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Headlines & Articles

Departments

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

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NEW

Continuing Education Calendar

Course listings are deemed to be reliable but are not guaranteed. This calendar is for information purposes only and inclusion of a course does not imply endorsement by The VDA or the VDA Journal/Etch. Email your CE course submission to jacobs@vadental.org.

- Teamwork-n-Treatment TNT (Biomet)
  Date: April 22, 2010 6:00-8:00pm
  Location: Virginia Center for Prosthodontics , Education Center– Richmond, VA
  For more information contact: Heather at 804-741-8689

- Dental Assistant Hands-On Workshop (Straumann)
  Date: May 13, 2010 5:30-9:00pm
  Location: Virginia Center for Prosthodontics , Education Center– Richmond, VA
  For more information contact: Heather at 804-741-8689

- New Dentist Continuum
  Date: May 21, 2010 1:00-4:00pm
  Location: Virginia Center for Prosthodontics , Education Center– Richmond, VA
  For more information contact: Heather at 804-741-8689

- Advances in Orthodontics for General Practice in Dentistry – Dr. Ralph Nicassio
  Date/Time: April 30, 2010 – 8:30am-4:00pm
  Location: The Institute for Advanced Learning Danville, VA
  Sponsoring Organization: Piedmont Dental Society
  Fee: Members TBA
  For more information contact: 276-673-6700
  CE Credit Hours: 7

- Laboratory Technicians CE "Removable Prosthodontic Principles
  Date: May 18, 2010 6:00-8:00pm
  Location: Virginia Center for Prosthodontics , Education Center– Richmond, VA
  For more information contact: Heather at 804-741-8689

- ASD 2010 Annual Symposium
  Date/Time: June 24-26, 2010
  Location: Ritz-Carlton Pentagon City Washington DC
  Sponsoring Organization: Academy For Sports Dentistry
  Fee: unknown
  For more information contact: ASD at 217-227-3431 or www.sportsdentistry-asd.org

Letter to the Editor

MORE MEDICATIONS – MORE PROBLEMS!

Fifty plus years of practice in a dental specialty with most patients referred by physicians and dentists has allowed me to recognize the problems relating to new and older medications.

The dramatic increase in new drugs has necessitated that doctors have more knowledge regarding pharmacology, drug effectiveness, side-effects and interactions with other medications. Knowing frequent as well as rare side-effects are essential. Doctors must differentiate between drug induced side-effects from the patient's altered physiology. Occasionally, unsuspected life threatening symptoms will require emergency intervention and this also is the prescribing doctor's responsibility.

Some suggestions for doctors prescribing or dispensing medications, including over-the-counter drugs, are presented:

(1) Every new patient should bring all bottles with medications they are presently taking to the office. This list should be reviewed periodically.

(2) Reducing unpleasant side-effects may be accomplished by reverting to a recent PDR (Physicians Desk Reference) or its equivalent, before advising or prescribing new and/or older medications.

(3) A doctor's judgment must be prudent. Risk versus Benefits of medications prescribed is an essential factor for alleviating a patient's illness and discomfort.

(4) Some medications require monitoring with periodic laboratory studies and clinical observation. A doctor who ignores this aspect of professional health care is not competent.

(5) Many pharmacies, when dispensing medications, include a pamphlet for the patient. This usually explains the purpose of this drug as well as proper dosage, precautions, and usual and rare side-effects. The patient will respond with confidence if they know of their doctor's availability. There are always some patients who cannot remember or read the instructions of the new medications. Frequently, the pharmacist can help – if not a phone call to the patient's spouse, relative or friend will alleviate the language barrier. A telephone service is available in many clinics and health professional's office where English is translated into whatever language is necessary for the patient.

(6) The patient may not have the financial means to purchase the desired medication. It is very important that the doctor realize the approximate cost of the prescribed drug. The doctor can alleviate this crisis by prescribing another medication with equal effectiveness. This should be done in conjunction with the pharmacist. Using generic names on a script will also lower cost of drugs.

(7) Some patients stop their medications when symptoms disappear – only to find them recurring two or three weeks later. A non-compliant patient will frequently refer to this doctor as incompetent and seek another doctor. This information should be recorded in the patient's chart – even if not verified.

(8) Pharmaceutical sales representatives can be a valuable asset with their new medication. Seeing these representatives between patients is not advisable. I prefer a fifteen (15) minute appointment before or after all patients have been seen. Most sales reps are persuasive, well-trained and armed with positive studies about their products. It is imperative that the doctor collaborates with pharmacists, PDR, internet and respected colleagues before prescribing new drugs.

Competent medicine and dentistry is time consuming for the doctor – but so is time spent in a courtroom as the defendant. More important, it is time that the patient is effectively treated and comfortable.

Marvin E. Pizer, D.D.S., M.S., M.A. (Ed)

Message from the Editor

Dr. Richard F. Roadcap

This should only take a few seconds, I thought. Type III alloy, microns thick, perforations here and there…a few seconds later, as the bur slid through the crown, my right eye began to sting. Pacing the floor, I wondered how the metal could circumvent safety glasses with side shields and land in my eye. Soon I was seated in the ophthalmologist's chair, rolling my eye in various directions while a bright light looked for debris. The offending particles were flushed, eye drops dispensed, and I was back chairside the same day, with only a sore eye to account for the incident.

We're numbingly familiar with universal precautions: mask, gloves, gowns, protective eye wear. What about our patient's eyes? The Centers for Disease Control recommends safety glasses be worn by patients during treatment[1]. Do you offer glasses to patients before the handpiece turns, or, instead, ask them to close their eyes when the procedure gets messy? The literature is thin on this subject, and the few articles in the archive contain only anecdotal evidence of eye injuries to patients. Only one-half of US dental schools responded to a 2006 survey on eye protection, with three-fourths of those responding saying eye protection for patients was required; one-fourth did not require students to do so.[2] I posed the question to Dr. B. Ellen Byrne, Senior Associate Dean at VCU School of Dentistry, and she said clinic policy requires eye protection for patients.

I read your thoughts. "I've practiced all these years and never had a problem." "This wouldn't happen if proper four-handed technique were used." Both comments ring true, but I suspect eye injuries are like the palatal burns with which we are familiar: the patient can't recall the incident. Many go unrecognized and unreported, as symptoms may not appear for several days after dental treatment. Think about our potions – phosphoric acid; hydrofluoric acid; bonding agents; primers; calcium carbonate. They carry great potential for injuries, as do hand instruments, burs, and sharps of all descriptions. I once bounced a #301 elevator off a patient's wraparound safety glasses, grateful I was that they were in place.

Consider them to be a productivity enhancer – time saved by not having to divert our focus to see if the patient's eyes are closed, and not having to remind them to do so. Have you tried to keep your eyes closed for an hour? It's difficult. Protective eye wear is available in many forms, from mirrored dark lenses to industrial, I-work-in-a-laboratory frames. Dental suppliers sell them, and most home improvement stores have a safety department. Look on the inside of the temples for the inscription "Z87", the ANSI standard for eye protection.[3] If you don't believe they serve a purpose, look at the lenses after a crown preparation (or similar procedure). There'll be a constellation of debris, each particle carrying many scions of the genus Streptococcus.

Neither doctors nor staff would consider operating without eye protection – OSHA won't allow it. Why not provide the same protection to our patients? Almost all eye injuries are preventable. It only takes a moment for an accident to occur: the fidgeting pediatric patient, the unexpected movement, the instrument squirting from our wet gloves. Do yourself a favor and require patients to use eye protection. They will appreciate your concern. Many times I have been asked by patients if they could keep the glasses, or where they could get a pair to match. A slight, elderly lady once remarked she could see more clearly with our safety glasses than her (prescription) lenses. I recommended an eye exam.

Eight year-old patient wearing eye protection.

1 http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5217a1htm

2 Hill, E.E.: Eye Safety Practices in US Dental School Restorative Clinics, J Dent Educ 2006; 70(12) 1294-1297

3 www.osha.gov/pls/oshaweb/owadsip.show_document?p_table=STANDARDS&p_id…

Guest Editorial

Rogers Hornsby and the Gecko

By: Kerry K. Carney, DDS

Reprinted by permission of the California Dental Association.

Everyone likes to be the beneficiary of regulation, but no one likes to be regulated.

What could Rogers Hornsby and the Geico gecko have in common? They are both icons of industries that share an unusual commonality: antitrust law exemption.

In 1922, Rogers Hornsby played second base for the St. Louis Cardinals and had one of the best years ever. In that year, he became the only player in history to hit more than 40 home runs and bat over .400 in the same season. That was the first year that he won baseball's triple crown: batting average (.401), home runs (42), and runs batted in (152). While he was busy on the field, Major League Baseball was busy in the courtroom.

In 1922, the Supreme Court ruled in the Federal Baseball Club of Baltimore, Inc. v. National Baseball Clubs case. The issue was whether baseball was an interstate or an intrastate event. The suit had been brought by the federal league claiming that it was hindered in its ability to sign players as a result of antitrust violations by the National and American Leagues. Justice Oliver Wendell Holmes wrote in the decision that though the teams traveled from state to state that the essential business occurred within that state. At the time, "there was no revenue sharing, no radio or television and no national sponsors or licensing deals."[1] Interstate commerce is subject to federal regulation' intrastate commerce falls under state regulation., MLB enjoys an exemption from antitrust laws unique in its breadth and duration.

Now how about that gecko? Before 1944, insurance had been defined as a simple contract of indemnity and was subject to state regulation. In 1944, that changed when the United States Supreme Court affirmed a lower court's decision that "the business of insurance did indeed affect interstate commerce and this was subject to congressional authority pursuant to the Commerce Clause of the United States Constitution."[2]

Everyone likes to be the beneficiary of regulation, but no one likes to the regulated. The ruling on the United States V. South-Eastern Underwriters Association, 322 U.S. 533 (1944) set the insurance industry in motion. It lobbied Congress and succeeded in convincing Pat McCarran, a senator from Nevada, and Homer Ferguson, a senator from Michigan, to sponsor a bill that would exempt the insurance industry from some federal antitrust laws. Unlike the baseball exemption that came from the judicial branch, the insurance exemption was the result of legislation.

The McCarran-Ferguson Bill was introduced within two weeks of the South-Eastern Underwriters decision. Versions of the bill passed in the Senate and the House without any hearing and little debate. When the conference committee considered the versions, the following phrase was inserted, "insurers are exempt from federal antitrust scrutiny so long as they are 'regulated by state law.'" Judicial interpretation of that phrase has transformed a temporary moratorium on federal scrutiny and prosecution into a permanent antitrust exemption. "Courts have interpreted this phrase to require only that state regulators have jurisdiction over particular conduct, regardless of whether that authority is ever exercised… As a result, anticompetitive conduct may escape both regulatory oversight and antitrust scrutiny.[3]

The McCarran-Ferguson Act of 1945 was supposed to be a stop-gap to allow the insurance industry to get its house in order before it came under federal antitrust laws. This was so clearly articulated in the Congressional Record that President Roosevelt provided the following press release after signing the bill, "After a moratorium period, the antitrust laws… will be applicable in full force and effect to the business of insurance."[3]

During the past 64 years, the insurance industry has forestalled attempts to repeal or modify McCarran-Ferguson. During the aftermath of Hurricane Katrina, bill S 168 was introduced in an attempt to allow the Federal Trade Commission regulatory control and jurisdiction over areas of the business of insurance. This bill failed in 2007. The Insurance Industry Competition Act of 2009, HR 1538, was introduced in March. The two bills are virtually identical. The ADA's stance on the bill is clear, "The fact is that dentists, their patients and the public health are all victims of McCarran-Ferguson's negative impact on robust competition among insurance companies, and all would benefit from its repeal."[2]

The argument for maintaining the insurance exemption springs from the notion that the pooling of historical and projected loss experience helps set rates more accurately and thereby benefits consumers. It is also proposed that smaller companies may compete more effectively based on pooled information than they could based on their own limited experience. Finally, opponents of lifting the antitrust exemptions for the business of insurance argue the status quo. If it has operated well for the past 64 years, why change now?

The proponents of eliminating the insurance exemption point out there are other mechanisms that allow competitive exchanges of information by industries that do not enjoy the same exemption as the insurance industry. They also remind us that the McCarran-Ferguson Act was proposed and passed in 1945 for the benefit of consumers. Specifically, the ADA points to the potential for unfair and biased industry calculations for usual, customary, and reasonable fees that may result in economic disadvantages for consumers.[4] The ADA concluded, "the limited antitrust exemption enjoyed by the insurance industry distorts markets to the serious detriment of both consumers and businesses." [2]

In California, we have another factor to consider. In the spirit of transparency of purpose and potential conflict, there is our relationship with TDIC. The for-profit subsidiary of our association is in the insurance business. The insurance business has been, in large part, responsible for the stability we have enjoyed in our dues. We have a disincentive to invite a more onerous regulatory environment for that business.

Things are seldom as simple as they initially seem. So the next time you see that gecko advertising insurance, imagine him being tagged out at second base by Hornsby, Take a moment to wonder about their anomalous antitrust law exemptions and what that might have to do with dentistry..

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1 ESPN: Baseball's antitrust exemption: Q&A Dec 5, 2001. Sports.espn.go.com/espn/print?id=1290707&type=story. Accessed Oct. 13, 2009.

2 ADA Alert Re:HR 1583 McCarran-Ferguson Act- Key Points for ADA Members, May 2009.

3 Statement, United States Senate Committee on the Judiciary the McCarran-Ferguson Act and antitrust immunity good for consumers? March 7, 2007. Hon. Trent Lott, United States Senator.

4 ADA 2009a. ADA American Dental Association, America's leading advocate for oral health, 2009 Washington Leadership Conference, HR 1583 Insurance Industry Competition Act of 2009.

Message from the President

Dr. Alonzo Bell

Despite a winter of historic snowstorms, we have been very busy during the three months since the last printing of our Journal in January. As most of you know, the majority of our efforts have been focused on promoting the passage of our legislative initiative concerning the fee setting of non-covered services by dental insurers. I am pleased to report that as I write this message, our bill looks very promising and that all we now need is the signature by the Governor and this bill will then become law. Once again, I say thank you to all who participated in any way in this monumental effort.

As I reflect on these efforts, I can't think of a better time to remind you of the important role that ADVOCACY plays in the future of our profession. The two most critical factors in the advocacy process are adequate resources in our PAC and strong membership numbers. If you have not already done so, I ask that you give generously to our VADPAC. If you have not already done so, I ask that you make contact with someone that you know is not a VDA member and ask him or her to join. We have just witnessed the power and the value of membership in our dental association and we must continue to stay strong to face the next challenge that will inevitably come to our profession.

Not surprisingly, there have been other activities taking place in addition to our legislative actions. During this period, I have had the opportunity to travel to several of our components, and in January, we had our committee meetings in Richmond. One highlight of our committee meetings was the combined workshop on membership facilitated by Dr. Bruce DeGinder. A common theme that I see from both my visits to components and our committee meetings is the difficulty we face in identifying members with the willingness and desire to serve in our committees. Since the committee structure is the backbone of our association, I implore anyone reading this message to make it known to your component leaders if you have interest in serving on any of our committees. Even if you want to serve but are unsure of where, make the contact and we will find a place for you. If you don't know whom to contact in your component, please feel free to call or e-mail the VDA offices and we will direct you to the proper person. I am a big believer in the "deep bench theory" and therefore we can always find a place for you to serve our association.

As the days are now getting longer, we know that spring is fast approaching and so I ask you to remember our upcoming Virginia Meeting in June. Please make plans to attend; bring your staff and invite your friends. This year's meeting in Williamsburg promises to be an exciting opportunity for fellowship with colleagues and excellent continuing education at the same time.

Take care and I hope to see all of you in Williamsburg!

Trustee's Corner

Dr. Charles Norman • 16th District Trustee

Mid-level providers – are they effective?

You cannot open any dental publication these days without reading some article about the use of midlevel providers to address access to care deficiencies. If you are like me, you have to be tired of non-dentists proposing a solution for the dental delivery system when they know very little about our profession. Of course, proponents point to their apparent successful use worldwide as a valid reason to support their use here in the US. In fact, there is no consistency of training, accreditation, scope of practice, or use in the delivery system amongst the countries using "midlevels". So, how can you evaluate their roles in the dental delivery system or their effectiveness in addressing dental disease and access disparities? The reason the US has the best dental care in the world is because we do have standards for education, accreditation, and licensure that are supported with sound science and a track record of success. Standardization and accreditation of the educational programs required for scope of practice of both dentists and the parafunctional auxiliaries under our supervision are the pillars on which the quality of our profession was established. Let's examine what we really do and do not know about the use of dental extenders, their role in delivery of dental services, and how we evaluate workforce proposals in the future.

First, what is a midlevel provider? Based on the goal of providing more care to more patients at the least cost, I contend that like our medical counterparts, dentistry has long recognized that the delegation of some tasks of patient care is the most efficient and cost effective way to extend the capabilities of a dentist. The ADA supports the expansion of duties to trained dental auxiliaries like hygienists and EFDAs to support the dental team and free the dentist's time for more complicated procedures. Today, with graduates of accredited training programs throughout the US, most dental offices utilize staff to provide excellent treatment to a far greater number of patients than was the case in the early to mid fifties. As a consequence, dental disease rates in the US have fallen dramatically in the last fifty years.

Ethics –
What Are We Saying About Ourselves?

By: Melissa L. Wolfe, D.D.S., Chair, Ethics & Judicial Affairs Committee

I have over time observed the various communications and advertisements placed into the public view, and I am left with some questions. What determines professional ethics? By what implement are we able to gauge the appropriateness of an action? I went to the Internet to look for an answer. In an article written for the Academy of General Dentistry by Donald Patthoff, D.D.S., F.A.G.D., and David Ozar, Ph.D. on the topic of ethics, they wrote that "...the content of a profession's ethics is not determined solely by the members of that profession, but rather in dialogue with the larger community in which it serves."

I infer from that statement that if we are listening to what our communities are saying and responding to their needs, we are taking appropriate action. We always make sure that our patients are receiving the best clinical care, but do we all make certain that we are communicating as clearly and purely as we should be? If our patients find a message or advertisement presented by a member of our profession to be misleading or confusing and no attempt is made to clarify the issue, then we are allowing the creation of an unethical situation. It follows then that all communication needs to be clear. The proliferation of the Internet within the last ten years has resulted in virtual bombardment of the public with information and greatly expanded the dialogue between doctors and patients. Is the information and advertising we use to distinguish ourselves from other dentists healthy for this dialogue?

In order to preserve the integrity of this dialogue there exists the need to implement a set of guidelines to be followed. This will ensure that we speak with a common voice which is consistent with the current language used by our governing organizations. Material written by members of these organizations that is inconsistent with or contradicts the current information grays the dialogue we are striving to maintain and destabilizes public perception of our profession and governing bodies. If we aren't in agreement with standards or information held to be current best practice, we need to present factual information that brings change rather than publicize information that contradicts it. We need to support our governing bodies in order to send a common and therefore clearer message. Are we doing everything we can to send a clear, consistent message to make sure that our patients are still listening to us? Herein lies the vital importance of ethics.

American Dental Association Statement on Zinc in Denture Cream

CHICAGO, Feb. 19, 2010—Millions of people use denture cream (also known as denture adhesive). Some, but not all, denture creams contain zinc. A few recent case reports in the scientific literature indicate a possible association between excessive use of zinc-containing denture creams and neurological and hematological problems.

In each situation, the patients had ill-fitting dentures and reported using excessive amounts of denture cream with zinc for years. Several people reported using two or more tubes of denture cream per week for years, when one tube would normally last for 3-10 weeks, when used as directed.
The authors theorize that the patients probably swallowed excess denture cream, and that over years of use, zinc may have built up in these individual's bodies. It is well documented that swallowing excessive amounts of zinc can raise blood levels of zinc which can lead to lower blood levels of copper. The lower blood level of copper can then lead to neurological and hematological problems.

More information is needed to determine if there is a cause and effect relationship. The U.S. Food and Drug Administration has not issued an advisory or recall of zinc-containing denture creams at this time. As of Feb. 19, 2010, Glaxo Smith Kline, a major manufacturer of denture cream, voluntarily decided, as a precautionary measure, to stop using zinc in the following denture cream brands: Super Poligrip Original, Super Poligrip Ultra Fresh and Super Poligrip Extra Care.
The ADA advises denture wearers to see their dentist if their dentures do not fit well or if they have questions about the use of dental cream. Dental examinations and appropriate care can reduce the need for denture adhesive products.

Regular dental checkups are important for everyone, including denture wearers. The ADA's Council on Scientific Affairs will continue to monitor this issue on behalf of our member dentists and the patients they serve.

