral Pathology Adventure

September 17-24, 2011

Cruise Itinerary

	Arrive/Depart
Day 1: Barcelona, ESP	5pm
Day 2: Provence, FRA	7am/5pm
Day 3: Nice, FRA	7am/7pm
Day 4: Livorno, ITA	7am/7pm
Day 5: Rome, ITA	7am/7pm
Day 6: Naples, ITA	7am/7pm
Day 7: Cruising	
Day 8: Barcelona, ESP	6am

All itineraries subject to change without notice.

Cruise Details

Cabin Rates (based on double occupancy)
Ocean View Cabin:$1606/person
Balcony Cabin: $1806/person
Jr. Suite: $2506/person
Rates Include: standard meals, activities and entertainment, taxes, port charges, fuel and government charges and gratuities.
Rates Exclude: Airfare, transfers, baggage handling, shore excursions and trip insurance.

CE Course Details

Title: *The Epicurean's Guide to Europe Continues...Another Oral Pathology Adventure*

Credits: 12 CE Credit Hours

Instructor: John A. Svirsky, DDS, M.Ed., professor of oral pathology, VCU School of Dentistry

Course Description: Experience oral pathology unlike anything you've experienced before! Dr. Svirsky is a storyteller extraordinaire whose subject just happens to be lumps, bumps, and lesions. Oral diseases are dramatized with emphasis on recognition, diagnosis, and treatment with conventional and non-conventional remedies. Pre-malignant and malignant lesions along with new diagnostic techniques will be introduced. Lesions seen more often as "boomers" get older and "dryer" such as Herpes, Aphthous ulcerations, Candidiasis, erosions and dry mouth will be reviewed with current treatment modalities presented.

Course Objectives: Demonstrate a logical approach to the diagnosis of oral lesions; Recognize, diagnose and determine a treatment plan for selected oral diseases; Integrate therapeutic regimens used to treat oral diseases; Manage xerostomia in the aging population; Interpret clinical, laboratory and radiographic findings to establish a differential diagnosis; Develop a final diagnosis and treatment plan.

Tuition: $529 (if you do not book through Classic Travel, tuition is $664)

To register for this CE Vacation, please contract Jean Southwick (jean@classictravelusa.com) or Joy Thrun (joy@classictravelusa.com) at Classic Travel—800-643-3449. For more information please visit: www.classictravelusa.com and click on the 'Go With a Group' link.

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A brief history of access to dental care issues in the U.S.

By: Dr. Samuel Galstan, VDA Director, Southside Dental Society

Starting well over 30 years ago, different entities began to examine how health care was delivered in this country, in an effort to achieve better health care for all Americans, especially towards children and the underserved. As part of this discovery process, it was noted that healthcare is not distributed evenly throughout this country, that there are barriers and discrepancies towards quality health care in some populations that result in less than favorable outcomes than in other populations. One particular note was that people from lower socioeconomic (SES) populations, especially those that were poor, children, the elderly and minority, did not receive as much high quality health care as did other populations. These discrepancies are even more significant with oral health care. There is a present move to obtain more equality in the healthcare system.

Until relatively recently, organized dentistry was thought to be the voice of dental health care in the U.S.. That has changed, due to a number of factors, primarily increases in consumerism and transparency, a drive to lower health care costs, combined with a rising sentiment that the number of people in this country without access to dental care is unacceptable. Many feel that organized dentistry has had an opportunity to deal with access to care barriers that exist and has failed. This implied failure to achieve health care equality has caused some from outside of the health care arena to make suggestions about how to "fix" the broken health care system. They use this existing data that shows health care disparities as evidence of this situation, and as support for outside intervention.

With evidence of long-standing and increasing disparities and barriers towards optimal dental health care in this country, some entities began to sidestep organize dentistry and propose their own solutions. Some have continued to collaborate with organized dentistry, realizing that organized dentistry has unique insights and abilities in delivering dental health care and should be a vital part of the solution. Other entities have specifically avoided contact with organized dentistry, or have chosen with whom they collaborate with very carefully. Many also feel that organized dentistry has let them down, and they are moving forward to find their own solutions.

In 1979 the first set of national health targets, known as Healthy People: The Surgeon General's report on health promotion and disease prevention was published. This began to establish the prevention agenda for the U.S. Department of Health and Human Services (HHS). (HHS is a powerful organization as it oversees all federal dollars that are expended on health care. Healthy People was a statement of national opportunities- a tool that identified the most significant preventable threats to health and focused public and private sector efforts to address those threats. "Healthy People" offered a simple but powerful idea: to provide the information and knowledge about how to improve health in a format that enables diverse groups to combine their efforts and work as a team. It is a road map to better oral health for all that can be used by many different people, states and communities, businesses, professional organizations, groups whose concern is a particular threat to health, or a particular population group. Healthy People is based on scientific knowledge and is used for decision making and for action. The original Healthy People from 1979 was followed by Healthy People 2000, which was released in 1990. Healthy People 2000 is a comprehensive agenda that is organized into 22 priority areas (Oral Health is one of these) with 319 supporting objectives. This was followed by Healthy People 2010, which was released in 2000, and Healthy People 2020 which was released in 2010. These are ten year, strategic management tools- for the Federal Government, States, communities and many private sector partners. To date, 47 states, the District of Columbia and Guam have developed their own Healthy People plans. Most states have emulated national objectives, but virtually all have tailored them to their own specific needs. Progress reviews are conducted periodically on each of the 22 priority areas and on population groups, including women, adolescents, people with disabilities, and racial/ethnic groups. Healthy People objectives have been specified by Congress as the metric for measuring the progress of the Indian Health Service, the Maternal and Child Health Block Grant, and the Preventive Health and Health Service Block Grant. Ongoing involvement is ensured through the Healthy People Consortium, an alliance of 350- national membership organizations and 300 state health, mental health, substance abuse and environmental agencies (U.S. Department of Health and Human Services, 2010).

Healthy People measures baseline health conditions, and then sets goals to improve these conditions. For instance, Healthy People 2020 has 39 topic areas, from Access to Health Services to Vision. Number 32 is oral health. All of these topic areas identify and group objectives of related content, highlighting specific issues and populations. Each topic area is assigned to one or more lead agencies within the federal government that is responsible for developing, tracking, monitoring and periodically reporting on objectives. An example of some goals and objectives from Healthy People 2020 under Oral Health are: OH-1: Reduce the proportion of children and adolescents who have dental caries experience in their primary or permanent teeth. OH-1.1: reduce the proportion of young children 3 to 5 years of with dental caries experience in their primary teeth. Baseline: 33.3 percent of children aged 3 to 5 had dental caries experience in at least one primary tooth 1999-2004. Target: 30.0 percent. Target-Setting Method: 10 percent improvement. Data Source: National Health and Nutrition Examination Survey (NHANES), Centers for Disease Control (CDC), National Center Health Statistics (NCHS). (U.S. Department of Health and Human Services, 2010). With Healthy People, baseline measurements are taken, goals are set, and then new measurements are taken at a later time to determine if progress has been made. This is ultimately how access to care is determined.

The government and a number of foundations (including the W. K. Kellogg Foundation and the Pew Charitable Trusts) have been interested in documenting these findings, as well as working towards solutions to make dental health care available to more Americans at more affordable cost. Today, HP 2010 is the major driver of public health policy, and therefore dental public health policy, at the federal state and local level.

Several papers were written in the 1990's and 2000's relating to disparities that exist in this country's oral health care system and barriers that exists relating to accessing dental care.

- In 1998 Mueller, Schur and Paramore analyzed data from the 1994 National Access to Care Survey, and found that 8.5 percent of the U.S. population wanted, but did not obtain dental care in 1994. The prevalence of unmet dental care varied by demographics, socioeconomic status, income and health insurance status. Those that had the most difficulty accessing the dental health care system tended to be those who were from minority groups, those with the lowest incomes, with language and cultural barriers, and those without health insurance. These differences created discrepancies in accessing dental health care (Mueller, C. D., Schur, C. L. & Paramore, L. C. (1998).

- In 2008, Allukian wrote: The neglected epidemic and the Surgeon General's Report: A call to action for better oral health. In this paper, the author noted that the Surgeon General's Report would be released in the near future and that oral diseases have been called a "neglected epidemic" because even thought they affect the entire U.S. population, they have not been made a priority in this country, and that they affect vulnerable and high-risk populations disproportionately. The oral health disparities of the underserved are seen in children, the elderly, individuals with low incomes, the developmentally disabled, the medically compromised, people who are homebound or homeless, persons with HIV, uninsured and institutionalized individuals, and racial, cultural and linguistic minorities. The author concluded that the oral disease epidemic has been neglected for too long in the richest country in the world, and that we can do much better to decrease barriers to access to dental care.

● On May 25, 2000, Surgeon General David Satcher released: "The Surgeon General's Report on oral health". This first-ever Surgeon General's report on oral health identified a "silent epidemic" of dental and oral disease, with uninsured children more than 2.5 times less likely to receive dental care than insured children, and with children from families without dental insurance to have 3 times more unmet dental needs than children from families with dental insurance. This report was commissioned by Secretary of Health and Human Services Secretary Donna Shalala, and called for a national partnership for individuals, communities, and the health professions to work together to maintain and improve the nation's oral health. Shalala stated: 'Together we can affect the changes we need to maintain and improve oral health for all Americans and remove known barriers that stand between people and oral health services". The press release for this report stated the need to: "enhance the public's understanding of the meaning of oral health and the relationships of the mouth and the rest of the body; raising the awareness of the importance of oral health among government policy makers to create effective public policy that will improve American's oral health; and education non-dental health professionals about oral health and disease topics and their role in assuring that patients receive good oral health care (U.S. Department of Health and Human Services, 2000).

Different groups began to review data relating to populations that were of interest to them, and began to advocate for ways to improve their specific population's health outcomes. Some worked within the frameworks of organized dentistry in a collaborative approach; others became frustrated with lack of progress and sought their own solutions.

There has been an ebb and flow in the enrollment of dental schools and the number of dental providers available in this country throughout history, resulting in a continuum between shortages and oversupplies of dentists. In the 1970s, after determining that there was a shortage of dentists in this country, the federal government began to subsidize dental school education and the enrollment in dental schools increased dramatically. By the late 1980s, these subsidies had been withdrawn, dental school enrollments decreased dramatically, and a number of dental schools in this country closed. This country went from an oversupply of dentists in the 1970s due to the governments overcorrection of a perceived shortage, to a shortage in the late 1980s. It must also be noted that shortages in dental providers is difficult to figure. If for instance you take the number of dentists in Virginia, divided by the population of the state, it doesn't appear that there is a shortage of dentists. If, however, you look at the distribution of dentists in relation to the population, you realize that there are an abundance of dentists in more affluent metropolitan areas, while there are shortages in rural, high crime inner-city, and less affluent areas. Additionally, there are employment and insurance issues, so there may be enough dentists in an area, but if none of them accept a patient's insurance, then this creates a localized shortage. Other issues that may cause barriers to dental care include language, customs, transportation, childcare and cultural issues. These factors are difficult to track on a government spread sheet.

In the 1990s, after a number of years of being frustrated by their population's barriers to access to dental care, the tribal leaders in Alaska through the Alaska Native Tribal Health Consortium began to consider other options of obtaining predictable, regular, long-term dental care for Alaska Natives. Previously, Alaska Natives were plagued with caries rates that were 2.5 times that of the national average, long standing vacancies and high dental provider turnover, high disease rates in adults including significant untreated edentulism, resulting in a population that had developed into acute dental care seekers. This population had a culture of distrust and fear of dentistry. Due to the massive geographic expanse in Alaska, and the wide separation of sparsely populated villages, travel to the dental professional or by the dental professional was difficult and costly, making the delivery of dental care unpredictable, difficult and extremely expensive. The Tribal Leaders perceived that organized dentistry was not providing acceptable solutions to their lack of dental care, so they took matters into their own hands. They recruited a class of 10 students and sent them to New Zealand to be trained as Dental Health Aid Therapists (DHAT). The idea was to have local people trained who would practice a limited scope

of dentistry in the communities in which they were from, following the trends of the most successful dental health programs around the world. Since 2003, there have been 10 New Zealand trained DHATs, and only one has stopped practicing in Alaska. Later, a U.S. based training program was developed in a partnership with the University of Washington MEDEX program. This program has graduated 9 students, and has 13 in training, and predicts 32 DHATs practicing in Alaska by the year 2012 (Williard, M., 2010).

