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APRIL, MAY & JUNE 2018

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HOW DO VIRGINIA DENTISTS BUILD THEIR NETWORK?

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A feature of the *Virginia Dental Journal*, "40 under 40" will introduce you to VDA members under forty years old in forty words or less.

DR. LAUREN REIS

I am a general dentist in Arlington, VA, where our office focuses on patient comfort and education. Our patients appreciate the "at-home" feel provided by our staff and updated dental office. We strive to treat our patients like family.

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American Association of Dental Editors & Journalists

PRESIDENT'S MESSAGE

Dr. Benita Miller

Happy Spring! Much like the stock market, there has been a flurry of activity at the VDA this winter and spring. Check out the newly released ADA Highlights for 2017. Always great to see what our ADA is doing for us! https://goo.gl/kLw5pX

Here are some highlights from the VDA:

By the time you read this article the Virginia General Assembly will have hopefully concluded a highly active session and passed the next biennial budget. Healthcare was a primary topic, and of the many bills we saw that either directly or indirectly impacted dentistry, our lobbyists were often able to influence positive outcomes. Thankfully a bill that would prohibit out of network healthcare providers from balance billing was not passed. VDA member dentists in practice, on faculty at VCU, in our General Assembly, and on the Board of Dentistry worked together to help craft legislation to curb the opioid epidemic in Virginia. You should also refer to the Board of Dentistry's website for the latest regulations for prescribing opioids. On a side note, I hope everyone will take the opportunity to hear Dr. Omar Abubaker's most compelling and informative presentation on opioid addiction, current concepts, and prescribing recommendations.

Under pressure from outside stakeholders and threat of lawsuit from ABDS (American Board of Dental Specialties), the Board of Dentistry presented a fast track amendment to the restriction on advertising dental specialties. There have been a number of objections to the wording in this amendment, and we expressed our concerns as well. At its March meeting the Board of Dentistry voted to move the amendment from fast track into a regular track. This process will allow the Board to see and hear comment from the public and will allow time for the Board to develop guidelines that will protect the public while still allowing freedom of speech and due process. I encourage you to visit https://goo.gl/Jaou3z (then scroll down to Board of Dentistry) and to **participate in the public comment** once active. We will also alert you through our communication channels. The Board of Dentistry also voted to withdraw pursuit of legislation that would allow for a PGY1 (Postgraduate Year 1) pathway to licensure.

Access to dental care continues to be an issue in many parts of our state. One solution to the problem is the CDHC (Community Dental Health Coordinator) - think of a community health worker with dental and oral health skills who can help improve oral health literacy in our communities and can help link you the practitioner to patients in need of a dental home. Our CDHC task force continues to investigate potential opportunities for CDHCs in settings that include hospitals, community health centers, free clinics, WIC, early Head Start programs, school dental clinics, and long-term care facilities. Please contact Dr. Frank Iuorno or Dr. Ted Sherwin, our task force co-chairs, if you have connections to any of these entities and could help make the introduction.

I encourage you to read Dr. Marko Vujicic's provocative article, published in the March 2018 *JADA* - "Our Dental Care System is Stuck: And Here Is What To Do About It" https://goo.gl/jJ9X6i With our present dental care system, he forsees a stall in dental care utilization and improvement in overall oral health, especially among those in greatest need, including young adults and seniors. He outlines four paradigm shifting reforms in our dental care system that would be needed in order to drive meaningful change. The question then becomes: "Who will lead the change?" Always provocative, he will present the keynote speech for the Opening Session of our upcoming Virginia Meeting in September. Plan to attend to learn more!

Speaking of annual meeting, put it on your calendar! The Council on Sessions and your VDA team have put together a wealth of continuing education ranging from (but not limited to) treatment of the worn dentition; nutrition for a lifetime; oral cancer screening primer; local anesthesia update; connecting the dots between cancer, chronic illness, and periodontal disease; practice management including lawsuit protection, tax reduction, and estate planning; and encore presentations on upgrading your travel experience. We have a number of opportunities to enjoy the beautiful outdoors with friends and family. Mike and I particularly love the Cascades Gorge Hike with Brian, and there is truly something for everyone at the Homestead. I hope to see everyone at the President's party - at the risk of sounding corny, it will be a hit for the entire family! All the Grand Slams of tennis will be represented, so bring your favorite racquet and dance shoes! The VDAF awards dinner on Saturday night is always a highlight and wonderful way to celebrate our outreach efforts while in elaborate costume. Registration for the meeting opens on April 16. New this year - you must register for the meeting in order to reserve rooms at the Homestead, so plan early - it will be a great meeting!

It's hard to believe, but we will reach our 100th MOM project in Wise this July 20-23. We have a new venue! The Convocation Center at UVa's College at Wise will provide a more comfortable and safer environment for us and for our patients. We will need more general volunteers to help with patient registration and management, so consider bringing friends, family, and dental team members who want to participate and make an impact.

If you have already renewed your tripartite membership, I thank you for your continuing support of our profession! If it's still on your to-do list, then talk to Jill Kelly, our Director of Finance, about monthly payments via credit card and auto renew options. Take the opportunity for Member get a Member initiative with a $200 discount on your membership when you get a new member to join. Be sure to complete our Member interest survey so that we can best identify your needs and interests and how you might like to be involved.

Our New Dentist Conference was a great success, in spite of the wind and the five hours it took my husband to get there (traffic accident and brush fire from the wind)! We learned many valuable take-aways from Dr. Kanyon Keeney's presentation on the team approach to successful implants. Dr. Chris Salierno, Editor- in- Chief of Dental Economics, gave invaluable advice on how to grow a quality practice and run your business successfully. There is a wonderful energy in this more intimate setting, and I am already looking forward to next year's conference. What I loved most was being surrounded by so many enthusiastic students, graduate students, and young dentists building their practices - our future looks bright!

LETTER TO THE EDITOR

GRANULOMA TO MELANOMA

Dr. Marvin E. Pizer*

Following an accidental fall on our front porch, I fractured my femur and ended up in an assisted living facility. Besides trying to walk again, I am left with much time to think about my post-professional life. I practiced oral and maxillofacial surgery (OMS) for about 65 years doing private practice, research, and teaching at local universities. I enjoyed it all, but after 50 (OMS) years, I began looking for more challenge and with my established practice I decided to limit my practice to OMS surgical oncology. The scope of my practice would include benign and malignant tumors and cysts in the anatomical area as defined by the definition of dentistry and OMS. However there were new situations, many of which I expected such as:

1. More time in hospitals.
2. Competition from plastic surgeons, ENT surgeons, and general surgeons who routinely have operated on malignant tumors in oral and maxillofacial territory. I know this as a fact as these were the "surgeons" who trained me for over a year during my postgraduate education in Pittsburgh.
3. The lower income families, frequently with no insurance, appeared be involved with OMS malignant tumors more often (tobacco, alcohol, excessive exposure to carcinogens).
4. Insurance companies pay minimal compensation for benign intraoral tumors such as osteoma (tori, exostosis) and even large destructive cysts in bone. It appears that insurance companies will pay physician surgeons larger amounts of compensation willingly. This will be changing – because today 50% of our OMS residents will be receiving their MD degrees. The single-degree OMS suirgeons are now being accepted for the FACS designation. This was the exclusive medical designation for physician surgeons in the American College of Surgeons. Last fall (2017) 58 single degree OMSs became fellows (FACS). This is *the* surgical society in the US and the world.
5. OMSs who limit their practice to surgical oncology may have difficulty in selling their practice. Suggest they find a partner with equal skills to buy their practice after a given period of time.
6. To remove some of the stress and have a successful and productive practice I have used the team approach in treating OMS malignancies. All of my patients with malignant neoplasia are seen by a medical oncologist and radiation oncologist before beginning treatment. All therapy on these patients must be agreed upon by the three of us. We advise the patient's family dentist and physician of their patient's status.

If any of my referring dentists and physicians are still around, thank you for your referrals.

To future OMSs who have an established practice, and are qualified in oncology, I suggest you give oncology some thought. I must admit the 15 years of this sub-specialty has given me many heartwarming experiences which I will cherish and never forget. If you are well-established give this a try!

If you desire more information about this specialty, contact the Editor of the *Virginia Dental Journal*, who can provide my contact information.

*Formerly:
1) Clinical Professor of Oral and Maxillofacial Surgery, Virginia Commonwealth University School of Dentistry, Richmond

2) Professor of Research, Adjunct Professor of Medical Physiology, Director of Pre-Professional Health Program; Chairman, Pre-Medical Advisory Committee, The American University, Washington, DC

VDA BOARD OF DIRECTORS

ACTIONS IN BRIEF - JANUARY 18 – 20, 2018

1. **Approved**: A resolution that the VDA will make a $5,000.00 donation to the American Dental Association Foundation.

2. **Approved**: A resolution that the duties of the President-Elect be amended to include that he or she will be an advisory (non-voting) member to all task forces and work groups.

3. **Approved**: The PR Task Force name will be changed to VDA Marketing Task Force.

4. **Approved**: A Council on Government Affairs resolution:
Background: Dr. Dag Zapatero, VDA member, presented an informative presentation on influenza and the possibility of dentists administering flu vaccines in their offices.

   Resolution: The Council on Government Affairs approved this concept and requests approval from the VDA Board of Directors to proceed with this initiative.

5. **Reaffirmed**: VDA Policy that the VDA supports Medicaid dental benefits for adults, provided that adequate funding for Medicaid benefits for children and adolescents in in place. (2009)

TRUSTEE'S CORNER

Dr. Kirk Norbo, ADA 16th District Trustee

There has been a lot of discussion about the specialty recognition process and how it ultimately can influence advertising practices throughout the country. Fearing FTC sanctions stemming from this specialty recognition issue, some state dental boards have started to move away from the traditional statutes that embrace the nine specialties recognized by the ADA and toward less restrictive definitions of specialty areas.

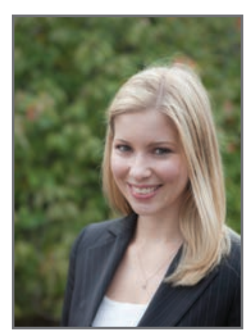
The Virginia Board of Dentistry is a prime example of a board that is recommending a change to state statutes that will most likely lead to an expansion of the field of accepted specialties. In addition to the nine ADA recognized specialties and the nine ADA recognized specialty certifying boards, the ABDS (American Board of Dental Specialties) recognizes four certification boards: American Board of Oral Implantology/ Implant Dentistry, American Board of Oral Medicine, American Board of Orofacial Pain and the American Dental Board of Anesthesiology. Other groups are bound to step forward as the specialty regulations are relaxed. Currently, the Virginia Board of Dentistry is proposing a change in state statutes that removes the "ADA recognized" qualifier thereby paving the way for expansion of recognized specialties in our state. The main consequence of this change will be in the advertising arena where anything will be acceptable as long as there are no complaints registered by the public.

In an effort to mitigate legal risk to their boards of dentistry, some states have dropped all references to specialties which has essentially created a "free for all" when it comes to advertising. For example, if a dentist completes a weekend course on implant placement, my understanding is that the practitioner may be permitted to advertise as an implant specialist with no repercussions. The limiting factor for such a wide open interpretation of specialties and postgraduate training is public harm. This "no harm, no foul" philosophy has the potential to devalue the time tested advanced education specialty programs that have been accredited by the Commission on Dental Accreditation (CODA) and recognized by the ADA to foster an excellent dental education system that ultimately protects the public.

On another front, CODA is removing the term "specialty" from all of its documents and replacing it with "advanced educational programs". This change in terminology clarifies that the Commission accredits education programs but does not designate which disciplines in dentistry are "specialties". This may expand the field of programs that CODA accredits from those that have been traditionally evaluated to a larger pool seeking CODA accreditation. CODA accreditation of advanced education programs in additional disciplines will give credibility to a greater number of specialties seeking to be recognized by state boards and our professional as a whole. As this movement gains momentum, the dental boards will be forced to reevaluate their state statutes in an effort to stay in good stead with the FTC and legal community.

Currently, the ADA requires any sponsoring organization seeking specialty recognition to satisfy six requirements. These can be found on the ada.org website, so I won't list them here. I will, however, focus on two of the requirements that have created the most controversy in our existing recognition process. One requirement that must be met states: the scope of the proposed specialty requires advanced knowledge and skills that: (a) are separate and distinct from any recognized dental specialty or combination of recognized dental specialties; and (b) cannot be accommodated through minimal modification of a recognized dental specialty or combination of recognized dental specialties. The other phrase that is subject to interpretation is: the specialty applicant must provide oral health services for the public; all of which are currently not being met by general practitioners or dental specialists. Both of these requirements have created a great deal of controversy in recent years as the ADA House of Delegates has been asked to vote on applications brought forth by groups who have argued that they have met these criteria.

The ADA is attempting to bring a degree of stabilization to this specialty recognition dilemma by forming the ADA National Commission on Specialty and Specialty Certifying Board Recognition. By removing this responsibility from the ADA HOD, the process will be viewed as more fair and not exposed to possible HOD conflict of interest issues This newly appointed group will have its first meeting on May 9 -10 this year. The commission consists of nine general dentists, nine specialists (one representative of each of the nine ADA recognized specialties) and one member from the general public appointed by the commission. Dr. Chuck Norman is the interim chair and intends to put together the governance documents for this Commission in May. Applications from groups seeking specialty recognition are expected to begin being accepted this fall. My faith for upholding a reasonable vetting process for our profession's specialties rests with the commission. Once this commission is up and running, the state dental boards will then have a resource available to them for verification of groups who are seeking specialty status. Time will tell if this new ADA commission brings some standardization to the specialty recognition process. Continuing down our current path is not an option if we are to advocate for our existing specialties as well as protect the public.



DR. ERIKA ANDERSON

Dr. Erika Anderson, a native North Dakotan, values collaborative dentistry. I feel fortunate to work with Drs. Gyuricza, Hartman, and an amazing network of specialists. My NVDS membership has given me a group of colleagues and friends who've made Virginia home.

LETTER TO THE EDITOR

LIFE IN A PARALLEL UNIVERSE

Dr. R.K. Rosenberg

The January issue of the *Virginia Dental Journal* came the other day, and it was filled with references to value; the value of VDA membership, the value of ADA membership, and so on. With the exception of the scientific abstracts, it was mentioned in every article – often several times – so often that I lost track counting them. But as far as I could determine, cost was never mentioned at all, which is unfortunate because there is a direct relationship between cost and value that's not being addressed. Everything we buy has both, but one is usually based on facts and the other more on personal desires. For example, most people pay about the same price for a specific make and model of car, but that same car also may have optional features that are of greater value to some buyers than to others. With cars, reliability, safety, comfort, and a good sound system are important to me; styling, mileage, a GPS, or a sun roof are not. I'll take them if they come with the car, but I won't pay extra for them, and the failure to recognize this cost-value relationship is the source of dentistry's biggest problem.