About the American Dental Association

The not-for-profit ADA is the nation's largest dental association, representing more than 157,000 dentist members. The premier source of oral health information, the ADA has advocated for the public's health and promoted the art and science of dentistry since 1859. The ADA's state-of-the-art research facilities develop and test dental products and materials that have advanced the practice of dentistry and made the patient experience more positive. The ADA Seal of Acceptance long has been a valuable and respected guide to consumer dental care products. The monthly Journal of the American Dental Association (JADA) is the ADA's flagship publication and the best-read scientific journal in dentistry. For more information about the ADA, visit the Association's Web site at www.ada.org

Aching tooth turns into a $44,000 bill

By: Frank Delano

Reprinted with permission from the Free Lance Star Publishing Company

Dr. Stuart Martin of Richmond (left) and VCU dental student Matt Chapman (right) talk to Kenny Van Deusen about a treatment plan for his teeth. Van Deusen's dental problems resulted in a $43,991 bill

Kenneth C. Van Deusen is a 32-year-old Westmoreland County laborer with bad teeth. He lives with his mother, sister and nephew near Montross.

Van Deusen is also poor. He takes work when he can find it. He reckons he earned $2,000 doing odd jobs last year. He lacks medical and dental insurance.

In September, a toothache sent Van Deusen to the Northern Neck Free Health Clinic in Kilmarnock.

It was the first 50 miles of a medical ordeal that cost nearly $44,000. He received rapid, lifesaving care, but most of its cost will be paid by everybody in one complex way or another.

His journey also illustrates the plight of the poor in obtaining dental care. Health care reforms now being debated in Washington appear to offer little hope for better dental care for the millions of people like Van Deusen.

At the Kilmarnock clinic, Van Deusen paid $25 to see a dentist, who outlined a plan for 10 of his teeth, including extractions and root canals. He said the dentist told him each tooth would require two or three visits at a cost of $25 per visit.

"It ain't a lot, but it is a whole lot when you ain't got nothing," Van Deusen said. "It just started adding up to the point that I couldn't afford it."

The clinic asked him to pay $25 in advance for a second dental appointment in October. "I didn't have it, so I didn't make the appointment," he said.

Van Deusen's toothache worsened. He woke up Sept. 27 with painful swelling in his jaw and neck. The swelling in his throat made it hard for him to breathe. His sister drove him to the emergency room at Riverside Tappahannock Hospital.

"As soon as the doctor saw me, he said that he'd have to send me to Richmond. He called an ambulance, but found out it would take the ambulance an hour to get to the hospital and another hour to get to Richmond. He said I was so bad off that he called the helicopter," Van Deusen said.

The ambulance that took him a quarter-mile to Riverside's helipad cost $457. The 41-mile LifeEvac flight to Richmond cost $16,298.52. The ambulance in Richmond that took him one mile to VCU Medical Center cost another $500.

He was admitted to the intensive-care unit at VCU. In surgery the next morning, doctors extracted three of his teeth and installed a tube to drain the abscess in his throat. He was discharged the next afternoon.

"When I left the hospital, they told me to follow up with my regular dentist, but I don't have one," he said.

The bills soon started to arrive. For his three days of treatment in the Richmond hospital, the bill was $25,012, "plus bills on top of that for other doctors," Van Deusen said.

"It just added up so fast. Now the total is more than $43,000, and the bills are still coming in.

"Nobody told me how much all this was going to cost. Nobody. But I really needed treatment at that point and didn't have a choice. I could have died and been buried four times for that amount of money," he said.

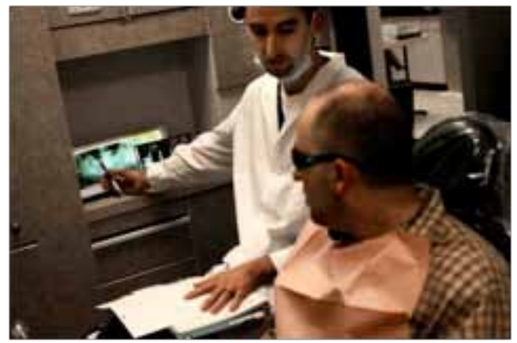
A DESPERATE NEED

Dental ordeals such as Van Deusen's "are situations faced by many adults in Virginia every day. Some of them are so desperate and in so much blinding pain that they pull their own teeth," said Deborah D. Oswalt, executive director of the Virginia Health Care Foundation.

Van Deusen is one of more than 100 million people in the United States without dental insurance. He is also a victim of what the U.S. surgeon general called a "silent epidemic of dental and oral diseases" caused by "profound" disparities in dental care.

"Those who suffer the worst oral health are found among the poor of all ages, with poor children and poor older Americans particularly vulnerable. Members of racial and ethnic minority groups also experience a disproportionate level of oral health problems," the surgeon general wrote in a 2000 report.

Locally, dental-care needs are especially great among the growing Hispanic population, said Dr. Cathie H. Butterworth, a Fredericksburg dentist who organizes an annual free dental clinic called Dentistry with a Heart.



Chapman shows Van Deusen the problems with his teeth. Van Deusen has no dental care insurance.

Outreach

"Patients start lining up at 3 a.m.," she said.

In July, 2,715 people from 16 states showed up at a free weekend medical and dental clinic staffed by 1,800 volunteers in Wise County. Dentists conducted 1,850 exams, pulled 3,857 teeth and filled 1,628 cavities.

The Virginia Dental Association was part of the Wise County clinic. In the past 10 years, the VDA has fielded 41 Missions of Mercy in mostly rural sections of the state. The missions have provided $16.5 million in dental services to 32,000 Virginians seeking relief from the pain and embarrassment of their teeth.

"I call this group 'the silent voices of need,'" said Dr. Terry D. Dickinson, executive director of the VDA. "You won't see them down at the General Assembly asking for adult benefits, as they would lose their jobs if they missed a day to advocate for themselves. This is truly a population that, for the most part, is unseen and unheard."

Regular dental care might have prevented Van Deusen's toothache. But the need to find a dentist, high out-of-pocket fees, and transportation and child-care issues often prevent low-income people from obtaining dental care, according to a 2008 report of the Kaiser Commission on Medicaid and the uninsured.

The Virginia Department of Health provides dental care, most of it for children, in 39 of the state's 134 counties and cities. A safety-net system of 57 community-based dental clinics provided 43,976 visits last year, "but that's just a drop in the bucket considering the hundreds of thousands of people with no dental insurance in Virginia," said the Virginia Health Care Foundation's director.

"There's an unbelievable unmet need," said Oswalt. Some community clinics are open only a night or two a week. Waiting lists can be months long. Oswalt said one clinic recently reported to the VHCF that "pain is not an emergency."

HOLES IN THE NET

It was into this flimsy safety net that Van Deusen jumped when his toothache forced him to seek help at the Northern Neck free clinic in September. It was his first trip to the dentist since he was in grade school, he said.

The clinic's six dental chairs are full four days a week. Two paid dentists, volunteer dentists and dental students see low-income patients like Van Deusen. "We're pretty close to maximum capacity," said Jeannie Nelson, the clinic's director.

She said it costs the clinic about $375,000 a year to provide nearly $2 million in dental services to the poor. In all, the clinic provides $6 million in medical, dental and pharmacy services on a $1.2 million budget that depends on donations and volunteers.

The bad economy has cut donations and increased demand for services. "Some donors are now patients. This year we're facing a $250,000 deficit. It could be the first time in our history that we've been in the red," Nelson said.

She said the $25 fee for dental appointments helps ensure that patients will show up for appointments. The fee can be waived, she said.

Van Deusen said nobody at the clinic told him about the waiver when he was there.

The misunderstanding resulted in Van Deusen's emergency treatment that cost $43,991.88.

The bill was paid by others, through taxes and higher costs for medical care and coverage.

Frank Delano: 804-761-4300 Email: fpdelano@gmail.com

Richard Barnette, 50, was among the thousands of people treated at the free dental clinic in Wise County.

Dr. Matthew Storm, a Spotsylvania dentist, was one of the volunteers at the 2007 free dental clinic in Southwest Virginia. The huge turnout at the annual event illustrates the need for better dental care for low-income people.

Missions of Mercy
Virginia Dental Health Foundation

Upcoming M.O.M. Projects

Piedmont Regional M.O.M.
May 1, 2010

Wise M.O.M.
July 23-225, 2010

Grundy M.O.M.
October 2-3, 2010

Register to Volunteer at www.vadental.org

Greater Williamsburg area added to the VDH Safety Net Clinics.

By: R. Lynn Browder, DDS, MBA - Quality Assurance Manager, Division of Dental Health

The Three Rivers Health District, of the Virginia Department of Health is a 10 county Health District. Five of its counties fall within the Greater Williamsburg service area (Gloucester , King & Queen, King William, Mathews, and Middlesex). These are the service areas for the dental van which will become an addition to the VDH safety net clinics.

The van is a 40 ft Armor Mobile coach with two full operatories, lab, x-rays, wheel chair accessible and shore power or generator operation capability. It is very similar to the one in use by the Richmond City Health Department and staffed with a full time dentist, assistant, dental hygienist/program coordinator and a part time driver .

It was purchased and managed through the VDH with consultation and technical support from the Office of Community Health Services and the Division of Dental Health and funded by a grant from the Williamsburg Community Health Foundation awarded as a result of Dr. Irungu's efforts.

The project's goal is to take dental services to the community using a mobile dental clinic. Services will include preventive, emergency and comprehensive care for both children and adults. The service area and population to be served will be all the residents of the five counties in the WCHF service area; we will specifically target low-income uninsured and underinsured children and adults, children with Medicaid/FAMIS and those without a dental home. The van will partner with local non profits, schools, private providers and the VDA in support of the local MOM projects.

Virginia Oral Health Plan 2010 - Excellent Oral Health for All Virginians

By: Sarah B. Holland, Virginia Health Care Foundation

In October 2009 leaders in oral health from throughout the state gathered at an oral health summit to create a five-year state plan designed to be a road map to bring all Virginians excellent oral health. Summit participants contributed their expertise and experiences in breakout sessions to identify goals toward achieving excellent oral health for all Virginians and to outline necessary steps and objectives to meet those goals.

The Virginia Oral Health Coalition (VOHC), a group of individuals and organizations from throughout the Commonwealth who are committed to improving the oral health of everyone in Virginia, convened a steering committee of representatives of a wide variety of groups who care about oral health to synthesize the information from the summit. The result is the Virginia Oral Health Plan, a living document designed to be used as a roadmap to meet the ultimate goal of excellent oral health for all Virginians. The plan is divided into six strategic areas:
Strategic Areas:

I. Public Awareness
II. Advocacy
III. Oral Health Data
IV. Education
V. New Oral Health Programs
VI. Virginia Oral Health Coalition Development

The plan's overarching goals are: educate and engage the public about the importance of oral health; make certain the laws and regulations in Virginia support oral health access and education; ensure that accurate, comprehensive oral health data exists; and prepare dental providers and future dental providers to meet the needs of the underserved in Virginia. The plan will be managed by VOHC, which has created workgroups for each strategic area. Members of the workgroups will actively manage the action steps to make certain the objectives and goals of the plan are met.

If you are interested in improving oral health in Virginia, VOHC seeks your participation in one of the workgroups. For more information about the Virginia Oral Health Coalition or the Virginia Oral Health Plan, please contact Sarah Bedard Holland at: sarah@vhcf.org or 804.828.5804

An Interview With:
Sonja Lauren

Editor's Note: "An incredible tale of abuse, neglect, parenting and triumph…" says Lynn Mouden, DDS, MPH, founder of P.A.N.D.A.. Dr. Terry Dickinson calls it "A story of hopelessness that turns into a story of hope." Past ADA President Kathleen Roth says "…the facts behind her dental saga are…important for all of us in dentistry to hear and understand." Since its publication in 2003 The Covered Smile has touched the lives of many dentists and their patients. The VDA Journal spoke with author Sonja Lauren as she prepared to launch her foundation dedicated to helping victims of dental neglect and abuse.

How has your life changed since *The Covered Smile* was published in 2003?
I've worked harder than I ever imagined. Networking, public speaking, volunteering, lecturing to students, and trying to find ways to help those in need. I went from working as an ophthalmologist's assistant to working in the dental field, being the president of The Covered Smile Inc., and the President of the Sonja Lauren Foundation Inc. Life is never boring. Also, my daughter graduated from the Chesterfield Tech Center and earned her D.A., and recently has become an oral surgery assistant. My daughter's life and mine were changed when we volunteered at our first MOM Project in 2006, in Wise County. For the first time – I found out there were people who truly cared and that I was not alone. My daughter's desire to help others was born at this MOM project. I've changed from being a beggar to being someone who can now help others. My daughter's dental assisting teacher requires her students to read the book and attend a MOM Project. Every fall, I am invited to speak to the Chesterfield Tech Center students after they have read *The Covered Smile* -they are truly my favorite audience.

Has writing this book led to any unexpected consequences?
It took much longer than I thought. I struggled long and hard to complete this. I tell people who want to be published: walk into Barnes and Noble and look around. That's your competition. Also, published authors are expected to be public speakers. I joined Toastmasters – it was very hard for me at first, speaking in public, in front of people. I gave my first lecture to the students at MCV, on Clinic Day, the class was asked if they wanted to hear a lecture from a faculty member, or hear about a patient who had all her teeth extracted at age thirteen. They voted to hear my story-"a patient's point of view".

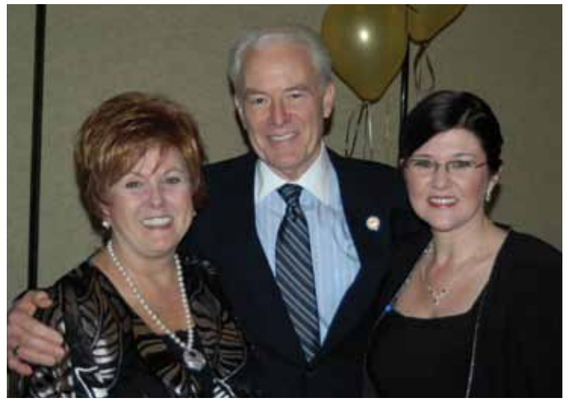
What encouraged you to start your own foundation?
John Randall, who was on the board of Prevent Child Abuse Virginia, met me at a charity event and I sent him a copy of my book. He's become a mentor to me, providing help and encouragement at every turn. When I told him I wanted to help more people, but I have a day job, he said, "You need a foundation so you can combine your passions!" Later the Shoe Carnival company contacted me and wanted to make a donation to my foundation, but I told them I didn't have one. Finally I admitted John was right all along, and began the process of developing the Sonja Lauren Foundation, Inc. So far, my effort has not freed me to do other things, but it has expanded my contacts, speaking engagements and ability to help others.

What makes the Sonja Lauren Foundation unique?
I've been told by many we have a fresh new way of doing this. I ask myself: what could have helped twelve year-old Sonja Lauren? I deeply understand the importance of this issue because I have worn dentures since the age of thirteen. We will provide education, exams, cleanings, prevention, and also, we will ask clients to be part of the educational process and be followed for one year after treatment. Dentists can contact us and apply on behalf of a patient – we will help pay for treatments when the funds are available. We want children and each succeeding generation to have good oral hygiene practices. We want to help those patients who don't have Medicaid or dental insurance. Those who are stuck in the middle, if you will, those who are where I once was.

Over the past ten years, has abuse and neglect of children gotten worse or better? Why?
I contacted the experts on this one. Johanna Schuchert, at Prevent Child Abuse Virginia, says sexual abuse, physical abuse, and emotional abuse have declined since the '90s, but emotional neglect has increased. Both she and Dr. Lynn Mouden of PANDA say abuse and neglect have increased in the last two years due to the economy. Abuse and neglect always go up when unemployment increases. I thought it was getting better, but it is still a very big problem. I've never given a lecture when at least one to three people did not come up to me afterwards and say, "that was me".

Do you have mentors? Who are they?
Yes, I have so very many wonderful mentors who I am thankful for! I've already mentioned Mr. John Randall, and there's Dr. Billie Unger, my purple- penned writing professor who taught me far more than how to write, she taught me to never give up. Deborah Hatchell, executive assistant at Chicken Soup for the Soul, called me back after I left a message, and has since took me under her wing –and protected me when I was negotiating with publishers. I was blessed to find her. Dr. Lynn Mouden founder of PANDA (Prevent Abuse And Neglect Through Dental Awareness) has been a mentor, along with Linda Miles (she's from West Virginia, too), and of course Dr. Dickinson, Dave Pelzer, who wrote A Child Called It, and Dr. Kathy Roth, who was president of the ADA. There are many more who have helped along the way. My "adopted mom and dad" as I call them, have loved me, guided me and supported me since the age of 18.

In what ways is the dental profession failing its patients?
I don't feel the profession is failing its patients. Dentists and dental organizations are working hard to increase access to care, but there's still so much to be done. Now we have dentists not wanting to have poor access to oral health care and its consequences: there's Give Kids A Smile, MOM, Oral Health America. They are all reaching out to legislators and our country to bring awareness of how important oral health is to the overall health of one's life.



Mrs. Linda Miles, Dr. Terry Dickinson and Sonja Lauren.

Visit the Sonja Lauren Foundation website at:
www.sonjalaurenfoundation.org

From your perspective as a patient, has the dental profession redeemed itself?
As for the group of dentists that wrote "situation hopeless" on my dental chart and removed all of my teeth forcing me to wear dentures at the age of 13 years and 3 months of age – I don't associate them with other dentists. Somehow, I never have. During my adulthood, I have been treated with kindness and respect by many dentists. Especially by Dr. John Ward who through kindness and generosity made me beautiful dentures which not only gave my smile back, but also my self esteem and life back for the first time since I was thirteen years old…

Do you have any advice for new dentists?
When I lecture to dental students, I suggest that they consider building their practice on the concept of "word-of-mouth" type marketing. While marketing agencies and strategies can be helpful, the most important factor of all is the satisfaction of the patient. I suggest new dentists volunteer with the MOM Projects, Give Kids A Smile, or other forms of community service, because patients and their community will know them as a dental practice who truly cares. I also believe dental students need to read and understand the dental creed fully.

What changes should be made in the education of dentists?
One, dentists should be required to attend a MOM or similar project before they are allowed to graduate. Two, dental (students) should be required to read *The Covered Smile*. I spoke to the students at West Virginia University (School of Dentistry) and the dean made it required reading for third-year students. One student (in the class of 2013) did his master's thesis on the book before he enrolled. I have been told repeatedly that *The Covered Smile* is making a difference, not only in the lives of those in need, but also in the lives of those who serve as professionals in all medical and dental fields…

smiles AT FAIRFAX CORNER

DONATIONS NEEDED

Dr. Tara Zier and Dr. Grace Lee of Smiles at Fairfax Corner are going on a missions trip to Rwanda, Africa June 28th through July 9th. We will be providing dental care to an indigent community in Kigali, Rwanda. Currently there are no instruments or supplies available. Our plan is to set up a facility with instruments and equipment for future mission trips. Our clinical focus for the initial trip is surgery and oral hygiene. We are in need of extraction set ups, local anesthetic, needles, syringes, Tylenol®, Motrin®, penicillin, sutures, toothbrushes, toothpaste, floss, masks, gauze, small and extra small gloves. Any donations are greatly appreciated. If you have any questions, feel free to contact Dr. Tara Zier at (703) 222-3245 or email her at tzier@fcsmiles.com. Please send any supplies to:

Smiles at Fairfax Corner
4210 Fairfax Corner West Avenue
Suite 220
Fairfax, Virginia 22030

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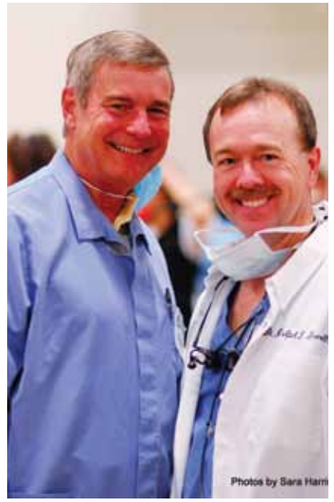
AMERICAN DENTAL ASSOCIATION
gotoADA.org
PREMIER SOURCE OF ORAL HEALTH INFORMATION

Middle Peninsula/Northern Neck M.O.M. Project

By: Phyllis Bryant Harris

The 25° temperature did not deter patients from lining up in the early morning hours of Saturday, February 13, 2010 at Gloucester High School for the first ever Middle Peninsula/Northern Neck M.O.M. Project. The project was held from 7 a.m. to 5 p.m. with setup and pre-registration of 125 individuals on Friday afternoon. It was funded by the Gloucester/Mathews Free Clinic and the Northern Neck Free Health Clinic.



Dr. Ron Tankersley, president of the American Dental Association and Dr. Ralph Howell, past president of the Virginia Dental Association at the MPNN MOM Project.

As this was our first MOM Project in the Gloucester area, the planning started over a year ago in the office of Dr. Charles (Chuck) R. Harris, Jr. of Hayes with Kelly Cooper and Sharon Hargis leading the charge. We were blessed with an overflow of volunteers, having to turn away more than we cared to.