● A key event caused increased public scrutiny of the access to care crisis. On Sunday, February 25, 2007, 12 year old Deamonte Driver died of complications that resulted from an abscessed tooth. Deamonte's mother stated that Deamonte had never received routine dental care because previous jobs that she had held did not provide dental insurance. When Deamonte got sick, his mother did not realize this because she had been focusing on Deamonte's brother DaShawn, who "complains about his teeth all the time". Difficulties occurred with the Driver family, including lapses in Medicaid dental coverage, change of address, homelessness, difficulty in finding dental providers that accepted Medicaid, difficulty in obtaining specialty referrals, and difficulty in obtaining appointments in a timely manner (Otto, M., 2007). In spite of such modern innovations as the fluoridation of drinking water, tooth decay is still the single most common childhood disease nationwide, five times more common than asthma. Poor children are more than twice as likely to have cavities as their more affluent peers, but far less likely to get treatment (Otto, M., 2007, U.S. Department of Health and Human Services, 2000). Serious and costly consequences of dental treatment are "not uncommon" said Dr. Norman Tinanoff, chief of pediatric dentistry at the University of Maryland Dental School in Baltimore. For instance, Deamonte's bill for his two week stay at Children's Hospital in Baltimore was expected to be between $ 200,000 and $ 250,000 (Otto, M., 2007). After Deamonte's death, many people questioned how and why a 12 year old child could die from a simple cavity. This event also energized a number of entities outside of dentistry to exert influence towards decreasing barriers towards access to dental care for all Americans, especially those of lower socioeconomic status (SES).

● <u>Approval of National Healthcare plan:</u>
On March 23, 2010 President Obama signed HR 3590, the Patient Protection and Affordable Care Act (PPACA) into law. This health care reform has broad sweeping implications, especially towards expanding access to oral health care to children. This law calls for establishing pilot programs to examine alternative dental health care providers such as D.H.A.T.s.

● <u>Change in the public's perception of dentists.</u>
Dentists as a whole have recently seen significant increases in income compared to physicians. A report in the Wall Street Journal that used survey data from 2000 from the American Dental Association and the American Medical Association found that in the past few years that dentists have started earning higher incomes than many types of physicians, including internal medicine doctors, pediatricians, psychiatrists and family practice doctors. On average, dentists earned $ 166,460, compared to $ 164,100 for general internal medicine doctors, $ 145,700 for psychiatrists, $ 144,700 for family practice physicians, and $ 137,800 for pediatricians. All recent data shows that dentists have at least kept pace with physicians since then. These figures show a sharp increase

in income for dentists since 1988, when the average general dentist made $ 78,000, which was at the time about two-thirds of the average income of internal medicine doctors. From 1988 to 2000 dentists' income more than doubled, while the average physician's income grew 42 percent (which is lower than the rate of health care inflation.) The ADA says that most dentists generally work 40 hours per week, while the AMA says that more physicians generally work 50 to 55 hours per week, making the earning discrepancy even greater (Maremont, M., 2005). The recent economic downturn in this country may have decreased the earnings of both dentists and physicians. However, there is a great deal of public perception that most dentists work about 3 days a week, drive expensive cars, drink lattés, and don't care about the poor and underserved in this country.
There are a number of issues, and some key historical events that are important in understanding the access to care crisis that presently exists in this country. By understanding these issues, we can perhaps better understand where we are today and how we got here. Some of these issues are real, some are perceived and misrepresented. We can no longer ignore them.
We all need to be aware that dentistry is facing some severe challenges to our profession, and if we are going to survive, we need to be aware of our history and need to be step up to the challenges facing us.

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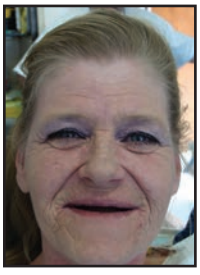
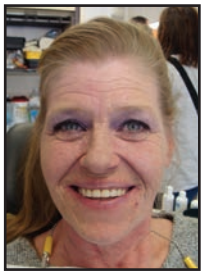
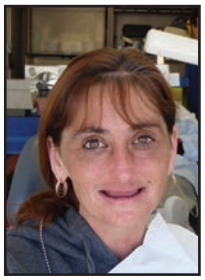
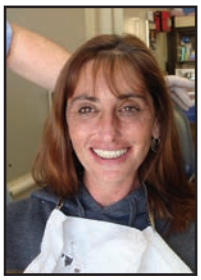
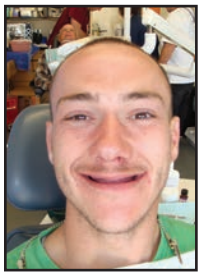
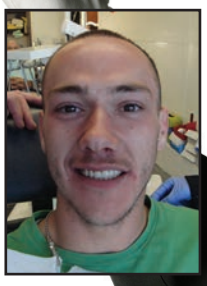
First Class Dentures, Same Day!

Gloucester M.O.M. Tests New Denture System

By: Stephen B. Alouf, DDS

I am happy to report we may have turned the corner on providing prosthetics at our Missions of Mercy projects. I started offering dentures and partials to our Missions of Mercy patients at the Roanoke M.O.M. Project in 2008, with the partnership of Greg Gray, CDT, of Southern Gray Dental Lab. We have worked hard to produce start-to-finish dentures in two days for Roanoke, Wise, Grundy, Eastern Shore, and West Virginia M.O.M. patients in the last three years. We've had some amazing results, but I never felt we were doing enough to keep up with the extraction rates at our projects.

Greg and I are now working with Dr. Lawrence Wallace, an oral surgeon from California and President of the Larell One Step Denture. The Larell Denture System is a new process for the fabrication of complete dentures in one visit in about an hour. The system is comprised of five different size denture templates which are processed with ADA-approved denture materials. Alginate impressions are taken of the patient's arch or arches to be restored and poured up in quick set snap stone. The templates are then border trimmed, heated and molded to the arch form on the model. A try-in is next to establish lip sup[illegible] speech sounds, and the occlusal plane using an occlusal plane gauge. The templates are then ready for a functional chairside reline. I have completed close to 100 of these dentures in Bristol (with the help of Dr. Scott Miller), the RAM project in Oneida, Tennessee and the latest (38 dentures) in Gloucester. I am amazed at our results thus far and we are following a number of these patients to establish longevity and function over time. At all of these projects, we have had minimal follow up adjustments reported. My goal is to deliver many more dentures to patients in need at our Missions of Mercy Projects.

Many thanks to my team in Gloucester: Dr. Michael Clark, Greg Gray, Anna Harrison, Tracey Bourassa, Tammy Runion, and all of the other hard working volunteers. This was truly a successful project all around. We hope to build on our success at the Roanoke MOM Project.

Piedmont Regional Dental Clinic Near Opening

By: Mary F. Hintermann

Progress continues in Orange County where the Piedmont Regional Dental Clinic (PRDC) approaches opening day. Building on the momentum created around the Missions of Mercy project in Barboursville last May, the Clinic expects to open mid-summer 2011 with one dental team and four operatories serving Orange, Greene, Madison and Culpeper counties.

What have PRDC volunteers learned from starting this new dental safety net clinic? A lot. Here are our top ten lessons learned over the past twelve months:

#10 From fundraising to day-to-day organizational tasks, starting the clinic has been a huge undertaking for an all-volunteer Board. It could be said it is too big an undertaking for a group of volunteers. Hire a Dental Practice Manager/Executive Director nine months before planned opening date. Money well spent.

#9 A dental safety net clinic accepting tax payer dollars and grant funding has more rigorous information collection, data mining and reporting requirements than private dental practices. Pending changes in health care coverage will only increase these demands. Budget for it.

#8 Don't underestimate the credibility created by an attractive and functional website. From recruiting, encouraging press coverage, donor recognition, Board Member communication to community outreach, your website will convince constituencies you are 'real'. It will actually save you money.

#7 To quote one of our Board members: "Every project costs twice as much as you think and takes twice as long as you hope." That's pretty much true.

#6 Allow 18 months for fundraising. Grant cycles have long lead times and the probability of receiving a grant from a donor who has never met anyone from your organization is negligible. Corporations have marketing budgets as well as philanthropic foundations from which they can support your cause. Sometimes marketing dollars are easier to tap.

#5 Donor recognition is truly an art form. Think about things like naming rights, website visibility, repeated references at every press opportunity, and donor recognition in newsletters and at special events. If anyone has good donor recognition ideas, let us know.

#4 It takes money to raise money. It will be hand-to-mouth existence with start- up capitalization under $30,000. Moreover, major donors are skeptical when they don't see a critical mass of funds already committed. Initial capitalization under $100,000 twelve months prior to opening will make fundraising more difficult.

#3 Do a Missions of Mercy (MOM) project early in your organizational life cycle. The process is a big undertaking but resonates throughout a community long after the MOM is over. Doing a MOM integrates a new nonprofit with the wider dental community throughout the state. It convinces local governments that you offer real value to their citizens. It convinces the press they should take your media alerts and press releases seriously. It energizes volunteers whom you will badly need during start up and it persuades the patient population that hope is coming.

#2 Virginia Health Care Foundation support is pivotal, obviously in terms of funding, but even more so in terms of having their imprimatur. Fundraising becomes easier when other major donors see that you have VHCF's support. The VHCF process is rigorous and, if you don't have all your spreadsheets and research completed when you start their grant application, you will have them perfected by the end of it. Start eighteen months before your target grant cycle and make the time to get to Richmond, meet their account managers, update them periodically on your progress, participate in "ToothTalk" and the Virginia Oral Health Coalition, and establish the credibility of your nonprofit.

#1 Get to know the good folks at Augusta Regional Dental Clinic. They have figured out how to make the 70/30 dental safety net clinic model work and are incredibly generous with their time and knowledge. PRDC has benefited incalculably from their support. Thank you, Chris and Margaret.

Missions of Mercy

JOIN THE M.O.M. TEAM!

Upcoming Projects:

Special Olympics M.O.M.
June 11, 2011

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.vadental.org. Please see page 39 for the signup form if you prefer.

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

THE Virginia MEETING

June 16-18, 2011

Williamsburg Lodge

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WILLIAMSBURG, VIRGINIA

Dates to Remember

Please make note of these important dates for the Virginia Meeting.
Register before April 30th and receive the early bird discount pricing!

- **Early Bird Registration DEADLINE** — **on or before April 30, 2011**
- **Hotel Reservation DEADLINE** — **May 16, 2011**
- **Pre-Registration DEADLINE** — **June 3, 2011**
- **Onsite Registration** — **June 16-18, 2011**

Lodging Information

Williamsburg Lodge & Conference Center
310 South England Street
Williamsburg, VA 23185

Deluxe: $229
Superior: $204

Williamsburg Inn
Main Building: $395
Providence Hall: $289

Woodland Hotel & Suites:
Superior: $139

Phone reservations: 1-800-HISTORY or 1-800-261-9530 Virginia Meeting Discount Code: 5507

Online reservations: https://resweb.passkey.com/go/5507

Register online at: www.virginiameeting.org

Thursday, June 16, 2011

Continuing Education

Code	Course Title	Speaker	Time	Cost
1	Scheduling for Success	Amy Kirsch	9:00am-Noon	Free w/ Badge
2	Dynamic Internal Marketing	Amy Kirsch	1:00-4:00pm	Free w/ Badge
3	Invisalign Clear Essentials 1	Dr. Doug Sakurai	8:00am-5:00pm	$1,695
4	Invisalign Team Member Registration - Breakout		8:00am-5:00pm	up to 4 free with 03

Events

Code	Event	Time	Cost
30	Opening Reception	4:00pm-5:00pm	Free w/ Ticket
32	Annual VDA Golf Tournament	9:00am start	$160
33	Ghost Tour	9:00pm-10:00pm	$15
41	Afternoon Tea	1:00pm-2:30pm	$35
n/a	ACD Dinner	6:30pm-10:30pm	register through ACD

Friday, June 17, 2011

Continuing Education

Code	Course Title	Speaker	Time	Cost
5	Why Are Women So Strange and Men So...	Bruce Christopher	8:00am-11:00am	Free w/ Badge
6	Are We Having Fun Yet?	Bruce Christopher	Noon-3:00pm	Free w/ Badge
7	Healthcare Provider CPR	Tidewater Ctr for Life Support	8:00am-Noon	$60
8	CAD/CAM Technology for the Restorative...	Dr. Robert Kenney	9:00am-Noon	Free w/ Badge
9	The “Nuts & Bolts” of Adhesive...	Dr. Stephen Poss	8:00am-11:00am	Free w/ Badge
10	Predictable Direct Resin Restorations	Dr. Stephen Poss	1:30-4:30pm	$195
11	Straightforward Ultrasonic Debridement	Cynthia Fong, RDH	8:00am-11:00am	Free w/ Badge
12	Simplified Ultrasonic Instrumentation	Cynthia Fong, RDH	1:30pm-4:30pm	$195
13	Predictable Restoration of Endodontically...	Drs. McAndrew & Overton	2:00pm-5:00pm	Free w/ Badge
14	Digital Impressions, A Path to the Future…	Dr. Suzette Stines	2:00pm-5:00pm	Free w/ Badge
15	Successful Systems for A/R and Ins...	Teresa Duncan, MS	9:00am-Noon	Free w/ Badge
25	Considering Practice Ownership?	Stephen Trutter & Brian Cogan	9:00am-Noon	Free w/ Badge
46	Heartsaver CPR	Tidewater Ctr for Life Support	2:00pm-4:00pm	$50