The cost of dental care is currently the biggest obstacle to accessing it. New HPI statistics indicate that twice as many people say money is the reason they avoid us as mention the next most important reason: fear. They look for cheaper options such as Mexico, or things like mid-level providers. This cost factor also affects the membership figures in our professional organizations as well; those that don't join (they're called "individualists" now) may have simply concluded that the value of that membership isn't commensurate with its cost. The VDA's own poll of three years ago showed that the reason dentists didn't join initially, left within five years, or wouldn't return, was the cost but nothing was done about it. The suggestion that we ease costs by altering the tripartite system to allow people to join at one level at a time also went nowhere, but we nevertheless continued to push our CDHCs and our Ambassador Program, strategies that concentrate on selling value but totally ignore any cost involved. And when the ADA continued to lose a greater market share of dentists who could have joined the ADA but didn't, they simply stopped using market share as a benchmark and moved to a different standard. That's like changing the rules of football so the winner is no longer determined by the total number of points on the board but by the number of first downs or by the time of possession.

I often wonder if the current leaders of organized dentistry aren't residing in a private, parallel universe someplace where cost factors don't exist. Life in this parallel universe also allows us to believe that going down to Southwest Virginia for a weekend a year, or taking a day off for a M.O.M., a GKAS, or the clinic is sufficient to show that we care about the "underserved," our new politically correct synonym for "poor people." I have a question: How many of you would walk around with a toothache for an entire year waiting for us to return to your little underserved backwater town on one of our annual forays? It's no wonder these people want mid-level providers; otherwise, they'd have no care at all and at least they'd be there when they need them, not just once a year. Now do you see our problem?

I'm retired now, so none of these issues affect me much anymore, but I practiced dentistry for over 50 years. I am very concerned about our profession's future and I'm not at all happy with what I see. To solve any problem you first have to acknowledge it, but we stubbornly refuse to address our cost problems while government regulations and general inflation make practicing dentistry more expensive every year. In addition, most of our efforts are now geared to courting "millennials," or on placing implants, implant retained dentures, selling cosmetic dentistry, making sleep disorder appliances, and other high-end procedures for those "wealthy seniors" referred to recently by the HPI because that's where the money is. We long ago deserted the "underserved;" now we're walking out on the middle class as well and expecting our PACs and lobbyists to quiet our critics and stifle any competition, but that will no longer fly. We say that our concern is for our patient's well-being, but no one believes that anymore. Organized dentistry can't continue operating as it has in the past; we simply can't afford to be all things to all people. We will have to make difficult choices, or the public will start making them for us. It's time to leave our private, parallel universe and return to the real one where everyone else lives if it's not already too late.

DR. JUSTIN JOHNSON

I am a 2014 graduate of VCU's AEGD program and I currently work in a private practice in my wife's hometown of Stafford. I practice comprehensive general dentistry and I am supported by my loving family - Amber, Owen and Norah.

MESSAGE FROM THE EDITOR

Dr. Richard F. Roadcap

Each issue of the *Journal*, much like a table rests on four legs, is anchored on four themes: science, membership, outreach, and advocacy. State, or ADA "Component", journals are sometime referred to as "gray" publications. There's a little science, news about meetings and awards, volunteer activities, and rumblings from the state legislature and Capitol Hill. Unlike peer-reviewed journals such as *The Journal of Prosthodontics*, which are filled with original scientific manuscripts, we try to cover all the bases.

Scientific journals often compare their assigned "Impact Factor" (JIF) as a measure of their standing in the scientific community. JIF compares the frequency that published articles are cited by other journals. Component publications are unlikely to compete with the *Journal of Dental Research* for top billing in the annual review of JIFs. Now that we've established the *VDJ's* place in the publishing universe, the question arises: how much "science" should be in our diet?

Our practice has been to include in each issue 1) abstracts written by residents in post-graduate programs at VCU School of Dentistry 2) the "Pathology Puzzler", a feature carefully prepared by Dr. John Svirsky, one of the foremost oral pathologists in the US (and a frequent presenter at meetings such as the Hinman and the ADA annual session), and 3) peer-reviewed scientific manuscripts when they are approved for publication. If you'll glance at our masthead (page 2) you see a list of unsung heroes under the heading "Editorial Board". Their diligence and good judgment insure that published manuscripts are based on sound science and easily understood. Their efforts also help prevent an editor's worst nightmare, the retraction of an article because it was later found to be fraudulent or plagiarized. They deserve our deepest gratitude. Unfortunately, we can't acknowledge their efforts publicly, as submitting authors are unaware of reviewers' identity.

Our profession prides itself on being based in science. Dentistry was fast becoming a trade when in the 1920s Columbia University professor William J. Gies, Ph.D. founded the current system of dental education and rescued the profession from the clutches of manufacturers and suppliers. We like to think there's a scientific basis for everything we do. I won't wade into the current discussion surrounding Evidence-Based Dentistry, which has been ongoing for some time. The ADA has made EBD a prominent feature of its website. Practicing dentists know both empirically and from the scientific evidence, for example, that pit and fissure sealants prevent decay, but a search of the literature on PubMed will reveal articles, published in respected journals, that cast doubt on the ability of BIS-GMA resins to seal out *S. mutans* and other cariogenic bacteria from enamel surfaces. I often wonder if the insurance industry that seems to control our lives is using EBD as a stalking horse in its efforts to deny claims for clinically successful procedures.

How much science do our readers want? More? Less? Or, do we have just the right mix? Some state and regional dental publications have abandoned science altogether, opting to re-print articles rather than seek original research, or leave the science to high "Impact Factor" journals. Do readers want full articles, abstracts, or merely a summary, with links to other resources? Do they want full plates or small bytes? I dread the day when *our* (emphasis mine) *Journal* devolves into a catalogue of topical concerns and ephemeral subjects for practicing dentists. I hope that we'll always be an opportunity for authors and researchers who may not always be a good fit for *JADA* or *The Angle Orthodontist*.

State and regional journals have, as one of their mandates, the job of building a sense of community among their readers. If science is not an adhesive which holds together members of the profession, then we risk becoming journeymen, merely competent, but never excelling. Max Planck, the founder of quantum theory who received the 1918 Nobel Prize, said "Every advance in knowledge brings us face to face with the mystery of our own being." A platform with only three legs may prove unstable.

DR. CHAD FLANAGAN

I love the practice of dentistry and the people that I serve in Mechanicsville. Alongside a supportive team at Virginia Family Dentistry, I offer a wide variety of dental services and continuously challenge myself to improve upon my practice and expand the procedures I offer to my patients.

LETTER TO THE EDITOR

DOGS IN THE OFFICE

Dr. Henry Botuck

Recently there was an article in the *Virginia Dental Journal* featuring Therapy Dogs in a dental office. I also saw an article in another periodical about a family pet who visits his master's dental practice. It was accompanied by a picture of the dog sitting in a dental chair. This got me thinking about when, and if, it was appropriate for a dog to be in a dental office.

The first two categories that came to my mind were Service Dogs and Therapy Dogs. A Service Dog is trained to perform tasks for people who have disabilities. This definition does not include Therapy Dogs, whose function is to provide comfort or emotional support.

If a patient tells you that he/she is going to be accompanied by a dog, you must make your decision to allow or not, to be based solely upon the answers to the following two questions: (1) Is the dog a service animal required because of a disability; and (2) What work or task has the dog been trained to perform. You cannot ask about the person's disability (except, of course, when filling out the patient's health questionnaire), require medical documentation, require a special identification card or training documentation for the dog, or ask that the dog demonstrate its ability to perform the work or task.

According to the Americans with Disabilities Act, the owner of a Service Dog has the right to have the dog accompany him/her to any place the owner goes, with very few exceptions. And a dental office is not considered one of those exceptions. If the patient is going to have general anesthesia, the dog can be excluded from the operatory. Therapy Dogs do not have this protection and can be accepted or excluded from the office at your discretion.

When it comes to Service Dogs, the owner is in the best position to advise if the dog should remain in the room during treatment. Discuss this with the patient. Just as people have different personalities, animals have different dispositions too. The owner would know best whether his/her dog would be disturbed by the sounds or movements in the operatory. If so, the patient should bring along someone to look after the dog in the reception area.

Many Service Dogs are trained not to defecate or urinate until allowed by the owner. Of course, accidents can happen. If an "accident" does happen, treat the area as you would if a patient had vomited in that area. Wipe up the mess (even blind owners are capable of picking up their dog's feces), wash the area with soap and water, dry the floor, and then wipe the floor with a good surface disinfectant. Make sure that the area remains wet for the kill time listed on the directions. (Never use glutaraldehyde!!) You could also use chlorine bleach diluted 1:10. If you use chlorine bleach, make sure that the area stays wet for at least ten minutes.

There have been numerous stories about dogs visiting patients in dental offices and hospitals, and their positive effects on patients. It is important to note that none of the studies about these visits connect the dogs with the transmission of disease. However, all of the studies have involved a very select group of dogs. These are animals that (a) have been specially trained, (b) adhere to a conservative health regimen with their veterinarians, and (c) are always controlled. They are not your average family pet, and they are not allowed to roam the office or the hospital at will.

I understand that a few dentists bring their pets from home and let them roam freely through their offices without close supervision. These animals are not held to the high standards of Service and Therapy Dogs. What are the risks of allowing your pet to roam the office? No matter how "friendly" the dog, it does not have the special training necessary to mix freely with patients. Bites are the first hazard. "But my dog is friendly and has never bitten anyone!" A good Service or Therapy Dog does not growl, jump, or bark when excited. That would be considered too aggressive. Does this describe your pet? All it takes is one time.

But it doesn't even have to be a bite. All it takes is a scratch! This happened to my dog when I was a boy. A neighbor child and my sister were playing. They were teasing the dog and it grabbed the neighbor girl's hand. He didn't actually bite her, but his teeth scratched her hand as she pulled it away. He had all of his shots, etc., etc., but the child's parents went ballistic. In today's litigious environment we probably would have been sued. So, if you bring your pet to the office you had better purchase a liability policy that covers the actions of your dog.

Then there are animal-borne diseases (zoonoses). In addition to the usual culprits we might get from humans (viruses, bacteria, and fungi) there are internal and external parasites. These can be spread both by direct or indirect contact.

Does your dog have regular flea and tick treatments, veterinary evaluation of stool samples for parasites, regular vaccinations, etc.? You have an obligation to your staff and your patients to see to it that your dog's health is closely monitored and held to the highest standards. Immune compromised patients, such as diabetics, pregnant women, arthritic patients, transplant patients, cancer patients, children under age five, and adults over sixty-five, have the greatest risk for acquiring zoonoses.

As it happens, there is a multistate outbreak of multidrug-resistant Campylobacter that has affected people in 17 states as of December, 13, 2017. It has been traced to puppies sold in a pet store.[1] The CDC says: "Did you know that infected animals can make you sick, even if they appear healthy and clean?"[2]

What about allergic patients and staff? An estimated 15-30% of people with allergies are allergic to dogs and cats.[3] Being bathed twice weekly cuts down on shedding of hair and dander, and thereby reduces allergens. If you bring your dog to the office, you should be expected to do this.

But, if an employee is adversely affected by the presence of the dog (allergy, fear or phobia), the dog should not be allowed into the office. To terminate an employee because you want to feel free to bring your dog to the office might be seen as a violation of the Disabilities Act.

If the pet lies down or walks into the path of a patient or a staff member hurrying down the hallway, it could become a fall hazard. People can also trip over chew-toys or spills from water bowls. "...31.3 % of falls associated with dogs were caused by falling or tripping over the pet."[4]

If you choose to bring your dog to the office, you are ethically and legally held to a higher standard than the average pet owner.

And, by the way, in case you were wondering, dentists are not allowed to treat animals unless they are also licensed veterinarians. If you are a dentist AND a veterinarian, you must keep the instruments used on animals separate from those used on humans.

References:

1 CDC: Multistate Outbreak of Multidrug-Resistant Campylobacter Infections Linked to Contact with Pet Store Puppies. Posted on-line December 13, 2017

2 CDC: Zoonotic Diseases (Diseases from Animals), on-line

3 Foreman, Glenn, et. al; Dogs in the Workplace: A Review of the Benefits and Potential Challenges, Int J Environ Res Public Health.
2017 May;14(5)498. Published online 2017 May 8

4 Ibid.

HOW CAN I DETERMINE MY RISK TOLERANCE?

Jimmy Pickert, CFA, CRPS®

Until recently, things had been a breeze for investors. Major U.S. stock indices continued to finish higher month after month while measures of volatility were persistently at or near all-time lows. Starting in February of this year, however, uncertainty seems to have crept back into the stock market, bringing with it choppy returns and large short-term declines. Now that investors have been reminded that stocks don't always provide a smooth ride, many may be wondering whether they're taking the right amount of risk in their investment portfolios.

Taking risk is an unavoidable aspect of investing. We tend to have a negative connotation of the word "risk," but when it comes to investing, taking on a certain amount of risk is acceptable. In fact, if you don't take on risk in your investment portfolio, then you expose yourself to other types of risk: the risk that your savings will lose purchasing power due to inflation, and the risk that your savings won't sustain you in retirement.

Still, even if you understand and accept that you should take risk in your investment portfolio, you may be unsure of how much risk you should take. This "how much risk?" question is referred to in the industry as an investor's risk tolerance. The answer to the question can be boiled down to two factors: ability and willingness.

YOUR ABILITY TO TAKE RISK

Your ability to take risk in your investment portfolio is completely dependent on time. In other words, how much time is there until you will need the money that you're investing?

For example, you are probably investing for retirement. If you're 60 years old and plan to retire in the next five to seven years, you don't have the ability to take the sort of investment risk that a 30-year-old might take with his/her retirement savings. At least, it would not be prudent to do so.

The reason that time is so important is that you can't often control when you need your money—perhaps you have to retire at 65—and you certainly can't control when your investments go up or down in value. If your portfolio has taken on a lot of risk, you don't want to be caught needing your money at a time when the market has fallen. This can have a serious impact on your ability to recover from investment losses.