Dr. Nathan Vogt performs restorative work on a patient during the MPNN MOM Project at Gloucester High School, of which he is an alumni.

A Volunteer Dinner was held Friday night after set up. The delicious fare was donated, prepared and served by members of the Abingdon Ruritan Club. Many of their members also volunteered time in other aspects of the M.O.M. Project. A total of 367 volunteers were fed and left full of food, fellowship, and filled with excitement.

I'm embarrassed to admit that I've never participated in a MOM Project prior to MPNN other than dropping Chuck off at the door. I've listened in awe about the Eastern Shore, Emporia, and Nags Head projects but, as a retired educator, never felt I had the skills to contribute. Boy, was I missing the spirit of the project.

It was AWESOME! Dr. Carol Brooks's VCU dental students transformed our auxiliary gym into a dental extravaganza like a well-oiled machine on Friday. After a few initial bumps Saturday morning, patients moved through registration and x-ray and were banded according to their dental needs. Children were fortunate to be the first to use two brand new Navy mobile dental units and the Three Rivers mobile unit, which had only been in use two months. A local child care provider entertained and cared for children while their caretakers were being seen by our wonderful professional volunteers.

The Numbers...

Total patients treated: 501

549 Volunteers! Amazing!!

Total value of care provided: $323,827

To date: 44 Completed projects

Patients treated: 34,398

Total value of donated care: $17.4 million

Along with the 86 students and faculty from VCU, we had 57 doctors, 24 hygienists, 65 dental assistants and other amazing individuals totaling 385 cheerful volunteers giving of their time and talents to help serve our area. We were honored to have as one of our volunteers, Dr. Ron Tankersley, president of the American Dental Association.

We served a total of 501 patients on Saturday, 442 adults and 59 children and turned away 300 people. Our patients not only came from the Middle Peninsula and Northern Neck but from Chesapeake, Charles City, Lynchburg, Hampton, Newport News, York County, and Manassas. There were 129 cleanings, 630 fillings, and 709 extractions with an estimated value of care at $323,827. That's a lot of fast moving fingers!

Our sincere thanks to Dr. Terry Dickinson, executive director of the Virginia Dental Association, for his guidance and vision for the MOM Project; to Barbara Rollins for her expertise and data; to Dr. Carol Brooks, who has my total admiration as an educator; to Bill Hall for making it all happen; and to Gloucester County Public Schools & Ed Berry for making the miracle of electricity occur without a hitch. Special thanks also to Chuck's office for their dedication and for including me as part this momentous endeavor.

Sylvia Ransome, hygienist

Did I mention our phenomenal volunteers? We were blessed with the most giving, enthusiastic, pleasant, and wonderful group of volunteers. The entire MOM project has been an event that has united our community, working together to help each other in a time when there are so many in need.

Thank you to the Gloucester M.O.M. Volunteers...

Dr. Mike Abbott
Dr. Ana Maya Adkins
Dr. Heath Allen
Dr. Seth Anderson
Dr. Baughn
Dr. Sidney Becker
Dr. Berry
Dr. Bob
Dr. Brickhouse
Dr. David Burns
Dr. Donna Burns
Dr. Henry Cathey
Dr. Michael Clark
Dr. Dennis Cleckner
Dr. Greg Cole
Dr. Charles Counts
Dr. Benjamin Crowley
Dr. William Davenport
Dr. Bobby Davis
Dr. Cris Dedmond
Dr. Terry Dickinson
Dr. William Dodson
Dr. Robert Dreelin
Dr. Rodney Dukart
Dr. Edwards
Dr. Steven Forte
Dr. Bobby Garofalis
Dr. Ira Goldstein
Dr. Chuck Harris
Dr. Ralph Howell
Dr. Mark Huie
Dr. Alfred Hurt
Dr. Husson
Dr. Thomas Irungu
Dr. Charles Johnson
Dr. Kordis
Dr. Trisha Krause
Dr. Ann Lagonegro
Dr. Randy Lazear
Dr. Ray Lee
Dr. Timothy Leigh
Dr. Casey Leser
Dr. Lanny Levenson
Dr. Joseph Lombard
Dr. Preston Loving
Dr. Stuart Martin
Dr. Katie Martin
Dr. Kristin Mastros
Dr. Ben McCarty
Dr. Rodney McDaniel
Dr. Daniel Messerschmidt
Dr. Eric Miller
Dr. Shanail Moorman
Dr. David Morris
Dr. Stephen Murphy
Dr. Aubrey Myers
Dr. Susan O'Connor
Dr. John Owen
Dr. Darryl Pirok
Dr. Daniel Pouchot
Dr. Reed
Dr. Scott Reid
Dr. Philip Render
Dr. Melvin Ressler
Dr. Richard Roadcap
Dr. Juan Rojas
Dr. Noel Root
Dr. Michael Shuck
Dr. Jeremy Shulman
Dr. Harry Simpson
Dr. Maria-Paz Smith
Dr. John Speelge
Dr. Patrick Sprague
Dr. James Stevens
Dr. Daniel Stockburger
Dr. Matthew Storm
Dr. Kenneth Tankersley
Dr. Ronald Tankersley
Dr. Michael Trudeau
Dr. Cassidy Turner
Dr. Nathan Vogt
Dr. Warren West
Dr. Thomas Witty
Dr. Hollis Wolcott
Dr. Harvey Woodruff
Dr. James Woodson
Dr. Greg Zoghby
Siobhan Abbott
Ashley Abesamis
Molly Adler
Darlene Aebodicz
Amen Alemayehu
Chele Allen
Zaid Al-Samir
Khalid Amin
Katherine Anderson
Loretta Anderson
Rita Anderson
Brenda Ashe
Melody Ashley
Tina Bailey
Beth Barry
Ed Barry
Brenda Bazemore
Angela Beachy
Dick Beasley
Dorena Beck
Jon Beck
Adam Becker
Amy Belloli
Sanjay Bhagchandani
Tamara Bishop
Graham Blake
Sue Blake
Taylor Blake
Leigh Blakiston
Pam Blankenship
Katie Blanks
Don Blazek
Jenni Bobbi
John Boon
Molly Boon
Pam Bowens
Jennifer Boyland
Linda Bradfrod
Kay Bradley
Robert Bradley
Sharon Brinkley
Nicole Brooks
Nilka Brown
Taylor Brown
Lisa Brown
Carol Bruce
Ron Bruce
Amanda Burak
Kristy Burak
Randy Burak
Susan Burak
Marshall Butler
Rose Marie Butz
Judy Cahill
Renee Callis
Ann Carter
Bridget Carver
Daniel Carver
Brandon Castor
Judy Cathey
Betty Cerro
Kathy Chandler
Rachel Charlton
Cindy Cheely
Eddie Choi
Min Choi
Matthew Chroust
Jamie Clark
Jessica Clark
Steve Clawson
Carol Cleckner
Sylvia Clifton
Andy Coalter
Mark Cockerham
Susan Cockerham
Frank Collins
Pat Collins
Selena Collins
Crystal Colwell
Robin Combs
Cindy Comer
Mike Comer
Ashley Compton
K.D. Cooper
Kaiten Cooper
Kamryn Cooper
Kelly Cooper
Donna Cowherd
and daughter
Darlene Cox
Christina Cramer
Marianna Cross
Ben Crowly
David Dalling
Sharon Darnell
Jeff Davidson
Lindy Davies
Cherie Davis
Renee Davis
Roy Davis
Chuck Dawson
Joan Dawson
Brittney Dedmond
Ann DeLusa
Julie DeLusa
Stephen DePasquale
Chantel Devalk
Roger Dick
Kim Disilva
Yvonne Dodson
Brittany Doss
Linda Douglas
Christine Dragoo
Vicki Dreelin
Neil Drumheller
Susanna Drumheller
Ann Dugas
Sid Dugas
Betty Jane Duncan
Michelle Dunlevy
Mitchell Dunston
David Durham
John Dutton
Rennie Dutton
Courtney Dye
Dora Dye
Anne Dyle
Malinda Edgecomb
Ashley Edlin
Ahmed Eldib
Jody Emerson
Rita Engle
Libby Epps
Joyce Estes
Cindy Eubanks
Ed Ewell
Janet Ezzell
Mary Fary
Brittany Field
Wanda Fletcher
Rachel Foreman
Lindsay Forte
Steven Forte
Tammy Fortune
John Foster
Pam Foster
Kurt Francis
Elizabeth Freeman
Donna Funkhouser
Mary Galloway
Jessica Gardner
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Kelly Greet
Karen Gregg
Sean Gregg
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Chris Harris
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Cheston Harris
Dian Hartle
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Cindy Hastings
Joanie Haury
Lisa Hayes
Liz Hayes
Cindy Haynes
Rudy Heinatz
Stephanie Heinatz
Tiffany Hellebranat
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David Herce
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Mary Hinterman
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Pam Hollis
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Becky Horsley
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Betty Hundley
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Sarah Kandrac
Chelsea Kanode
Gail Kerns
Caroline Kersey
Lisa Kersey
Helen Kietz
Cindy Killinger
Janet King
Stephen King
Mary Jane Kipper
Erin Knouse
Jo Koontz
Karen Kraus
Thomas Krebs
Tommy Krebs
Jonathan Kremser
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Theresa Lates
Mary Helen Layne
Dennis LeFever
Gail LeFever
Annie Leffingwell
Bonnie Leffingwell
Jimme Leiffer
Sandra Leiffer
Meg Lemaster
Carole Lewis
Debra Lilly
Scottie Loving
Peyton Loving
Raquel Loving
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Gene Medkiff
Amy Melvin-Ward
Kathy Menefee
William Menefee
Chrissy Ogura Meyers
Sandy Mikulecky
Marsha Miller
Paul Miller
Robert Miller
Sixieme Miller
Bill Minnick
Paige Mitchell
Courtney Moore
Michelle Moore
Anthony Morande
Gus Morande
Isabella Morande
Jacquelyn Morande
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Patsy Morgan
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Marilyn Morris
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Melissa Newsome
Peggy Newsome
Brenda Nichols
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Justin Norbo
David Onesty
Nick Pappas
Lourdes Parker
Bruce Parmiter
David Parmiter
Janet Parmiter
Ariana Parodi
Suzanne Parodi
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Amber Phelps
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Guenivere Robbins
Emilie Roberts
Kathy Rochelle-Bernhardt
Michael Roddy
Barbara Rollins
Joe Rollins
Kim Ronan
Laura Rowe
Jessi Rowsey
Patrick Ruck
Aman Sabharwal
Carolyn Salmon
Gerald Salmon
Laura Sams
Eu Niece Samuel
Donald Sandridge
Tasha Sauls
Jackie Saunders
Alex Schick
Leo Scholl
Geoff Schreiber
Glenda Schroeder
Charlie Schwabe
Carolyn Scott
Jessie Seeley
Eloise Shankle
Christy Sharpe
Pete Shepard
Sue Sheppard
Alex Shick
Emily Shuck
Howard Shye
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LaTonya Slade
Dawnleigh Slaughter
Anthony Smith
Becky Smith
Ethel Smith
Gordon Smith
Michelle Smith
Rose Smith
Mary Smithe
Roy Snowden
John Snyder
Susan Soles
Betsey Soulsby
Janet South
Tiffany Speas
Betty Speegle
John Spruill
Valinda Stairs
Amber Stephenson
Barbara Stevens
Jen Stevens
Robin Stewart
Stephanie Stewart
Heather Stoddard
Debra Stodgehill
April Strickland
Michelle Swartz
Kristen Swartz
Adam Taylor
Joyce Taylor
Kent Taylor
Kerry Taylor
Lou Taylor
Meghan Taylor
Shelby Taylor
Ron Taylor
Kelley Tenhagen
Rupert Thomas
Corey Thompson
Sylvia Thompson
Harper A Thompson
Jessica Thompson
Pam Tokarz
Cole Tomlinson
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Amy Trn
Dorothy Valentine
Luz Marina Vaughn
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Bill Warner
William Warner
Mary Warren
Tonya Weaver
Wyatt Weaver
Ella Webster
Deena West
Austin Westover
Mana Westover
Julie White
Tori White
Candace Whitehead
Arlene Will
Angela Williams
Bobby Williams
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Rachel Wilson
Daniel Luke Winter
Stephanie Wisniewski
Deborah Wood
Martha Woodruff
Diana Wooten
Gray Wooten
Lauren Wunder
Melissa Yard
Linda Young
Robin Zophy

Jack and The Mortgage Master

By: E. Wayne Bullis, Ed.D., CSA, CRFA

Once upon a time in a land not so far away lived a young lad (well, maybe not so young) named Jack. Jack helps people plan for their financial futures and manage their assets. His burning desire is to make certain that his advice is always sound and cutting-edge. So, he surrounds himself with other advisors who have the same philosophy.

As a part of his work, Jack always wants to make sure that his clients are prepared to manage the Mortgage Beast, so his friend, Charles, the Mortgage Master, is one such advisor. This beast always seemed to be so large, complex, and ever-changing, and Jack wants to be certain that his clients can always keep the beast under control. So, off Jack goes on a journey to find out what to say to his clients when they ask, "What mortgage can I afford?"

Jack skips merrily (actually, he drives) to Charles, The Mortgage Master's mountain. He finds Charles at his desk, calmly reviewing rates, signing papers, and talking with his clients. "Charles, my friend," Jack says, "I have some questions that I think only the great Mortgage Master can help me with. Will you?"

"Certainly, Jack. What would you like to know?" replied Charles, TMM.

"Well, first, great Mortgage Master, I'm often asked the question, How much mortgage should I have? What do I say?

"Jack, you already know the answer. They're asking the wrong question!"

"Great Mortgage Master, what do you mean?"

"Jack, the right questions are: How much mortgage can I afford? How much mortgage can I qualify for comfortably?"

"Yes, you're right. They are the right questions, but what are the answers?"

"Well, Jack, as of January 1, 2010, there are new rules for qualifying for a residential mortgage. They are based on ratios; for example, how much income you have versus how much home value you want to buy. Or, said another way, what is the proposed house payment plus your total debt in relation to your gross income or ability to pay without potential default?"

"Ah, I see, Great Mortgage Master. You have to have the income to be able to ultimately pay off all debt that you incur. There are no longer an 'unbelievable free or highly leveraged' mortgage packages."

"That's right, Jack. While there are some great deals available, the economic environment has finally realized that debt is an issue and you have to be able to pay for what you get. So, keeping your credit record clean is important. There are some compensating factors that we consider, though. For example, good credit, income stability, and liquid assets are all areas we consider positively when we're reviewing a request."

"O.K., then. Next question. What are the biggest problems you encounter when you try to help people get residential mortgage. I've asked the question, but I bet I can tell you the answers."

"As a financial advisor, Jack, I bet you can. Of course the biggest problems we encounter are: 1. Excessive debt, and 2. Unrealistic expectations about what they want to buy versus what they can afford."

"Great Mortgage Master, that's exactly what I would have said. Unfortunately, I think that the economic exuberance and leveraging programs of the mid-1990s caused folks to be a bit greedy and think unrealistically. Some forgot that debt has to be repaid, regardless of future economic circumstances. When the markets began to whirl out of kilter, debt was still there to be paid, even though there was substantial loss. So, what's your advice now to folks seeking residential mortgages?"

"Jack, I think I'd tell first time home buyers to seek a mortgage with which they feel comfortable making the monthly payments. Having a big first-time home that you really can't afford or are squeezed in other areas in order to pay will probably get you in trouble. If you're renting, consider the comfort of the rent level you're paying now. In whatever your circumstance, build your mortgage payment around your comfort zone.

If you're a 'mid-life' type of person seeking a larger home, again know your comfort zone with some upgrading. Remember, there are additional costs such as insurance, taxes, maintenance, upgrades, and continuing issues. Consider all potential costs.

If you're facing retirement you have various options. You might want to pay off your mortgage as quickly as possible to have additional income in retirement. But check with your financial advisor to make certain that's best for you. Or you might want to consider a reverse mortgage or second home. Each option has other factors that need strong consideration. Research, ask questions, get to know the facts. Base your decision on your comfort zone and the facts.

"Good information, Great Mortgage Master. But what would be your final advice to give someone seeking a home mortgage?"

"Know your credit-worthiness and protect it. Make sure that you have an income and assets to pay your debts, including your mortgage, regardless of economic circumstances. And above all, know your financial comfort zone." If you work with all of these factors, you'll be O.K."

"Thanks, Great Mortgage Master. You've confirmed my thoughts. I can go now in peace, knowing that my clients will receive good advice."

Note: If you'd like to get to know Charles the Mortgage Master, please contact him at: Charles A. Merrill, II, Senior Mortgage Consultant, Dominion Mortgage Corporation, 2810 N. Parham Road, Suite 245, Richmond, Virginia 23294, Office: 934-9500, ext. 113, toll free; 877-542-8500, ext 113, or cmerrill@dommtg.com

PathologyPuzzler

with Dr. John Svirsky

A 42-year-old Caucasian male was referred from a general dentist to an oral surgeon for evaluation of a radiolucent lesion of the anterior mandible between teeth numbers 26 and 27 (figure 1-3). The lesion measured 1.0 cm by 0.8 cm and extended from the distal of tooth number 26 and overlapped the root of tooth number 27. The teeth were vital and the lesion was asymptomatic. There was slight divergence of the roots (figures 1-2) of teeth numbers 26 and 27 with slight expansion to the lingual on the sagittal cross section of the CT scan (figure 3).

Your differential diagnosis would include:

A. Lateral periodontal cyst
B. Odontogenic keratocyst
C. Ameloblastoma.
D. Central giant cell granuloma
E. Calcifying epithelial odontogenic tumor
F. Calcifying odontogenic cyst
G. Central ossifying fibroma
H. Adenomatoid odontogenic tumor

Figure 1

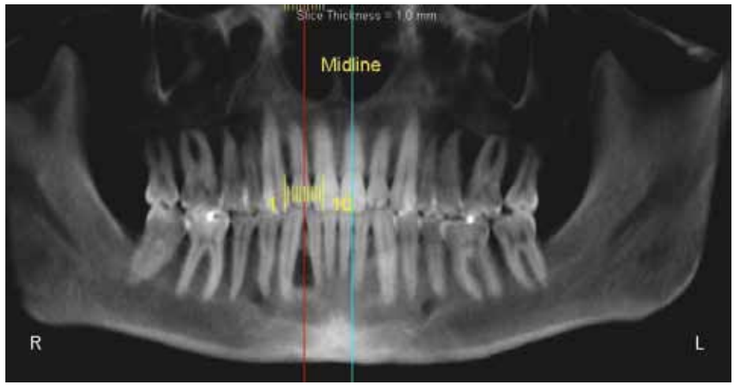


Figure 2

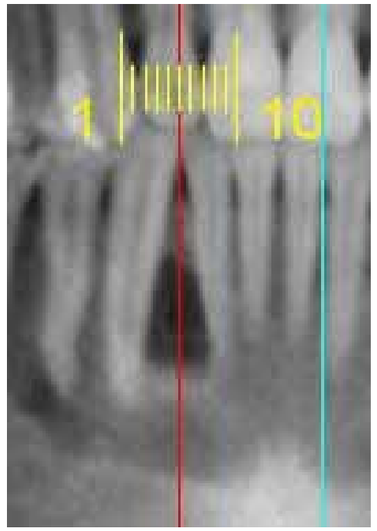
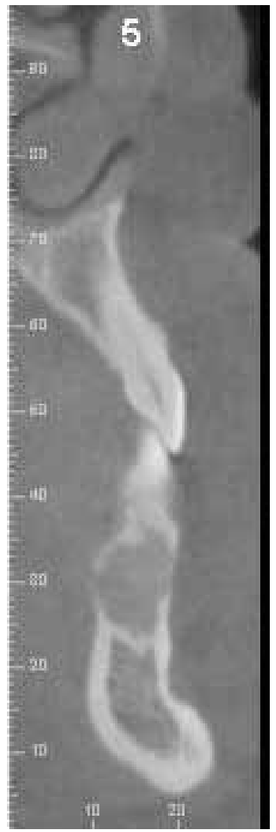


Figure 3



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Pediatric Abstracts

Diversity of asthma, evolving concepts of pathophysiology and lessons from genetics. Lilly, C. J Allergy Clin Immunol 2005;115(4-S1):S526-531.

In the developed world asthma is now an epidemic with as many as one in four urban children affected. Asthma is associated with substantial morbidity, mortality, and an economic burden to the medical infrastructure. Asthma is a complex disorder of bronchial hyperresponsiveness and is a disease of gene environment interaction with complex immunobiology. Allergic asthma is initiated early in life by the delivery of an allergen to the airway resulting in a subsequent immune recognition. Another component of asthma is the genetic make up of an individual. Recent advances in human DNA sequencing has made it possible to identify asthma genes and their asthma mediators. Expression array technology allows comparison of the expression of the human genome in cells from asthmatics and healthy individuals. The authors have identified 141 sequences as having increased expression and 8 that have decreased expression. Several genes are known to be associated with allergen exposure, these include lipocortin, the p65 subunit of NFKP, IL3, IL4 and IL 5 receptor subunits. A large percentage of the identified genes are known to be a factor in growth, differentiation, and proliferation. The results imply asthma is not only a disease of airway inflammation but involves changes in the growth and tissue responsiveness to antigen exposure which evolve over an extended time period.