Events

Code	Event	Group	Time	Cost
34	AGD Breakfast*	AGD	7:00am-8:00am	$0 w/ ticket
35	Pierre Fauchard Lunch*	Pierre Fauchard	Noon-1:30pm	$40
36	President’s Party		7:00pm-10:30pm	$30
37	MCV/VCU Reception	MCV Alumni	6:00pm-7:00pm	$0 w/ ticket

Saturday, June 18, 2011

Continuing Education

Code	Course Title	Speaker	Time	Cost
16	Why Are Women So Strange & Men So...	Bruce Christopher	8:30am-11:30am	Free w/ Badge
17	Creating a Good Life...	Dr. Kimberly Reynolds	8:00am-4:00pm	Free w/ Badge
18	Straightforward Ultrasonic Debridement	Cynthia Fong, RDH	8:00am-11:00am	Free w/ Badge
19	Advance Dental 3D Imaging Interpretation	Dr. Bruno Correa de Azevedo	9:30am-1:30pm	Free w/ Badge
20	How to Live Well Through Retirement	Haigh, Blair, Oder, & Hunter	8:30am-11:30am	Free w/ Badge
21	Clinical update in current concepts and...	Dr. Domenick Coletti	1:00pm-4:00pm	Free w/ Badge
22	Achieving Predictable Esthetic Results	Dr. John Cranham	8:00am-11:00am	$25
23	Treatment Planning the Worn Dentition	Dr. John Cranham	1:00pm-4:00pm	$25
26	Healthcare Provider CPR	Tidewater Ctr for Life Support	8:00am-Noon	$60
39	Advanced Cerec Technology	Dr. Suzette Stines	8:00am-4:00pm	$295
40A	ACD Lunch & Learn - Orthodontic Hope...	Drs. Scott Berman & Edwin Lee	11:30am-1:00pm	$40
40B	ACD Lunch & Learn - The Science of...	Dr. Terence Imbery	11:30am-1:00pm	$40
40C	ACD Lunch & Learn - The Laser in Ortho...	Dr. Anthony Peluso	11:30am-1:00pm	$40
40D	ACD Lunch & Learn - Esthetics - An ADA...	Dr. David Anderson	11:30am-1:00pm	$40

Events

Code	Event	Group	Time	Cost
24	Past Presidents Breakfast*	VDA Past Presidents	7:30am-9:00am	$0 w/ ticket
38	ICD Breakfast*	ICD	7:30am-8:30am	$25
42	Sunrise Yoga		6:30am-7:30am	$17

Admission Tickets

Code	Ticket	Time	Cost
44	Colonial Williamsburg Historic Area Ticket	Good for length of Conference	$25

* Only members of these groups can attend this event.

2011 Virginia Meeting - Registration Form For All Registrants

Mail to: VDA - PO Box 3095 Henrico, VA 23228 Fax to: 804-288-1880 Online:www.virginiameeting.org

ACD Luncheon For Learning:

40A- Berman & Lee
40B- Imbery
40C- Peluso
40D- Anderson

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1st _____ 2nd _____
☐ Refund if choices are not available

VDA Golf Tournament
Code: 32 - Additional Information

Handicap: _____

I would like to be grouped in a team with the following players:

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Virginia Meeting mailing list opt out (see page 18 for details)

☐ Yes, I would like to opt out of the Virginia Meeting mailing list.

Leave blank if you would like to be included in meeting mailings.

1 Primary contact for conference registration (if questions arise the VDA will contact this person)

Contact Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Specialty: _____

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Component # _____ Membership #: _____

2 Registration Categories:

	On/before 4/30	5/1-6/3	Onsite Rates 6/16-6/18
A. First Time Attendee Dentist	$110	$160	$210
B. VDA Member Dentist*	$195	$245	$295
C. ADA Dentist (non-VDA)*	$295	$345	$395
D. VDA Member Dentist (1st Yr Out of Dental School)	$35	$47	$60
E. NON Member Dentist	$495	$530	$565
F. Active Military Dentist (non-VDA)	$195	$245	$295
G. ODDS Member (non-VDA)*	$195	$245	$295
H. Retired Life/Life VDA Member	$0	$0	$0
i. Assistant - VDAA member*	$50	$55	$60
J. Assistant - Non-VDAA member	$60	$65	$70
K. Spouse/Guest of registrant	$25	$30	$35
K2. Guest (ages 12 and under)	$5	$7	$10
L. Student (Dental, Hygiene & Assisting)	$0	$0	$0
M. Office Staff	$50	$55	$60
N. Lab Technician	$50	$55	$60
O. Hygienist	$75	$80	$85

*membership verification required

3 4 5 6

Reg Category	Fee	Registrants List Primary Registrant on the first line (Please print clearly)	Friday Lunch Option +$16	Course #1 Code/Fee	Course #2 Code/Fee	Course #3 Code/Fee	Event #1 Code/Fee	Event #2 Code/Fee	Subtotal
		1	Veg ☐ RB ☐ Trky ☐ Opt Out ☐						$
		2	Veg ☐ RB ☐ Trky ☐ Opt Out ☐						$
		3	Veg ☐ RB ☐ Trky ☐ Opt Out ☐						$
		4	Veg ☐ RB ☐ Trky ☐ Opt Out ☐						$
		5	Veg ☐ RB ☐ Trky ☐ Opt Out ☐						$
		6	Veg ☐ RB ☐ Trky ☐ Opt Out ☐						$

If you have more than 6 attendees, feel free to make additional copies of this form.

7 **Grand Total:** $

8 **Payment Options:**
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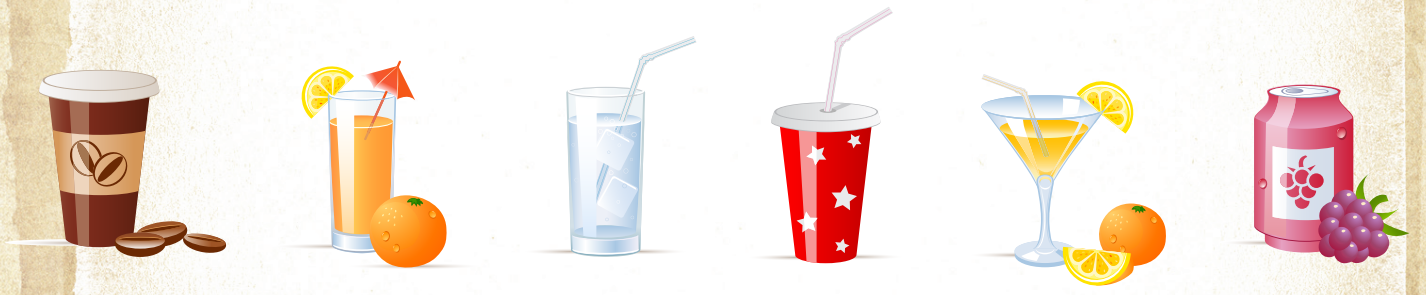
Exhibits



New!

New for 2011...

Vendor Meet & Greet Reception

Friday, June 17, 2011
4:30pm-6:00pm

It's time to relax after a long day of continuing education classes. Come down to the VDA Exhibit Hall and redeem your free drink ticket while meeting some of our vendors.

Each registered attendee will receive a drink ticket for this reception. Tickets can be redeemed for any drink type. Alcoholic drinks are available for ages 21+.

Make plans to stop by the VDA Exhibit Hall

Exhibit Hours:

Friday, June 17, 2011 9:30am-6:00pm
Saturday, June 18, 2011 9:30am-1:00pm

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Event

Annual VDA Golf Tournament

In Memory of Dr. Donald Martin

Thursday, June 16, 2011

Captain's Choice Tournament. Entry fee includes: Range Balls, Tournament Entry, awards reception lunch, gift bag.

Golden Horseshoe Golf Club - Gold Course
401 S. England Street, Williamsburg, VA 23185
(Directly across the street from the Williamsburg Lodge Conference Center Entrance)

Sorry, no on-site ticket sales.

Cost: $160 per player

Time: 9:00am start

Registration Code: 32

Location: Golden Horseshoe Golf Club - Gold Course

Mulligans: $20 for a set of two (purchase only available on-site)

President's Casino Night

Join VDA President,
Dr. Michael Abbott

Friday, June 17, 2011
for a family fun Casino Night!

Your ticket includes:

- Entry into the President's Casino Night
- Two Complimentary Drink Tickets
  (Good for any drink type. Alcoholic drinks available for ages 21+)
- A generous hors d' oeuvre meal
- Casino Games: Blackjack, Craps, Roulette and Slot Machines
- Opportunity to win great prizes
- Finish the night out with dancing

Cost: $30 for Adults, $10 for Children ages 3-12
Children 2 and under are free and do not need to register.

Time: 7:00pm doors open, 7:30pm-10:30pm Gaming and Dancing

Registration Code: 36 Adult, 36A Children ages 3-12

Location: Williamsburg Lodge Colony Room

Attire: Casual

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- ☐ Friday, July 22, 2011
- ☐ Saturday, July 23, 2011
- ☐ Sunday, July 24, 2011

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Dental Ethics – Education of Ethics in Dental School

By: Jamie Clark - Ethics and Judicial Affairs Committee; VCU School of Dentistry, Class of 2013

Teaching ethics to dental students is extremely important for the future and reputation of our profession but is difficult to teach effectively to students. The VCU School of Dentistry should approach teaching ethics differently in order to make students better prepared to practice as student dentists and future dental professionals. The amount of time spent on the subject, when the topic should be addressed, and making the information valuable and effective should be discussed in an effort to improve students' ethics education. A change in the curriculum could encourage students to take a more active role in calibrating their own ethical compass and encourage a higher standard of ethics from their peers. Also, it will empower students with information so they will make educated ethical decisions in their future practices. We should reevaluate the issues of education and ethics to better prepare the next generation of dentists.

Ethics education needs to be a continuous learning process throughout dental school. Currently at VCU students are required to take one ethics course during the second semester of the sophomore year. The class meets once every two weeks and discusses "what if" case scenarios. Third and fourth year students have no required curriculum-based ethics lectures or classes. Although professors and faculty make efforts to teach ethics in other required classes it is often overlooked by students because of the immense amount of clinical information taught along side. Are there enough ethics classes in the curriculum? Nancy W. Berk, Ph.D., in the article "Teaching Ethics in Dental Schools: Trends, Techniques, and Targets" refers to a study performed in 1998 that revealed 61% of dental schools reported teaching ethics in the first year curriculum (1). A balance must be formed because "the curriculum cannot…be dominated by courses in professional ethics, [however] hiding of ethics within other courses may result in students' perceiving ethics as unimportant." (1) Teaching ethics early in dental education and requiring more of students in the curriculum could help convey professional ethics to students more clearly.

Dr. Ronald Tankersley, past-president of the American Dental Association, spoke to first and second year dental students on the subject of ethics education. He described ethics as a "continual process that can be learned".(2) At the last Virginia Dental Association ethics committee meeting Dr. Elizabeth Reynolds, from the ADA Council on Ethics, Bylaws, and Judicial Affairs Committee, discussed with me and my fellow VDA Ethics and Judicial Affairs committee members how the American Dental Association is trying to implement ethics courses for dental continuing education credits (3). Dr. Berk references how "the need for ethics instruction begins at year one and continues with increased applicability over the course of a student's training experience." (1) The ADA past president and ADA Council both believe that dental education and ethics is continuous and, therefore, must begin early and continue as practicing dentists. Beginning ethics curriculum earlier and emphasizing its importance throughout the four years of dental school can be effective in teaching students their responsibilities.

As a second year dental student at VCU, my personal experience has shown that the more my classmates and I have learned about ethics, the more we realize how little we truly understand. For example, The "White Coat Ceremony" at VCU School of Dentistry is where second year dental students take their oaths as dentists. This signifies the beginning of students' responsibility to treat patients. This ceremony is performed every year so faculty and our families can witness our accomplishments. However, is it effective to take our oaths before we even truly understand what it means?