YOUR WILLINGNESS TO TAKE RISK

Your willingness to take risk can be tougher to determine. It comes down to whether you believe that you can stomach seeing investment losses in your account. It's human nature to get caught up in the short-term and lose focus on the longer-term goals, like retirement. It's also natural to lose patience with an investment, even if it has done reasonably well, if you see something else out there that has had better performance. Your ability to overcome these emotions and biases and arrive at investment decisions objectively is what determines your willingness to take risk. You already see the flaw here: in practice, people don't do a great job of determining their own objectivity. For that reason, it's helpful to talk with a financial advisor to get a professional's take on this.

WHAT IF ABILITY AND WILLINGNESS CONFLICT?

It's common to see investors who have conflicting ability and willingness when it comes to risk. An investor nearing retirement may be used to taking on investment risk and be reluctant to miss out on big market gains. On the other hand, an investor who has plenty of time until retirement might objectively be fine taking on more risk, but they might be more nervous about seeing their account value go down. Ultimately, an investor should follow whichever factor—ability or willingness—leads to a more conservative outcome. It doesn't matter if you have decades to absorb investment losses if your reaction to every market correction is to panic and sell low.

If you've read this and still have trouble assessing your risk tolerance, contact a financial advisor to explore the question further. It's often the case that an investor has greater ability to take risk than they thought—perhaps you can rely on pension income for some of your retirement goals, for example. We also frequently see that an investor's willingness can quickly change once they gain a better understanding of how investing works and what they can expect.

The conversation around risk tolerance is a critical conversation to have, and, in fact, it should never end. As circumstances in our lives change, so does our ability and willingness to assume investment risk.

Editor's Note: Jimmy Pickert is a Portfolio Manager at ACG Advisory Services, Inc. www.acgworldwide.com

Member RESOURCE

DR. LATASHA SAULS

In April 2016 I welcomed my first child, Reece, and began construction on my new dental practice in July. Making the transition to ownership while tending to a newborn was a challenge, but certainly worth it.

CREATING AND IMPLEMENTING A SOCIAL MEDIA PROCESS FOR YOUR PRACTICE

Kelsey Leavey

When you peer into your practice's waiting room, you'll likely see many patients hunched over their phones, checking their favorite social media platforms.

Sometimes business owners want to jump on every social media platform – because that's where their customers are. But it's important to remember that while social media can be a powerful marketing tool, it also takes time and resources.

Before starting or reengaging on social platforms for your dental practice, here are a few areas to think about.

Decide what platforms are most important to you and your audiences. You want to reach your existing patients and potential patients where they spend their time online. When you have limited time and resources to spend on maintaining your social platforms, quality is definitely better than quantity. Decide where to focus your efforts and stop wasting time on the platforms that won't move the needle. The graph below should help you determine how to communicate to different demographics within your practice.

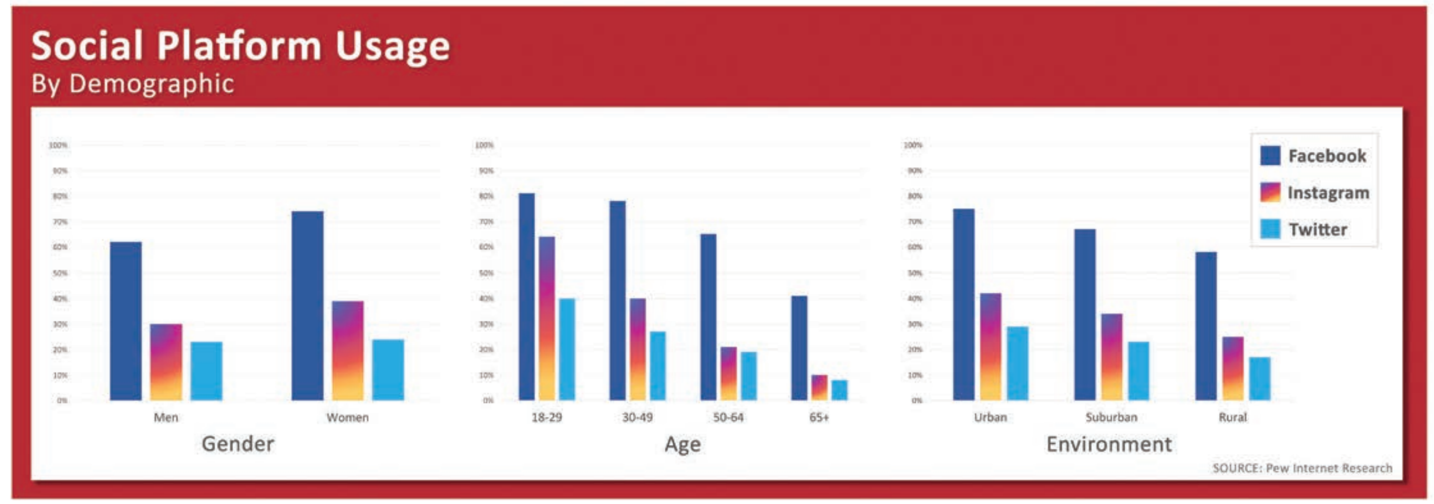
Define roles and approval structure. Decide who on your team will be responsible for creating your practice's social content, and then determine who will proof and approve the content before it is published to your social platforms. Clearly outlining roles and responsibilities gives a layer of accountability to your social strategy.

Work with your staff to develop content bins. Content bins are the categories of content that you want to post about on a regular basis. Visit https://goo.gl/c1YYd8 for a downloadable resource to help you develop your own content bins. The downloadable resource will help you develop and define content bins for your practice, then determine how frequently you want to post about each content bin. Be realistic about what you or your team can handle. This document will give direction to those developing your social content and ensure that your whole team is on the same page. Here are some examples of content bins to get you started: research/ studies (dental technology, patient care, etc.), dental trends, healthy dental habits, practice news and staff profiles.

Now that you've taken care of the basic pieces of your practice's social media strategy, you can start thinking about creating a social media process for your team to follow. Consider using the worksheet on the next page as a guide for you and your staff.

Half the battle of having social media presence for your practice is being active on a consistent basis and developing a workable process that helps you accomplish goals. The good news is that creating and sharing social media content that bolsters awareness of your practice doesn't have to be a full-time job.

Editor's Note: Kelsey Leavey is a public relations and social media specialist at The Hodges Partnership. She can be contacted at kleavey@hodgespart.com.



RECOMMENDED SOCIAL MEDIA ACTIVITIES

If your practice is on social media, you should have a clearly defined social media process that is reevaluated each quarter. The process outlined below is meant to serve as a starting point. Consider it a checklist for delegating tasks to your team. Ultimately, each business's social media process will be different.

DAILY

- [ ] Monitor for incoming reviews/messages and respond where appropriate. This can be done multiple times throughout the day, depending on your resources. *Estimated time 5-10 minutes.*
- [ ] Capture any real-time content happening (example: take pictures of the new piece of equipment being delivered, or the celebration of a work anniversary). This content could either be shared in real time to your practice's social channels or saved for a later date. *Estimated time 5 minutes.*

WEEKLY

- [ ] Identify/plan the pieces of content to share for the next week, use content bins to guide what is being shared on your platforms. *Estimated time 10-15 minutes.*
- [ ] Once the content you want to share has been identified, follow the approval structure that has been identified, and schedule the content using the in-platform tools or free tools like Buffer or Hootsuite. Helpful links: how to schedule posts on Facebook, how to schedule posts on Twitter. *Estimated time 10-15 minutes.*
- [ ] Sprinkle in unplanned posts that fit into your content bins and are timely in nature, when necessary. This won't happen every week, but don't be afraid to swap out a scheduled post with something that is more relevant or timely than what was planned. Example: newly released reports or studies in the news that are related to dental health, your interview about brushing correctly on the local news, a therapy dog's visit to your office, etc. *Estimated time 5 minutes.*

MONTHLY

- [ ] Tally/track the number of negative and positive reviews for the month across various social platforms and website. *Estimated time 5-10 minutes.*
- [ ] Identify big content opportunities happening in the next month. Mark these events in your calendar so that you don't forget to capture them. *Estimated time 5 minutes.*

QUARTERLY

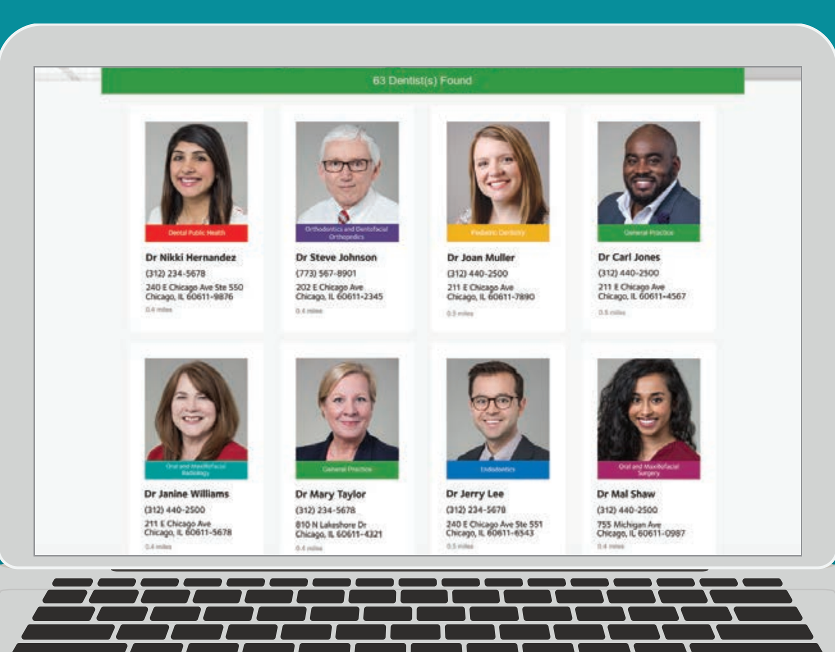
- [ ] Refine your social media process. For example: you might find that it is unnecessary to check for reviews daily. Making that activity a weekly or monthly function might work better for your practice. *Estimated time 30 minutes.*

ANNUALLY

- [ ] Review who has access to the pages and remove/add people as you see fit. *Estimated time 5 minutes.*
- [ ] Take the time to research tools that could help further streamline your process. *Estimated time 30 minutes to one hour.*

Put your best face forward

The new Find-A-Dentist is live — and it's a hit with patients.



1MM
visits to Find-a-Dentist

348K
member profile views

ADA's Utilization Campaign
Resolution 67H-2016 Results to Date
April-September 2017

Update your profile in 5 minutes or less!

Patients can see your location, office hours & more

Photo profiles get 11x more clicks

More complete profiles appear higher in search results.

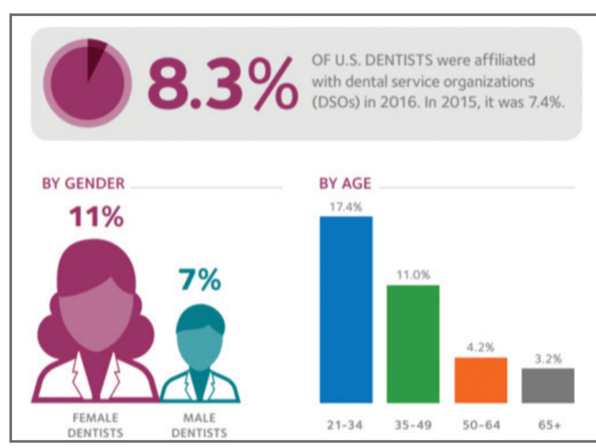
Don't have time? Ask a staff member to do it for you.

ADA's Find-a-Dentist® campaign is designed to help bring in new patients.

Learn more about the ADA campaign to help build your practice.
Visit ADA.org/UpdateNow to check your profile and add your photo.

ARE YOU PLAYING GOLF OR BASKETBALL?

Dr. James R. Schroeder



How Big Are Dental Associations?
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For decades, going solo was the pathway many general dentists chose when graduating from dental school. Much like a game of golf, running a successful practice was largely dependent on how much time you put into the "game". Unlike basketball, where you can focus on what you're good at and allow your teammates to fill in the gaps. If you don't demonstrate that you're a strong team player, you'll find yourself on the bench.

While there are benefits to both team and individual sports, they differ vastly. In team sports, achieving success is much different. With few exceptions, it doesn't matter which team has the best players, the final result hinges on a multitude of variables.

The business of doing dentistry today is looking a lot more like a team sport than solo game. Without a group of players each performing a series of complex tasks that are pointed toward the same goal, the risk of failure increases.

SOLO OR GROUP?

According to the American Dental Association (ADA) the trend of solo ownership is changing for a multitude of reasons. The ADA has published a number of reports from The Health Policy Institute (HPI), a trusted resource for policy knowledge on critical issues affecting the U.S. dental care system. Practice ownership rates in dentistry are declining slowly and steadily, while the number of group practices is increasing and changing in character and structure.

Findings reported by HPI over a 10-year period (2005-2015) show that practice ownership is declining in almost every age group. Over 8% of US Dentists were affiliated with dental service organizations (DSOs) in 2016, up from 7.4% in 2015. And although the decline in practice ownership is moving slowly, the decline is far more pronounced amongst our physician counterparts. So let's take a look at their "play book".

There have been two major phases of attempts at health care consolidation. The first phase began in the 1990s characterized by the development of management service organizations (MSOs). MSOs evolved from an increased emphasis on the integration of treatment, increased cooperation among physicians, consolidation of providers, and the stated aim of payers to shift reimbursement from the traditional fee-for-service basis to capitation. MSOs contracted with physicians – solo practitioners and/or groups – to provide facilities, equipment, staffing, contract negotiations, administration and marketing, freeing up doctors to provide care exclusively. Physicians believed that contracting with an MSO provided increased security that allowed them to retain professional autonomy since they still "owned" their practice (patients). Plus, MSOs were prohibited from interfering with professional judgment. Yet, many reported a loss of control over their professional lives, a tradeoff for the increased security they gained through employment.

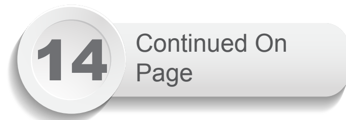
The dental support organizations (DSOs) of today are very similar in structure and function to the MSOs developed in medicine in the 1990s.

By the early 2000s, many MSOs disappeared, citing reasons for failure: paying physicians too much for their practices, inability to achieve economies of scale in operations, inability to coordinate chronically ill care, and inadequate information systems to manage risk-bearing contracts. MSOs essentially failed to live up to expectations.