Dr. James Dibelka is a resident in pediatric dentistry at Virginia Commonwealth University

Fused Teeth: A Review of the Treatment Options. Tuna E, Yildirim M, Seymen F, Gencay K, and Ozgen M. Journal of Dentistry for Children 2009; 76(2): 109-116

The purpose of this article was to review treatment options for fused teeth by describing two clinical cases showing different treatment methodologies. Fusion is defined as the union of two or more separate developing tooth germs at the dentinal level, yielding a single large tooth. The treatment of fused teeth may be interdisciplinary and include endodontic, surgical, and periodontal involvement. In the first case a ten year-old female presented in the mixed dentition with class I molar relationship, and fusion of the permanent maxillary right central incisor to a supernumerary tooth. The case was treated intraorally by separating the two fused teeth and extracting the distally positioned supernumerary tooth. The crown was restored with composite resin and orthodontically splinted. Systemic antibiotics were given and chlorhexidine rinse was recommended. At 3, 6, and 12-month follow up appointments the tooth was asymptomatic with no pulpal necrosis or root resorption. The second case consisted of an eight year-old female presenting in the mixed dentition with an anterior open bite, severe maxillary crowding and the permanent maxillary left lateral incisor fused to a supernumerary tooth along the length of the root. The case was treated by extracting the fused teeth and extraorally separating them. The distal portion was reimplanted and orthodontically splinted. Systemic antibiotics were given and chlorhexidine mouth rinse recommended. At 1, 2, 6 and 12-month follow-up appointments the tooth was asymptomatic and bone healing improved. At four-year follow up the tooth was vital and the periapical and periodontal health was preserved. Both presented treatments yielded favorable esthetic, periodontal, and periapical results for patients with fused teeth.

Dr. Andrew J. Zima, Jr., is a resident in pediatric dentistry at Virginia Commonwealth University

Sporadic Burkitt's Lymphoma of the Jaws: The Essentials of Prompt Life-saving referral and Management. Jan A, Vora K, Sándor GK. Journal Canadian Dental Association. 2005;71(3):165-8.

This purpose of this article was to give a brief review of Burkitt's lymphoma (BL), present a case report, and to help clinicians recognize such cases.

Burkitt's lymphoma (BL) is a malignant tumor of B-cell lymphocyte origin and is classified as a non-Hodgkin's lymphoma (NHL). Three clinical variants are recognized: African (endemic), American (sporadic) and HIV-associated. Each BL subtype has different characteristics. Endemic BL is usually diagnosed between ages of 5 and 7 years and involves the jaws as well as other facial bones in 60% to 80% of cases. Also, endemic BL is strongly associated with the Epstein-Barr Virus (EBV). Sporadic BL is associated with slightly older children, average age 12 years. The abdomen is the most common site of presentation. About 25% of sporadic BL cases involve the head and neck, most commonly in the form of cervical lymphadenopathy. Adult BL patients are almost always afflicted with AIDS. BL accounts for 40% of HIV-associated NHL cases. Unlike endemic BL, both sporadic and HIV-associated BL have low association with EBV.

Signs and symptoms of oral BL, which include mobile teeth, toothache, oral masses, gingival enlargement, pain, jaw expansion, swelling and sensory disturbances, have been recorded with pain being the most common presenting symptom.

A patient may be referred to you for a consultation from another dentist or physician and may present with a variety of worrisome signs and symptoms. A high level of suspicion should cause a dentist to act appropriately and promptly to avoid any disastrous consequences. A thorough dental and medical history is important along with the appropriate radiographs, including a computed tomography scan to look for any active lesions.

Justin Edwards, DMD, is a resident in pediatric dentistry at Virginia Commonwealth University

An evidence-based assessment of the clinical guidelines for replanted avulsed teeth. Part II: prescription of systemic antibiotics. Hinckfuss, S., Messer, L..; Dent Traumatol. 2009;25(2):158-64.

Approximately 30% of children have experienced a dental injury. Dental avulsion injuries occur most frequently in children between the ages of 7 and 9, an age when the alveolar bone is more pliable and accommodating of traumatic injuries. Injuries involving the permanent teeth are almost twice as common in school-aged boys, as compared to females of the same age. Sports accidents and fights are the most common cause of dental trauma in teenagers. The maxillary central incisors are the most commonly injured teeth. Maxillary teeth protruding more than 4 mm are two to three times as likely to suffer dental trauma than normally aligned teeth. Current clinical guidelines recommend systemic antibiotic therapy for patients who have an avulsed permanent tooth replanted. The objective of this meta-analysis was to use the principles of evidence-based dentistry to answer the PICO question. (PICO= procedure or condition, intervention, comparison to intervention, and outcome) The primary question is: when replanting avulsed permanent teeth, does prescribing systemic antibiotics result in an increased likelihood of successful periodontal healing as compared to replanting an avulsed tooth without antibiotic coverage? The authors performed a literature search for relevant citations. Inclusion criteria were applied and three papers reporting on 326 total teeth were included in the analysis. Results: Meta-analysis found no statistically significant difference between prescribing or not prescribing antibiotics for acceptable periodontal healing without progressive root resorption (common odds ratio = 0.90, SE = 0.29, 95% confidence intervals = 0.51–1.58). Conclusion: The evidence for an association between prescribing systemic antibiotics and an increased periodontal healing is inconclusive. Upon review of the available literature, there is inconclusive clinical evidence to either contradict or support the recommendation of systemic antibiotics. Pending future research to the contrary, dentists are recommended to follow current antibiotic guidelines when replanting avulsed teeth.

Dr. Andy Reed is a resident in pediatric dentistry at Virginia Commonwealth University.

Indirect Pulp Capping and Primary Teeth: Is the Primary Tooth Pulpotomy Out of Date?
Coll, J. Pediatric Dentistry 2008;30(3):230-6

The aim of this article is to review the dental literature and new research in vital pulp therapy to (1) determine if the pulpotomy is indicated for a true carious pulp exposure, (2) identify a diagnostic method to reliably identify teeth that are candidates for vital pulp therapy and (3) determine if the indirect pulp cap technique (IPT) should replace the pulpotomy. Primary tooth pulpotomies should be performed only on teeth that are determined to have a vital pulp. Current agents used in pulpotomies include formocresol which works by 'fixing' the vital pulp, ferric sulfate, which forms a clot barrier to preserve deeper pulp tissue, and mineral trioxide aggregate (MTA) and calcium hydroxide which act by healing the radicular pulp and aiding in formation of a dentinal bridge. Shovelton found that in permanent teeth, as caries approximated 0.25-0.3mm of the pulp, hyperemia and pulpitis were seen, thus impairing the pulp's repair capacity. In this article, Coll concludes that primary tooth pulpotomies should not be performed on teeth with carious pulp exposures because those teeth have a low likelihood of being totally vital and thus are poor candidates for the procedure. Likewise, if a pulpotomy is performed on teeth without carious exposures, there is a great chance of displacing affected dentin chips into the pulp which will affect the pulp's repair capacity by increasing the risk of pulpal inflammation. The use of the glass ionomer-caries control method (GICC) is indicated in teeth with cavitated carious lesions to diagnose vitality. This method is useful in treating teeth with signs and symptoms of reversible pulpitis or a symptomless tooth thought to have no pulpitis before instituting pulp therapy. The use of the GICC method has been shown to decrease total bacterial count and caries excavation significantly reduced the mutans streptococci present in the lesion. Moreover, sealing the cavitated lesion with glass ionomer contributes to remineralization. The GICC technique involves minimally removing outer, superficial, decay using a slow-speed with a #4 or #6 round bur, or a spoon excavator. Then, a glass ionomer temporary filling material is used, such as Fuji IX® (GC America Inc, Alsip, IL), Ketac Molar® (3M ESPE, St Paul, MN), or a resin-modified glass ionomer. No matrix band is needed but the restoration must not be in occlusion. After 1-3 months of GICC, if the tooth is asymptomatic and shows no clinical or radiographic signs of irreversible pulpitis, then vital pulp therapy can be instituted using IPT or pulpotomy. There are several factors to consider when determining whether to treat a carious lesion using IPT versus pulpotomy. IPT's long-term success (3-4 years) surpasses all other pulpotomy studies, with the exception of MTA. Coll mentioned that most dentists including pediatric dentists fail to utilize the IPT simply because the method was neither taught nor emphasized in the dental school curriculum. Studies have also shown that in the case of reversible pulpitis pain, IPT has been shown to have a higher success rate than those teeth treated with formocresol pulpotomy. Moreover, primary teeth treated with formocresol pulpotomy were shown to exfoliate significantly earlier (>6 months) than nonpulpotomized teeth, whereas IPT-treated teeth exfoliate normally. Lastly, IPT is less expensive than a pulpotomy, requires no pulpal entry, and thus does not require profound anesthesia.

Dr. Latrice Foster is a resident in pediatric dentistry at Virginia Commonwealth University.

Local Anesthesia Affects Physiologic Parameters and Reduces Anesthesiologist Intervention in children Undergoing General Anesthesia for Dental Rehabilitation. Watts, A., Thikkurissy, S., Smiley, M., McTigue, D., Smith, T. Pediatric Dentistry 2009;31(5):414-9.

Background- Pain stems from a variety of events and is a conscious, emotional and individual experience. Nociception is physiologic activity resulting from tissue damage. The balance between nociception and antinociception is commonly based on nonspecific autonomic reactions such as hypertension, tachycardia, sweating, or tearing, as well as patient movement in response to pain. Previous literature reports that in conjunction with General Anesthesia (GA), regional anesthesia can produce a more hemodynamically stable patient, and controls pain in the immediate postoperative period. There is a paucity of literature on the use of intraoperative local anesthesia (LA) as analgesia. The American Society of Anesthesiologists and the American Dental Association (ADA) currently have no recommendations as to the use of LA during GA and dental treatment. No directive statements exist in the American Academy of Pediatric Dentists (AAPD) guidelines regarding the use of LA with GA; they suggest only that LA "may be used" to reduce pain in the postoperative recovery period, and practitioners may choose to use LA during GA cases based on anecdotal experiences or training.

Purpose-The purpose of this study was to evaluate the use of intraoperative local anesthetics in pediatric outpatient dental surgery. The objectives included examining the physiologic effects of the representative pediatric dental procedure (rubber dam [RD] clamp placement, pulpotomy, cementation of a stainless steel crown [SSC], and extractions) on children undergoing General Anesthesia, and to determine if there is a relationship between LA usage and therapeutic intervention by an anesthesiologist.

Methods-The study included 48 children 12 to 84 months of age, requiring at least one extraction of a primary maxillary tooth, use of a RD clamp, and one maxillary tooth requiring pulp therapy and a SSC. Operators used 2% lidocaine with 1/100,000 epinephrine, and no patient exceeded 4.4mg/kg total. The study used the same dentist anesthesiologist throughout to allow for standardization of the anesthetic regimen. Patients were assigned to a control group (no LA) or a treatment group (LA), prior to the study. Data was based on objective reading from the physiologic monitors, and recorded whether or not intervention by the anesthesiologist was necessary, due to vital sign changes during the procedure.

Conclusions-Patients who were not given intraoperative LA were more likely to experience vital sign fluctuations that required anesthesia intervention.

Dr. Malinda Husson is a resident in pediatric dentistry at Virginia Commonwealth University.

Contemporary Perspectives on Vital Pulp Therapy: Views from Endodontists and Pediatric Dentists. Seale,N.; Glickmann, G. Pediatric Dentistry 2008; 30(3): 261-7.

The purpose of this study was to determine the level of agreement between pediatric dentists and endodontists at the pulp therapy symposium sponsored by the AAE and AAPD in November 2007. Two surveys were given involving questions about pulp therapy for cariously involved permanent teeth, indirect pulp treatment (IPT) for cariously involved young permanent teeth, pulp revascularization and regeneration. One survey was a pretest, the other was given after presentations via electronic real time audience response system. Responding to the surveys were 231 pediatric dentists and 79 endo

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Scientific

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dontists. Results on formocresol showed that 37% of the endodontists and 18% of the pediatric dentists said it is a carcinogen and should not be used on patients. Five percent of the pediatric dentists and15% of the endodontists think that formocresol is a danger to patients. Mineral Trioxide Aggregate was the favorite pulpotomy agent of 30% of the pediatric dentists and 34% of the endodontists. If cost was not an issue 85% of pediatric dentists and endodontists said it would be used in their offices. Ninety-four percent of pediatric dentists and 69% of endodontists said they perform IPT on young permanent teeth. Among all respondents 87% agreed that revascularization/regeneration would be a viable treatment option in the next ten years. Conclusions revealed pediatric dentists and endodontists agree that formocresol will be replaced as a primary tooth pulpotomy agent, while MTA is the first choice to take its place when it becomes affordable. Also, IPT is an acceptable pulp technique for cariously involved young permanent teeth with open apices, and IPT in cariously affected primary teeth holds hope for replacement of the pulpotomy. Revascularization/regeneration will bring exciting new treatment options in the near future.

Dr. Heath Whitfield is chief resident in pediatric dentistry at Virginia Commonwealth University

Topical Anesthesia for Rubber Dam Clamp Placement in Sealant Placement: Comparison of Lidocaine/Prilocaine gel and Benzocaine. Yoon, R., Chussid, S. Pediatric Dentistry 2009;31 (5): 377-381.

Abstract: Purpose: Topical anesthetics are used commonly in dentistry for many purposes, the most common being application to non-keratinized oral mucosa prior to local anesthetic injection. The objective of this article was to compare topical anesthetic gel effectiveness and pain perception with rubber dam clamp placement for sealants using Oraqix® (2.5%Lidocaine, 2.5%Prilocaine, Dentsply Pharmaceutical) non-injectable gel and 20% Benzocaine gel. Methods: A single operator treated all participants aged 7-12 years old (N=45) recruited from regularly scheduled patients in a postgraduate pediatric dental clinic. Use of a split mouth design with Oraqix® gel placed on one side and 20% Benzocaine on the other. The children were asked to rate their pain after topical anesthetic and rubber dam clamp placement using the Facial Pain Scale (FPS). Results: Subject population; 27 female, and 18 male with 15 less than 9 years and 30 greater than 9 years old. The overall differences in mean FPS ratings between Oraqix® and Benzocaine was not statistically significant (P=.27) as well as the children less than nine years old(P=.77). No statistical difference was noted between genders. There was a statistical difference in children greater than nine years old with Oraqix® being slightly more effective than Benzocaine. Conclusions: Oraqix® application for 2 minutes before clamp placement did not significantly reduce pain when compared to 20% benzocaine. Oraqix® was slightly more effective in pain reduction for the 9-12 year- old group. More studies with a larger sample size are needed to determine the effectiveness of this new non-injectable topical anesthetic and its application in dentistry.

Larry Shults, DDS, is a resident in pediatric dentistry at Virginia Commonwealth University.

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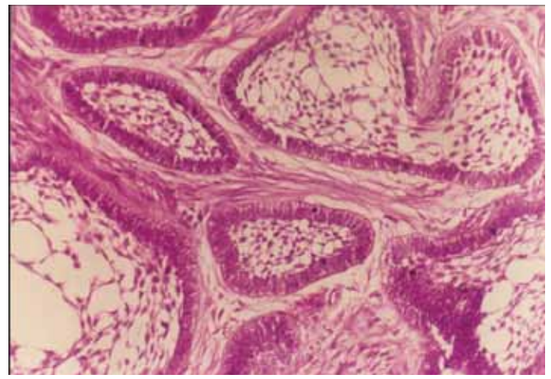
PathologyPuzzler

Most likely possibilities include A, B, C, and D since all are radiolucent. Since the lesion is expansile without a sclerotic border, an odontogenic keratocyst is unlikely. Lateral periodontal cysts normally do not occur in this area (most common location is between mandibular bicuspids) and only on rare occasions are expansile. Both ameloblastoma and central giant cell granuloma can cause expansion. The location favors a central giant cell granuloma since the ameloblastoma is found more frequently in the posterior mandible. The age is typical for an ameloblastoma. Calcifying epithelial odontogenic tumor, calcifying odontogenic cyst, central ossifying fibroma and adenomatoid odontogenic tumor would normally be mixed radiolucent and radiopaque lesions. Early lesions that induce calcification, nevertheless, can appear radiolucent until they mature. My differential diagnosis in order of probability is: 1) ameloblastoma based on age and expansion; 2) central giant cell granuloma based on location and expansion; 3) odontogenic keratocyst; and 4) lateral periodontal cyst. CGCG tends to cross the midline and favors the anterior mandible. Adenomatoid odontogenic tumor has a predilection for young females and the anterior maxilla.

The biopsy findings proved this lesion to be an ameloblastoma (figure 4). The recommended treatment would be local segmental resection removing involved teeth. With reconstructive surgery and implants this patient should have complete esthetic and functional rehabilitation.

This case was submitted by Dr. Amir Naimi, an Oral and Maxillofacial surgeon in Northern Virginia.

Figure 4



The histology shows multiple islands of odontogenic epithelium showing reverse polarization of the basal cell layer with a central zone of stellate reticulum appearing tissue.

Understanding Delta Dental's New Payment Policies

By: Dan Schulte, J.D.
MDA Legal Council

Reprinted, with permission, from the Journal of the Michigan Dental Association, November 2008 issue.

The author's comments relate to the Delta policy as it exists in Michigan.

This summer Delta Dental announced payment policy changes affecting its Michigan participating dentists. Apparently, in connection with a "system upgrade" Delta Dental has established a maximum fee participating dentists may charge for certain procedures. This maximum fee is called the "Maximum Plan Allowance." For example, fees charged for composite fillings and porcelain crowns are now subject to a Maximum Plan Allowance.

This means Michigan dentists who participate with Delta Dental may no longer charge any patient enrolled in a Delta Dental underwritten or administered dental plan a fee exceeding the Maximum Plan Allowance if one has been established for a procedure. Contrary to past practice, the Maximum Plan Allowance applies whether or not the patient actually has coverage provided by the Delta Dental underwritten or administered plan. Delta Dental has taken control of the fees participating dentists charge these patients even when only the patient is liable for payment of the fee and would be willing to pay a higher amount for a non-covered service.

For example, let's assume your patient is enrolled in a Delta Dental underwritten or administered dental plan. The plan provides that either Delta Dental or the plan's sponsor (usually the patient's employer) will pay $50 for the procedure you just completed on this patient. The Maximum Plan Allowance for this procedure Delta Dental has established to be $135. The fee you customarily charge for this procedure is $150. Under Delta Dental's new payment procedures, the most you can balance bill the patient is $85 (the difference between the Maximum Plan Allowance and the amount Delta Dental pays) and is no longer $100 (the difference between your customary fee and the amount Delta Dental has paid). The $15 you used to collect from the patient (and presumably the patient agreed to pay for the procedure) is now lost. Delta Dental is prohibiting you from collecting it.

Questions raised

Many questions have been asked regarding Delta Dental's new payment policies. What members want to know is whether Delta Dental can legally: (1) establish a maximum fee for services that are not covered by a Delta Dental underwritten or administered dental plan; (2) restrict participating dentists from balance billing for services that are not covered; and (3) unilaterally amend the participation agreements to impose these new restrictions?

The answers to all of these questions depend on the terms of the contracts in place between Delta Dental and its participating dentists. We have reviewed the DeltaPremier Fee-For-Service Participation Agreement and the Uniform Requirements by Delta DeltaPremier Participation. I will refer to these two documents collectively in this article as the "Contract."

Delta Dental is literally construing and broadly interpreting the Contract. Whether and to what extent dentists understood and/or intended the Contract to have such a broad application can only be determined upon a review of the facts and circumstances of each individual case. The circumstances surrounding each individual dentist's interactions with Delta Dental both at the time the Contract was signed and following its signing may give rise to defenses to enforcement of the Contract on an individual basis.

The Contract requires participating dentists "to provide dental care to Enrollees" in accordance with the terms of the Contract. The Contract is not limited to only that dental care that is covered in some fashion by the Enrollee's plan. Instead, it applies to all dental care provided to any Enrollee. "Enrollee" is defined in the Contract to include any patient eligible for dental benefits pursuant to any dental program that is either administered or underwritten by Delta Dental or another entity that pursuant to an agreement with Delta Dental has made the Contract applicable.