During the ceremony the abundance of inspirational speeches, picture taking, performances, along with our ceremonial coating by faculty seemed to mask the seriousness and privilege of taking The Dentist's Pledge. As I was repeating the words with my classmates I stumbled across the sentence, "I shall faithfully observe the Principles of Ethics and Code of Professional Conduct set forth by the profession."(4) What exactly was the ADA Code of Professional Conduct and what were my responsibilities to uphold the ethics of my profession? I fully intend to treat my patients fairly and to do their work to the best of my ability, but did the Principles of Ethics and Code of Professional Conduct expect more? Dr. Berk discloses that the "Mastery of the ADA Code of Conduct does make the 'big ethical decisions' easier to recognize and easier to identify acceptable professional responses." (1) Therefore, it is important for students to fully recognize the meaning of taking oaths as dentists, as it will help students make the correct ethical decision.

Although dental ethics is included in the curriculum of many US dental schools it appears that it is not being taught effectively. During the Mirmelstein Ethics Lecture, Dr. Tankersley referred to a study that reported "Dental students know less about the ethical expectations of their chosen profession than medical students, law students, engineering students, and business students." And although we may have the best intentions, our lack of education may lead us to (unintentionally) disregard ethics. He also said that, "the vast majority of dentists in practice aren't even aware they are in misconduct."

Dr. Tankersley expressed his concern for the importance of learning ethics in dentistry saying,

"It's essential that, by the time students graduate from dental school, they fully understand their ethical responsibilities and know that most dentists take those responsibilities seriously. If they don't know those things when they graduate, there's not much chance that they will be concerned about them in practice."

Dental education in ethics can be easily improved by making changes to the current curriculum. Dr. Berk suggests that teaching effectively is done with "true patient cases" because it is "endorsed by most dental educators as a means of capturing the attention of its students and making ethics instruction clinically relevant". (1) Dr. D. A. Nash says, "It is preferable that the content of courses be taught by clinical dentists who are knowledgeable in the field of ethics". (5) Perhaps we should have speakers from private practice speak to students about ethical dilemmas they face, or speakers from the VDA's Ethics and Judicial Affairs Committee could discuss current infractions among dentists. These improvements can only benefit the dental community and better prepare dental students to tackle ethical situations with confidence and ease.

Many students have expressed their concerns about ineffective education in dental ethics. While most students have every intention to treat patients well many do not know how to proceed in "gray" areas of dental ethics. It is important to have an open dialogue between faculty and students in order to know 1) what students do not understand and 2) what they want to learn more about. Also, ethics should be taught early and continually to reinforce its importance in dentistry. By making these changes ethics education can be improved and make graduating students confident when faced with an ethical dilemma.

(1) Berk, N. W. Teaching Ethics in Dental Schools: Trends, Techniques, and Targets. J Dent Educ; 2001; 65(8), 744-750.

(2) Dr. R. Tankersley. Mirmelstein Ethics Lecture to 1st and 2nd year dental students, February 9, 2011.

(3) Dr. E. Reynolds –ADA Council on Ethics, Bylaws and Judicial Affairs Committee

(4) The Dentist's Pledge, ©American Dental Association

(5) Nash, D.A. On Ethics in the Profession of Dentistry and Dental Education. Euro J Dent Educ; 2007; 11(2), 64-74

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Staff Interactions with Patients Influence Compliance and Satisfaction

By: Kathleen M. Roman

Risk management focuses on preventing error, misunderstanding, and dissatisfaction among patients and staff. Dentists can reduce the risk of liability by engaging in preventive strategies, such as helping office staff understand the contributions they make to patient safety and satisfaction. Educating staff about patient compliance and satisfaction improves the dentist's ability to work effectively with members of his own team and the patients they treat.

Below are selected scenarios outlining staff education opportunities regarding compliance with office policies and patient satisfaction.

Complaining about office policy

Mrs. Smith arrives for her first appointment with Dr. Joyce Bennett. Receptionist Debra Dorn greets her as she signs in. Once the sign-in process is completed, Debra gives several other documents to Mrs. Smith. They include a medical history, a practice policy statement, and a HIPAA policy form.

"Oh no," Mrs. Smith says. "Not another HIPAA form!'

"Well, I'm sorry, but I do need your signature on it," Debra replies.

"Oh, for heaven's sake," Mrs. Smith laughs. "It's getting so you can't even buy a cheeseburger without having to sign a contract!"

"I know how you feel," Debra commiserates. "I'm the one who has to file all this stuff!"

If Debra had understood the importance of the HIPAA policy, she might have responded differently. Rather than reinforcing Mrs. Bennett's negative opinion about HIPAA requirements, Debra might have said, "I agree, our HIPAA policy does take a few minutes to review and understand, but I'll be glad to answer any questions you may have about this government requirement, Mrs. Smith. It is important that you and your family understand your rights to have your health information kept private and secure."

Responses should always emphasize that practice policies attempt to benefit patients. Wherever possible, staff should help patients to understand this important objective. In addition, staff members should also emphasize the importance the practice places on compliance with legal regulations.

Refusal to cooperate with acceptable standard of care

Mary Johannsen is Dr. John Barstow's dental assistant. She loves her job and gets along well with Dr. Barstow's patients and their parents. But she is somewhat intimidated by parents like Mrs. Fraily. When Mrs. Fraily makes appointments for her children, she "doesn't intend to waste time or money on unnecessary pictures!" As a result, the Fraily children have not had X-rays in three years. Mary is not comfortable confronting Mrs. Fraily and instead notes in the children's records, "Mother refuses X-ray."

In this example, Mrs. Fraily gets her way by making firm "pronouncements" about the treatment her children receive. Unfortunately, her refusal of X-rays may be harmful to her children's oral health. Creating an X-ray policy for patients and informing new patients of the policy is one way to prevent future occurrences such as this. Staff should also be trained to explain and reinforce the value of X-rays, and other treatments, as part of the dental standard of care.

Missed appointments, failure to follow home treatment protocols, refusal to see a consultant/specialist, noncompliance with medication orders – these are all areas in which office policies should be clearly defined for patients. And, staff should be advocates for these policies.

In addition, dental staff should be encouraged to discuss difficult patients with the staff dentist. Together, they can engage in a discussion with the patients or with patients' parents, about office policies and the patient's specific dental issues.

Defusing the waiting room

The Ruckus family has four children–all boys. Mrs. Ruckus wants back-to-back appointments, which means her children must remain in the waiting room, sometimes up to two hours. Office Manager Tanya Lester thinks the children are disruptive and that Mrs. Ruckus should keep a better eye on her boys.

"Every time they come into the office, somebody gets hurt. There's a big risk to other patients, too. And they set a bad example for other kids." Tanya wants Dr. Chambers to discharge the family from his practice. But so far he has not done so.

Every dental practice should have a policy regarding unacceptable waiting room behaviors. The policy should address employee and patient safety, from physical and verbal abuse to roughhousing behaviors. In most cases, a simple sign reading, "Indoor voices and quiet play behavior are appreciated" will suffice. However, as in the example above, parents may seem oblivious to the disruptive tendencies of their offspring.

In such instances, staff would benefit from scripted remarks to children/parents to curtail the rowdy behavior. Scripted comments should focus on patient safety and not on embarrassing the parent or child. Staff can remind the children to use their indoor voices and play quietly. They might focus on an individual child, "Michael, I'll bet you are the fastest boy in the schoolyard. The other kids would probably want to follow your example and be able to run that fast. But here in Dr. Chambers' office, I need for you to set an example of how children can play quietly and safely so that no one gets hurt."

Inappropriate behavior should be addressed early. If a parent does not intervene at the first signs of rough play, the staff should step in. And, of course, corrected behavior should be commended. "Hey, Michael, thanks for your help today."

Getting up to speed

Monthly office meetings should encourage discussion of any problematic office situations. Staff members play a key role in identifying incorrect assumptions, misunderstandings, unrealistic expectations, refusal to acknowledge boundaries and clinical noncompliance. This is a good time to share these observations and to agree on methods for addressing them.

As a group, it is easier to ensure consistency in the way that specific challenges are addressed. Also, it is possible to practice challenging conversations, e.g., asking Mrs. Ruckus if she will read a story to the children so that they can have a quiet time. Working out appropriate ways to address office issues will build more effective relationships among staff members. And staff will acquire a better comfort level in their interactions with patients and their families. A final benefit is that these skills can also help the doctors reduce liability risk.

Training programs related to customer satisfaction and clinical standards are available from many dental societies and from a host of companies that provide customer service and service recovery education products. Doctors can also contact their professional liability insurance companies for guidance on specific patient relationship challenges.

Kathleen M. Roman, MS, is risk management education leader for The Medical Protective Company, the nation's oldest professional liability insurance company, founded in 1899. Kathleen can be reached at: kathleen.roman@medpro.com

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

VDA SERVICES

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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

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 of 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
PO Box 3095
Henrico, VA 23228
Fax: 804-288-1880

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 of 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
PO Box 3095
Henrico, VA 23228
Fax: 804-288-1880

Fellows Lunch

2011 VDA Elected Leadership Candidates

Special Note: Change in Number of ADA Alternate Delegate Positions Available for Election in 2011 for the 2012-2013 Term.

Article V, Section 1 of the VDA Bylaws states that the Dean of the VCU School of Dentistry shall serve a two year term as ADA Alternate Delegate upon the approval of the Board of Directors.

Dr. David Sarrett, Dean of the Dental School, was approved for the two year term 2012-2013 at the Board's January 22, 2011 meeting. As a result, the number of positions open for election in 2011 is reduced to four.

HELLO
my name is

Dr. Kirk M. Norbo

Candidate for the office of:
President Elect

Over the past 27 years of my professional career, I have been truly blessed to be able to serve my colleagues in several capacities at local, state and national levels. Our profession continues to be held in high esteem thanks to the dedication each of you have to your patients and organized dentistry. We must not be complacent, however, since outside threats to our traditional practice model continue to mount.

My greatest concern revolves around the much discussed midlevel provider. It is imperative that we maintain the value of a dental education (DDS or DMD). Our dental educators have worked diligently to deliver a quality education to our future practitioners viewed as the worldwide benchmark. Our patients deserve the quality of care that only a dentist can provide. The VDA and ADA have lobbied tirelessly to assure that the dentist is the leader of the team.

We must continue to foster a strong VADPAC. One of the proudest accomplishments I have experienced as a VDA dentist was when dentistry prevailed in the non-covered service fee legislation last year. This would not have been possible without your PAC contributions and volunteer time spent at the legislature.

Another aspect of our profession that must be maintained is our strong ethical standards. As we continue to see other facets of our society struggle with ethical dilemmas, we must encourage our colleagues to keep ethics in the forefront when making practice decisions. In that light, the VDA Ethics and Judicial Affairs Committee should become more active in helping direct the association on a course that abides by our "Code of Ethics".

While access to care still haunts our profession, Virginia is a recognized leader when it comes to providing care to the underserved. The CMS (Centers for Medicare and Medicaid Services) recently recognized Virginia as one of eight states designated as best practice localities. This speaks highly of the leadership the VDA has assembled as well as the charitable nature of our member dentists. We all realize that MOM, Give Kids A Smile, Donated Dental Services and Take Five programs are not the ultimate solution to the access problems, but these projects have made a difference. Thanks to all the volunteers who have made Virginia the envy of many other state dental associations.

As our profession continues to evolve, it is imperative that we strive to remain a unified body. A strong VDA coupled with intensive lobbying efforts will position our member dentists to cope with future demands on our practice of dentistry.

I am proud to be VDA member dentist and would be honored to serve as President of your Association.

HELLO
my name is

Dr. Alonzo M. Bell

Candidate for the office of:
ADA Delegate

I thank you the members of the Virginia Dental Association for giving me the great honor of serving as VDA President for the 2009-2010 year. I wish to continue my service to you our members and to the profession of Dentistry as an ADA Delegate; and so I ask that you support me for election as ADA Delegate.

The ADA continues to face many issues that will affect the future of our profession. These issues range from workforce issues to the management issues of our association. Having served on our delegation for 8 years both as an Alternate Delegate and as a Delegate, I feel confident in my understanding of the issues before us as well as of the operation of the ADA House of Delegates.

Through my service on our delegation, I have developed many contacts and friendships both within our 16th district and throughout the ADA House of Delegates which is instrumental in building coalitions and having our opinions heard. My varied experiences in serving organized dentistry have given me a clear perspective to fully understand the interests and concerns of our members. I feel this knowledge and understanding enables me to represent you our VDA member dentists at the ADA level. I am eager and enthusiastic to continue to serve in our delegation. I will listen to your concerns and will advocate for your interests to the best of my ability. I thank you for your vote for ADA Delegate.