The second phase of consolidation continues today, spurred on by the current unsettled health care marketplace and particularly by some of the provisions of the Affordable Care Act (ACA). Employment, as opposed to practice ownership, is an attractive alternative for reasons that include: income security in light of decreasing reimbursements and increased practice operational costs; potential for a less stressful work environment (81 percent of physicians who owned their own practices reported that they were "over extended" or working at "full capacity"); better "work-life balance"; less administrative responsibilities; ability to overcome erosion of their referral stream occurring in private practice; and the need to belong to an organization with increased market power that enjoys economies of scale.

For today's dentists, the benefits of consolidation are strikingly similar. The graduating dentist just out of school has higher levels of student debt, often upwards of $200,000, and facing large startup costs to open a practice. The choices aren't easy for graduating students. As dental school focuses on preparing them in technical skills and decision-making capabilities, it has done very little with equipping them for success in today's rapidly changing world of health care. And for the mid-to late-career dentists, they are recognizing the group consolidation benefits being realized by their medical colleagues. But the question still remains, "Are the specific resources available to the dental industry filling the real gaps that exist within our industry?" Today's dentists are still looking to improve the quality of life for themselves and their staff. The resources must help create the kind of thriving culture that dentists and staff want to embrace. There are promising models being developed by our colleagues that allow the professional to benefit from the leverage of a group but still retain the autonomy of patient care. Caution must be exercised to understand to understand the "pros" and "cons" which will be featured on my web site LBDtransitions .com

Though the movement toward consolidation is nowhere near that of the medical profession, it is a reality we face. The regulatory environment is not favorable to the increased involvement of non-dentists in the ownership and/or operation of dental practices. But, efforts are underway to make the legal and regulatory environment for non-dentist involvement more hospitable. Antitrust concerns have arisen in the medical care world because of consolidations in hospitals and health insurance organizations. That is not currently the case in dental care, but it is coming plus concerns over health insurance do impact us greatly.


14 Continued On Page

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DENTAL INSURANCE: COMPLICATING MATTERS

One major challenge the solo practitioner has to navigate is the handling of insurance. More and more patients are not insured. Medical insurance is mandatory, but dental insurance is still not. This increases more financial concerns for patients and challenges the dentist to provide optimum care. The mindset of those graduating from dental school is ill equipped with the critical thinking skills to understand they are not treating an insurance company but a patient.

Many solo dentists are facing pressures that cause pain and disruptive change to their practice. In the face of these challenges, where should one look for solutions? A growing response will most likely be to evaluate the benefits of becoming part of a group practice. However, just coming together under one roof does not assure an improvement in your Profit and Loss; nor the environment in which you practice. For physicians, big health reforms like the health maintenance organization movement in the 1990s and the Affordable Care Act accelerated trends away from practice ownership. Dentistry has largely been insulated from many of these shocks to the health care system, but that is rapidly changing. Potential game changers like adding dental benefits to Medicare may accelerate the trend away from practice ownership. Large corporate DSOs are moving into areas with large marketing budgets, expanded hours coupled with insurance agreements to attract patients. This also appeals to recent graduates with debt and a guaranteed salary.

The bottom line: a lot more systems development, marketing, and managerial expertise is going to be needed to run a successful dental practice of the future. Will dental schools add a mini MBA program into the curriculum? Perhaps more dentists will expand their game with improved managerial and leadership skills. Whether you choose to perfect your putt or expand your team, it's still your game to play. Even with the game shifting, it's about acquiring a new set of skills to play ball. These group skills were not taught in dental school. Teamwork, communication, transparency, metrics, decision making and finally, accountability to your teammates is required for maximum success. Recognize that you alone don't know everything as you navigate these decisions regardless of your age. Please give me a call for a conversation.

Reference:

Guay A, Wall T. Considering large group practices as a vehicle for consolidation in dentistry. Health Policy Institute Research Brief. American Dental Association. April 2016.

Editor's Note: Dr. James R. Schroeder practiced dentistry in Richmond and is the founder of Leadership by Design. If you have any questions or would like help implementing a change in your office, contact Dr. Jim Schroeder at 804-897-5900. jim@drjimschroeder.com.

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PATHOLOGY PUZZLER

Dr. John Svirsky

Directions: Listed below are six cases. Please give your best clinical impression and treatment of each. Once you're done, you can check your answers on the next page.

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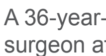
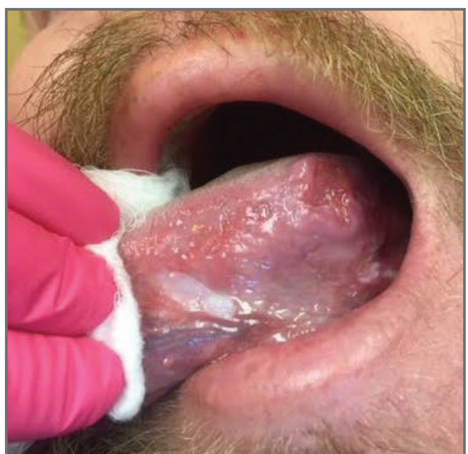
CASE 1

A 32-year-old male presented with a large painful ulcerative lesion that has been present for over 6 weeks and does not appear to be getting better.

CASE 2



A 36-year-old male presented to a local oral surgeon after being followed by a general dentist and an ENT for several months with various non-effective therapies. The lesion has continued to enlarge.

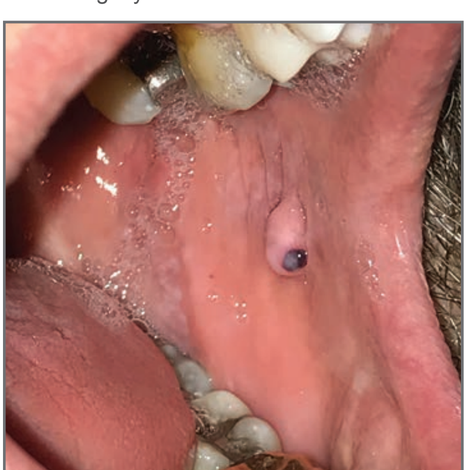


CASE 3

This case represents incidental findings on the head and neck examination. The patient noticed the lesions and was concerned. There were no symptoms.

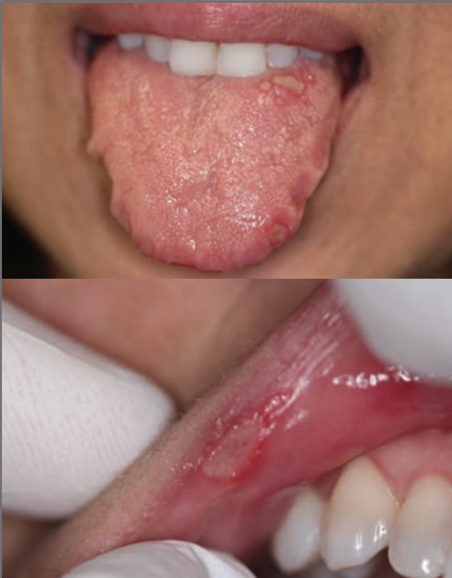
CASE 4

This lesion has been present for over a year and was not a problem until bitten one day previously. The patient said it has increased in size slightly and does not hurt.



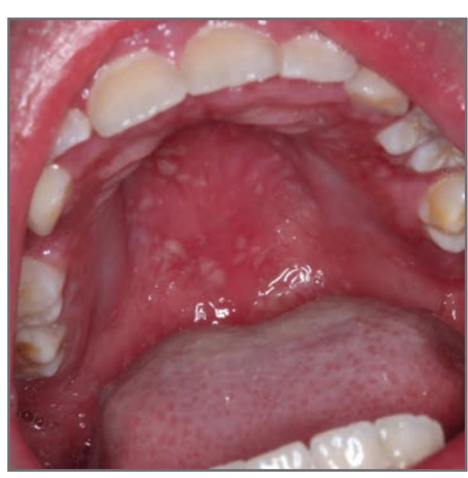
CASE 5

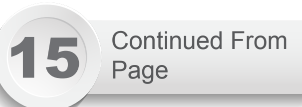
The patient presented with multiple painful ulcerations that come in crops of up to 20 at any given time. The pictures are representative of the type of lesions present.



CASE 6

Findings on oral examination. The lesions were irritating but not painful.

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PATHOLOGY PUZZLER

Dr. John Svirsky

ANSWERS:

CASE 1

The biopsy showed an ulceration without evidence of dysplasia or cancer. The treatment recommended was topical clobetasol and plaquenil.

Rx: Clobetasol propionate .05% gel (Temovate) (ignore external use only)
Disp 30 gram tube
Sig: Apply a thin amount to affected area up to two times a day.

Rx: Hydroxychloroquine (Plaquenil) 200 mg tabs
Disp: 60
Sig: Take 1 tab by mouth BID

CASE 2

The diagnostic biopsy was squamous cell carcinoma. A lesion that does not regress or gets bigger should be biopsied before "a few months".

CASE 3

These findings are classic for erythema migrans (ectopic geographic tongue) and no treatment is indicated.

CASE 4

Fibroma with small hematoma.

CASE 5

The diagnosis is aphthous herpetiformis (non contagious and not viral). These are painful aphthous ulcerations that occur in crops of 20 are more and never seem to go away. In patients like this I use systemic prednisone followed by topical steroids and pain control.

Rx: Prednisone 20 mg tablets
(Under 130 lbs dispense 30 ten mg tablets and use 40 mg/day in am with food for 3 days followed by 30, 20, & 10 mg in the morning with food for 3 days each.)
Disp: 24
Sig: Take three tablets (60 mg) in morning with food for four days;

Followed by 2 tablets (40 mg) in the morning with food for four days;

Rx: Fluocinonide (Lidex) .05% gel
Disp: 15 or 30 gm tube
Sig: Apply a thin amount up to 3 times daily. (ignore "external use only")

Rx: Magic Mouthwash
(1 part viscous lidocaine 2% + 1 part Maalox + 1 part diphenhydramine 12.5 mg per 5 ml elixir)
Disp : 240 ml bottle
Sig : Rinse and expectorate 5 ml prn - up to 4 times/day

CASE 6

The diagnosis is candidiasis.

Rx: Clotrimazole troche (Mycelex) 10 mg
Disp: 70
Sig: One (1) troche up to five (5) times a day (let dissolve in mouth) x 2 weeks

AEGD ABSTRACT:

AL-MAGALEH WR, SWELEM AA, RADI IAW. THE EFFECT OF 2 VERSUS 4 IMPLANTS ON IMPLANT STABILITY IN MANDIBULAR OVERDENTURES: A RANDOMIZED CONTROLLED TRIAL. J PROSTH DENT. 2017; 118(6): 725–731.

Statement of problem: The mandibular overdenture is widely accepted as the standard of care for the fully edentulous mandibular arch. It is often assumed that a greater number of implants allows for more favorable distribution of functional load, resulting in improved stability of each individual implant. However, this assumption has not yet been validated.

Purpose: The aim of this randomized clinical trial was to study the effect of implant number on implant stability with 2 versus 4 implants in mandibular implant overdentures.

Materials/Methods: Twenty participants were randomly assigned to one of two treatment groups: 4 implant, experimental group or 2 implant, control group. For both groups, two anterior implants were placed in the lateral incisor-canine region. For the 4 implant group, two additional posterior implants were placed in the premolar region. To be eligible, all participants were required to have an edentulous mandibular ridge opposed by complete maxillary dentition (natural dentition or dentition restored with fixed restorations), and adequate mandibular bone allowing for placement of 3.7x11.5mm implant. Participants with parafunctional habits, systemic contraindication to implants, history of head/neck radiation, or who were heavy smokers were all excluded. All participants were first restored with a conventional mandibular denture, which was then used to fabricate a Cone Beam CT stent and surgical guide. All implant placements were performed by two prosthodontists, and uncovered three months later. After two weeks, housings were picked up according to standardized protocol. An external assessor evaluated implant stability following placement (0 month) and then at 1,3,6,9,and 12 month follow-up utilizing an Ostell implant stability quotient. A blinded researcher used statistical software to complete all analysis. Data was summarized by use of mean and standard deviation and then compared using a paired t test. A 1-way ANOVA was performed to explore group-time interaction.

Results: At the conclusion of the study, 0% attrition and 100% survival was observed. Overall, the average Implant Stability Quotient (ISQ) values of anterior implants in the 4 implant group at all intervals were marginally higher than those recorded for implants in the 2 implant group. However, these differences were not of statistical significance. For all implants, regardless of site, initial ISQ was higher than 1 month ISQ. This decrease in implant stability was statistically significant for both groups, but was subsequently followed by a gradual increase in stability of all implants.

Conclusion: The authors of this publication concluded increasing the number of implants from 2 to 4 in mandibular overdentures did not show a significant influence on implant stability. In addition, all implants over time demonstrated an initial decrease in stability, followed by a gradual increase. Clinically, the implication of these results is that a 2 implant retained mandibular overdenture is a cost-efficient treatment for the edentulous patient.

DR. KATHERINE DESILVA;
Resident, Advanced Education in General Dentistry, Virginia Commonwealth University

AEGD ABSTRACT:

MOUNAJJED R, SALINAS T, INGR T, AZAR B. EFFECT OF DIFFERENT RESIN LUTING CEMENTS ON THE MARGINAL FIT OF LITHIUM DISILICATE PRESSED CROWNS. J PROSTH DENT. 2017 NOV 15. PII: S0022-3913(17)30517-6. DOI: 10.1016/J.PROSDENT.2017.08.001

Statement of problem: During the cementation process of lithium disilicate crowns, the vertical marginal fit can increase leading to microleakage and secondary caries. The type of cement used can influence the increase in vertical marginal discrepancy of e.max crowns.

Purpose: This study compared the vertical marginal discrepancy of lithium disilicate crowns using the following resin luting cements: Harvard PremiumFlow cement (flowable composite resin), RelyX Ultimate cement (dual-polymerized resin), and Enamel Plus HRi preheated composite resin.

Materials and Methods: The authors used 18 extracted third molars collected from the department of Oral Surgery, Faculty of Medicine and Dentistry, Palacky University (Czech Republic). The teeth were prepared with a 1 mm chamfer margin, 2mm occlusal reduction, and 1.5 mm axial reduction. IPS e.max press crowns were fabricated for all 18 teeth by one lab technician. They divided the crowns into three groups. The groups were separated according to the cement they used (Harvard Premium Flow (HAR), RelyX Ultimate cement (REL), and Enamel Plus HRi (ENA)). Before cementation, the crowns were prepared first by etching the intaglio surface with 9% hydrofluoric acid for 20 seconds, Air/water rinse for 20 seconds, Immersion in 96% alcohol in ultrasonic bath for 5 minutes before air drying, silane application, followed by bond application. The teeth were prepared first with 37% phosphoric acid etch for 30 seconds, rinsed/ air dried, primer application, bond application, thin layer of resin cement according to the group, press crown down with finger pressure and clean excess cement before light curing for 60 seconds. Crowns were analyzed at four different points (buccal,lingual,mesial, and distal). The study measured one point on the finish line and one point on the margin of the crown. Statistical analysis included nonparametric Kruskel-Wallis test of the median marginal increase of the three groups.