Therefore, the Contract applies when Delta Dental is:

- actually underwriting the funding of the benefits provided to the enrollee;
- when Delta Dental is merely processing claims and otherwise administering the dental plan for a third party (usually the patient's employer) who is funding the benefits; and
- when Delta Dental merely sells to a third party the right to use its network of dentists. Delta Dental claims it has not sold the right to use the network to a third party. However, the Contract gives Delta Dental the right to do so at any time.

When read literally, the Contract allows Delta Dental to set maximum fees for services provided by participating dentists even though there is no coverage or only partial coverage by a dental plan for the service.

Balance-billing limited

The extent to which participating dentists may balance bill a patient is also governed by the Contract. Specifically, the Contract restricts a participating dentist's ability to balance bill a patient for an amount in excess of "the maximum fee that Delta Dental approves for the service." Again, the Contract makes no distinction between covered services and services that are not covered.

Finally, the Contract gives Delta Dental power to amend the terms of participation. Included is "the right to make changes in its Processing Policies and the Uniform Requirements of DeltaPremier Participation." Therefore, Delta Dental has the contractual right to change at-will any of the terms of participation including the setting of the fees you charge any patient enrolled in a Delta Dental underwritten or administered dental plan.

Obviously, many member dentists are upset about these changes. Many have said that they have never been subject to fee limitations by Delta Dental or any other payor applicable to non-covered services. Even more have indicated that they had no idea the Contract could be applied in this way and that this was never explained to them at the time they signed the Contract.

Participating dentists have four choices, as explained below:

1. The first is to accept the new Delta Dental policies and limit the amount of your balance billing to the Maximum Plan Allowance.

2. The second is to continue balance billing up to your customary fee as you have in the past. The risk you run obviously is that Delta Dental will terminate your Contract and take action against you for breach of the Contract. Delta Dental has the right to terminate your Contract at will upon 30 days written notice.

3. Third, you may likewise terminate your Contract by providing 30 days written notice to Delta Dental.

4. Finally, you may stop providing certain services to Delta Dental Enrollees if the Maximum Plan Allowance is not at a level acceptable to you.

Selling a network

Another question that has been frequently asked is why Delta Dental would limit fees for services that patients know are not covered by the terms of their dental plan and for which patients have been willing to pay? The answer to this question has more to do with how Delta Dental uses the network to generate income then it does the delivery of dental care and/or patient choice.

Delta Dental generates income primarily from the sale of dental plan products and dental plan administrative services. The ability to control the amounts paid for dental care (whether by Delta Dental directly or by the sponsor of a dental plan administered by Delta Dental) makes its insurance products and administrative services more attractive to its customers. Delta Dental's ability to control the cost of dental care varies directly with the size of the network of dentists and the scope of the fee limitations the participating dentists have contractually agreed to.

Therefore, having a large network of dentists who have agreed to a broad scope of dental services for which control of fees has been given up, results in a significant competitive advantage for Delta Dental in the sale of its underwritten dental insurance products and dental plan administrative services.

This advantage is the centerpiece of Delta Dental's recent advertisements, which state:

"Your Company Deserves a Deeper Network
The Delta Dental system includes three of every four dentists -- which makes our network the biggest in the nation. Offering your employees access to the deepest networks improves the chance that their preferred dentist participates in one or more of our plans. That, in turn, helps us deliver greater plan savings to you. So if you are not with Delta Dental, shouldn't you be? To learn more about Delta Dental, please contact your broker or visit DeltaDentalMI.com."

Delta Dental is acknowledging that greater plan savings for their customers result directly from "the deepest networks."

Individual dentists must make their own decision how to react to Delta Dental's payment policy changes. The Michigan Dental Association cannot legally and will not facilitate any joint response to these changes on behalf of MDA members. To do so is illegal, violating federal and state antitrust laws. The purpose of this article (and future communications) is to educate MDA members about what these changes mean and why it is in Delta Dental's interest to implement the changes.

Mark Your Calendar

Financial Boot Camp

a VDA event

Sheraton - Richmond, VA

October 15-16, 2010

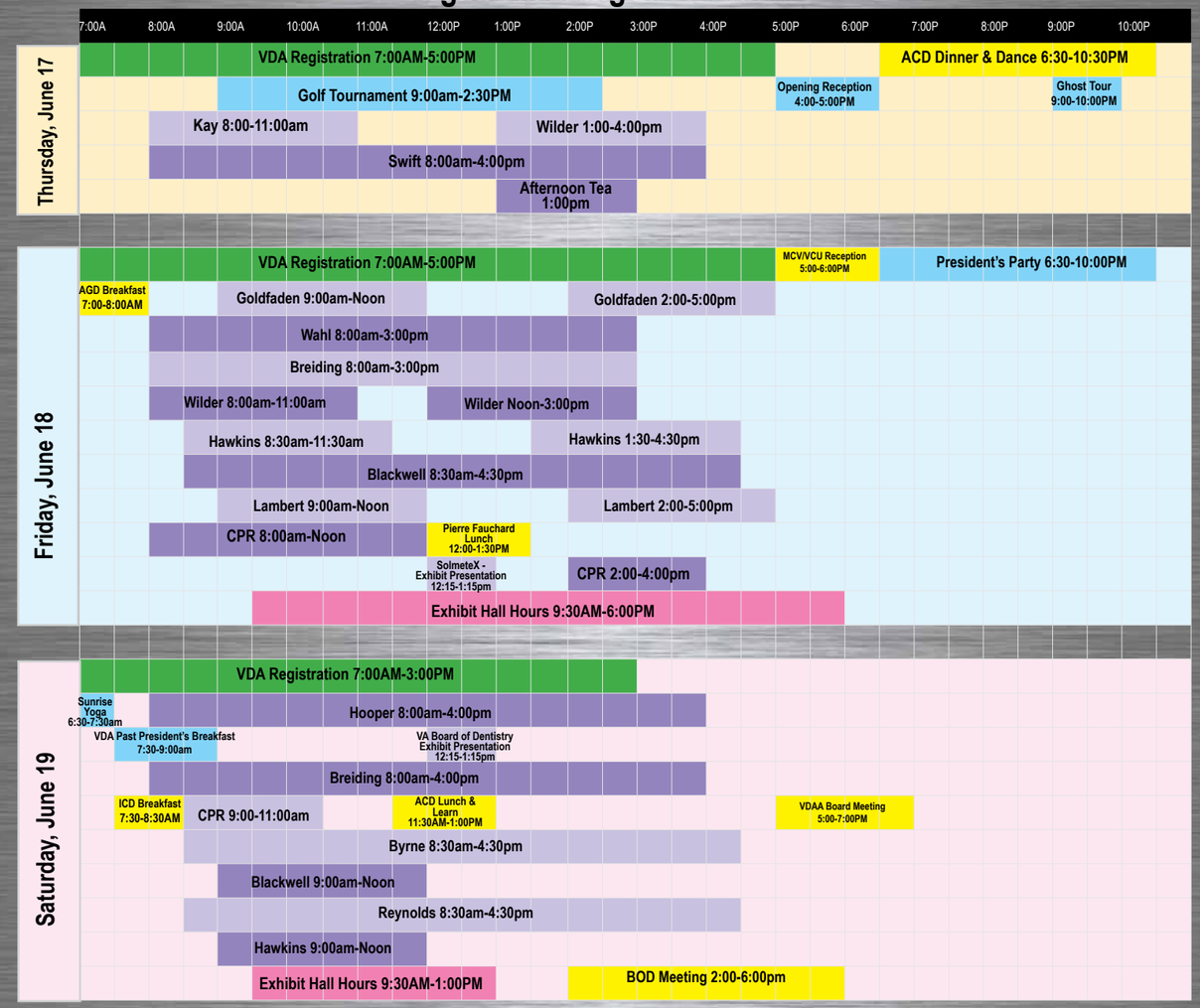
Details coming soon!

THE Virginia MEETING

JUNE 17-19, 2010

Williamsburg Lodge
Williamsburg, VA

Virginia Meeting At A Glance



REGISTER ONLINE AT WWW.VIRGINIAMEETING.ORG

Hotel Information

Williamsburg Lodge
310 South England Street
Williamsburg, VA 23185

Photo courtesy of The Colonial Williamsburg Foundation, Williamsburg, VA

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HOTEL RESERVATION DEADLINE: MAY 17, 2010

Reservations:
By Phone: 1-800-HISTORY (1-800-447-8679)
Meeting Code: VIRF10A

Online: https://resweb.passkey.com/go/virf10a

Virginia Meeting room rates:
Williamsburg Lodge: Deluxe $229; Superior $199
Woodlands Hotel & Suites: Superior $139
Williamsburg Inn: Main Building $395; Providence Hall Wing $289

Rates listed do not include 10% and $2.00 per room per night occupancy tax.

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Making it Happen...

2010 Council On Sessions

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	Dr. Sharon Colvin	Dr. Michael Abbott
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2010 Local Arrangements Committee

Chair:	Dr. Melanie Love
Social:	Dr. Kitt Finley-Parker
Golf:	Dr. Bruce Hutchison
Hosts:	Dr. Brenda Young

Detailed course listings can be found on our web site at www.virginiameeting.org by clicking on Education.

Continuing Education Tickets

Thursday, June 17, 2010

Code	Course Title/Speaker		Cost
01	**Kay -** OSHA	8:00-11:00am	Free w/ Badge
02	**Swift** - Materials	8:00am-4:00pm	$79
03	**Wilder** - Providing WOW Ser...	1:00-4:00pm	Free w/ Badge

Friday, June 18, 2010

Code	Course Title/Speaker		Cost
04	**Wilder** - Periodontal Procedures	8:00-11:00am	Dentist: $65 All others: $45
05	**Wilder -** Products & Promises	Noon-3:00pm	Dentist: $65 All others: $45
06	**Wahl -** Leading Change...	8:00am-3:00pm	Free w/ Badge
07	**Healthcare** Provider CPR Hands On	8:00am-Noon	$60
08	**Breiding** - Sorry, Customer...	8:00am-3:00pm	Free w/ Badge
09	**Blackwell** - Implant Dentistry	8:30am-4:30pm	Free w/ Badge
10	**Hawkins** - Oral Sedation...	8:30-11:30am	Dentist: $35 All others: $25
11	**Lambert** - Smile Design...	9:00am-Noon	Free w/ Badge
12	**Lambert** - Conservative Prep... Hands On	2:00-5:00pm	$195
13	**Goldfaden** - Endodontics Hands On	9:00am-5:00pm	Free w/ Ticket
14	**Hawkins** - Local Anesthesia	1:30-4:30pm	Dentist: $35 All others: $25
15	**SolmeteX -** Amalgam Separators	12:15-1:15pm	Free w/ Badge
46	**Heartsaver Adult & Child CPR** Hands On	2:00-4:00pm	$50

Saturday, June 19, 2010

Code	Course Title/Speaker		Cost
16	**Hooper** - Contemporary Funct...	8:00am-4:00pm	Dentist: $65 All others: $45
17	**Breiding** - Turning Patience ...	8:00am-4:00pm	Free w/ Badge
18	**Byrne** - Pharmacology Update	8:30am-4:30pm	Free w/ Badge
19	**Blackwell** - Treatment Plan...	9:00am-Noon	Free w/ Badge
20	**Reynolds** - Vitality & Youth...	8:30am-4:30pm	Free w/ Badge
21	**Hawkins** - Medical Emergen... Hands On	9:00am-Noon	$225
22	**VA Board of Dentistry Update**	12:15-1:15pm	Free w/ Badge
26	**Heartsaver Adult & Child CPR** Hands On	9:00-11:00am	$50

Event & Affiliate Group Tickets

Thursday, June 17, 2010

Code	Event	Cost
30	**Opening Reception** 4:00-5:00pm	Free - ticket required
32	**Annual VDA Golf Tournament** 9:00am **(Fill out additional information section on registration form)**	$125.00
33	**Ghost Tour** 9:00-10:00pm Recommended for ages 6 and up.	$15
41	**Afternoon Tea** 1:00-2:30pm	$35.00

Friday, June 18, 2010

Code	Event	Cost
34	**AGD Breakfast*** 7:00-8:00am	n/c
35	**Pierre Fauchard Luncheon*** Noon-1:30pm	$40.00
36	**VDA President's Party (Adult)** 6:30-10:00pm	$30.00
36A	**VDA President's Party (Child 2-12 yrs old)**	$10.00
37	**MCV/VCU Reception*** 5:00-6:00pm	$0

Saturday, June 19, 2010

Code	Event	Cost
38	**ICD Breakfast*** 7:30-8:30am	$25
40A-G	**ACD Luncheon For Learning** 11:30am-1:00pm	$40.00

Table Topic
40A- Al-Anezi - Review of the Masticatory System and Its Function
40B- Archer - Problem Solving in Dental Anesthesia
40C- Brickhouse - Clinical Management of the Challenging...
40D- Carter - Digital Radiography Update
40E- Haselton - CAD-CAM and Your Practice
40F- Imbery - Advanced Topics In Restorative Dentistry
40G- Tufecki - Etiology, Prevention and Treatment...

42	**Sunrise Yoga** 6:30-7:30am	$17.00

Admission Tickets

Code	Event	Cost
44	**Colonial Williamsburg Historic Area Ticket** Tickets good for length of conference	$22.00

* Only members from these groups can attend these functions

Virginia Meeting

REGISTRATION FORM FOR ALL REGISTRANTS

Please use a ballpoint pen. Feel free to make additional copies as needed.

1 Primary Contact for Conference Registration (*If questions arise, VDA will contact this person*)

Contact Name: _____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **ADA#:** _____

E-Mail: _____ **Component #:** _____

2 Registration Categories:
(Dentists many only register as a dentist)

	On or Before 4/30	5/1-6/4	Onsite Rates 6/17-6/19
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 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 will be required

ACD Luncheon For Learning: (Only for those attending luncheon)

40A- Al-Anexi
40B- Archer
40C- Brickhouse
40D- Carter
40E- Haselton
40F- Imbery
40G- Tufecki

Choices: 1st _____ 2nd _____ 3rd _____

☐ *Refund if choices are not available*

VDA Golf Tournament - In Honor of Dr. Donald Martin
Code: 32 - Additional Information (only for those playing in tournament)

Handicap: _____

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

_____

Friday & Saturday Lunch Option

The Virginia Meeting will be offering a boxed lunch option for Friday, June 18, 2010, and Saturday, June 19, 2010. For $16 per person you can enjoy a boxed lunch (Veggie, Turkey or Roast Beef) with a drink. Lunch choices are on a first come, first served basis. Lunches will be available in the exhibit hall on Friday from 11:30am-1:45pm and Saturday from 11:30am-1:00pm. If you opt not to have lunch on either Friday or Saturday, please indicate that on the form below in section 4 or 5 . Your name badge will indicate if you purchased a lunch and will be your ticket to pick it up.

Complete Details on page 25

3 Category	Fee	Registrants List Primary Registrant on first line	4 Friday Lunch Option	5 Saturday Lunch Option	6 Course #1 Code/Fee	Course #2 Code/Fee	Course #3 Code/Fee	7 Event #1 Code/Fee	Event #2 Code/Fee	Subtotal
		1.	+ $16 ☐ Opt Out Veg ☐ Trky ☐ RB ☐	+ $16 ☐ Opt Out Veg ☐ Trky ☐ RB ☐						$
		2.	+ $16 ☐ Opt Out Veg ☐ Trky ☐ RB ☐	+ $16 ☐ Opt Out Veg ☐ Trky ☐ RB ☐						$
		3.	+ $16 ☐ Opt Out Veg ☐ Trky ☐ RB ☐	+ $16 ☐ Opt Out Veg ☐ Trky ☐ RB ☐						$
		4.	+ $16 ☐ Opt Out Veg ☐ Trky ☐ RB ☐	+ $16 ☐ Opt Out Veg ☐ Trky ☐ RB ☐						$
		5.	+ $16 ☐ Opt Out Veg ☐ Trky ☐ RB ☐	+ $16 ☐ Opt Out Veg ☐ Trky ☐ RB ☐						$
		6.	+ $16 ☐ Opt Out Veg ☐ Trky ☐ RB ☐	+ $16 ☐ Opt Out Veg ☐ Trky ☐ RB ☐						$

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

8 Grand TOTAL

9 Payment Options:

☐ **Check (payable to VDA - Enclosed)**
☐ **Credit Card #** _____ **Exp. Date:** _____

Security Code: _____ **Address on credit account:** _____

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

2010 Exhibit Marketplace

as of March 18, 2010

Exhibit Hours:

Friday, June 18, 2010 9:30am-6:00pm
Saturday, June 19, 2010 9:30am-1:00pm

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B&B Insurance Assoc., Inc.
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Biomet 3i, LLC
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Delta Dental of Virginia
Dental Direct
DentaQuest - Smiles For Children
DENTSPLY
Dentsply Tulsa Dental Specialties
Designs for Vision, Inc.
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Drake Precision Dental Laboratory
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Federal Bureau of Prisons
Gazz Consulting
Gendex Dental Systems
Give Kids A Smile
Hayes Handpiece Repair of Eastern Virginia LLC
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Hermitage Wealth Management, Inc.
Ivoclar Vivadent, Inc.
Kerr Corporation
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RBS Worldpay
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RGP Dental
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SolmeteX
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VDA Services Glove Program
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Yodle Dental Marketing
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Friday & Saturday Lunch Option

Back by popular demand...for your convenience.

For $16 per person you can enjoy a boxed lunch (Veggie, Turkey or Roast Beef) with a drink. Lunch choices can be indicated on your registration form but are on a first come, first served basis.

Lunches will be available in the exhibit hall on **Friday from 11:30am-1:45pm and Saturday from 11:30am-1:00pm. Grab a boxed lunch and join us in the Exhibit Hall for a 1 hour timely dental update and 1 hour CE opportunity.**

If you opt not to have lunch on either day please indicate that on your registration form in section 5 or during online registration. Your name badge will indicate if you purchased a lunch and will be your ticket to pick it up.

There will be NO on site lunch sales.

The Virginia Dental Association would like to thank the following individuals/companies for their generous support of the Virginia Meeting!!! (Sponsorships as of 3/18/10)

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Saturday Coffee Break

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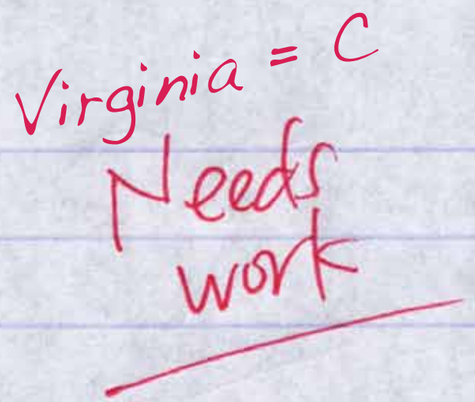
Pew Report Finds Majority of States Fail to Ensure Proper Dental Health & Access to Care for Children

Author: The Pew Center on the States



WASHINGTON, Feb. 23 2010 - An estimated one in five children in America go without dental care each year and two thirds of states do not have effective policies in place to ensure proper dental health and access to care, according to a report by the Pew Center on the States. The Cost of Delay: State Dental Policies Fail One in Five Children, released with support from the W.K. Kellogg Foundation and the DentaQuest Foundation, grades each state's policy responses to the urgent challenges in dental health among America's low-income children. February is National Children's Dental Health Month.

"Millions of children go without dental care each year but the good news is, it's fixable," said Shelly Gehshan, director of the Pew Children's Dental Campaign. "By enacting a handful of effective policies, states can help eliminate the long-term health and economic consequences of untreated dental problems among kids. Several states are leading the way--but all states can and must do more to ensure access to dental care for the 17 million children left out of the system."

Pew scored all 50 states and the District of Columbia, using an A-F scale, on whether and how well they are employing eight proven policy solutions to ensure dental health and access to care for children. These policies fall into four categories: cost-effective ways to help prevent problems from occurring in the first place; Medicaid improvements that enable and motivate more dentists to treat disadvantaged children; new workforce models that expand the number of qualified dental providers; and gathering data to gauge progress and improve performance.

Only six states merited "A" grades: Connecticut, Iowa, Maryland, New Mexico, Rhode Island and South Carolina. These states met at least six of the eight policy benchmarks and had policies in place that met or exceeded the national performance standards. These high grades do not mean that all people in the state have access to quality dental care services. Severe access problems still exist in states that received "A" grades, but these states have policies in place needed to improve dental care.

Nine states received a grade of "B": Alaska, Colorado, Idaho, Illinois, Maine, New Hampshire, Ohio, Texas and Washington. Twenty states received a grade of "C" because they met four or fewer of the eight policy benchmarks. Six states and the District of Columbia earned a "D" grade: Alabama, Indiana, Mississippi, Montana, Nevada and Utah. Nine states earned an "F," meeting only one or two policy benchmarks: Arkansas, Delaware, Florida, New Jersey, Hawaii, Louisiana, Pennsylvania, West Virginia and Wyoming. No state met all eight targets. New Jersey ranked lowest in the nation, meeting only one benchmark.