Please note: CV information for all of our candidates can be found on the VDA website www.vadental.org

HELLO
my name is

Bruce R. Hutchison, DDS

Candidate for the office of:
ADA Delegate

Having served on the Virginia Delegation to the ADA for the past 14 years, I have developed a good relationship with dentists from other areas of the country and the officers of the ADA. This becomes necessary when debating the issues in both finding out what others are concerned with and how to get what we, in Virginia, would like to have. I listen to my friends and colleagues throughout the state and am aware of the issues that are important to them. Knowing what is important to our members, and knowing how to get the job done make me an effective representative for Virginia dentists. It has been such a pleasure representing you these years and I hope I can count on your vote to continue my service to the VDA and ADA.

HELLO
my name is

Roger E. Wood, DDS

Candidate for the office of:
ADA Delegate

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

HELLO
my name is

Dr. Kirk M. Norbo

Candidate for the office of:
ADA Delegate

It has been an honor to serve you as a delegate and alternate delegate to the ADA. During this time, I have completed a four year term as a member of the Council on Ethic, Bylaws and Judicial Affairs. This CEBJA experience, as well as my previous service to the VDA and our delegation, has helped to expand my understanding of the issues confronting our profession. Please see my preceding President-Elect column to review a few of my additional thoughts and concerns. It would be a privilege to continue serving you as an ADA delegate. Thank you for your support.

HELLO
my name is

Dr. Michael Abbott

Candidate for the office of:
ADA Alternate Delegate

I would like to thank you for the opportunity to have served the VDA in the past as an ADA Alternate Delegate. To be effective in facing the many issues that confront our profession, it is important to have continuity on the ADA Delegation. Please reference my CV for my qualifications. It would be a privilege to continue to serve you as your ADA Alternate Delegate.

HELLO
my name is

Dr. Vince Dougherty

Candidate for the office of:
ADA Alternate Delegate

Dentistry has always been a part of my life. I watched my father practice without all of today's technological advances. So much change has occurred over the last forty plus years. I want to continue helping direct the change in a way that benefits the practice of dentistry and our patients. Even though I am a relative newcomer, I once again ask for your support as an Alternate Delegate to the ADA.

I have the will, the confidence, and the passion for the position. I will represent you in the best way possible. Serving as ADA Alternate Delegate and as past President of Northern Virginia Dental Society, I have acquired leadership and decision making skills to act on your behalf. Two of today's critically important issues are access to care and environmental safety. As recent chair of the VDA task force on access to care and work force issues, and past chair of the VDA infection control and environmental safety committee, I feel I have the knowledge to make informed decisions.

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

HELLO
my name is

Samuel W Galstan, DDS

Candidate for the office of:
ADA Alternate Delegate

Dentistry is facing some serious challenges in the next several years and I believe that I can help work through some of these issues. I feel that I am blessed and fortunate to practice general dentistry in Chester with my wife, Dr. Sharone Ward, who I met on the first day of dental school. Dentistry has been very good to many of us in the profession, yet there are many concerns for us in the future, including dealing with access to care issues and government and insurance interference and attempts to take over and control dentistry. If we do not take an activist, proactive position, we may not recognize what dentistry becomes in the future, and we may not be happy with where we end up. To that end, I have been involved with access to care issues in dentistry since the early 1990's, working with "Give Kids a Smile!", Children's Dental Health Month, Missions of Mercy and Donated Dental Services projects. I am presently enrolled in a Masters in Public Health (with an emphasis in dentistry) program, and anticipate completion in 2/12. I have been a Director with the VDA for the past several years and am honored to represent Southside Dental Society in this capacity. While Southside Dental Society may be a small component, we have many caring and passionate leaders who bring a fresh perspective to organized dentistry, and I feel that I will be able to continue to represent this constituency with energy and dedication.

HELLO
my name is

Dr. Paul Olenyn

Candidate for the office of:
ADA Alternate Delegate

Over the years I have had the privilege of serving on various committees, both at the component and the state level. This has allowed me to develop good working relationships with other dentists throughout the state. My having served as chairman of the Patient Relations Committee has taught me how best to deal with individuals and conflict. As past president of Component 8, I saw that our interests were similar in many aspects as other members statewide. Over the past few years, I have been able to present to legislators in Richmond and at the local level, issues that concern dentists statewide. I would like to continue to represent your interests as Alternate Delegate to the ADA.

HELLO
my name is

Dr. Ted Sherwin

Candidate for the office of:
ADA Alternate Delegate

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

During the past seven years of service on our ADA delegation I have had the privilege to serve as Reporting Chairman and three times Chairman of the Observation Team on Budget and Finance. These have been terrific opportunities to work with other members of our District Delegation as well as other delegations to build consensus on the ADA budget. I ask for you support for another term in order to build on this experience.

Welcome New Members!

March 2011

NORTHERN VIRGINIA DENTAL SOCIETY

Dr. Ziad Ali graduated from the University of Pennsylvania in 2001. He complete his specialization in oral surgery in 2007 at the University of Texas at Houston. Dr. Ali is currently practicing with Integrative Oral and Facial Surgery in McLean.

Dr. Gerald Benson graduated from University of NC – Chapel Hill in 2006. Dr. Benson comes to us from Georgia and is now practicing with Neibauer Dental Care in Fredericksburg.

Dr. Thomas Bierman graduated from the University of Iowa in 2009. He is currently practicing with Neibauer Dental Care in Woodbridge.

Dr. Kelly Bowlin graduated from VCU in 2009. She received her GPR in 2010. Dr. Bowlin is currently practicing with, Jamie Park, DDS and Associates.

Dr. Mita Dulabh graduated from the University of Kentucky in 2007. She received her GPR from the Ohio State University in 2008. Dr. Dulabh is currently practicing in Woodbridge.

Dr. Tawana Feimster graduated from Howard University in 2003. She completed her Endodontic Certificate/MS in 2006 from the University of Maryland. Dr. Feimster is practicing in the Northern Virginia area.

Tong-Yen Huang graduated from Columbia with his Certificate in Endodontics in 2009. Dr. Huang is currently practicing with the VA Endodontic Group in Chantilly.

Dr. Gloria Kim graduated from VCU in 2009. She received her GPR in 2010 at the Veterans Affairs Medical Center. Dr. Kim is practicing with Freidank &Freidank in Manassas.

Dr. Tuan Le graduated from Boston University in 2006. He is currently practicing with Dr. Landy in Washington, DC.

Dr. Snehal Patel graduated from Columbia University where he completed his M.D. in Oral Surgery in 2007. Dr. Patel is practicing in Lorton.

Dr. Sridevi Rajendran graduated from University of Florida in 2009. Dr. Rajendran is practicing in the Northern Virginia area.

Dr. Adam Sherman graduated from Boston University in 2009. He received his GPR at Washington DC VAMC. Dr. Sherman is practicing with Dr. Joseph Grieco in Fairfax.

Dr. John Ullrich graduated from VCU in 2007. He is currently practicing with South Riding Family Dentistry in South Riding.

Dr. Giovanni Caballero completed his AEGD from Howard University in 2010. Dr. Caballero will be practicing in Alexandria.

PENINSULA DENTAL SOCIETY

Dr. Monica Contract graduated from the University Of Pittsburgh School Of Dental Medicine in 2009. She then continued and completed her VA Pittsburgh Healthcare System GPR in 2010. Dr. Contract is currently practicing in an associateship with Hampton Roads Center for Cosmetic Dentistry in Williamsburg.

Dr. Harry Joseph graduated from NYU in 2005. Dr. Joseph is now practicing in Hampton with KoolSmiles.

Dr. Irina Novak graduated from the University of Louisville in 2010 and is currently practicing in Williamsburg.

PIEDMONT DENTAL SOCIETY

Dr. Keira Greene graduated from University of Texas, San Antonio in 2007. Dr. Green is now practicing in Blacksburg, with Dr. Lawrence J. Kyle.

RICHMOND DENTAL SOCIETY

Dr. Elena Black graduated from Boston University with her PHD/Certificate in Orthodontics in 2009. Dr. Black is currently living in the Richmond area.

Dr. Chad Kim graduated from Loma Linda University in 2010. Dr. Kim is currently practicing in Richmond, VA, with Kool Smiles.

Dr. Rani Koganti graduated from NYU College of Dentistry in 2009. She is now practicing with KoolSmiles in Richmond.

Dr. Pamela Lichtman graduated from UNC – Chapel Hill in 1997. She then completed her GPR in 1998 from Brigham Women's Hospital. Dr. Lichtman is currently living in the Richmond area.

Dr. E. PaigeTurner graduated from the University of North Carolina in 2003. She received her General Practice Residency certificate in 2004 from the University of Washington. Dr. Turner continued to VCU, where she completed her specialization in endodontics in 2010. Dr. Turner is currently practicing with Southside Endodontics in Colonial Heights.

SOUTHSIDE DENTAL SOCIETY

Dr. John Agapis graduated from VCU in 2010. Dr. Agapis is practicing in Chester with his father, Dr. Tony Agapis.

SHENANDOAH VALLEY DENTAL ASSOCIATION

Dr. Franklin Varanelli graduated from University of Maryland in 1987. Dr. Varanelli is now practicing in Winchester.

SOUTHWEST VIRGINIA DENTAL SOCIETY

Dr. Robert Lunka graduated from VCU in 2008. He received his GPR in 2010 from UVA General Practice Dentistry. Dr. Lunka is practicing in Charlottesville

Dr. Brian Thompson graduated from the University of Pittsburgh in 2006. He continued to Virginia Commonwealth University, where he completed his specialization in oral surgery in 2010. Dr. Thompson is currently practicing with Hollyfield & Perkins, LTD. in Marion.

TIDEWATER DENTAL ASSOCIATION

Dr. Kristen Benes graduated from VCU in 2001. She completed her GPR in 2003 from the University of Oklahoma. Dr. Benes is practicing with Lefcoe, Weinstein, Sachs, & Schiff Family Dentistry in Suffolk.

In Memory Of...

Name	Component	City	Date
Dr. Robert E. Schell	Northern Virginia	Woodbridge	December 20, 2010
Dr. Milton W. Brockmeyer	Southwest	Pulaski	December 8, 2010
Dr. Howard B. Watkins	Shenandoah Valley	Charlottesville	August 28, 2010

Board of Directors
Actions in Brief
January 20-22, 2011

The following is reported as information only:

A. The following resolutions were approved:

1. Background: Per the CMS Review of Virginia Medicaid Dental Services, Oct. 2010.

   Resolution: The VDA support the meeting to establish common best practices that lead to improvements in access to care and to fund the meeting up to $20,000.00.

2. Background: The existing VDA website is outdated and the Template design prevents upgrade changes. The Communication and Information Technology Committee has evaluated various web design companies. The Committee discussed modern technology and new website goals and design with four companies. WSI (WebStrategies Incorporated) is a Richmond based company that has given the Committee a proposal for a new website that achieves the goals of design to benefit the VDA and its members in the future.

   Resolution: Accept the Communication & Information Technology Committee's recommendation to contract with WSI to develop the new VDA website, with approval to exceed the 2011 budget up to $5,000.00 if needed.

3. Resolution: The VDA provide an informational press release (as read by Sam Galstan) to go along with the Governor's recognition of Children's Dental Health Month and Give Kids a Smile.

4. Background: The Board believes it would be to the VDA's advantage to select the Homestead for the 2014 Annual Meeting. A second year would improve negotiation by our Director. This is not to be considered a policy of rotating the meeting around the state.

   Resolution: The 2014 Annual Meeting be held at the Homestead and the Executive Director be given authority to sign contracts to commit the VDA for two years in a row.

5. Background: HB2169 and SB1097 address the substance abuse problem particularly in southwest Virginia. This would require CE on substance abuse, etc.
   Resolution: The VDA Legislative committee recommends that the VDA Board of Directors sign the letter, as written by MSV, which asks the patrons of SB1097 and HB2169 to withdraw this legislation so that the groups can join forces to promote a CE program for substance abuse, etc.

6. Background: The VA Board of Dentistry would like the VDA to support SB1146, which would require permits for all dentists who administer general anesthesia and sedation.

   Resolution: Accept the amendment to SB1146 as stated.

7. Background: At the request of the VCU School of Dentistry, HB1642 and B1311 were introduced to the 2011 General Assembly. The VDA has concerns with this bill and would like to educate the members and go through appropriate VDA process before supporting.