Results: The analysis showed the ENA group had a statistically significant increase in marginal fit compared to the HAR group. There was no significant increase between group HAR and REL or REL and ENA. The mean marginal increase of HAR was 42 ± 11μm, 45 ± 29 μm for REL, and 116 ±47 μm for ENA. These results support what other research has shown regarding the increased film thickness of preheated composite resins compared to flowable resins.

Conclusion: Preheated restorative composite resins demonstrated an increased marginal fit compared to flowable resins or dual-polymerized resin cements. This result suggests that it would not be recommended to cement lithium disilicate crowns with Enamel Plus HRi cement due to the increase in vertical marginal discrepancy. It would be well advised to use either Harvard Premium Flow or RelyX Ultimate cement.

DR. DAVID S. NICHOLS;
Resident, Advanced Education in General Dentistry, Virginia Commonwealth University

SCIENTIFIC

AEGD ABSTRACT:

FERRARI M, SORRENTINO R, JULOSKI J, GRANDINI S, CARRABBA M, DISCEPOLI N, FERRARI CAGIDIACO E. POST-RETAINED SINGLE CROWNS VERSUS FIXED DENTAL PROSTHESES: A 7-YEAR PROSPECTIVE CLINICAL STUDY. J DENT RESEARCH. 2017; 96(13):1490-1497.

Statement of problem: Endodontically treated teeth can be difficult to restore when there is little coronal tooth structure remaining. Fiber-reinforced composite posts are commonly used in such cases, and have gained favor due to their biocompatibility and advantageous physical properties. When treatment planning for a fiber post, the type of restoration (single crown or fixed dental prosthesis), amount of remaining coronal tooth structure, and tooth position should all be considered.

Purpose: This study aimed to assess the 7 year survival of endodontically treated teeth restored with fiber posts, comparing single crowns vs. fixed dental prostheses (FDPs) consisting of one healthy abutment and one abutment restored with endodontic treatment and fiber post. The study also examined whether or not survival was affected by loss of coronal tooth structure.

Materials/Methods: Two experimental groups (n = 60), totaling 120 patients, were divided based on type of treatment needed. All patients required endodontic treatment and fiber post restorations. Group 1 patients received single-unit PFM crowns, while Group 2 patients received 3 or 4-unit PFM FDPs (with 1 healthy abutment and 1 endodontically treated and fiber post-restored abutment). No cantilevers were present, and all FDPs had two abutments only. These two groups were then subdivided (n = 30) based on amount of coronal tooth structure remaining. Subgroup A teeth had more than 50% coronal tooth structure remaining and at least 2 sound walls of 3 mm or more height. Subgroup B teeth had equal to or less than 50% of coronal tooth structure remaining and at least 1 sound wall of 3 mm or more height. All teeth were in the posterior, had at least 1.5 mm ferrule, and lacked periapical lesions. A single operator performed all clinical procedures. The teeth were examined clinically and radiographically by two other blinded, trained examiners at 6, 12, 24, 36, 28, and 84 months. Survival was defined as the absence of post debonding, post fracture, vertical or horizontal root fractures, and periapical lesions requiring endodontic retreatment. Survival rates were calculated by nonparametric Kaplan-Meier analysis and Cox regression models used to assess the interaction of variables.

Results: The overall 7-year survival rate of endodontically treated teeth restored with fiber posts and PFM restorations was found to be 69.2%. The subgroup with the highest survival rate was Group 1A (single crowns, greater than 50% coronal tooth remaining), which had a 7-year survival rate of 90%. Group 2A (FDPs, greater than 50% coronal tooth remaining), had a 7 year-survival rate of 66.7%, followed by Group 1B (single crowns, less than 50% coronal tooth remaining) with a rate of 63.3%. Group 2B (FDPs, less than 50% coronal tooth remaining) had the lowest 7-year survival rate: 56.7%. The differences amongst survival rates for the 4 groups were found to be statistically significant. Cox regression analysis further revealed that both the amount of coronal tooth structure remaining, as well as the interaction between coronal tooth structure and type of restoration (single crown vs. FDP) significantly influenced risk of failure.

Conclusions: According to this study, endodontically treated teeth with fiber posts have a higher 7-years survival rate as single crowns than as abutments in fixed dental prostheses. Furthermore, the amount of coronal tooth structure remaining plays a critical role in the longevity of the restoration. Before a tooth is treated endodontically and restored with a fiber post, the dentist should first consider the amount of tooth structure that will remain following treatment, as well as the final prosthetic treatment plan.

DR. KATRINA A. THATCH;
Resident, Advanced Education in General Dentistry, Virginia Commonwealth University

DR. SUSAN ST. GEORGE

Susan took over a small dental practice in Petersburg in 2013. She has enjoyed the challenge of being an owner and has two wonderful employees. The practice will celebrate its fifth anniversary in March.

AEGD ABSTRACT:

AL-DAJANI M. CAN PREOPERATIVE INTRAMUSCULAR SINGLE-DOSE DEXAMETHASONE IMPROVE PATIENT-CENTERED OUTCOMES FOLLOWING THIRD MOLAR SURGERY? J ORAL MAXILLOFAC SURG. 2017; 75(8): 1616–1626

Statement of problem: Patients undergoing impacted third molar extractions can experience a variety of post-operative complications. Increased attention has been paid to corticosteroids, including dexamethasone, as a treatment modality for managing pain and discomfort following surgery. Corticosteroids have been shown to exhibit anti-inflammatory, immunosuppressive, and anti-inflammatory effects. More evidence is needed to assess the efficacy of dexamethasone for treating post-operative complications following impacted third molar surgery.

Purpose: This study evaluates the efficacy of single-dose dexamethasone in treating complications following impacted third molar surgery. Patient outcomes were assessed, including pain intensity, patient discomfort, analgesic intake, oral function limitation, and daily activity limitation.

Materials/Methods: The author conducted a randomized controlled clinical trial using a triple blinded, split-mouth design. The study population included thirty two adults 18-30 years old diagnosed with bilateral impacted mandibular third molars that required surgical extractions. Patient exclusion criteria included noncompliance with post-operative instructions, presence of systemic diseases, presence of craniofacial syndromes or developmental disorders, having high risk of infection, steroid use currently or within past 3 months, pregnancy, contraindications for dexamethasone, and allergy to amoxicillin. The null hypothesis assumed there was no significant difference in patient outcomes between patients receiving single-dose dexamethasone and those receiving a placebo. Each patient underwent a randomized extraction over two consecutive sessions. All extractions were completed by the same surgeon. At the first session, each patient was given a single dose of dexamethasone (0.1 mg/kg), administered intramuscularly into the deltoid muscle prior to surgery. At the second session, a placebo injection was administered prior to extraction. There was no statistically significant difference in depth and angulation of third molar impaction between the dexamethasone and placebo groups. Site selection and type of intramuscular injection were randomly assigned. Patients were masked to type of injection given. All patients received a preoperative single dose of amoxicillin 2g, and prescribed 400 mg ibuprofen to be taken every 6 hours as an analgesic. All patients were given the same postsurgical instructions. Bias was minimized by blinding the research assistant (data collector) and the biostatistician to the type of injection given. Data were collected daily for seven days following surgery. Several patient-centered outcomes were assessed using the administration of dexamethasone as the primary predictor variable. Pain intensity was measured using a 0-10 VAS, intake of analgesics was measured by number of tablets taken per day, while patient discomfort, oral function impairment and limitation of daily activities were measured using a 5 point Likert scale. Differences between variables were considered statistically significant if a 2-tailed P value was less than 0.05. Chi squired test or Fischer exact tests were used to evaluate variables in the different categories.

Results: Significant differences were found in the dexamethasone group versus the placebo group ($p < 0.05$). The dexamethasone group showed decreased post-operative pain, decreased swelling, lower intake of analgesics, less difficulty in eating and enjoyment of food, decreased malodor during post-op day 2, less absence from work/daily activities, and less limitation of mouth opening. There was no statistically significant difference in outcomes between the two groups in malaise, bleeding, unpleasant taste or smell 3 days after surgery, speech function, sleepiness, or absence from school or work 5 days after surgery.

Conclusions: Prophylactic intramuscular administration of single-dose dexamethasone prior to third molar surgery may be implemented as a safe and effective treatment for decreasing post-operative complications including pain and discomfort, as well as for improving oral function and quality of life.

DR. CHAO YI ZHANG;
Resident, Advanced Education in General Dentistry, Virginia Commonwealth University

DR. BRADLEY HAMMITT

After graduating from VCU in 2015 I began working as an Associate in a two dentist practice in Orange. When I am not helping the residents of rural Virginia, I am working towards achieving Fellowship in the AGD.

SCIENTIFIC

AEGD ABSTRACT:

KORSCH M, WALTHER W, BARTOLS A. CEMENT-ASSOCIATED PERI-IMPLANT MUCOSITIS. A 1-YEAR FOLLOW-UP AFTER EXCESS CEMENT REMOVAL ON THE PERI-IMPLANT TISSUE OF DENTAL IMPLANTS. CLIN IMPLANT DENT RELAT RES. 2017;19(3):523–529.

Statement of problem: Peri-implant inflammation, if not treated, can lead to bone loss and may threaten the survival of an implant. Methacrylate based cements, such as Premier Implant Cement®, have been noted to cause peri-implant inflammation, due to its propensity for biofilm accumulation. Conversely, zinc oxide eugenol cement, such as TempBond®, has been shown to have an antimicrobial effect. It dissolves in liquid, which likely allows the oral cavity to rid it from the sulcus, preventing a long term source of peri-implant inflammation.

Purpose: The purpose of this study was to determine if eliminating methacrylate based cement from a site with peri-implant mucositis would lead to an implant sulcus without any inflammation. The implant restorations were evaluated in a one year follow-up period. A total of 61 implant crowns that had been placed at least 3.5 years earlier were evaluated. Three subgroups were created. One group (26 implant crowns) were cemented with Temp Bond® (TB). The remaining 35 implant crowns were cemented with Premier Implant Cement® (PIC). This group was split into two: the PIC[+] group (21 crowns), which showed excess cement left in the sulcus, and the PIC[-] group (14 crowns), which showed no excess cement.

Materials/Methods: The baseline parameters evaluated were periodontal probing depths, bleeding on probing (BOP), and peri-implant suppuration. The implant crowns and abutments were removed and each sulcus was evaluated for excess cement, which was then removed. All TB cemented crowns were re-cemented and all the PIC crowns were re-cemented with TB. The patients returned for a 4-week follow-up and a 1-year follow-up, at which probing depths, BOP and sulcus suppuration were also examined.

Results: At the beginning of evaluation, 60% of the PIC implant crowns showed excess cement while none was found around the TB cemented crowns. At the initiation of the study, BOP was found in 100% of PIC[+] crowns, and in 93% of PIC[-] crowns. Only 42% of TB crowns showed BOP. Four weeks after the therapy of switching all PIC crowns to TB and cleaning any excess cement, the patients were re-evaluated. From the PIC[+] group, BOP was then present in only 19% and 21% in PIC[-] group. In the TB cement group, 31% showed BOP at the re-evaluation.

One year after initial therapy, patients were again evaluated. BOP was found in 33% of PIC[+] group, 29% of PIC[-] group and 42% of TB group. The results at one year did not differ significantly from the evaluation at 4 weeks. However, in comparison to the initiation of the study, BOP was greatly reduced in all PIC crowns. McNemar's test was done to show statistical significance in the reduction of BOP in PIC crowns from baseline evaluation to 1 year. From initial evaluation to the follow-up at 1 year, in the PIC[+] group, BOP was reduced by 67% and by 64% for the PIC[-] group.

Conclusion: Most agree that excess cement can cause inflamed peri-implant tissues. This study demonstrates that it is not only the mechanical irritation caused by excess cement but also the type of cement that may play a role in peri-implant mucositis. Even without excess cement present in the sulcus, a methacrylate based cement has been shown to cause BOP and inflammation around implants. This study recommends the use of a zinc oxide eugenol cement, such as temp bond for a number of reasons. Because it is water soluble, excess cement in the sulcus dissolves, eliminating the chance of any mechanical irritation. The authors agree that the antimicrobial properties of zinc oxide and eugenol make it a more ideal cement for implant restorations.

KELLY A. SCHWABE, DDS;
Resident, Department of Advanced Education in General Dentistry, VCU School of Dentistry

DR. ANNA SIDOR

Anna is proud to be an endodontist in a great Northern Virginia Community. She resides with her husband Eddy, a periodontist, in NOVA and serves her community in Annandale. She loves the outdoors and is currently training for a marathon.

ORAL CANCER HAS A NEW RISK FACTOR: HPV

Tira Hanrahan, MPH,* and Shillpa Naavaal, BDS, MS, MPH†

Tobacco and alcohol use are no longer the only major risk factors for oral cancers. Research illustrates there is an association between the human papillomavirus (HPV) and oral cancers, particularly for a subset of oropharyngeal cancers (back of the throat, including the base of the tongue and tonsils).[1] The awareness of the risks associated with HPV and oropharyngeal cancers is on the rise as the virus infects nearly 14 million people each year and currently infects around 79 million Americans.[2]

HPV is the most common sexually transmitted infection in the United States. Nearly 80 – 90% of all males and females will be infected with the virus at some point in their lives.[3] HPV infects both mucosal and cutaneous areas of the body with over 150 different strains of HPV between the two sites.[4] Mucosal infections can be caused by either high risk (oncogenic) HPV strains and cause cancer or low risk (non-oncogenic) HPV strains and cause warts at those sites in the body. The sites of infection for at least 40 types of mucosal HPV include the cervix, vagina, anal canal and oropharynx. The majority of HPV infections are transient, asymptomatic, causing no clinical problems and clears on its own within two years.[5] When the virus persists in the body for longer periods it can become an infection which increases the likelihood of the virus turning into health problems, such as genital warts and cancer. HPV 16 and 18 together account for nearly 70% of cervical cancers, and HPV 16 is linked to more than half of oropharyngeal and other anogenital cancers.[6]

HPV is the leading cause of oropharyngeal cancers. In the United States, HPV is linked to approximately 70% of all throat and neck cancers with approximately 60% of oropharyngeal cancers caused by HPV 16 alone.[3,7] Rates of oropharyngeal cancers and the prevalence of HPV associated oropharyngeal cancers are rising in both men and women nationwide.[8] By 2020 the annual number of HPV associated oropharyngeal cancers will outweigh the annual number of cervical cancers.[9] HPV associated oropharyngeal cancers will account for nearly half of all head and neck cancers by 2030[9]. The rise in HPV associated oral cancers disproportionally impacts men.[3,10] There are about 3,200 new cases of HPV associated oropharyngeal cancers diagnosed in women whereas about 13,200 are diagnosed in men each year in the United States.[11]

Common signs and symptoms of oropharyngeal cancer may include persistent sore throat, earaches, hoarseness, enlarged lymph nodes, pain when swallowing, and unexplained weight loss.[3] Cancer caused by HPV can take years to develop after the initial HPV infection. Some people may show no signs or symptoms whereas others may experience symptoms but its cause may not be obvious to the individual who is developing a disease.[12,3] The combination of the absence of symptoms, long latency period, lack of early detection processes, difficulty to visualize oropharyngeal cancers due to their location and inadequate knowledge about link between HPV and oral cancer cause most HPV associated oropharyngeal cancers to be diagnosed at the later stages.[9] Although there is the pap smear for the screening for cervical cancer, there is a lack of early detection processes for other sites of high risk mucosal HPV, such as oral HPV.