"The challenge of ensuring disadvantaged children's dental health and access to care is one that can be overcome," said Ralph Fuccillo, president, the DentaQuest Foundation. "We hope states will use the information in this report to make improvements in dental care for children. There are a variety of solutions that can be achieved at relatively little cost; the return on investment for children and taxpayers is promising."

"Unfortunately, while some states are improving access to oral health care, there are still millions of children and families - especially those who are poor and live in communities of color - who can't gain access to the care that exists," said Sterling K. Speirn, president and CEO of the W.K. Kellogg Foundation. "States need to explore creative workforce solutions, such as the dental therapist model, for addressing this glaring gap in our health care system, and improving access to quality oral health care for all children."

There are many solutions that can be achieved at relatively little cost and the return on investment for children and taxpayers will be significant. Americans are expected to spend $106 billion on dental care in 2010. This includes many expensive restorative treatments - from fillings to root canals - that could have been mitigated or avoided altogether with earlier, easier and less expensive ways of ensuring adequate dental care when they were children.

Report Shows Need for Low-Cost Solutions

The Pew report highlights four proven solutions that can improve both the dental health of children and their access to care:

-- Sealants: Protective coatings applied to the teeth by a dentist or hygienist cost one third as much as filling a cavity and have been shown to prevent 60 percent of cavities. School-based programs are the most cost-effective strategy for providing sealants to disadvantaged children, yet this strategy is vastly underutilized.

-- Community water fluoridation: Identified by the Centers for Disease Control and Prevention (CDC) as one of 10 great public health achievements of the 20th Century, fluoridated water counteracts tooth decay and strengthens teeth. Fluoride occurs naturally in water, but the level varies within states and across the country. In addition to being the most far-reaching preventive measure states can enact, fluoridation also offers an unmatched return on investment, saving $38 in dental treatment costs for every dollar spent. About 30 percent of the population on community water systems does not yet receive fluoridated water.

-- Medicaid improvements: Making minor changes to this federal program can enable and motivate more dentists to treat low-income children. Only 38 percent of Medicaid-eligible children received dental care in 2007, largely because too few dentists are willing to treat them. The number of children receiving dental services more than doubled over just four years in several states that have increased Medicaid reimbursement rates.

-- More dental providers: New professionals, similar to nurse practitioners in the medical field, can expand the number of qualified dental providers who can fill the unmet needs of children. A growing number of states are exploring new models that increase the involvement of physicians, hygienists, and new types of dental professionals.

The report can be found at: www.pewcenteronthestates.org/costofdelay

ADA Response link: www.ada.org/public/media/releases/1002_release04.asp

Extraoral

By: Dr. Elizabeth M. Wilson

IS WASHINGTON BROKEN??

GAME CHANGE Obama *and the* Clintons, McCain *and* Palin*, and the* Race of a Lifetime*

By: John Heilemann and Mark Halperin - New York, Harper Collins Publisher, 2010
ISBN: 978-0-06-173363-5, $27.99

GAME CHANGE Obama and the Clintons~ McCain and Palin. and the Race of a Lifetime* is like the kid in class, arm waving and squealing "ooh, ooh, I know, I know .... "

I admit it, I wanted to read this book. Yes, it's gossipy and really sort of unseemly, but if you are a political junkie, it is also "data". Amidst the many shockers (and there are many if you haven't heard), John Heilemann and Mark Halperin give us the broad background of the last Presidential election, beginning with the lead up. As the title references, no one gets a bye.

The tone the authors use reflects the pace of unfolding events, keeping the reader engaged and involved. Many details, quotes, and opinions are included. Consequently, the "process" of the election is revealed for all to examine. And like Congress and their sausage making business, it is not pretty.

In the first half of the book, the authors narrate the democratic race for the nomination. Sometimes depressing, other times outright funny, but always illuminating, the key players duke it out. We might remember the basics of the democratic nomination fight: the debates, New Hampshire, Mrs. Clinton's tears, "You're likeable enough Hillary", the post-racial speech, and so on. The book though is no sketch. And, again, not pretty.

In the highest heat of it, the authors describe Bill Clinton's thoughts as he realizes the Clinton side is losing to Obama: "To Bill, the picture was all too clear. By accusing him and Hillary of slapping the race card on the table, the Obama campaign was doing exactly that itself. And though it infuriated him, he couldn't help but respect the artfulness of the play."

I wonder if anyone realizes what they wrote right there. Race as a "play", and respecting it? From a more sober perspective, trivializing race is no longer acceptable, even in a book of this nature.

As the book continues, momentum dashes about, lurching this way and that, some egos soar, some crash and burn. Oh, and yes, the Edwards debacle gets plenty of attention. Although Edwards as a serious candidate does not.

Also, we know who won.

The authors move on to the Republican nominations in the middle section of the book. A broader brush is used in this portion; perhaps we would all agree the Democratic race was a bit more eventful, certainly more historic.

The national presidential race plays out next. Here, the authors present the McCain/Palin campaign as a train wreck. Following the Couric interview, and Tina Fey on Saturday Night Live, they write of Palin specifically:

" ... .in the eyes of the broader public - and even more so those of the national media and political Establishment - any traces of her image as a maverick reformer had been erased. For them, Palin had been reduced to nothing more than a hick on a high wire." Should we wait for history's judgment here?

Obama survives really unscathed. One interesting line near the conclusion from the authors:

"But what Biden quickly discovered was that Obama's policies were awfully thin, not terribly specific, more rhetoric than substance."

I mention that because, although, no one says so in the book, Biden must not have minded.

After finishing the book, my thoughts drifted to the question dominating the airwaves ... is Washington broken?

Based on the "data", one might consider not Washington, but those who people it.

An intriguing and fun book, I encourage you to read it. No doubt it will be followed by others filled with "all knowing" comments.

Currently, how do we relate this book to the "Tea Party Movement", to the provocative responses to it and to our forthcoming election battles?

Politics is a fascinating arena - very difficult to stay in the middle and view it dispassionately.

*Harper Collins Publishers

Editor's Note: Dr. Elizabeth Wilson has been a practicing dentist in Richmond since 2001. 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.

When Should You Call Your Med-Mal Carrier's Risk Management Team?

By: Kathleen M. Roman -

Dr. Michael has just had an unpleasant telephone conversation with a former patient. Originally, the patient had expressed satisfaction with the results of her treatment. But her account is now six months overdue and she still owes a substantial amount of money. Dr. Michael's billing team is pressing the patient to honor the payment schedule she signed and suddenly she's begun to claim that the results are "horrible" and Dr. Michael should write off the remainder of her bill. The conversation ended with the patient's comment that she hopes the matter can be resolved "without my having to contact an attorney."

Dr. Michael understands the threat but isn't at all certain about how to respond. Should he tell the patient he'll talk with his lawyer -- with his malpractice carrier? Should he tell her he'd like to review her file and get back to her? Should he tell her, "Fine! See you in court!"? Should he ignore her demand and hope she'll just go away?

The fact is that Dr. Michael doesn't really know what to do since he's a pleasant man and a good dentist – and he really doesn't like to get involved in conflict. Many of his patients have been with him for years and speak highly of him and his staff. He's had very little experience dealing with unreasonable complaints. And, because he has a clean slate when it comes to lawsuits or dental board complaints, he's afraid that if he calls his malpractice insurer, his rates will be raised or his insurance will be cancelled.

As is often the case when we feel rushed to make a decision or take action, this would be a good time for Dr. Michael to step back and give himself some time to think. He might reply to the patient that he'd like to reexamine her file and that he'll be glad to get back to her within a specific period. This time frame may vary from maybe a couple of days, to about a week. The specific situation will usually dictate how aggressive the doctor should be about setting a follow-up date. Once this information has been communicated to the patient, he should promptly call the risk management department of his malpractice insurance company. Here are several reasons why:

1. Most carriers provide risk management consulting to their insureds; it's generally considered a part of the insurance service and is usually available to the doctor at no additional charge. There's a win-win result for both the dentist and the insurance company when a patient's complaint can be prevented from turning into a lawsuit. For the doctor, it's much less stressful to work with an expert risk manager, someone who deals with this kind of situation on a daily basis, and who knows the ins and outs of this type of interaction. In addition, the insurer can typically reduce expenses by preventing a lawsuit, as compared to defending one.

2. Dr. Michael might inadvertently make the situation worse if he tries to handle it on his own. His verbal responses to the patient, or his documentation of the discussion with the patient, might muddy the waters. What if, for example, he promised the patient that he'd "take care" of the situation? From his perspective, he'd meant that he'd look into the matter but the patient might opportunistically interpret this statement to mean that he'll discount her bill, write off the balance due, or possibly even refund her partial payment.

3. Even when the quality of the dental work is perfectly sound, many dentists are so afraid of litigation that they bend over backwards to accommodate demanding patients. Lacking experience in these matters, the doctor may not have the ability to thoroughly evaluate the individual's motivation. Through listening to the doctor's story and asking questions, the risk manager may be able to uncover details the doctor may not have considered – and to help develop a response strategy. Too often, the doctor is ready to fling money at the patient in order to close the matter, without thinking through all of the ramifications of such a plan. A savvy risk manager, however, may look at the demand with a dispassionate focus – and the resulting response is likely to be more favorable to the doctor.

4. Knowing "when to fold 'em" is another benefit to the doctor who has a risk manager helping to manage this type of demand. The risk manager may ask the doctor questions about the patient's history with the practice, the nature of the treatment plan, whether or not the patient had been cooperative and compliant at some point or whether the relationship had been dysfunctional right from the start. The risk manager may ask about documentation in the patient's record of information such as diagnostic discussions, treatment options, patient education, informed consent, and patient compliance. The risk manager isn't thinking only about the clinical integrity of the record but also evaluating its potential as courtroom evidence. In Dr. Michael's case, for example, his risk manager will want to know if the patient's record includes any statements about her earlier satisfaction with the results of the dental treatment. An astute defense attorney will be quick to point out to a jury that the patient had been pleased with the results of Dr. Michael's work at the time it was completed. "Isn't it odd," the attorney will inquire, "that Ms. Patient was perfectly satisfied – until she was asked to pay her bill?"

If the documentation is sound, the doctor may have greater leeway in forestalling the patient's demands. If, on the other hand, key elements of the record are missing, inadequate, or inaccurate, the risk manager may be able to help the doctor negotiate a reasonable resolution for the smallest possible outlay – and obtain a signed release from the patient acknowledging that the matter has been satisfactorily resolved.

In one recent example, a dentist attempted to placate a money-seeking patient by offering her a cash settlement. She accepted and promptly cashed his check. Then she sent him a letter demanding more money because she claimed to have lost additional days of work subsequent to the settlement. At this point, he saw the light and called his risk manager.

By this time, there was little the risk manager could do except help the doctor offer a small additional sum – and require a signed release.

Rather than agree to this, however, the patient promptly filed a complaint with the state dental board.

This battle might have been prevented had the doctor called his risk manager after the patient's first demand. A well-worded reply at that time might have weakened the patient's resolve. Alternatively, a cash settlement, accompanied by a signed release-from-liability statement, would have prevented any further finagling by the patient.

5. Sometimes doctors report that they've been reluctant to contact their carrier's risk management team out of fear that the issue at hand would lead to an automatic premium increase or non-renewal. Obviously, this article cannot attempt to explain every insurer's philosophy on this matter but a rigid stance is generally not in either party's best interests.

Insurers understand that delay in responding to a complaint increases the likelihood that it may become a lawsuit. From this perspective, it is clearly to the advantage of both doctor and insurer to collaborate in a response to the patient's demands.

Further, risk managers have access to the technical language that will document a closed dispute in a way that can foil a patient's attempt to reopen the matter. Risk managers are more likely than the practicing dentist to be aware of insurance department mandates, state board requirements, and peer review processes. They can steer the doctor through legalistic language and obscure regulations. They can help the doctor strategize responses to patients' demands and they can help the doctors with documentation and written communications. A good risk manager should know when to get an attorney involved in a dispute and will help the doctor access good legal representation via the insurer's claims initiation processes.

6. Peace of mind is perhaps the most compelling reason why Dr. Michael should call his risk manager. Often, doctors will end a conversation with their risk manager by saying, "Oh, thank you for your help! I am so glad I called you. I feel so much better now that I've had a chance to talk with you." If for no other reason than it helps to know that an expert is on the doctor's side, it is a sound idea to make the call. Rule of Thumb: If the doctor is worried about something that's going on in his or her practice that is related to patient safety and/or satisfaction, then it's probably better to call the insurer's risk manager than to lie in bed at night worrying.

Kathleen M. Roman is Risk Management Education Leader for The Medical Protective Company. She can be reached at kathleen.roman@medpro.com

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- Dr. Patick Sammon – *Prescription Drug Abuse and Meth Mouth*
- Dr. Kelly Jones – *Pharmacotherapy Review for Dentists*
- Ms. Stacy McCauley – *Practical Information on Teen Health Issues & Customized Care for Healthy Patients and a Healthy Practice*
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SCDA

South Carolina Dental Association
120 Stonemark Lane
Columbia SC 29210
803.750.2277

Dean Ron Hunt Moves On

By: Martha Bushong,
Director of Communications and Public Relations, VCU School of Dentistry

Virginia Commonwealth University and the School of Dentistry bid Dr. Ron Hunt farewell at a reception held in his honor on Friday, February 12.

In his remarks during the gathering, Dr. Michael Rao, president of VCU said, "We are here to celebrate 12 years of tremendous success. This beautiful facility and other accomplishments leave a lasting legacy. It is a privilege and a pleasure to say thank you to Ron."

Dr. Hunt will leave VCU to take on new challenges at Midwestern University's School of Dentistry in Glendale, Arizona. The newly established school is part of a health sciences only campus in the suburbs of Phoenix.

"My 12 years at VCU have been the most rewarding of my life," said Dean Hunt, "but I found the challenge of building something brand new irresistible. Midwestern University focuses entirely on educating primary care practitioners – for dentistry that means general dentists."

While VCU conducts a national search for a new dean, Dr. David C. Sarrett, associate vice-president for health sciences will serve as the school's interim dean. Dr. Sarrett knows the school well as a former department chair, academic dean and current president of the faculty practice association.

Standing, L-R: Drs. John Gunsolley, David Sarrett, Michael Rao, Sheldon Retchin. Seated: Dr. Ronald Hunt.

"I am pleased to be able to help the school in this role," said Dr. Sarrett. "I look forward to getting reacquainted and making the transition a positive one for the school."

Amalgam Separators Make School of Dentistry Greener

By: Martha Bushong - Director of Communications and Public Relations, VCU School of Dentistry

Reduce, reuse, recycle. These familiar words take on new meaning when placed in the context of the VCU School of Dentistry. Even before the university's president, Dr. Michael Rao, kicked off the Year of the Environment in fall 2009, the dental school had implemented some important earth-friendly practices.

Among many actions to make the school greener, one major decision was the installation of amalgam separators for the clinics in each of the school's three buildings.

"No one required their installation." said Dean Ron Hunt. "As we built the Perkinson Building, however, we thought if we could lessen any environmental impact by installing separators in all three of our buildings, it was the responsible thing to do."

Now, three separators – one in each building -- collect amalgam waste from the school's clinics. The separators the school needed are much larger that what a dental office would require. Their cost was over $39,000, but students and faculty remove or place many times more amalgam restorations every day than dentists in their private offices.

According to the American Dental Association, eight states and some cities already require dentists to install amalgam separators. This mandate appears to be a national trend as local wastewater treatment plants seek to reduce the concentration of mercury in effluent from their plants.

Currently Virginia does not mandate the use of the amalgam separators, but some of the commonwealth's dentists are on board, and like the school, have installed them in their offices.

"All the separators sold now are over 99 percent efficient." said Dr. Craig Dietrich of Martinsville and member of the Virginia Dental Association (VDA) Board of Directors. "The cost is really minimal; I paid around $700 for mine and installed it myself. All things considered, it is the right thing to do. The VDA and the ADA have environmental guidelines in their 'Best Management Practices for Amalgam Waste'," Dietrich continued, "So we are just doing what our association already recommends."

The largest of the three newly installed amalgam separators resides on the ground floor of the Perkinson Building. This unit collects amalgam waste from the Douglas and Graduate Periodontic Clinics.

Last year the VDA Board of Directors, recognizing its political importance, proposed a resolution calling for an amalgam separator mandate that would be crafted by dentists, rather than state regulators. But the VDA House of Delegates did not support it.

"The separators are relatively inexpensive and fairly easy to maintain," concurred Dr. Terry Dickinson, VDA executive director. "Eventually, if we don't do it, the state will require it. I am pleased Dean Hunt and the dental school took the lead and implemented this best practice."

Non-Patient Based Licensure Coming to a State Near You?

By: Richard Carlile, VCU School of Dentistry, D-2011

When you think of Minnesota you may think of snow, people with funny accents, or even Al Franken. On June 26, 2009 Minnesota also became known as the first state in the Union to institute a non-patient based licensure exam.

The Minnesota Board of Dentistry has approved using the National Dental Examining Board of Canada's two-part exam as a means for dental students to obtain a license in Minnesota. This two-part exam consists of a written portion and a non-patient based Objective Structured Clinical Examination (OSCE). Along with passing the exam, students must graduate from a school accredited by the Council on Dental Accreditation (CODA), pass Part I and II of the National Boards, and take a Minnesota jurisprudence examination.[1]

Dental students around the country who are actively engaged in the American Student Dental Association (ASDA) are very excited about the new developments. The exam aligns itself fairly well with ASDA's L1 policy, which calls for a non-patient based licensure exam.[2]

Licensure boards have officially begun at the VCU School of Dentistry, and at dental schools across the nation. As students begin to get frustrated over finding the ideal Class II or III lesion they may want to ask themselves- "Should I move to Minnesota?"

1 http://www.dentistry.umn.edu/news/CanadianLicensureExam/home.html

2 http://www.asdanet.org/_AboutPage.aspx?id=1568#L-1

A Smile Restored

Notes from the VCU School of Dentistry

By: Joseph L. Rodriguez, Class of 2011

Midway through the first semester of my third year of dental school I was assigned "Susan", a prospective patient referred by Dr. Reed Boyd, who practices in Petersburg. I called and asked if she would come in for an appointment, and she replied, "I'm not sure if you can do what I need done." Susan had little confidence in coming to the dental school, but after much persuasion, she decided to schedule an oral evaluation to determine her treatment needs and to explore the treatment options available to her at the school.

Susan came in for the initial appointment and Dr. Cleckner, an adjunct faculty member, oversaw the treatment planning session. After much discussion, Susan decided she would like to have porcelain veneers done on her maxillary anterior teeth, and premolars #5 and #12. The treatment plan was then presented to and approved by Dr. Janus, a prosthodontist and full-time faculty member. Although this would be my first veneer case, I was excited to put into practice what I had learned in Dr. Janus's crown and bridge class. I also gained confidence knowing I would be under the guidance of Dr. Chin, Dr. Baechle and Dr. Cleckner, with whom I had worked most closely.

At the second appointment extensive pre-operative photos, a facebow, and preliminary impressions for two sets of diagnostic casts were taken, poured in stone and mounted on a semi-adjustable Hanau® articulator. I took on the task of waxing up teeth #5-12, and performing mock enameloplasty on the mandibular anterior teeth to improve esthetics. A custom tray was fabricated for the final impression and an impression with polyvinylsiloxane was made as the template for temporaries.

When we showed Susan the wax-up at the following appointment, she was thrilled and was eager to proceed with the proposed treatment. Prior to veneer preparation, shade selection was done using the Vitapan® classic shade guide and shade A2 was selected. Several of her anterior teeth had failing composite restorations, which needed replacement. After the teeth were restored, the veneer preparations were completed, retraction cord was placed and the final impression taken. The teeth were temporized with veneers fabricated with Integrity®. Susan was then given the chance to view and critique the temporary veneers so that desired changes could be made. An impression of the temporaries was taken. The pindexed master cast was trimmed and the margins were marked. After faculty approval, the completed case including pre-op photos, diagnostic cast, wax-ups, mounted casts, casts of the temporaries and master impressions were sent to Drake Dental Laboratory. Dr. Larry Holt, the clinical director for Drake Lab, personally supervised the production of the veneers. He also took excellent photos during the fabrication process. The veneers were delivered to the school sealed and packaged, etched on the inside, and ready to be placed. On delivery day, Dr. Chin, a full-time faculty member, guided me through the cementation process. After achieving local anesthesia, cord was placed and the teeth were isolated. Try-in of the veneers was accomplished in pairs with try-in paste, and they had an excellent fit. Etching, silanating, and bonding were accomplished and the veneers were cemented with NX3® Third Generation resin cement. Susan was very pleased with the result and was ready to show off her brand new smile to family and friends, and tell them what the dental school had to offer.

Preoperative

Temporary Veneers

Permanent Veneers

A happy patient!