   Resolution: The VDA Legislative Committee supports in concept the ideas included in HB1642 and SB1311. We feel that this legislation needs to be fully vetted through the VDA process and be a VDA legislative initiative in the 2012 GA session. This process would include the BOD appointing a task force to work with the Dean of the VCU School of Dentistry to develop legislation incorporating the ideals encompassed in HB1642 and SB1311.

8. Background: Dr. Dag Zapatero presented to the Legislative Committee on Dental Labs and how, since they are not regulated in VA, there is concern as to where the materials are made and the content of materials in their products.

   Resolution: The Legislative Committee recommends that the Board of Directors form a task force to study this issue with the appropriate entities within the VDA to pursue legislative initiative.

9. Resolution: The VDA Mentoring Committee approach the VCU School of Dentistry and request that the Dental School incorporate the Mentoring Program into the Practice Management Course for dental students.

10. Background: Article V, Section 1 of the VDA Bylaws states that the Dean of the VCU School of Dentistry shall serve a two year term as ADA Alternate Delegate upon the approval of the Board of Directors.

    Resolution: Dr. David Sarrett, Dean of the VCU School of Dentistry, will be an ADA Alternate Delegate serving a two-year term for the years 2012-2013.

11. Resolution: Dr. David Sarrett be named secretary of the Virginia delegation to the 2011 ADA Annual Session in Las Vegas and be reimbursed for expenses up to the level of the ADA delegate.

B. The following items were referred:

1. To the Ethics Committee: The Peninsula Dental Society's letter to the Board of
   Dentistry re. ethical advertising.

2, To the Membership Committee for further study:

   Background: In an effort to be more inclusive of the voice of dental care in Virginia and in response to the dental technicians with their support of legislative activities, we feel there is a place for the voice of this integral part of dentistry within the Virginia Dental Association.

   Resolution: The Membership Committee recommends that the Virginia Dental Association create a new membership category of, Auxiliary Member, for the express purpose of allowing membership of Dental Laboratory Technician Auxiliary Members. These members shall be entitled to participate in education, service, and benefits program offered to Virginia Dental association members. This class of membership will not be eligible for any additional membership privileges.

   Budgetary Impact: A fee will be assessed to members to cover all cost. That said, it will require some initial out of pocket cost to get this program running.

   BOD Resolution: The possible inclusion of dental labs into some sort of membership in the VDA be presented to the eight component Laboratory Committees to gage the level of interest in establishing a Laboratory Auxiliary Membership.

Awards & Recognition

Dr. William Bennett becomes the new Regent of the International College of Dentists, District 16. Pictured L-R: Dr. Terry Imbery, Dr. William Bennett, Dr. Scott Francis, Dr. Bill Harper and Dr. Buster Woodruff.

Dr. Marvin Pizer receives NOVA Dental Society Lifetime Achievement Award. Pictured L-R: Dr. Marvin Pizer, Mrs. Selma Pizer (spouse), Mr. Glen Pizer (Son) and Ms. Minday Laumann (Daughter).

Governor Bob McDonnell proclaims February as Children's Dental Health Month. Pictured L-R: Dr. Samuel Galstan, Joanne Wells, RDH, Gov. Bob McDonnell, Dr. Terry Dickinson, Dr. Melanie Spears, Dr. Sharone Ward

PathologyPuzzler

with Dr. John Svirsky

A 64-year-old white male was referred to the oral medicine clinic for an expanding lesion of the right maxilla that has been present since 1997. The patient's past medical history includes removal of a melanoma in 2008 and prostatectomy in 2009. He is currently taking Levothyroxine and Simvastatin. The patient brought a stone cast of his maxilla taken in 1998 (figures1-2) and radiographs taken in 2004 (figure 3). Clinical pictures were taken at the appointment (figures 4-5). It appears that the lesion has expanded since 1997 and now measures 6 cm by 3 cm in its greatest dimensions. The lesion appeared to have increased in size (all on the buccal) approximately 0.6 cm. There were no other lesions present. The patient said that his bite was changing on the side of the mass.

Which of the following are possible diagnoses and what is your most likely diagnosis?

A. Central Cemento-Ossifying Fibroma
B. Central Giant Cell Granuloma
C. Ameloblastoma
D. Calcifying Epithelial Odontogenic Tumor
E. Adenomatoid Odontogenic Tumor
F. Osteoma
G. Fibrous Dysplasia
H. Osteogenic Sarcoma

Continued on page 55

Figure 1

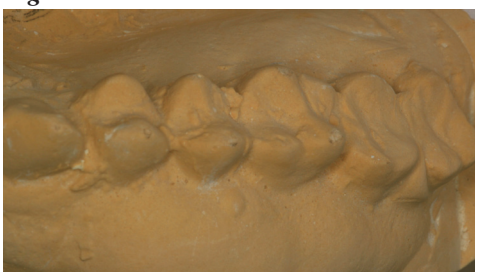


Figure 2

Figure 3

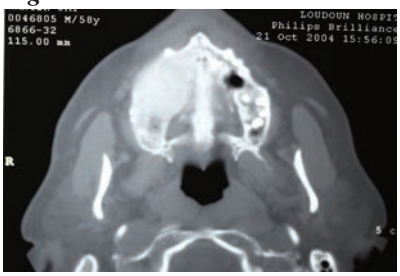
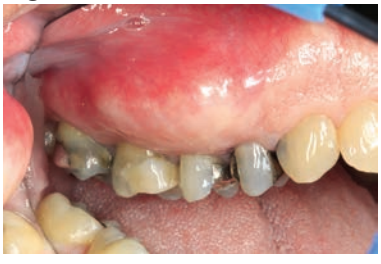


Figure 4



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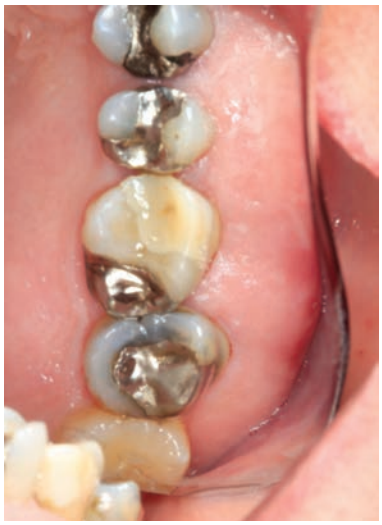

Palatal Perforation Due to Chronic Intranasal Drug Use

By: Scott R. Miller, DDS, Anne C. Adams, DDS, MS, Charles L. Cuttino, DDS, Daniel M. Laskin, DDS, MS

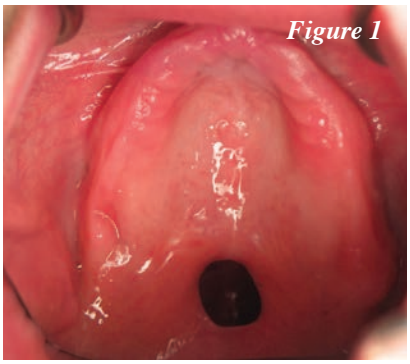
Figure 1

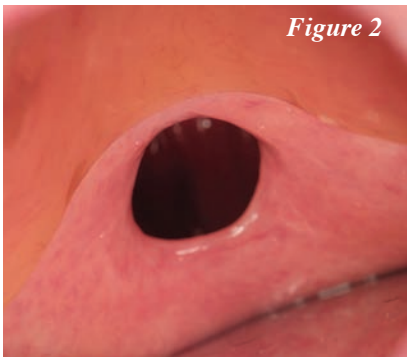
Figure 2

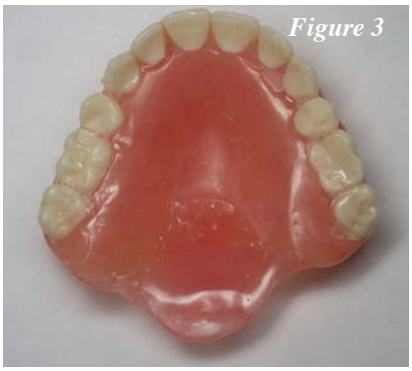
Figure 3

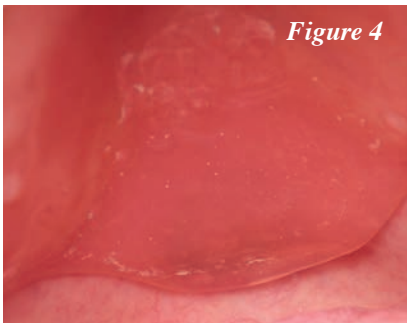
Figure 4

There are a number of conditions that can result in an oronasal fistula. Among the most common causes are trauma, neoplasia and incomplete closure of a palatal cleft. It is also well known that a palatal perforation can result from the chronic nasal inhalation of cocaine (1). However, there are also a number of rarer causes that have been reported in the literature. These include rhinolithiasis (2), syphilis (3), a denture suction cup (4), and chronic snorting of oxycodone/acetaminophen (OxyContin®) (5) and hydrocodone/acetaminophen (Lortab®) (6, 7). The purpose of this report is to describe another rare cause of oronasal fistula, the chronic use of a nasal decongestant, and to add an additional case resulting from the snorting of hydrocodone/acetaminophen. The former cause has not been previously reported in the literature.

Case 1.

The patient was a 47-year-old, white female who first presented at a Missions of Mercy clinic in Wise, Virginia in July, 2009 with a complaint of difficulty in eating due to the passage of food and liquids into her nose through a hole in the roof of her mouth. She stated that the perforation had been present for over two years, but had recently doubled in size. Her medical history was negative for systemic disease and there was no history of trauma. She denied snorting cocaine but noted that she does use a nasal decongestant spray. Upon further questioning she indicated that she had first started doing this over 30 years ago when she developed a cold and "couldn't stand for her nose being stopped up" and has continued to do so daily. She initially used Afrin® (Oxymetazoline HCl) spray six to seven times daily and later switched to a generic (OTC) version of oxymetazoline.

Clinical examination revealed an edentulous maxilla with a large perforation located at the junction of the hard and soft palate (Figure 1). The patient wore a denture, but it did not cover the opening (Figure 2). There was no evidence of inflammation or infection in the area of the perforation.

The treatment options of either surgical closure or provisionally obturating the hole with an extension of her denture were offered to the patient and she selected the latter based on her financial status. She presented to the dentist's office (SM) for treatment in October 2010, at which time a provisional obturator was constructed using her old denture (Figure 3, 4). She reported that she is still using the nasal spray, but only three times daily.

Case 2.

A 38-year-old white female presented to the dental office (SM) in September 2010 with a complaint of difficulty eating, drinking and speaking due to a hole in the roof of her mouth that has been present for about eight months. The patient was a disabled veteran who had been wounded in Afghanistan in 2008. The resulting surgeries had left her with a chemical dependency for pain medication. She indicated that she began snorting crushed 7.5 mg or 10 mg hydrocodone/acetaminophen tablets in 2009. She preferred the nasal rather than the oral route because of the faster effect. She obtains her narcotics on the street and pays an average of one dollar per milligram.

Extraoral examination revealed destruction of the right nostril (Figure 5). Intraoral examination showed a large, circular midline perforation in the anterior aspect of the hard palate (Figure 6). There was no evidence of inflammation in the surrounding mucosa. Focused on a mirror placed in the oral cavity, a light could be seen extending through the perforation into the nasal cavity (Figure 7).

Treatment consisted of construction of an obturator to cover the perforation. She is awaiting admission to a facility for drug rehabilitation.

Discussion

Although the effects of chronic intranasal cocaine use have been widely described in the literature (1), there are only a few reported cases involving the chronic intranasal use of hydrocodone/acetaminophen (6, 7). In both instances, the drug is thought to result in tissue destruction by producing vasospasm and ischemia, chemical erosion and local infection. The most common complication in chronic cocaine snorters, other than nasal septal perforation and saddle-nose deformity, is a palatal perforation, but external nasal erosion has also been described (8). However, this appears to be the first case reported involving hydrocodone/acetaminophen use in which external nasal erosion has also been present.

Oxymetazoline is available over the counter as a topical nasal decongestant in a variety of different nasal sprays (Afrin®, Sudafed®, Dristan®, Dimetapp®, and Vicks Sinex®). It is a nonselective adrenomimetic that agonizes α1 and α2 adrenergic receptors and thus results in vasoconstriction. Therefore, its method of producing tissue necrosis is very similar to that of the opiods. Because the chronic use of nasal sprays containing oxymetazoline results in rebound nasal congestion (9), the labeling indicates that it should not be used for more than three days. Patients who continue to use the nasal spray may become reliant on the medication as a means of trying to relieve the chronic rebound nasal congestion, thus establishing a vicious cycle. This is what occurred in the case reported.