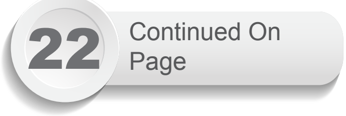
Fewer teens consider vaccination *as important to maintaining their health* as most other aspects of healthcare.

MAINTAINING GOOD ORAL HYGIENE	88%
EATING HEALTHY	80%
GETTING RECOMMENDED VACCINES	65%

The challenges of the virus highlight the importance of HPV vaccination. Completion of the HPV vaccine series provides safe, effective, and lasting protection against nine types of HPV infections. The HPV vaccine has similar efficacy as other vaccines.[4] The HPV vaccine can prevent HPV associated cancers of the cervical, vulvar, vaginal and anal mucosa and may reduce HPV associated oropharyngeal cancers. Over 10 years of vaccine safety data and ongoing systems to monitor the efficacy of the vaccine determine the HPV vaccine is safe.[4] The National Advisory Committee on Immunization Practices recommends routine HPV vaccination for girls and boys ages 11 and 12, as well as individuals ages 13 to 26 if they haven't received the vaccine already.[13] The vaccine is recommended at adolescence because the vaccine is most effective at preventing HPV infections and associated cancers when it is administered before the patient has been exposed to the virus. Additionally, the body has a stronger immune response when the vaccine is administered between 11 and 12 years of age than later in adolescence. If the vaccine series is initiated before the patient's 15th birthday, then the adolescent only needs two doses, whereas three doses are required if the series is initiated after the 15th birthday.[3]

The Center for Disease Control and Prevention (CDC) states that the HPV vaccine was initially developed to protect against cervical and other genital cancers.[3] The Oral Cancer Foundation further explains, "the FDA restricts the manufacturers from talking about other potential positive implications of these vaccines in different anatomical sites that HPV is known to infect."[14] Therefore "if you can't get the virus, you can't get things the virus might cause."[14] Research supports that the HPV vaccination reduces the prevalence of HPV 16 in girls who received the HPV vaccine suggesting that the vaccine may offer protection against HPV associated oropharyngeal cancers.[15] Additionally, the Association of State and Territorial Dental Directors (ASTDD) "endorses promotion of HPV vaccine to reduce the risk of HPV-related oropharyngeal cancer."[16]

Healthy People 2020 objective states the goal of increasing HPV vaccination completion rates to 80% for males and females by 2020.



21 Continued From Page

However, the adolescent immunization rates are far below the projected goal.[17] The National Immunization Survey (NIS-Teen) is a nationwide survey that collects data from parents and guardians about the vaccine uptake of eligible adolescents aged 13 – 17 years old.[18] For 2016, NIS-Teen found that 49.5% of females and 37.5% of all males between the ages of 13 to 17 years have completed their HPV vaccine series.[18] In Virginia less adolescents are protected from HPV associated cancers as compared to the national coverage rate with only 41.1% of female adolescents and 37.4% of male adolescents up-to-date on their HPV vaccine series completion.[18] The most common reasons parents reported not vaccinating their child with the HPV vaccine are a lack of or weak provider recommendation, lack of education, and limited awareness about the importance of the HPV vaccine from a healthcare professional.[19] It is important that all health care professionals and parents understand the importance of vaccinating adolescents.

Dental offices are a common place for adolescents to interface with the health care system. Teens are seen less regularly by their primary care physicians which makes it challenging for medical providers to recommend the HPV vaccine. A compounding result is that parents are then less likely to be informed about the importance of adolescent vaccines because they have fewer interactions with their teen's doctor in comparison to their child's early age visits.[20] A comprehensive study on adolescents found that American teens value maintaining good oral hygiene (88%) over getting recommended vaccines (65%).[20] Dental care providers are a trusted resource and can help to reduce missed opportunities for HPV vaccination by providing education and recommendation during interactions with teens and their parents at their bi-annual visits. Dental health professionals can play a crucial role in improving completion rates of HPV vaccine and reducing HPV associated cancers.

For dental providers, the conversation with adolescents about the HPV vaccine can remain simple, such as "You are the perfect age for getting a cancer prevention vaccine. It can prevent you from getting 9 different viruses, 7 different types of cancer, one of which is in your mouth. Here is more information so you can tell your mom or dad or guardian that you need it, and should get it before you turn 15"[21] Similar conversations can take place with parents too. In an effort to further facilitate and encourage conversations about HPV immunizations, dental providers can also have HPV and oral cancer pamphlets and posters in their office, exam rooms and waiting room areas.

The Virginia Department of Health (VDH) is actively seeking to partner with the dental community to improve HPV immunization rates among Virginia adolescents. Ms. Tira Hanrahan, Adolescent Immunization Coordinator at VDH, partnered with Dr. Shillpa Naavaal, a diplomat of American Board of Dental Public Health and an assistant professor in the Department of Oral Health Promotion and Community Outreach at the Virginia Commonwealth University, School of Dentistry and the Philips Institute for Oral Health Research to create a HPV and oral cancer education presentation. If you are interested in accessing resources related to HPV and oral cancer, learning more about HPV and oral cancers and/or you want to have Ms. Hanrahan and Dr. Naavaal to provide an educational seminar, please contact Tira Hanrahan at tira.hanrahan@vdh.virginia.gov.

*Adolescent Immunization Coordinator, Virginia Department of Health
†Assistant Professor, Department of Oral Health Promotion and Community Outreach, VCU School of Dentistry

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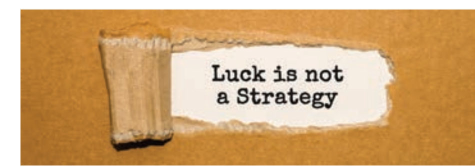
LESSONS TO BE LEARNED:

ONE VOTE MATTERS -YOUR VOTE MATTERS

Dr. Bruce Hutchison, Chair, ADPAC; Chair, VADPAC

This year, 2018, the control of the Virginia House of Delegates was not only decided by one vote, it was decided by a drawing of lots; a game of chance. Unbelievable! For the first time since 1971, almost 50 years ago, a Virginia District (District 94) resulted in a tie vote (11,608 to 11,608). On election night, the Republican candidate was announced as the winner by a 10 vote margin. In a subsequent recount, the Democrat candidate gained 11 votes for a 1 vote win. The next day a panel of three judges decided to allow a previously disqualified ballot to be counted, in favor of the Republican, creating the tie vote. In Virginia, when there is a tie vote, the winner is determined by "drawing lots." Each name was written on a piece of paper and placed in a film canister, the two canisters were placed in a ceramic bowl, and one canister was drawn and opened. The Republican candidate was chosen, therefore winning the delegate position. The other canister was then opened to confirm the second candidate's name was inside it.

In November 2017, in Virginia, there were many close races and four were close enough to require recounts. In District 40, the Democrat was announced to be the winner late election night. But the following day, during a canvass, where results at each precinct are looked at and compared to the number actually reported to the Board of Elections, two precincts had reported the numbers incorrectly, giving the Republican candidate a 100 plus vote lead. A recount confirmed the Republican win by 106 votes. The 2016-2017 Legislative session, Virginia House of Delegates, was composed of a 66 to 34 Republican majority. No one in their wildest dreams would ever have imagined that the Democrats would pick up 15 seats. In the end the Republicans lost a 16 seat majority and barely held onto a one seat majority (51 to 49). All by the luck of a lot drawn. All because of one vote. No one saw this coming, no one predicted this, and everyone was flabbergasted by it. All the prognosticators were wrong. Many "safe" Republican districts, where Democrats often choose not to even run, were won by strong Democratic candidates. The election resulted in a massive change in the Virginia House and has the nation talking about what this means. Democrat or Republican, it doesn't matter.



The Virginia elections in 2017 were a mystery and a shakeup. Things are changing. It doesn't matter on which side of the fence you sit, or even who you vote for. What matters is, one vote can make a difference. YOUR vote can make a difference. If this isn't proof of that then there isn't any proof. We must all partake of our civic duty and choose, by voting, who will represent us. Don't ever again allow a canister to be drawn out of a bowl to decide which party will lead the Virginia House of Delegates. One vote decided not only who represented you, but which party was in control of committee assignments, committee Chairs, and all decisions regarding how the House functioned. That ONE VOTE made a big difference in Virginia. We must heed this lesson and learn from it.

2018 VDA DAY ON THE HILL:

MEMBER DENTISTS AND DENTAL STUDENTS ADVOCATE FOR SUPPORT OF VDA FOUNDATION OUTREACH PROGRAMS

Laura Givens, Director of Legislative and Public Policy

We faced a year of much change in Virginia's legislature- many new legislators to meet and a different building to navigate- the General Assembly Building is currently being remodeled and the temporary building, called the Pocahontas Building, is just a couple of blocks away. In January over 100 VDA member dentists and VCU dental students set out to advocate on a beautiful crisp winter morning in downtown Richmond.

The morning began as it has many times before with breakfast at the downtown Omni. We were honored to have VDA member and House of Delegates member, Dr. Todd Pillion as our guest speaker. Dr. Pillion was appointed to the Appropriations Committee this year. Following his remarks, VDA lobbyists Chuck Duvall and Tripp Perrin addressed the group about the day's mission- to visit legislators and share information on the good work that the VDA and VDA Foundation continues to do for the citizens of Virginia.

All legislators were given a pamphlet during these visits with information on the success of the many programs that the VDA Foundation has established (Missions of Mercy Projects, Donated Dental Services and Give Kids a Smile). We also asked for continued support of funding for the MOM Projects.

We would like to thank all the member dentists and dental students who attended this important event! Your participation helps immensely in making a positive difference for your profession and patients. We welcome and encourage all members to join us at next year's Day on the Hill, scheduled for Friday, **January 18, 2019.**

TAKE A LOOK AT OUR DAY ON THE HILL PHOTO ALBUM AT: HTTPS://GOO.GL/G1RFJT

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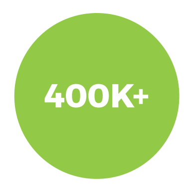

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2018 GENERAL ASSEMBLY WRAP UP

Tripp Perrin and Chuck Duvall, VDA Lobbyists

**Note – March 10th the General Assembly Adjourned Sine Die without producing a budget. Therefore, a Special Session will be called in the days ahead to work on a deal for the biennial budget.*

MILITARY TRAINED DENTISTS

Passed as amended House 100-0 and Senate 40-0. A bill (HB533-Freitas) that requires many Boards, including the Board of Dentistry, to accept the military training, education, or experience of a service member honorably discharged from active military was AMENDED to put our language back in about such instances. The original bill struck the language below but we convinced the patron to put it back in – so this is the status quo moving forward:

- C. The Board of Dentistry may accept the military training, education, or experience of a service member provided the applicant for licensure (i) has been honorably discharged from active military service in the armed forces of the United States, (ii) has been in continuous clinical practice for four of the six years immediately preceding the application for licensure, (iii) holds a diploma or certificate of a dental program accredited by the Commission on Dental Accreditation of the American Dental Association, and (iv) has successfully completed all required examinations for licensure. Active patient care in the Dental Corps of the United States armed forces, voluntary practice in a public health clinic, or practice in an intern or residency program may be accepted by the Board to satisfy requirements for licensure.

BALANCE BILLING

Legislation (HB1584-Byron) designed to prohibit an out-of-network health care provider from charging a covered person who is insured through a health plan an amount for ancillary services that is greater than the allowed amount the carrier is obligated to pay to the covered person DID NOT PASS. We had several conversations with the patron and it was not her intent to ensnare dentists in the legislation and was prepared to take dentists out of it with an amendment we prepared before the legislation was carried over in committee. There are going to be meetings in the off-season to discuss the broader issue of balance billing. We will be part of those discussions and ensure nothing happens to jeopardize dentists' ability to balance bill. A resolution in the Senate (SJ57-Sturtevant) asking JLARC to study the issue of balance billing was NOT PASSED.

BUDGET ISSUE – MOM FUNDING

The Governor's introduced budget has $116,280 in each year of the biennium for MOM funding. We have talked to legislators to ensure this stays in the final budget and possibly add some additional monies to help with costs in at the Wise MOM -- $25,000. The MOM project has gotten frequent praise from both sides of the aisle in recent years.

BUDGET ISSUE – ADULT DENTAL MEDICAID

There was a budget amendment in both the House and Senate to allow for adult dental Medicaid. These were put in at the request of the Virginia Oral Health Coalition NOT the VDA. Not surprisingly this idea made it into neither the amended Senate budget nor the amended House budget.

BUDGET ISSUE – MEDICAID EXPANSION

As noted above, the General Assembly adjourned without a budget for the next two years. The standoff between the House and Senate is primarily over expanding Medicaid to over 300,000 more Virginians. The House version of the budget has expansion, whereas the Senate version does not. If ultimately the sides agree to take down some Federal dollars and add Virginians to the Medicaid rolls, more people could be eligible for dental Medicaid (i.e., kids in the Smiles for Children program, some disabled populations and pregnant women). The actual numbers will be determined by a number of factors that will need to be analyzed.