I am grateful to Dr. Boyd for referring Susan and making possible this rewarding experience in my dental education. The treatment would not have been possible without the excellent communication we had with Drake Dental Laboratory. Witnessing Susan's transformation from being an apprehensive and anxious patient to being extremely confident and excited about getting her dental treatment done in the VCU dental school setting has made this journey all the more meaningful.

Awards & Recognition

Dr. Roger Wood, a pediatric dentist in Midlothian and President of the Virginia Dental Services Corporation, received the 2010 First Humanitarian Award for physicians. Given by Chippenham-Johnston Willis (CJW) Medical Center, the award recognizes a doctor "who demonstrates remarkable concern for the welfare and happiness of patients, has performed extraordinary acts of kindness, shows a level of commitment to community service...and whose contributions may be overshadowed by (his) modesty and humility."

In Memory of Julie Kent (Pat) Watkins

Julie Kent (Pat) Watkins, 88 passed away January 27, 2010, in Virginia Beach, VA following a long battle with Alzheimer's disease. Pat served for 24 years as Executive Director of the Virginia Dental Association before retiring in 1994. Her retirement banquet featured multiple letters of thanks from Virginia Congress members, former Virginia Governors, a U.S. Sentor, and featured a U.S. Congressman as one of the evening's speakers. A memorial service was held on February 6, 2010 followed by internment at Blue Ridge Memorial Cemetery in Lenoir. Memorial donations can be made to the Alzheimer's Association or charity of your choice.

VDA

Virginia Dental Association

Governance Meeting

September 24-26, 2010

Roanoke, VA

The 2010 Virginia Dental Associations Governance Meeting will be held September 24-26th. We have endeavored to give you value for your time. In addition to doing the business of the Association with the House of Delegates and Reference Committee meetings, we will have Dr. Ron Tankersley, ADA President, speak during the Annual Business Meeting Saturday afternoon. We will also have a DR update from Dr. Richard Taliaferro, DR Committee Chair, at the Business Meeting opening session Friday afternoon.

The fellowship opportunities include the very popular component receptions, the business meeting and the well received awards banquet. These opportunities make the process a lot more collegial as they allow us to discuss items of interest casually and they allow us to get to know others from around the state much better. Long term friendships have emerged from these gatherings.

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 this year 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 the 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

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HOTEL RESERVATION INFORMATION

THE HOTEL ROANOKE & CONFERENCE CENTER
ROANOKE, VA

ROOMS ARE AVAILABLE UNDER THE VDA ROOM BLOCK FOR THE NIGHTS OF SEPTEMBER 23rd – 25th

ROOM RATE $145.00
(Price does not reflect the local room tax.)

RESERVATIONS MUST BE MADE BY September 3, 2010 TO RECEIVE BLOCK RATE

CALL: 540-985-5900 or 866-594-4722
(Be Sure To Ask For The VDA Governance Conference Room Block)

ONLINE:
Hotel Reservation Link Listed In Governance Meeting Information on the VDA Website

2010 VDA GOVERNANCE MEETING SCHEDULE

Friday, September 24th

7:30am - 2:00pm	Board of Directors Meeting
2:15pm - 3:00pm	HOD Registration
3:00pm - 4:30pm	Business Meeting Opening Session House of Delegates Opening Session
2:00pm - 6:00pm	Election of Officers
4:45pm	16th District Delegation
6:30pm	Component Receptions

Saturday, September 25th

7:30am - 8:30am	Breakfast
7:30am - 8:30am	Fellows Breakfast
8:00am - 12:00pm	Election of Officers
8:30am - 10:00am	Reference Committee 1000
10:15am - 12:00pm	Reference Committee 2000
10:00am - 12:00pm	VDSC
12:00pm - 1:00pm	Lunch
1:30pm - 3:00pm	Annual Business Meeting
3:00pm	Constitution & Bylaws Committee
6:00pm	Reception
6:30pm	Awards Banquet

Sunday, September 26th

7:00am - 8:00am	Breakfast
7:30am - 8:30am	Component Caucuses
8:15am - 9:00am	House of Delegates Registration
9:00am - 11:00am	House of Delegates
11:15am - 12:30pm	Board of Directors Meeting

VDA AWARDS BANQUET

When: Saturday, September 25, 2010
6:00PM Reception 6:30PM Dinner

Where: The Hotel Roanoke & Conference Center
110 Shenandoah Ave.
Roanoke, VA 24016

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

TICKET SALES DEADLINE: SEPTEMBER 10, 2010 – NO ONSITE SALES

Name: _____ Number attending: _____

Amount enclosed: _____

Payment: Check payable to VDA

Credit Card # _____ Expiration Date: _____

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Please mail or fax to: Virginia Dental Association, 7525 Staples Mill Rd., Richmond, VA 23228, Fax: 804-261-1660

Awards Banquet

CAN'T MAKE IT TO THE GOVERNANCE MEETING? VDA MEMBER VOTING OPTIONS

There are two methods of absentee voting available:

1. Written Absentee Ballot:
   - Absentee ballots may be requested from the VDA Central office beginning 30 days prior to the election (August 25th). 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 22nd) in the envelopes provided.

2. Online voting:
   - A secure Member Voting Module will be available on the VDA website (www.vadental.org) beginning August 25th.
   - 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 25, 2010.

In person voting at the Governance Meeting will also be done online on secure computers provided by the VDA.

It is impossible 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 1:30pm Saturday, September 25, 2010.

VDA FELLOWS BREAKFAST

Fellows of the Virginia Dental Association are Invited to Attend the 2010 Annual Fellows Breakfast

Date: Saturday, September 25, 2010
When: 7:30am – 8:30am
Where: The Roanoke Hotel
110 Shenandoah Ave.
Roanoke, Virginia 24016
Cost: $18.00

TO ATTEND PLEASE COMPLETE THE FOLLOWING AND MAIL OR FAX TO THE VDA CENTRAL OFFICE BY SEPTEMBER 25, 2010 NO ONSITE TICKET SALES

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Card Billing Address: _____
Please mail or fax to: Virginia Dental Association, 7525 Staples Mill Rd., Richmond, VA 23228, Fax: 804-261-1660

Fellows Breakfast

2010 VDA Elected Leadership Candidates

HELLO
my name is

Roger E. Wood, DDS
Candidate for the Office of:
President-Elect

I am announcing my candidacy and requesting your vote for the position of VDA President-Elect.

I have been involved in organized dentistry all of my professional career. I began as the local chair of what was then Children's Dental Health Month. Since that time, I have been pleased and honored to serve in leadership positions at all levels of organized dentistry. I have served as local committee chair on several committees, as president of our component, as VDA delegate, as an ADA alternate delegate, as chair of the ADA Council on Dental Education and Licensure, and as President of the Virginia Board of Dentistry.

Having the honor of the chair of the ADA Council and the Presidency of the Board of Dentistry taught me how important it was for VDA members and their leaders to be aware of legislative actions that affect our dental practices on a daily basis. I was extremely proud of the members of the dental profession who responded so well to the most recent issues during the present legislative session.

Access to care is also a passion of mine. I was a member of the VDA Task Force responsible for developing the Mission of Mercy (MOM) project. This program celebrated its 10th Anniversary in 2009. I am a member of the Donated Dental Services and have been the local chair of Give Kids A Smile for the past eight years. During that time we have provided preventive care and follow-up dental care (including comprehensive dental treatment under general anesthesia in a hospital setting) to children whose parents are unable to afford care for their family.

I will be a strong advocate for the dental profession and feel that my history of service will help me represent and serve all members of the profession. I ask for your vote and your support as President-Elect, and I take that responsibility very seriously. Thank you.

11601 Robious Road, Midlothian, Virginia 23113
(804) 794-3498
Component:4

Curricula Vitae (CVs) for all candidates can be viewed online at www.vadental.org

HELLO
my name is

Richard D. Barnes
Candidate for the Office of:
ADA Delegate

I feel that with my experience as a teacher at MCV, an active practitioner in the field and my service as an officer for several dental associations, that I will be able to face the challenges associated with being a Delegate.

I have been actively working with a Dental Benefits Committee to address our ongoing trials and tribulations in dealing with insurance companies; particularly with the processing and denial of dental claims. We are also working to open avenues towards providing adequate dental benefits for people who have previously had no access to dental care. This process is something that will need constant monitoring on the local, state, and national levels.

I look forward to working with the Dental Benefits Committee and other areas that impact dentistry today. I have committed myself to the time and energy needed to address these issues. I also remain committed to the Virginia Dental Association and will work hard to complete tasks at hand. It would be my honor to serve the ADA as a delegate from Virginia.

2240 Coliseum Drive Suite C, Hampton, VA 23666
(757)-826-1121
Component 2

HELLO
my name is

Ralph L Howell, Jr., DDS
Candidate for the Office of:
ADA Delegate

I wish to thank you, the members of the Virginia Dental Association, for giving me such a wonderful opportunity to serve the profession as your President for the 2008-2009 year. It has been a pleasure to serve the Association and the ADA as an Alternate Delegate these past six years, and I seek your support to continue my service as an ADA Delegate. I feel that there are many issues that we as a profession face on a daily basis and we need leaders who will represent your wishes and our interests on a national level. Having served as a member of the Budget, Finance, and Administrative Matters Reference Committee and currently serving as a member of the ADA CERP Committee, I feel my experience will be useful in making me an effective Delegate to the American Dental Association and I humbly ask for your support.

102 Western Ave, Suffolk, VA 23434
757-539-7695
Component: 1

HELLO
my name is

Dr. Bruce Hutchison
Candidate for the Office of:
Alternate 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 affective representative for Virginia dentists. It has been such a pleasure representing you these year and I hope I can count on your vote to continue my service to the VDA and ADA.

14245-P Centreville Square
Centreville, VA 20121
703-830-9110
Component 8

HELLO
my name is

No photo available

Dr. David Anderson
Candidate for the Office of:
Alternate ADA Delegate

Respectfully I ask you to return me to the position of ADA alternate delegate. Over the past two years I have tried my level best to represent Virginia forcefully at the ADA house. Speaking both on the floor and in reference committees, putting Virginia's ideas before the rest of the districts has been a distinct honor and privilege. And may I say, it's been a heck of a lot of fun. To continue to represent you would be a joy and it would make my work with the VDA far more fulfilling.

5288 Dawes Ave
Alexandria, VA 22311
703-671-6060
Component 8

HELLO
my name is

Edward J. Weisberg, DDS
Candidate for the Office of:
ADA Delegate

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

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

801 W. Little Creek Road, Ste 103,
Norfolk, VA 23505
757-440-0044
Component: 1

HELLO
my name is

Alfred J. Certosimo, DMD
Candidate for the Office of:
Alternate ADA Delegate

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

VCU School of Dentistry,
PO Box 980566
Richmond, VA 23298
804-828-2977
Component: 4

Michael J. Link, DDS
Candidate for the Office of:
Alternate ADA Delegate

First, let me say that it has been a privilege and honor to represent you at the ADA over the past four years. I would like to ask for your continuing support as I seek re-election to the position of ADA Alternate Delegate.

Dentistry today faces many new trials and tribulations. Some of today's major issues are Healthcare, DHATS, ethics, the hygiene mid-level provider, and the patient's access to dental care. In order to have meaningful solutions to our problems, we need to "think outside the box". As we have seen over the past few months, Foundations, Representatives from Congress and some state Legislators are trying to come up with their own solutions for our issues. By coming up with our own innovative ideas, we as a dental community can provide a unified voice to address these problems. The welfare of our profession is best served and protected when we join together to produce workable solutions. Through all of the upcoming debates we must keep the Dentist in charge of the Dental team.

Our Virginia Delegation has provided strong leadership over the past years. The election of Dr. Ron Tankersley's as our ADA President is one of our proudest moments. I feel that my work ethic and past experience on the Virginia Delegation and on the Virginia Board of Dentistry have provided a strong foundation for my continued service on the National level.

11007 Warwick Blvd
Newport News, VA 23601
757-596-7000
Component 2

Dr. Elizabeth Reynolds
Candidate for the Office of:
Alternate ADA Delegate

I have had the distinct pleasure of representing the VDA as an Alternate Delegate to the ADA for the past six years, and I would be honored to be chosen to do so again. My three terms have been during exciting times for organized dentistry; we are fighting to maintain our practice independence while doing everything possible to ensure that we attend to the dental needs of the underserved. We continue to put ethics at the top of our professional commitments. We continue to make difficult decisions that we feel are in the best interest of the dental profession. We have been able to experience political success statewide with the recent passage of the two bills preventing the insurance companies from dictating fees on noncovered services and we hope to have the same success nationally with repeal of the McCarran-Fergusson Act exemption for health care companies. This type of member involvement is what makes the ADA so effective and important to our profession. We do make a difference! I have truly enjoyed my terms as an ADA Alternate Delegate, and I hope you will offer me the opportunity to continue my service.

6901 Patterson Ave
Richmond, VA 23226
804-288-5324
Component 4

Component News

Component 5
Dr. Gene Ayers - Editor

The snow is falling as this brief entry is composed. However, this journal should reach you when a burgeoning, beautiful springtime fed by the snowmelt arrives throughout the Commonwealth. Get out there and admire the daffodils!

As spring settles firmly into place, join us in the Piedmont at the excellent Danville Advanced Learning Institute for our component meeting on Friday,April 30, featuring Dr. Ralph Nicassio presenting " Advances in Orthodontics for General Dentistry". For information or last minute registration call Executive Director Ann Huffman at 276-673-6700.

Piedmont President Chris Payne announced the opening in February of a new volunteer manned dental clinic in association with the Danville Community Dental Hygiene School. Another response by dentistry in the Commonwealth to access to care issues. At the same time final plans are underway for the Roanoke M.O.M. project March 26 and 27. The local arrangements and support for this recurring clinic are top notch. Come along and enjoy service for others.

Component 8
Dr. Chris Spagna - Editor

Happy belated New Year from component 8! As the first few months of 2010 have come and gone, much has gone on in Northern Virginia. In December our legislative brunch was well attended, as much conversation took place regarding the mandated fees bill. Later in January, we were able to follow up with a nice showing in Richmond for the "Day on the Hill". Thanks goes out to all the dentists (and especially those from Northern Virginia) who wrote their legislators regarding this very important subject.

Due to the generosity and support of our members, over $21,000 was raised during the 2009 Annual Holiday Greeting Card campaign. Monies raised will enable the Northern Virginia Dental Clinic to continue assisting those who are most at need in our community. THANK YOU!

Inclement weather forced us to reschedule our February 5th Give Kids a Smile event to April 9th. We are looking forward to that as well as the upcoming Mission of Mercy project on March 12, 13. Both are sure to be a success!

The end to winter couldn't come any sooner here in Northern Virginia, as we are looking forward to spring more than ever before. Take a look at our website, nvds.org, for more information on the upcoming CE programs scheduled.

Welcome New Members!

February 2010

Northern Virginia Dental Society
Dr. Ibrahim Alhussain graduated from the University of Pennsylvania in 2003. He is currently practicing in Fairfax.

Dr. Navid Asgari graduated from Temple Dental School in 1996. He then continued to receive his General Practice Residency Certificate in 1997. Dr. Asgari is currently practicing in Springfield.

Dr. Charles Brown III graduated from the Medical College of Virginia in 1996. He then received his General Practice Residency Certificate from the University of Mississippi Medical Center in 1997. Dr. Brown is currently practicing in Alexandria.

Dr. Janice Dionisio-Ma graduated from Temple Dental School in 2007 and is currently practicing in Alexandria.

Dr. Josemari Imao is currently practicing in Lake Ridge.

Dr. Anthony Moawad graduated from Boston University in 2008 and is currently practicing in McLean.

Dr. Hamdi Mohamed graduated from the Howard University College of Dentistry in 2008. She then completed her General Practice Residency in 2009. Dr. Mohamed is currently located in Alexandria.

Dr. Jennifer Kim graduated from the University of Florida Dental College in 1999. She is currently practicing in Chantilly.

Dr. Mignonette Lobo graduated from Tufts University in 2000. She is currently practicing in Falls Church.

Dr. Howard Miller graduated from Howard University in 1979. He then continued to receive his Masters of Business Administration in 2003. Dr. Miller is currently working with the Virginia Department of Health in Fredericksburg.

Dr. James Moshier graduated from the Tufts School of Dental Medicine in 2009. He is currently practicing in an Associateship in Centreville.

Dr. Vladyslav Ovcharenko graduated from the NYU College of Dentistry in 2009. He is currently practicing in Centreville.

Dr. Geetika Tahim graduated from the NYU College of Dentistry in 2001. She is currently practicing in Herndon.

Dr. Ximin Yang graduated from the Shanghai Dental School in 1989. After a three-year residency, he then received his certificate in Periodontics from the New Jersey Dental School in 2009. Dr. Yang is currently practicing in an Associateship with Neibauer Dental Care in Fredericksburg.

Peninsula Dental Society
Dr. Tammara Bell graduated from the University of Tennessee. She is currently practicing with Kool Smiles Corporation in Yorktown.

Dr. Joelle Hairston graduated from the University of Michigan in 1998 and continued to receive her General Practice Residency Certificate from Wake Forest University Baptist Medical Center in 2000. Dr. Hairston is currently located in Williamsburg.

Dr. Jeffrey Raphael graduated from the University of Maryland School of Dental Medicine in 1974. He then continued on to receive his certificates in General Practice Residency and Prosthodontics in 1976 and 1983, respectively. Dr. Raphael is currently practicing in West Point.

Piedmont Dental Society
Dr. Misty Lenk graduated from the VCU in 2002. She then continued to receive her certificate in Orthodontics and Dentofacial Orthopedics from the University of Florida in Gainesville and Ohio State University in 2006. Dr. Lenk is currently practicing in Daleville.

Dr. Young Chul Park graduated from Loma Linda University in 2009. He is currently practicing with Small Smiles Dental Clinic in Roanoke.

Richmond Dental Society
Dr. Andrew Estill graduated from Virginia Commonwealth University in 2008. He then continued to receive his GPR from the University of Alabama – Birmingham. Dr. Estill is currently practicing in Midlothian.

Dr. Elizabeth Miller graduated from Virginia Commonwealth University in 2007. She then received her Certificate in Pediatric Dentistry from the University of Michigan in 2009. Dr. Miller is currently practicing in Richmond with the Atkins, Maestrello and Associates Pediatric Dentistry.

Dr. Andrea Mitman graduated from MCV in 1988 and is currently practicing in Aylett.

Dr. Alexis Oristian graduated from Virginia Commonwealth University in 2007. She is currently practicing with W.B. Perkinson and Associates in Midlothian.

Dr. Shekha Patel graduated from the University of Florida in 2008. She is currently practicing in Richmond.

Shenandoah Valley Dental Association
Dr. Rusty Davis graduated from VCU in 2007. He is currently practicing in Waynesboro.

Dr. Richard Kapitan graduated from Ohio State University in 2002. He then completed his specialization in oral and maxillofacial surgery in 2006. Dr. Kapitan is currently practicing with Blue Ridge Oral Surgery in Fishersville.

Dr. Chanda Ashley graduated from VCU in 2005. She then continued on to Univeristy of Connecticut, completing her specialization in orthodontics and dentofacial orthopedics in 2009. Dr. Ashley is currently practicing in Staunton.

Southside Dental Society
Dr. Timothy Marshall graduated from VCU in 2008. He is currently practicing with Kool Smiles in Colonial Heights.

Dr. Tina Kao-Reasoner graduated from the University of Iowa in 2009 and is currently practicing in Boydton.

Dr. Juan Rojas graduated from Virginia Commonwealth University in 2008 and will complete his General Practice Residency in June, 2010.

Tidewater Dental Association
Dr. Pye Kyu graduated from Virginia Commonwealth University in 2006. He then continued to receive his AEGD Certificate in 2007 then his Endodontics Certificate, both from the VCU School of Dentistry. Dr. Kyu is currently practicing with Hampton Roads Endodontics in Chesapeake.

Dr. David Trop graduated from the Medical College of Virginia in 1977 and is currently practicing in Norfolk.

In Memory Of...

Dr George Barnett	Tidewater Dental Association	Suffolk	December 28, 2009
Dr. James Boyd	Southside Dental Society	Virginia Beach	December 30, 2009
Dr. James O Hodgkin, III	Northern Virginia Dental Society	Warrenton	January 25, 2010
Dr. Arthur Siegel	Tidewater Dental Association	Norfolk	January 7, 2010
Dr. Robert F. Jackson	Southwest VA Dental Society	Salem	January 4, 2010

Board of Directors - Actions in Brief
January 14 - 16, 2010

I. Items considered (require action by the House of Delegates):

A. The following By-law change was considered:

1. Background: Since the Association now elects its officers by an online method and there is no geographic advantage to holding the Annual Meeting in a rotating fashion it is recommended that meetings of the Association be held in areas that will provide the best economic advantage to the Association. Also by direction of the 2009 House of Delegates, the Board of Directors is challenged with the possibility of recombining the Virginia Meeting and the Annual Meeting Therefore it is resolved the following changes to the Bylaws.