Since nasal sprays are frequently prescribed for patients who have a possible antral perforation following tooth extraction, or who have undergone nasal or antral surgery, it is important that such patients be informed about the potential of rebound nasal congestion and the need to limit their use. Although nasal necrosis and palatal perforation may not be common occurrences, becoming habituated to the use of a nasal spray in an attempt to treat rebound nasal congestion is a real possibility that may occur more often than we realize. Proper instruction of the patient will not only prevent this from happening, but also will eliminate the chance of future nasal and palatal damage.

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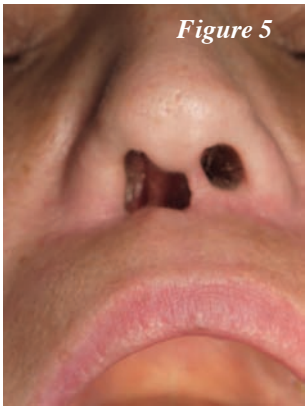

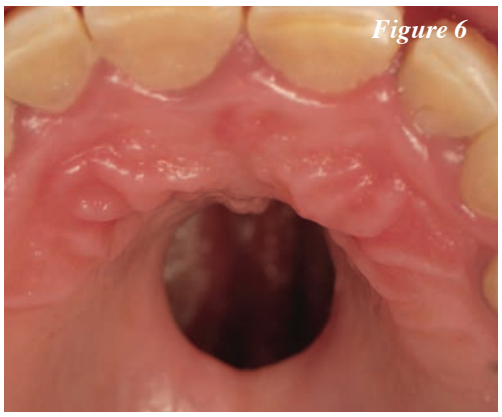

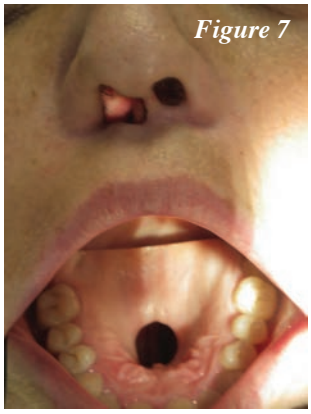

Figure 3. Obturator constructed from patient's denture.
Figure 4. View with provisional obturator made from the old denture in place. Note that the palatal perforation is now covered.
Figure 5. Extraoral view of patient showing destruction of the right nostril.
Figure 6. Intraoral view of patient showing the anteriorly located palatal perforation.
Figure 7. View showing the passage of light from the mouth into the nasal cavity through the palatal perforation.

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Figures:
Figure 1. View of the palatal perforation at the junction of the hard and soft palate.
Figure 2. View with denture in place. Note that the perforation is beyond the posterior border of the denture.

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PathologyPuzzler
with Dr. John Svirsky

Possible diagnoses: A, D, G Most probable diagnosis: Fibrous Dysplasia

This lesion presented as an expansile lesion of bone with marked bone density. It has been present since 1997 and only slowly increased in size. The radiographic appearance was of a diffuse expansile radiopacity with which is consistent with fibrous dysplasia. A typical radiographic appearance is ground glass which was not prominent in this case. When the disease is limited to one bone, as in this case, it is termed monostotic fibrous dysplasia (MFD). MFD accounts for 80-85% of cases of fibrous dysplasia. This case was typical for fibrous dysplasia in presenting as a painless swelling that exhibited a slow growth pattern over many years. The atypical aspect of this case was the patient presented and was diagnosed at age fifty. Most patients are diagnosed during the second decade of life.

The patient was referred to the Virginia Commonwealth University Oral Surgery Department for evaluation for surgical recontouring. It was decided that at this time the "treatment might be worse than the disease" and he is to be reevaluated in six months. If the lesion changes and continues to grow, an additional diagnostic biopsy will be performed.

A central cemento-ossifying fibroma (CCOF) would be more circumscribed and not as diffuse as this lesion. It occurs over a wide age range with most of the cases occurring in the third and fourth decades. The most common location for the CCOF is the mandibular premolar and molar region. Radiographically most lesions are well defined and not normally become completely radiopaque. The central cementifying fibroma and central ossifying fibroma are now all classified as CCOF.

A calcifying epithelial odontogenic tumor (CEOT) is unusual in this location and will not normally attain the size of this lesion. The CEOT usually occurs between the ages of 30-50 and two thirds of the cases occur in the posterior mandible. It would also present as a painless slow growing swelling. The radiographic appearance of the CEOT would be a "driven snow" appearance of radiopaque flecks. The CEOT does not attain the size and density of this case. The ameloblastoma and central giant cell granuloma can be excluded because they are completely radiolucent on radiographs. The adenomatoid odontogenic tumor (AOT) is well circumscribed with a female predilection and occurs in the anterior maxilla twice as often as in the mandible, in the second decade of life. They seldom exceed three cm in size and the radiographic appearance is that of scattered radiopaque foci. A number of AOTs are associated with an impacted canine.

Osteomas may arise on the surface of bone or may be located in medullary bone. Most are diagnosed in younger adults as asymptomatic and appear on radiograph as well circumscribed sclerotic masses. They are also the most common head and neck finding associated with Gardner Syndrome (malignant polyps of the large intestine).

Osteosarcomas (OS) can reach appreciable size but do not attain the density or slow growth of fibrous dysplasia. They frequently occur on the surface of the mandible and grow outward in a "sunburst" pattern. Osteosarcomas have a grave prognosis and an untreated patient with an OS would be unlikely to be alive thirteen years later.

Figure 1: Cast of patient 1998 showing an expansile lesion of the right buccal maxilla.

Figure 2: Cast of patient 1998 showing the expansile lesion of the right buccal maxilla without evidence of a lesion on the lingual.

Figure 3: Radiograph showing a 6 cm by 3 cm densely radiopaque lesion of the right maxilla.

Figure 4: Clinical photograph taken February 2011 showing buccal expansion of the right maxilla that appears to be larger than the lesion of the cast from 1998.

Figure 5: Clinical photograph taken in February 2011 showing the buccal expansion without lingual expansion. ■

Pediatric Abstracts

Omer R., Anthonappa R.,King N. Determination of the Optimum Time for Surgical Removal of Unerupted Anterior Supernumerary Teeth. Pediatric Dent 2010;32(1):14-20.

Background-Supernumerary teeth may be found during a routine examination and may not be responsible for any discernible adverse effects on adjacent teeth. In such cases, it is reasonable to recommend that no surgical intervention is essential. Conversely, supernumerary teeth may: compromise esthetics; delay the eruption of adjacent teeth; induce crowding/malocclusion; cause dentigerous cyst formation; complicate bone grafting; and impinge on nerves leading to parasthesia and/or pain. In these cases, removal of the supernumeraries is vital to resolve the complications and prevent further damage. Nevertheless, the optimum time for surgical removal of unerupted supernumerary teeth still remains controversial.

Although it is obvious that early interventions can potentially prevent later complications, several authors anecdotally claim that this approach is hazardous due to the risk of damage to the developing tooth germs. By contrast, delaying intervention to minimize risk of damage to the adjacent teeth permits supernumerary teeth to cause undesirable effects.

Purpose-The purpose of this study was to determine the optimum time for surgical removal of supernumerary teeth and to identify the complications that occur to the adjacent teeth in relation to their stage of root development.

Methods- The study population consisted of 126 children. Comparisons were made between the different stages of dental development of the maxillary central incisors and 1) complications to these incisors that occurred at the time of surgical removal of the supernumerary teeth and 2) persistent malalignments before and after removal of the supernumeraries.

Conclusions- Delaying surgical removal of unerupted anterior supernumerary teeth beyond 10-years-old causes more developmental defects to the adjacent permanent teeth. Root resorption of the adjacent incisors was the most commonly occurring complication, followed by dilacerations, arrested root development, loss of continuity of the lamina dura, and bone deformities, respectively. Early removal of unerupted anterior supernumerary teeth seems to be advantageous up to approximately 6- to 7-years-old after which time further complications are expected.

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Savage MF, Lee J, Kotch, J, Vann, W. Early Preventive Dental Visits: Effects on Subsequent Utilization and Costs. Pediatrics 2004; 114(4); e418-423.

Background -Early Childhood Caries (ECC) is defined as dental decay in children five years of age or less. ECC is more prevalent among low income families with Headstart reporting a 90% caries rate in some programs. Children with ECC are significantly more likely to weigh less than 80% of their ideal body weight and to experience failure to thrive. Anticipatory guidance is critical to briefing the parents on developmentally appropriate information about their child's health to prepare parents for significant milestones physically, emotionally, and psychologically. The American Academy of Pediatrics adopted recommendations regarding well-child visits. The recommendations specify that the first dental risk assessment should occur beginning at six months of age and that the establishment of a dental home should occur by one year of age for children considered to be at risk for dental caries.

Purpose -The purpose of the research study was to determine the effects of early preventive dental visits on subsequent utilization and costs of dental services among preschool-aged children.

Method - The longitudinal cohort study used data from North Carolina children continuously enrolled in Medicaid from birth for a five year period. Four large administrative datasets were used to analyze the research: NC composite birth records from 1992, Medicaid enrollment files from 1992-97, Medicaid claim files from 1992-97, and the Area Resource File. Of the 53,591 Medicaid enrolled children born in 1992 in NC, 9,204 were continuously enrolled for five years and met the inclusion criteria.

Result - The results of the study showed that children with first preventive visits before one year of age were more likely to have subsequent preventive visits, but more unlikely to have subsequent restorative or emergency visits. Children with first preventive visits at ages 2-3 were more likely to have subsequent preventive, restorative, and emergency visits. The age of the first preventive visit had a significant positive effect on dentally related expenditures with the average dentally related costs being less for children who received earlier preventive care.

Conclusion - Researchers mentioned that the results "should be interpreted cautiously, because of the potential for selection bias" because of the exclusive population and inclusion criteria; however it was concluded that preschool age, Medicaid enrolled children who had an early preventive dental visit were more likely to use subsequent preventive services and experience lower dentally related costs. Less than one year old children that had a first preventive visit resulted in an increase in preventive visits, a decrease in emergency and restorative visits and lower dentally related costs. The study found that children from racial minority groups had significantly more difficulty finding access to dental care, as did those in counties with fewer dentists per population. Preschool aged children were more likely to receive dental services of all types in counties with greater DPCRs (defined as the number of dentists per 10,000 patients, dental providers in county of residence).

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Orhan, AI, Oz FT, Orhan K. Pulp Exposure Occurrence and Outcomes after 1- or 2-visit Indirect Pulp Therapy Vs Complete Caries Removal in Primary and Permanent Molars. Pediatric Dent 2010; 32(4):347-355

A major area of concern regarding deep carious lesions is the effective treatment. When removing all the caries, a pulp exposure may occur which endangers the pulp vitality. The principle objective of the management of primary and young permanent dentition is to preserve the teeth's vitality while causing as little trauma as possible to the pulp. Therefore, Indirect Pulp Therapy (IPT) has been proposed.

IPT consists of removing the outer layers of carious dentin and leaving the carious dentin approximating pulp tissue. An antibacterial material is applied on the carious dentin and then it is sealed to prevent substrate from reaching the bacteria causing the carious process to arrest. Infected outer carious dentin must be removed and inner affected dentin must be protected. It is difficult to distinguish between the infected and affected dentin. Studies have shown that an experienced professional can use tactile hardness to differentiate dentin quality.

IPT can be performed in 1 or 2 visit treatments. In the 1 visit approach a permanent restoration is placed. In the 2 visit approach, a temporary restoration is placed. The cavity is then reopened and the final excavation is performed.

The purpose of this study was to determine which type of IPT is more successful and whether the operator can successfully decide when to stop removing caries without exposing the pulp, particularly when it is intended to leave only the thinnest layer of demineralized, carious dentin.

Methods: One visit IPT, two visit IPT, and direct complete excavation (DCE) were carried out in both primary and young permanent molars with deep carious lesions. Incidence of pulp exposures and outcomes after one-year follow-up with each treatment were also compared.

Results: Pulp Exposures: Pulp exposures were more likely in DCE when compared to 1 visit IPT. The treatments completed without pulp exposure showed high success during one year follow up. For 1 visit IPT there was a 100% success rate. 2 visit IPT was 98%, DCE was 95%. Statistical analysis did not reveal any significant difference among treatment modalities.

Conclusions:

1. No statistically significant difference was found among 1- and 2-visit indirect pulp therapy in terms of pulp exposure and success rate in this study.
2. Caries removal with IPT resulted in fewer pulp exposures compared to complete caries removal.