CONTRIBUTION UPDATE

Laura Givens, Director of Legislative and Public Policy

Political Action Committee
VIRGINIA DENTAL ASSOCIATION

When you give to VADPAC, you are raising the voice of dentistry and protecting the profession for future generations.

How can VDA members help advocate? **Contribute to VADPAC.** The incredible generosity of VDA members has played a large part in VADPAC's success through the years and we must remain more vigilant now than ever in protecting patients and our profession from outside forces that want to disrupt the dentist-patient relationship. Having said that, we need your generous support today- don't delay! The 2018 Session was very productive and we must now turn our attention fully on budgeting VADPAC dollars. If you have not already contributed to VADPAC for 2018 or, if you would like to increase your contribution, contact Laura Givens at givens@vadental.org or 804-523-2185.

Component	% of 2018 Members Contributing to Date	2018 VADPAC Goal	Amount Contributed to Date	Per Capita Contribution	% of Goal Achieved
1 (Tidewater)	33%	$45,500	$26,635	$292	59%
2 (Peninsula)	41%	$27,500	$21,915	$342	80%
3 (Southside)	36%	$14,000	$9,165	$316	65%
4 (Richmond)	33%	$67,750	$54,085	$348	80%
5 (Piedmont)	37%	$30,000	$23,155	$305	77%
6 (Southwest VA)	50%	$25,250	$17,833	$313	71%
7 (Shenandoah Valley)	34%	$30,000	$25,140	$340	84%
8 (Northern VA)	32%	$135,000	$88,645	$305	66%
TOTAL	**35%**	**$375,000**	**$266,573**	**$320**	**71%**

TOTAL CONTRIBUTIONS: $266,573
2018 GOAL: $375,000
MUST RAISE $108,427 TO REACH GOAL

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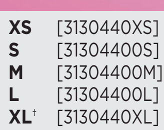

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SEE THE ACCOMPANYING VIRGINIA MEETING REGISTRATION BROCHURE FOR DETAILS ON THIS YEAR'S EVENT.

2018 Virginia Meeting • September 19-23, 2018 • The Omni Homestead Resort • Hot Springs

THE VALUE OF ETHICS

Garrett Gouldin, DDS; Member, Ethics & Judicial Affairs Committee

"Often, ethical transgressions stem more from a lack of awareness of where these admittedly blurry lines may be crossed, and less from ill intent."[1] This quote from a published piece on the ethical challenges we, as dentists, face in modern times is so true. And yet, thankfully, there are clear guidelines and even laws we can point to when we lose our way or when fellow dentists err.

One such example was a topic of interest at the recent state level Ethics Committee meeting in Richmond on January 19, 2018. Website accuracy, and more specifically, dentists falsely advertising that they are active members of the tripartite when in fact they have not paid dues, often times for years, has become an issue. Ethics Committee members, component and state level staff now have to actively track both those dentists who have not renewed membership, as well as all non-member dentists, to ensure that they do not unfairly benefit from having the trademarked ADA/VDA logo, or the claim that they are member dentists of the tripartite, on their website.

1 (http://www.dentistrytoday.com/news/todays-dental-news/item/1083-dentists-face-new-ethical-challenges-in-the-21st-century)

On false advertising, there is no ambiguity – the line is not "blurry". The ADA Principles of Ethics and Code of Professional Conduct states in 5.F. ADVERTISING:

" … no dentist shall advertise or solicit patients in any form of communication in a manner that is false or misleading in any material respect."

And the laws from the Virginia Board Code of Virginia are clear as well. § 54.1-2706. Revocation or suspension:

"the Board may … suspend for a stated period or indefinitely, or revoke any license … for: 7. Publishing or causing to be published in any manner an advertisement relating to his professional practice which (i) is false, deceptive or misleading,…"

With this backdrop, several thoughts come to mind. First, we all have experienced oversight with bills/dues payment, and many of the dentists in violation, when contacted, rejoin. Regretfully, other dentists decide not to renew, and then remove their advertisement. Still others, albeit a small percentage, ignore their violation and then are passed to the state level Ethics Committee, and if noncompliant, are referred to the Board of Dentistry. While unfortunate, it should be heartening for the vast swath of paying members that there is a system of discipline where necessary.

The concept of the value of membership also comes to mind, which as a noun "value" is defined as the regard that something is held to deserve; the importance, worth, or usefulness of something, and as a verb it means to estimate or assign monetary worth. Dr. William Bennett, our state level Ethics Committee Chairman points out that,

"The value the ADA provides to members, the profession, patient's welfare and even to non-member dentists is significant. ADA members are carrying the torch for this and are…hopefully recognized for that effort by a universal belief by the public that being an ADA member gives reason to expect credibility and professionalism."

He also rightly points out that each one of us should be involved in maintaining professional standards, and that a constant grassroots effort is critical to keep our reputation high. It is critically important to remind our fellow dentists who may be going astray that perhaps of all of the things we spend money on in our business, it could be argued that tripartite membership is the most beneficial for us, and for our patients.

NOTES FROM THE REGISTRATION DESK

Sarah Mattes Marshall, VDA Membership Advocate

The 2018 New Dentist Conference was my first and, by all attendee accounts, a big hit! We had a great turnout, exceptional CE, and several fun social events! In fact, we heard from one attendee who was planning to leave early on Saturday that they opted to stay because the CE was so compelling. Thanks to Richmond-based Oral Surgeon, Dr. Kanyon Keeney, and Dental Economics Editor-In-Chief, Dr. Chris Salierno, for your presentations! We also heard from several exhibitors who enjoyed their conversations so much that they've already signed up to exhibit at the Virginia Meeting. And lastly, as advertised, the '80s themed costume contest was totally tubular.

While I hope that the CE was helpful to you, please know that seeing each of you in person is equally helpful to our VDA staff. Something as short as a 5-minute chat can help me identify VDA or ADA resources that may be helpful to you, or to make an introduction and help you build your network. And while my primary charge is to help each of our members as individuals, our conversations can also highlight issues that affect broader membership segments. The steps we make together will continue to make the VDA one of the ADA's strongest state associations.

We hope that the mix of clinical and practice management CE with laid-back networking opportunities is something you'll continue to enjoy, but we're always open to suggestions! And on that note, we couldn't host a great conference like this without our exceptional New Dentist Committee, led by Dr. Stephanie Vlahos. Our members in leadership roles help set the direction for our events, so if you're interested in getting involved or have other ideas on how we can improve our events, please let me know!

DON'T LEAVE YOUR FRIENDS OUT

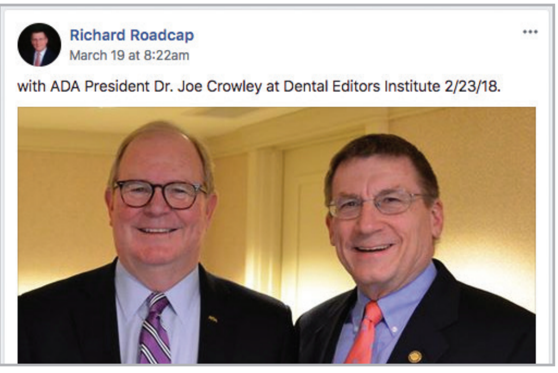
Shannon Jacobs, VDA Director of Communications

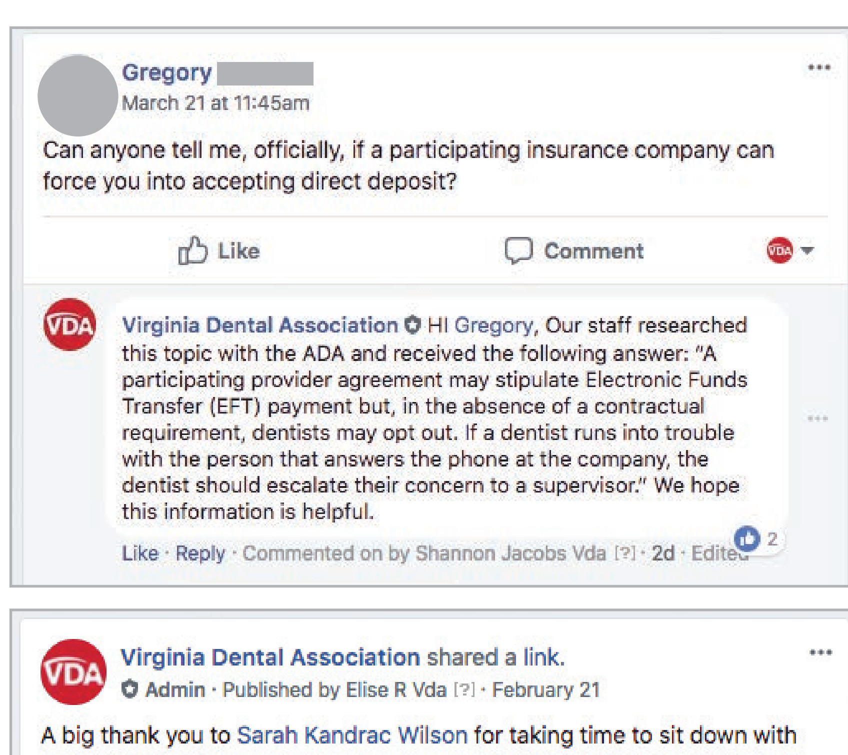
Many of you have joined and are actively participating in our member only Facebook group. Recently, you've been busy sharing pictures, stories, and posing questions to the group. We've seen a lot of comments and "likes" on these posts and they're exactly why we started this group. Please help us continue to build this dialog by inviting your dentist friends to the group. Don't worry, VDA staff will be sure that everyone that joins the group is a current VDA member.

If you haven't joined the group yet yourself... what are you waiting for? The group is free to join and is simply another way for you to connect to other VDA members and support each other in an online community.

Take a look at some of the recent examples of what's been going on in the group (below). Then take a moment and join our group. You'll be glad you did!

https://www.facebook.com/groups/VDAmembersonly





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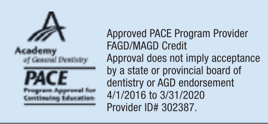

STILL ON TAP

DENTISTS UNITE TO SAVE FLUORIDATION IN SPOTSYLVANIA

Dr. Frank Iuorno; Associate Editor, Component 4

In 2015, Spotsylvania resident Larry Plating started his crusade to end water fluoridation in Spotsylvania County. He cited reduced IQ levels along with a host of other health problems as reasons to discontinue water fluoridation, a practice that has been in service in Spotsylvania County since 1981. "Let the fluoride be provided by peoples' choice, not government coercion, and save us all taxpayer dollars in the process," Plating, a retired chemist, was quoted as saying in June of 2017.

His arguments were supported by the Fluoride Action Network and the International Academy of Oral Medicine and Toxicology. Plating, along with the aforementioned groups, asserted that water fluoridation was an outdated form of "mass medication", was unnecessary and ineffective at reducing caries, and was not safe because it caused fluorosis, severe bone disease in dialysis patients, arthritis, damage to developing brains, and various other detrimental health outcomes.

In January, 2018 the Board of Supervisors for the county met and heard arguments for and against water fluoridation. Dr. Lloyd "Jeppy" Moss a dentist from Fredericksburg expressed his disappointment that the Board would even reconsider the practice for water fluoridation despite the plethora of scientific information outlining its benefits.

The Centers for Disease Control have touted water fluoridation as one of the 10 "great public health achievements of the 20th century." The city of Fredericksburg Public Works Director, Dave King, was in firm support of water fluoridation. The overwhelming preponderance of scientific literature on the subject supports public water fluoridation. The World Health Organization, Harvard School of Dental Medicine, American Medical and Dental Associations and more than 100 other worldwide healthcare organizations all support public water fluoridation.

Yet the Board was on the fence.

In February 2018, the Spotsylvania Board of Supervisors voted 4-3 to continue water fluoridation; however, Board Supervisor Chairman Greg Benton is still interested in surveying residents about water fluoridation and putting an "informational statement and/ or warning" on water bills.

Earlier this year, the EPA denied the Fluoride Action Network's request to prohibit public water fluoridation stating that the FAN did not provide enough science to back up their claims. The FAN and anti-fluoride groups sued the EPA and most recently, a federal judge recently denied the EPA's motion to dismiss the complaint. Arguments will be heard and the FAN's along with other anti-fluoridationists' voices are loud, especially with the help of social media and the internet.

We have not heard the end of this debate and it will most likely affect some of you in the near future. It is our obligation, to educate our local political leaders as to the benefits of water fluoridation and dispel any misinformation that is disseminated. You may be called as a local dentist to take action when debate affects your area. We know that local leaders value the voice of local doctors more than the voice of the ADA or state associations. Dr. Moss' contribution to the debate of the Spotsylvania Board was invaluable!

For your patients who have questions, the VDA website provides concise information at http://www.vadental.org/for-the-public/faq on the benefits of fluoride. You can stay informed by searching the ADA's member website Fluoride FAQ's.

WISE M.O.M. 2018:

WE'VE MOVED

Barbara Rollins, Director of Missions of Mercy

Wise M.O.M. 2018 is moving to the UVA Wise Convocation Center to improve the patient's experience and our ability to serve their needs. This new venue will allow our patients to get out of the weather and receive their services in an air-conditioned and far more comfortable setting than the fairgrounds. The indoor space will provide a safer and more suitable clinical environment for both patients and volunteers. We are also celebrating a huge milestone, the 100th M.O.M. project. Spread the word and plan to join us as we celebrate in Wise.

VOLUNTEERS NEEDED!

MOM will need many additional volunteers to help in all areas, dental professionals and dental support volunteers including patient registration, volunteer registration, parking, patient flow, and set-up and break-down.

Mark your calendar for July 20-22, 2018 at the UVA College at Wise, Prior Convocation Center (1 College Avenue, Wise, VA 24293)

Volunteers are invited to register online at www.vdaf.org.

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Kambiz Tavakkoli, D.M.D. &
Kamran Tavakkoli, D.M.D.
have acquired the practice of
John T. Grubbs, D.D.S.
Alexandria, Virginia

We are pleased to have reprented all parties in these transitions.