(Current) ARTICLE II
Meetings

Section 1. Annual Membership Meeting: The Annual Meeting shall be held each year as approved by the Board of Directors. The Annual Meeting shall rotate in the following order: Northern Virginia, Eastern Virginia, Central Virginia, and Western Virginia. It shall be the purpose of this Meeting to foster the ideals of the Association as set forth in ARTICLE II of the CONSTITUTION of this Association.

The Bylaws of the Association shall be amended by substitution of Article II- Meetings with the following:

ARTICLE II
Meetings

Section 1. Annual Membership Meeting: The Annual Meeting shall be held each year as approved by the Board of Directors. It shall be the purpose of this Meeting to foster the ideals of the Association as set forth in ARTICLE II of the CONSTITUTION of this Association.

The Board of Directors approved the above resolution with a recommendation the House of Delegates vote yes.

II. The following is submitted as information only:

A. The following items were approved:

1. Background: The Sonja Lauren Foundation was established to aid the working poor by filling the gap between Medicaid and insurance.

   Resolution: The VDA donate $2,500.00 to the Sonja Lauren Foundation.

2. Reaffirmation of the resolution adopted by the 2009 House of Delegates to initiate a legislative bill prohibiting insurance companies from setting fees on non-covered services as defined below:

   House of Delegates Action – September 13, 2009:

   Adopted: The VDA House of Delegates recommends the Board of Directors create legislative initiative that would oppose the insurance companies from binding fees for non-covered services. (Policy)

3. Background: Last year the Board approved a $1,000.00 appropriation to develop a history of the Virginia Dental Association. While we are working on the project, we have yet to use the money. The Council would like this $1,000.00 to remain for their use and remain a line item in the VDA budget.

   Resolution: The $1,000.00 appropriation for developing a history of the VDA will remain a line item in the budget.

4. Background: Members are asked to pay dues and VADPAC dues at the end of the year, possibly the worst time to write a large check. This may result in fewer members contributing to VADPAC or giving less than they might otherwise.

   Resolution: The VDA seek a method of installment payments and work out the details to make this possible as soon as possible.

5. Referral of the Mentorship Committee's request for $15,000.00 (budget for 2010) to VDA Services.

6. The VDA communicate with all Virginia dentists and legislators, by all means possible (i.e. mail, fax, e-mail and VDA website), about the legislation introduced to the Senate on the Mandated Fees Bill. The Non-covered Services Task Force shall be responsible for compiling all material.

   Budget Impact: $7,500.00

2010 Day on the Hill: Dentists and Dental Students Embark On a Long General Assembly Session

By Laura Givens

Delegate Chris Peace was the keynote speaker at the VDA Day on the Hill Breakfast.

It was dark and cold outside but more than 150 dentists and dental students generated plenty of heat on January 15 as the VDA's annual Day on the Hill got underway at Richmond's Omni Hotel. When these legislative stalwarts completed their General Assembly visits three hours later, the state's insurance industry was on notice: overreaching by dental insurers would not be tolerated!

Already steamed by the opening salvo of a statewide insurance industry advertising campaign, attendees used the remarks of this year's keynote speaker, Delegate Chris Peace (R-Mechanicsville), to stay focused during their Capitol Hill visits. Delegate Peace, with a significant background in advocacy and public policy, advised the assembled VDA team to proceed methodically as the battle with the insurance industry moved into high gear. Aware that dentists had been lobbying the association's mandated fees legislation for several weeks, Peace recommended that
" … facts, not emotion …" carry the profession's arguments on Capitol Hill.

VDA lobbyist Chuck Duvall followed Peace to the podium and laid out the association's legislative objective in stark terms: "Without this legislation," Duvall said, "the profession is faced with giving over to insurance companies decisions about patient care that rightly should be made by dentists in consultation with their patients."

Thanks to Messrs. Peace and Duvall, the annual Day on the Hill did more than send an enthusiastic cadre of dentists, dental students, and other members of the VCU dental community to the Capitol. January 15 also marked the real beginning of an almost unprecedented hands-on lobbying campaign to preserve the independence of the profession, a campaign that continues as this edition of the Journal goes to press.

From left: Dr. Ronnie Brown, Steven Lutz, Christopher Davenport, Dr. Cynthia Southern, Dr. Dana Chamberlain, Emily Kate Bowen, Dr. Gus Vlahos and Stephanie Vlahos (center) at the VDA Legislative breakfast. All are dentists and VCU dental students from southwest Virginia.

From Left: Dr. John Marino, Chuck Duvall, Dr. Alonzo Bell, Audrey Gamulo and Denny Gallagher gather at the VDA Legislative breakfast before heading to the General Assembly.

From Left: Dr. Nathan Houchins, Dr. Scott Miller, Dr. Cynthia Southern, Senator Phil Puckett, Dr. Ronnie Brown, Dr. Dana Chamberlain, Dr. Gus Vlahos, and Dr. Ron Jessup.

From left: Dr. Ronnie Brown, Dr. Gus Vlahos, Dr. Dana Chamberlain, Dr. Cynthia Southern, Dr. Ron Jessup, Senator William Wampler, Dr. Nathan Houchins, Dr. Scott Miller, Dr. Mike Abbott.

Delegate From Left: Alexandra Barton, Bud Phillips, Dr. Carole Pratt and Dr. Jim Revere.

You Gotta Put A Face On It! Dentists Rally to the Cause

By Chuck Duvall and Dennis Gallagher

What do the following have in common?

Aetna
AFL-CIO
Anthem
International Brotherhood of Teamsters (BMWE Division)
Americas Health Insurance Plans
Delta Dental of Virginia
NFIB – National Federation of Independent Businesses
Northrop Grumman Shipbuilding (Newport News)
VA Association of Counties
Virginia Auto Dealers Association
Virginia Bankers Association
Virginia Association of Health Plans
Virginia Association of Health Underwriters
Virginia Chamber of Commerce
Virginia Manufacturers Association
VA Municipal League
Virginia State Employees Association

They were opposed to the legislation introduced at the request of the Virginia Dental Association to stop insurance companies from using contracts to dictate fees for services for which they do not pay.

When we met with the VDA leadership in the fall to discuss this situation, we noted the association's need to "put a face on the issue" if we were to succeed in the legislature. By this, we meant that dentists needed to show legislators that, indeed, this issue was important to them. Dentists across the state would need to contact their legislators to stress that they needed their help.

Senator William Wampler (R-Bristol) introduced Senate Bill 622 and Delegate Lee Ware (R-Powhatan) carried identical House legislation, HB 1263. Delta Dental, United Concordia, Anthem, and the Virginia Association of Health Plans activated the support of the entities above to oppose both bills.

Dentists from across the Commonwealth responded in an historic fashion: literally hundreds of emails, phone calls and letters were written. Scores of dentists, staff members and faculty and dental students visited the General Assembly on a daily basis and contacted one-on-one every member of the legislature.

When hearings on the bills were held in the Senate and House, it was standing room only with supporters of our legislation packing the rooms.

Our arguments were simple and straightforward:

- Mandating fees for non-covered procedures is a new concept in dental insurance plans and a bad idea.
- Our legislation dealt with non-covered services only. The fee agreed to by a dentist for covered services remains in place even though the patient may exceed the maximum payment under the dental plan.
- These new contracts shift a dentist's costs to patients without dental insurance or to patients whose dental plans do not contain the provisions being advanced by Delta and its allies.
- If dental insurers believe that non-covered procedures are important, they should include them as part of a policy's covered services.

In spite of a series of full-page ads run in at least three of the state's major newspapers, in spite of a sophisticated Internet petition drive, in spite of the retention of some outstanding lobbyists for the opposition, the General Assembly agreed with the dental community and responded accordingly. Both bills passed with overwhelming support!

As we file this report to meet the Journal's early March deadline, both bills are on their way to Governor Bob McDonnell. Simultaneously, we are reaching out to VDA members statewide asking them to encourage the Governor to sign these important bills.

All of us who have had the privilege of working with you on this issue - Chuck Duvall, Denny Gallagher, Melanie Gerheart, Scott Johnson - thank you for your outstanding efforts and the dignified fashion in which you delivered your message to the General Assembly.

We also would be remiss if we did not thank: Laura Givens for her great work in making all of the intricate logistics involved in our campaign work effectively; Dr. Terry Dickinson for his usual steady hand on the rudder; Dr. Alonzo Bell for his leadership as President; Dr. Bruce Hutchison who headed our grassroots lobbying effort; and the literally hundreds of dentists, staff and dental students and faculty from the Dental School who participated in this effort.

Politics can be very complicated but in its simplest form, it is about involvement. Everyone who participated in our success demonstrated what involvement channeled in the right direction can produce.

Thank you.

Dentists, staff members, VCU dental students and other members of the dental community attended the House Commerce & Labor Committee meeting on February 2nd to show their support of HB1263.

Delegate Lee Ware presents HB1263 to the House Commerce & Labor Committee while attorney Scott Johnson prepares to explain the purpose and legal implications of the bill on behalf of the VDA.

VCU dental students Barrett Peters (left) and Audrey Gamulo (right) gather with VDA President Alonzo Bell outside the General Assembly Building following the House Commerce & Labor committee meeting on February 2nd.

Over 150 VDA dentists, staff members ,VCU dental students and other members of the dental community attended the Senate Commerce & Labor Committee meeting on February 1st to show their support of SB622.

Senator William Wampler presents SB622 to the Senate Commerce & Labor Committee

Dr. Alonzo Bell, VDA President, awaits the Senate Commerce & Labor committee meeting with a crowd of dental community supporters.

Special thanks to all those who took time to visit the General Assembly!

Dentist who visited the General Assembly
Mike Abbott
Anne Adams
David Anderson
Rebecca Angus
Charles Atkins
Gary Banaji
Chuck Barrett
Alonzo Bell
Bill Bennett
Scott Berman
Sanjay Bhagchandani
David Black
Paul Brinser
Ronnie Brown
Robert Candler
Sandra Catchings
Fred Certosimo
Dana Chamberlain
Maqsood Chaudhry
JoAnn Clark
John Coker
Greg Cole
Sharon Colvin
Tom Cooke
Ken Copeland, Sr.
Ken Copeland, Jr.
Mark Crabtree
Charlie Cuttino
Jeff Cyr and staff
Craig Dietrich
Vince Dougherty
Ron Downey
Ashley Epperly and staff
Mona Farrahi
Gisela Fashing
Kitt Finley-Parker
John Flowers
Steve Forte and staff
Catherine Oden Fulton
Sam Galstan
Charles Gaskins
Garland Gentry
Paul Gibberman
Avi Gibberman
Scott Gore
Mike Gorman
Shantala Gowda
Barry Griffin
Ed Griggs
Michael Grosso
Monroe Harris
Faryl Hart
Nelson Herring
Nathan Houchins
Ralph Howell
Herbert Hughes
Bruce Hutchison
Frank Iuorno
Ronald Jessup
Charles Jewett
Charles Johnson
Claire Kaugars and staff
Carolyn Kelly
Rod Klima
Jay Knight
John Knight
Greg Kontopanos
Lou Korpics
Mark Kowal
Trisha Krause
Jamie Krochmal
Lanny Levenson
Jeff Levin
Mike Link
Brock Livick
David Major
John Marino
Norman Marks
Benita Miller and staff
Mike Miller and staff
Scott Miller
Kevin Mistry
Andrea Mitman
Mike Morgan
Marci Morris
Christa Morris
Lawrence Muller
Edmund Mullins
Kirk Norbo
Paul Olenyn
VaCora Oliver-Rainey
Anthony Peluso
Carole Pratt
McKinley Price
Rick Quigg
Stephen Radcliffe
David Alan Reid
Jim Revere
Elizabeth Reynolds
Chris Richardson
Richard Roadcap
Rod Rogge
Neil Small
Emily Smith
Cynthia Southern
Melanie Spears
Henry
Daniel Stockburger
Ken Stoner and staff
Frank Straus
Rob Strauss
Rick Taliaferro
Don Trawick
Brad Trotter
Bill Viglione
Gus Vlahos
Gloria Ward
Sharone Ward
Edward Weisburg
Clay Weisburg
John Willhide
Roger Wood
Gretchen Zelazny

Other General Assembly Participants
Lee Braden
Martha Bushong
Jim Curtis
Jim Doyle
Carol Gammons
Cathy Griffanti
Karen Kraus
Susan Laundrey
Linda Moore
Robbie Sherman
Catherine Sill
Linda Simon
Kelly Williams
Graham Gardner Staff
Members
VDA staff members

VCU Dental Student and Resident Participants
Mina Abdolahi
Zach Aberth
Ashley Abesamis
Molly Adler
Matt Aldred
Kevin Allred
Allie Angert
Courtney Ashby
Chelsea Balderson
Tyler Ball
Elvi Barcoma
Rachel Barone
Alexandra Barton
Sanjay Bhagchandani
Poonum Bharal
Fawzia Bhavnagri
Kevin Bibona
Carlos Blackmon
James Bolton
Emily Kate Bowen
Lauren Bowersox
Jen Boyland
Cassidy Bray
Heather Brooks
Nabil Bushara
Richard Carlile
Meredith Cash
Maria Chang
David Chesser
Aileen Chyn
Jamie Clark
Steve Clawson
Mark Crocker
David Dalling
Christopher Davenport
Dustin Davis
Brooke Dellinger
Stephen DePasquale
Spencer Dixon
Jessica Dombrowski
Darren Dorfman
Andy Duncan
Sonny Duong
David Durham
Sean Eschenbach
Tayeeb Faruk
Casey Feiling
Nancy Ferretti
Brian Fife
Chad Flanagan
Graham Forbes
Erik Fox
Josh Furniss
Audrey Gamulo
Davis Gardner
Mike Gigliotti
Thomas Glazier
Scott Green
Kate Helfrich
Brian Herod
Rachel Hubbard
Justin Hughes
Andrew Hutchinson
David Jones
Sarah Kandrac
Natasha Kapoor
Emily Keeton
Kris Keeton
Ida Kondori
Jo Koontz
Lee Kreger
Jon Kremser
David Lai
Aaron Laird
Brent Lamm
Patrick Lawrence
Magarette Le
Greyson Leftwich
Bobby Lenoir
Quoc Lu
Steven Lutz
Megan Lutz
Jen Lysenko
Nick Maddux
Fatima Mashkoor
Elizabeth Matteson
Kelly Mayer
Brianne McGuinness
Amanda Meade
Gardner Meek
James Meek
Jodie Meredith-Smith
Mike Milburn
Joshua Miles
Clay Miller
Will Moore
Jeppy Moss
Ryan Murray
Arya Namboodiri
Liz Neal
Josh Nehring
France Neilson
Diane Nelson
Rosie Noordhoek
Justin Norbo
Lindsey North
Justin Paige
Nick Pappas
Cana Pasierb
Anisha Patel
Christian Peck
Matt Pelais
Barrett Peters
Mary Raulfs
Carter Reeves
John Reynolds
Collin Rice
Cameron Roberts
Latasha Sauls
Lauren Schiff
Jason Schoener
Leo Scholl
Geoff Schreiber
Kristen Schwartz
Richard Sedwick
Shima Shadman
Nate Sherman
Gail Silveira
Milan Simanek
Will Slack
Ryan Smagalski
Chapin Smith
David Stafford
Lydia Sumner
Carter Tate
Brian Thompson
Kelly Thompson
Jon Mark
Laura Tolusso
Paige Turner
Daniel Vacendak
Stephanie Vlahos
Victoria White
Kime Whitman
Andrew Wissink
Phillip Worthington
Jeff Yelle

WHAT IS VADPAC?

By: Bruce R. Hutchison, DDS - Chair VADPAC

VDA members support the VDA's participation in the political process through the VDA Political Action Committee, the bipartisan voice of Virginia dentists who care deeply about their patients and their profession.

VADPAC's sole purpose is to elect candidates who understand the importance of dentistry and are committed to the oral health of Virginians. VADPAC is a critical component of the VDA's political strategy in Richmond.

Like it or not, the political system affects how we practice dentistry in the Commonwealth. Dentists need to be heard by the legislators. Regardless of party affiliation or your views on the political system, dentists cannot afford to turn their backs and assume problems will go away. We all have to be players; we cannot assume others will carry the load. We need all Virginia dentists to contribute to our VADPAC to ensure future success.

Contributions by all Virginia dentists will help ensure our VADPAC remains strong and our voice is heard. Consider contributing the fee of one crown, one root canal, a few fillings, or even a couple prophys. This small investment by all will make a huge difference. Your voice will be heard load and strong.

It is your obligation to keep dentistry the honest and ethical profession it is. If not you, then who?

Use the form below to make your contribution today.

If you would like to join VADPAC or increase your previous contribution, please fill out the form below with your check or credit card information.

Contributions to VADPAC are divided between a state account, controlled by VDA members and a federal account for support of candidates for federal office, affiliated with the American Dental Association. Election laws require that the two funds be kept separate.

☐	**Membership**	**$99**	**(50 State, 49 Federal)**
☐	**Commonwealth Club**	**$284**	**(235 State, 49 Federal)**
☐	**Governor's Club**	**$684**	**(435 State, 249 Federal)**
☐	**Apollonia Club**	**$1,009**	**(760 State, 249 Federal)**
☐	**Capitol Club**	**$200**	**(200 Federal)**

Name _____**Component:**____

Address _____

Payment Type
☐ Check (*payable to VADPAC*)
☐ Credit Card ☐ Corp. ☐ Ind. ☐ VISA ☐ MasterCard
#_____
Exp_____

Signature_____

Contributions not deductible for tax purposes.

Please complete this form and mail or fax to:
Laura Givens
VADPAC
7525 Staples Mill Rd.
Richmond, VA 23228
FAX: 804-261-1660

If you would like to contribute by phone, please call Laura Givens at 804-261-1610.
Thank you for your contribution in support of VADPAC!

Classifieds

Job Opportunities

Tri-Cities, TN Dentist Opportunity! Established Bluff City, TN practice owner is ready to add a dentist to her staff. Willing to consider dentists with full time or part time interest. Ideal candidate will be comfortable providing denture and extraction services on a daily basis. On-site, fully staffed, lab devotes full time to serving this practice owner. Practice visit and working interview are available to interested candidates. Contact Brian Whitley for more information: 1-800-313-3863 ext. 2290 or brian.whitley@affordablecare.com

Part-time dentists needed to review provider offices in managed care network in the northern VA, DC, MD area. Current license, travel, good communication skills, minimum 10 years practice experience required. Send resume to HRS, 1926 Hayes St., Nashville, TN 37203 or call 615-321-0707.

INTERIM PROFESSIONAL SERVICE:
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DENTISTS HELPING DENTISTS SINCE 1984

Dentist to work 2-3 days per week at dental office in Amherst Co. Submit resume to ajones@jhcvirginia.org or mail to: Johnson Health Center, Attn: A. Jones, 320 Federal St., Lynchburg, VA 24504.

Practices For Sale/Lease

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

Kentucky Practice Ownership Opportunities Own a dental practice with NO personal financial investment. Affordable Care Inc. provides practice management services to nearly 150 affiliated dental practices in 35 states. Each practice is owned by an individual dentist and is focused on a niche market by providing Extraction Services as well as full and Partial Dentures (www.affordabledentures.com) . If you are seeking an extremely stable opportunity and wish to be a part of a well established network of dental practices with a long-standing history, you should talk with us.
We are currently seeking dentists for development of additional new affiliated practices in **Hazard, and Carrollton, Kentucky trade areas**. You take care of your patients; we will take care of the paperwork and more. We provide the funding so that you may have a competitive salary and a full comprehensive benefits package with health/life/malpractice insurance, and a 401(k) plan along with unlimited financial success. Apply online at www.affordablecare.com or call Brian Whitley at 1-800-313-3863, ext. 2290 brian.whitley@affordablecare.com

Miscellaneous

IN-OFFICE HEALTH AND SAFETY EDUCATION AND CONSULTATION
Experts with over 20 years of experience educate and certify dental office staff in American Heart Association-based Basic Life Support and First Aid for in-office medical emergencies. Consultation and educational services are also available to guide dental practices in complying with OSHA and CDC infection and hazard control regulations and guidelines. Contact *RESPOND* Consulting, 540.290.6911 or respondbls@aol.com. *We come to you* for all of your office safety and health maintenance needs.

Are you missing out?

Hermitage Wealth Management, Inc. offers ***Group Discount Programs*** for *Long-Term Care* and *Disability Insurance*. For eligibility, please contact:

J. Cory Hoffer, CFP®
(804) 270-7877
jhoffer@jhnetwork.com

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

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

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

Wanted to Purchase. If you have a quality general practice in Northern Virginia area (Fairfax), would like to exit and have a qualified transition specialist represent you, we have an interested buyer. Contact PPP 412-673-3144 – stanpoll@aol.com.

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

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