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Godoy F., Godoy-Bezerra J., Rosenblatt A. Treatment of Posterior Crossbite Comparing 2 Appliances: A Community-Based Trial. Am J Orthod Dentofacial Orthoped 2011;139(1): e45-52.

Background – A unilateral or bilateral posterior crossbite can be seen in 8% of deciduous and 22% of mixed dentitions. Whether it is dental, skeletal, or functional in nature, it can result in a functional shift of the mandible and an increased risk for temporomandibular joint dysfunction. Through early correction during the transitional dentition, erupting teeth can be guided into their normal position and a favorable occlusion. Two appliances, the Quad-Helix and the Palatal Expander, are most frequently used to treat such a condition. Early studies show that both appliances are effective in correction of a posterior crossbite; however, more information is needed to determine which appliance is more effective clinically and financially.

Purpose – The purpose of this study was to compare the Quad Helix and Palatal Expander, in terms of effectiveness, cost, and complications, with an untreated control group.

Methods – The study included 99 children from the Santo Amaro Social Project with both dental and functional unilateral crossbites in the mixed dentition. The etiology of the crossbite was determined to be of skeletal origin in all patients. The patients were required to have all of their first permanent molars and incisors, have no sucking habits or previous orthodontic treatment and not have a Class III occlusion. The subjects were randomly assigned to three treatment groups, Fixed Quad Helix, Removable Palatal Expander, or No Treatment. Throughout treatment, the following aspects were evaluated: Maxillary and Mandibular Intermolar and Intercanine Expansion, Length of Treatment, Number of Complications, and Cost-Benefit Ratio (treatment time, number of appliances, and number of appointments).

Conclusions – The Quad Helix and Palatal Expander are equally successful in correcting posterior crossbites, while untreated group did not self-correct. The greatest disadvantage of the Quad Helix was frequent breakage, and that of the Palatal Expander was loss of the appliance. Greater expansion can be achieved with the Quad Helix, but this also results in greater relapse. The average treatment time was significantly shorter and 11% cheaper in the Quad Helix Group, making it the more cost-effective option.

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Tseng R, Vann WF, Perrin EM. Addressing Childhood Overweight and Obesity in the Dental Office: Rationale and Practical Guidelines. Pediatric Dent 2010;32(5):417-23.

Purpose: To clarify the definitions and summarize the effects of childhood overweight/obesity; review the rationale for the dental team's involvement in the weight-related data collection; offer instructions for height and weight screening and body mass index (BMI) calculations; and propose recommendations for "next steps."

Dental Implications – overweight/obesity can lead to acceleration in dental growth and development, increased incidence of smooth surface caries on permanent molars and an increased risk of chronic periodontitis in late adolescence or early childhood.

Practical Guidelines: Dentists who care for children are in a unique position to help address the childhood obesity for several reasons. Dentists may see children by age one which provides an opportunity for longitudinal counseling and monitoring of weight status starting at an early age. BMI is most easily integrated into current clinical practice and has acceptable clinical validity and high sensitivity.

Protocol for implementing BMI monitoring: Requires an accurate, reliable and regularly calibrated scale for measurement of weight (Digital scales are best) and a stadiometer for measurement of height. BMI can be calculated using English measurements, BMI=weight in lbs/(height in inches) x (height in inches) x 703. Using metric BMI can be calculated using weight in kg/(height in meters) x(height in meters) – also internet based calculators are available at the CDC. BMI growth trajectory calculated by comparing BMI percentiles across several appointments can be used in children as young as 2 years old to help predict the development of childhood overweight by age 12.

Recommendations Based on BMI percentiles:

- Underweight (0-5%) – Continue height and weight/BMI measurement at 6 mouth recall visits. A formal letter of referral to pediatrician for further evaluation and assessment of underweight.
- Health Weight (5-85%) – Continue height/weight/BMI measurement of 6 mo recall visits. Encourage continuation of health habits, counseling focused on healthy recommendations for "at risk of overweight" patients.
- Overweight (85-95%) – Continue height/weight/BMI measurements at 6 mo visits. Referral to pediatrician for further evaluation and assessment of overweight within 6 mo. Identify unhealthy habits and make healthy recommendations
- Obese (95%) – Continue height/weight/BMI measurement at 6 mo recalls. Referral to pediatrician for immediate evaluation and assessment of overweight or obese status. Referral to registered dietitian.

Conclusion – Dental teams who care for children are encouraged to assess diet, sedentary habits, physical activity, weight, calculate BMI percentiles and also observe trajectories at regular intervals for children who are at least 2 years-old. Measures indicative of unhealthy weights and behaviors should be explained to the parent or guardian in a positive and culturally sensitive manner.

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The History of the Old Dominion Dental Society

By: Randy Adams, D.D.S., ODDS Liaison to the VDA

As early as 1901, Dr. David A. Ferguson of Richmond, Virginia, began work on the idea of founding an organization of African-American dentists. He was able to convince many in his profession to attend a meeting held on May 1, 1901, at the Dental College of Howard University in Washington, D.C. There the National Association of Colored Dentists was formed. The new national organization met annually until 1905. Following the 1905 session, little interest could be generated in the next meeting scheduled for 906 and the meeting was cancelled.

In the early years, African-American dentists were persuaded to fulfill the need for organizational and fraternal groups within firmly established medical groups. There were many state-wide, multi-professional organizations, but in 1905 a National Organization of African-American Physicians was formed, and it included dentists and pharmacists. It was first called the National Negro Medical Association of Physicians, Dentists and Pharmacists, but later became known as the National Medical Association (NMA). Most appropriately, the founding President Dr. Robert Fulton Boyd, a native of Tennessee, was both a qualified physician and dentist.

Dr. Boyd earned both his MD and DDS from Meharry Medical College in Nashville, Tennessee. In 1907, dentistry became a subordinate section of the NMA and began to push its own agenda. Also in 1907, Dr. Charles Roberts, a dentist from New York, became the chair of NMA's Committee on clinical sessions. The second president of NMA was also an MD and a DDS, Dr. Henry Noel of Nashville. It seems prophetic that the first two presidents of the National Medical Association were both physicians and dentists.

Dr. David Ferguson, the Virginia dentist who founded a national organization in 1901, became the first non-physician president of the NMA in 1918. Dr. Ferguson pushed for autonomy for dentists and for a separate national dental organization.

In 1932, the National Dental Association (NDA) was founded. The Old Dominion Dental Society (ODDS) is the Virginia component of the NDA.
In February 1913, black dentists from around Virginia met at the We-Us Hotel in Newport News to establish the Old Dominion State Dental Society. Officers elected were President Norman Lassiter of Newport News, Vice President J.M.G. Ramsey of Richmond, Corresponding Secretary Hamilton Rance of Suffolk, Recording Secretary John T. Lattimore of Hampton, and Treasurer C.A. Tomlinson of Norfolk.

On July 19, 1913, a group of more than thirty dentists assembled at the Bay Shore Hotel in Buckroe Beach, Virginia. The 72-room hotel, operating on the European plan, was located within a few yards of the waters of the Chesapeake Bay. The resort boasted facilities that included a safe beach and bathhouse, dining room and meeting rooms. Other attractions were picnic tables, a dance hall, games, amusements, a fun house and kiddy rides. The new organization took the name of the Tri-State Dental Association, and would hold its summer meetings at the Bay Shore until 1930. With the addition of more states, the organization would change its name to the Interstate Dental Association and in 1932 to the National Dental Association.

The ODDS is divided into four localities in Virginia and each locality is named for some of the pioneers from that area:

John L. McGriff Dental Society	Norfolk area
Norman Lassiter Dental Society	Hampton, Newport News
Newman Taylor Dental Society	Northern Virginia
Peter B. Ramsey Dental Society	Richmond

The Old Dominion Dental Society (ODDS) holds its meetings at various locations throughout the state of Virginia and occasionally out of the state. The host for the meeting rotates annually. For many years, dentists from neighboring states like North Carolina, Maryland and the District of Columbia, as well as more distant states like Pennsylvania, Alabama and New York, would attend the spring meetings of the ODDS.

In the early years, an ODDS meeting held anywhere might be the biggest social event of the year for the African-American portion of the hosting city. The organization routinely had 100% attendance at its meetings. All African-American dentists in the state attended. In return, the hosting community put its best foot forward. Meetings were usually held at the local black high school, and often talented black students from the local schools would come to the business sessions to demonstrate their skills in music, poetry or oratory. Sometimes the hosting community would organize parades with marching bands and fraternal organizations in full military regalia high stepping through the heart of the black business district. The traditional Saturday evening dance given by the ODDS often drew crowds of 500 and more. Entertainment was often provided by top celebrities like Cab Calloway, Fletcher Henderson, or Count Basie.

Until 1966 the organization was relegated to segregated hotels. Many locations simply did not have the capacity to house a large number of out of town guests. Consequently, many members stayed at the private homes of local members, fellow professionals, or boarding houses. Many strong friendships were established from weekends where members received the hospitality of other members. Still the inherent problems associated with those arrangements, and the hardships brought on by Jim Crow laws led many ODDS members to look for improvements by working in the Civil Rights Movement.

In 1867, Dr. Thomas Bayne, a former slave who learned basic dentistry from his owner in Norfolk, escaped via the Underground Railroad to New Bedford, Massachusetts. He returned to Virginia to embark on a political career, and became a civil rights advocate. From that tradition a number of African-American dentists have followed his lead. In 1957, Dr. Hugo Owens initiated the first lawsuit ever against the city of Portsmouth by African-American citizens to have the right to use the city parks and golf courses. Many ODDS members would follow with similar lawsuits in their own communities.

Dr. Hugo Owens would serve as the president of the Portsmouth NAACP. Dr. Phillp Wyatt would hold the same position in Fredericksburg. Dr. Jesse Tinsley served as the state president of the NAACP for more than twenty years. In 1960, his wife, Mrs. Ruth Tinsley was featured in Life Magazine as she was carried away by police from a protest of segregated facilities in Richmond. In 1959, when the Farmville schools were shut down in the Massive Resistance Movement, Dr. Nathaniel Miller of Farmville allowed his office basement to be used as a classroom for the black Students who did not attend school.

In 1948, Dr. Henry Penn was the first African-American appointed to the Roanoke City School Board. He would be followed in Roanoke by Dr. E.D. Downing,

Dr. L.E. Paxton, Dr. Wendell Butler, Dr. Nathaniel P. Miller in Farmville and Dr. McKinley Price in Newport News. In 1970, Dr. Hugo Owens was elected to the Chesapeake City Council and then in 1974 he was elevated to Vice-Mayor. In 1984, Dr. James Holley III was elected Mayor of the city of Portsmouth. In 2010, Dr. McKinley Price was elected Mayor of the city of Newport News.

The ODDS meetings focus on continuing education for dentists. Each year great care is exercised in selecting lecturers who can educate and enlighten. In the early years, members were treated to such topics as anesthetics by Dr. M. Wiseman from Washington, D.C. Others were touted as experts in synthetic porcelain, while others lectured on cast gold techniques and removable bridgework. Sometime around 2001, the members were treated to a lecture on "Dentistry at the White House".

The women of the ODDS also made strides. The first African-American woman to practice dentistry in Virginia was Dr. Edwina Reeves, who opened her office in the Phoenix building in Suffolk in 1922. Dr. Clarissa Wimbush: of Lynchburg practiced for fifty years starting in 1926. Dr. Diane Harris started her Richmond practice in 1962. and participated in the Civil Rights struggle with her husband Henry Marsh III, who became the first black mayor of Richmond.

The ODDS has a strong tradition of education and public service. The dentists were well known in their communities and often were on the cutting edge of progress, growth and change. That tradition continues to this day.

Special thanks are extended to Dr. Jasper Watts, the ODDS Historian, for his help on this article.

Author's Note: It is of historical interest to note that years ago the ADA was known as the NDA and the current NDA is sometimes referenced as the other NDA or the NDA II. (Referenced from the NDA II – "The Story of the Second National Dental Association)' By Dr. Clifton Dummett ■

Dental Direct - An Alternative Dental Benefit for Employers of All Sizes

By: Elise Rupinski, VDA Director of Marketing and Programs

DENTAL DIRECT

Do you now that the Virginia Dental Association has been promoting a self-funded dental benefit to Virginia employers since 1996? Dental Direct Reimbursement and Assignment plans are not dental insurance, but rather a dental benefit that groups of all sizes can provide to employees. A concept that was developed in the 1970s, Dental Direct Reimbursement is recommended by both the American Dental Association and the Virginia Dental Association.

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If you have any questions about Dental Direct or would like some free resources for your office, please contact Elise Rupinski at the VDA Central Office (Rupinski@vadental.org, 804-288-5750).

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