Practices For Sale

Great Opportunity in Midlothian
This 6 treatment room facility is modern and digital, using Softdent software. The office has good visibility on a busy road. The practice grosses $900K and is open 4 days per week with many procedures referred out. **Opportunity ID: VA-5145**

Growth Opportunity in Fairfax
This 3 treatment room office has paperless charts and is equipped with the latest technology, including digital X-ray. The current gross is $600K with over $1M in unscheduled treatment. There is great growth potential from here. **Opportunity ID: VA-5113**

Exceptional Practice in Smaller Community
The 4 treatment room office is located on the Northen Neck. The seller owned facility is approximately 2,400 sq. ft. with digital X-ray and digital pan. The practice revenue is consistently in the $500-600K range and there is strong potential for growth. **Opportunity ID: VA-5112**

FFS Practice South of Roanoke
This office is in a stand-alone building with 4 equipped treatment rooms with space for an additional room. The facility has digital X-ray and up-to-date equipment. The practice has incredible growth potential, and is currently grossing $655K. **Opportunity ID: VA-5018**

Small General Practice in Desirable Chantilly
This established practice is currently seeing patients 4 days per week and is grossing $312K. The office has digital X-ray and uses EasyDental software. The nicely appointed 2 treatment room office would make a great satellite or a first practice for an associate that is ready for ownership. **Opportunity ID: VA-5010**

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BETTER COMMUNICATION, NO WORRIES

SECURE EMAIL FROM VDA SERVICES ENDORSED VENDOR

Richard F. Roadcap, D.D.S., Editor

In the early nineteenth century a loose-knit movement known as the Luddites arose in Great Britain. Craftsmen and artisans feared the machinery of the Industrial Revolution would destroy their livelihoods and leave them destitute. They banded together to damage machines and burn down factories. Military force was used against the rebels, and the movement soon died out. Today, the moniker "Luddite" is applied to anyone who disdains or rejects the use of modern technologies.

I'm not a Luddite, but there are times when I feel they had their hearts in the right place. For example, have you spent time in a Verizon Wireless® store lately? Tech can be frustrating. What if I told you VDA Services, through an endorsed vendor, offers a service that will make your practice life simpler, is very easy to use, and costs only a small fraction of your cell phone bill?[1] You'd say that's a no-brainer. The HIPAA-compliant encrypted email feature, iCoreExchange® is all that and more. Protected Health Information (PHI) must be secured before sending electronically, and iCoreExchange allows your office to forward PHI to other dental offices, and healthcare providers, securely, encrypted, and compliant with HIPAA requirements. The best part? It's $22.50 per month, available at this rate only to VDA members. Competing services are often double this amount.

If you use any of the popular email servers, I'm sure you've been hacked one or more times. You often find out when friends tell you to stop emailing them links to buy drugs from Canada. Yet many dental offices continue to send patient information by way of Yahoo!, AOL, or Comcast, and hope nothing goes wrong. Some excuses for not subscribing to secure email include:

- "I use Gmail."
- "My IT person takes care of that."
- "It comes with my software package."
- "I've never had a problem."
- "We don't send by email that often."

Invariably, another office, often a specialist referral, needs a document, photo, or radiograph right away (the patient is on the way) and we hit "SEND" and hope for the best. Hackers are licking their chops.

Getting started is as easy as calling iCoreConnect.com, (888) 810-7706, and scheduling a time for installation on your office computer. It takes about 20 minutes, and they'll walk you through it, even if you're a technophobe like me. You'll have an icon for your desktop, and once you double-click it will open to login and then display the functions. You can download all your email contacts from an existing address book; no need to create a new database for addresses. To compose, you can enter messages, attach documents of any type, and files of any size (remember, you're now on their website), and send to any recipient for whom you have an email address. This can include other dental offices, medical offices, and insurance companies.

If the recipient is not an iCoreExchange user, they'll have to create a user ID and password (once) to open your documents. If they also subscribe to iCoreExchange, that's even better! You can communicate seamlessly through the website without engaging their email server. When I started out, I called my specialty referrals, and each office reported no problems with the system.

Despite our digital environment, most offices still rely on paper documents, and need a hard copy one or more times. This is where iCore excels: you can print the messages, the attached documents such as letters, and the accompanying radiographs from any screen. There are no arcane series of commands needed to generate a paper copy, just click on the "Printer" icon at the top of the screen. And for documentation, the site keeps a chronological record of all messages sent and received to back up your paper charts.

You'll ask, "Do I have to be at my office to use the system? Suppose I'm out of the office and need to look at an x-ray?" The answer is '"No", iCoreExchange® can be accessed from any internet-connected web browser. So, yes, you can log on with your iPhone or Andrioid device. It makes life easier when traveling for CE, or on vacation.

In its product literature, iCoreExchange says that 2,000 doctors told them "I want to email anything to anyone, anywhere…and be fully HIPAA compliant." My experience of the last two and a half years has shown this to be the case. Why lose sleep over this? You can find lots of ways to save $22.50 in your office and pay for this valuable service. It's just one more benefit available only to VDA members.

1 https://www.icoreconnect.com/vda

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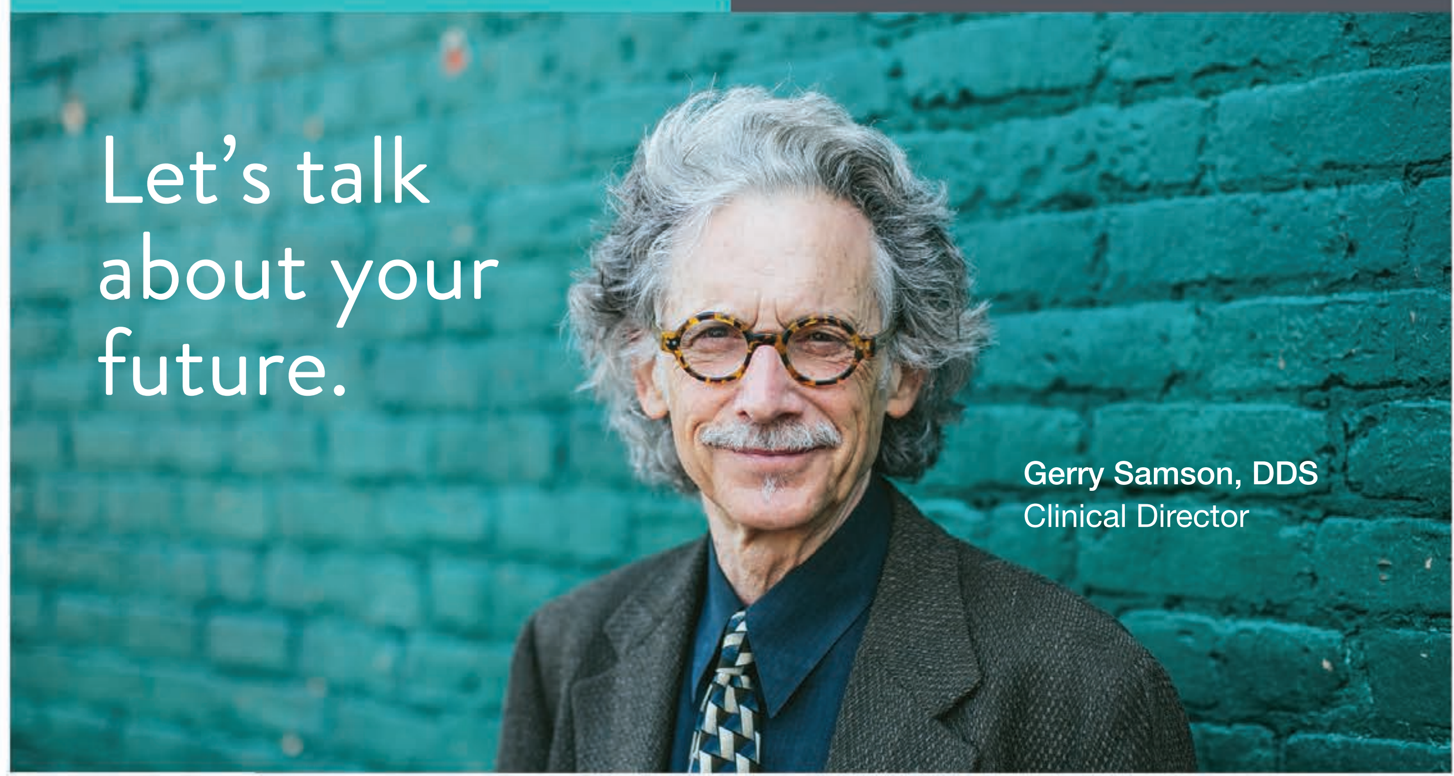

www.springandsprout.network

WHAT YOU NEED TO KNOW:

FROM THE MARCH 2018 VIRGINIA BOARD OF DENTISTRY MEETING

Dr. Ursula Klostermyer

A big thank-you goes out to all participants and speakers at the Regulatory-Legislative Committee meeting on Thursday March 8, 2018! For those private practitioners it was important enough to close their practices for some hours and speak during the public comment period, asking that the committee recommend the Board retract the fast-tracked amendment restricting the advertising of dental specialties and re-submit to go through the regular regulatory process. A total of 11 individuals asked that the fast-track amendment be revoked. This is a great example of strength in numbers, the importance of organized dentistry and what dentists can do to get their voices heard. As a result of our members' comments, the committee and the Board unanimously voted on both days to recommend that the Board retract the fast-track regulation and submit as a NOIRA (notice of intended regulatory action). Now the regulations will have to go through the longer regulatory process with much opportunity for public comment, input and Board discussions. This process might take up to two years.

Another topic discussed and voted on both days was the recommendation that the Board not pursue adding the PGY-1 Pathway for Licensure. No changes will happen as of this time.

The committee reviewed the Regulatory Advisory Panel Recommendations on Sedation Regulations. One item that the Virginia Association of Nurse Anesthetists has brought to their attention is that the law indicates that a dentist must obtain a sedation permit if moderate or deep sedation/ general anesthesia is provided in their office (even if it is being administered by hired CRNA, anesthesiologist, etc.). The regulations contradict this law so they would like clarification. Ms. Elaine Yeatts indicated that this is something that the Board will need to discuss with their legal counsel before pursuing any action.

It was agreed that there will be no CE credits for Board members attending board meetings.

For new licensees and for dentists' renewals there will be no dental law exam, which had been discussed previously.

Dr. John Alexander stressed the importance of regulations regarding the advisory panel on opioids. From 2020 on, all prescriptions have to be "e-scripts" for the purpose of prescribing opioid medications. This prevents the previous problems with stolen Rx-pads or fraudulent called-in opioid prescriptions.

Visit https://virginia.pmpaware.net/ for a listing of free CE courses available.

Regarding the renewal of dentist and hygienist licenses we all discovered that our fees are lower this year. The reduced fees will only apply this year. From now on the month for renewal of a dentist or hygienist license will be the month of birth.

The board had hired an independent research group to analyze the structure of sanctions and the structure of fines. Mr. Neil Kauder presented the group's findings and compared the fines for dental violations to the medical, veterinary and pharmacist sanctions. It was discovered that the data worksheets collected had to be compared to more updated data. Dr. Barbara Allison-Bryan, DHP Chief Deputy Director, stated that the fines should be adjusted to the different ranges of dentist and hygienist incomes.

The turnout of 10 or more people was crucial! Be active – stay informed! We can make a big difference!

Editor's Note: Information contained herein is deemed reliable, but not guaranteed. VDA members are advised to read and comprehend all Virginia Board of Dentistry policies and regulations.

VIRGINIA BOARD OF DENTISTRY

DID YOU KNOW?

- **SAFE AND SANITARY PRACTICE**
  Did you know that a dentist is responsible for maintaining a safe and sanitary practice, including containing or isolating pets away from the treatment areas of the dental practice, with an exception being made for a service dog?

  18VAC60-21-60.A(1)

- **PRACTICE TRANSITION AND PATIENT NOTICE**
  Did you know that when closing, selling or relocating a practice, the licensee shall meet the requirements of §54.1-2405 of the Code of Virginia for giving patients advance notice and information on obtaining or transferring their treatment records?

  18VAC60-21-90.F

- **PATIENT RECORDS**
  Did you know that a patient's records cannot be withheld because the patient has an outstanding financial obligation?

  18VAC60-21-90.D

WORK WITH A DEDICATED HEALTHCARE BANKER WHO UNDERSTANDS YOUR BUSINESS.

As a dentist and business owner, you know it's often the little things that make the biggest difference. That's why you're always looking for ways to improve your practice. PNC's dedicated Healthcare Business Bankers can offer you guidance and cash flow tools to help you make your business better. Whether you're managing payables and receivables, purchasing new equipment or expanding your services, talking to a banker who knows your practice is another small change that can make a big impact.

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Banking and Lending products and services, bank deposit products and treasury management services, including, but not limited to, services for healthcare providers and payers, are provided by PNC Bank, National Association, a wholly owned subsidiary of PNC and Member FDIC. Lending and leasing products and services, including card services and merchant services, as well as certain other banking products and services, requires credit approval. All loans and lines of credit are subject to credit approval and require automatic payment deduction from a PNC Bank business checking account. Origination and annual fees may apply. ©2017 The PNC Financial Services Group, Inc. All rights reserved. PNC Bank, National Association. **Member FDIC**

SOCIAL MEDIA AND DENTISTRY:

HELPFUL OR HARMFUL?

Amanda Toulme, Associate Editor; Class of 2019,
VCU School of Dentistry

Do you remember when patients found your practice in the newspaper? Or when they found your practice's advertisement in a phone book? If you are a new dentist, you most likely are not as familiar with these traditional forms of publicity. In the last decade, the uncontainable rise of social media has revolutionized the way that many dentists connect with prospective patients. The world-wide-web provides great opportunities for dentists, but utilizing social media in your practice comes with significant responsibility, along with possible drawbacks.

According to *The Wealthy Dentist*, Facebook is the largest website in the US and accounts for one in every eleven internet visits. Dental practices utilize Facebook and Instagram to spread the word about their practice, to publicize new specials or offers that their office may be participating in, and to demonstrate positive stories, reviews, and even "before and after" pictures. Presenting your own work on social media can be an amazingly easy and efficient way to showcase your talents. Many patients are happy to lend a helping hand (or their pearly whites) to add to your online post.

However, even when patients are excited to be a part of their practice's social media presence, there are still key legal and ethical considerations involved with using this form of publicity. Just like in any patient care scenario, it is incredibly important to safeguard against any possible exposure of Protected Health Information (PHI). If patients do not completely understand how social media works or that their identity may be revealed through your page, then the confidentiality between you and your patient could inadvertently be broken. Most dentists are cognizant of protecting PHI, but sometimes personal identifiers are revealed in ways that go overlooked. In clinical photos, personal identifiers such as tattoos, irregular anatomy, or even unique jewelry can give away a patient's identity, especially in a small town. If a patient offers to be a part of your social media presence, make sure that they completely understand what the post will contain. Many practices have specific written release forms for this purpose.

What about social media posts that you can't control? Many prospective patients look for reviews of dentists before they book their first appointment on websites such as Yelp or Angie's List. If your practice is present on these websites, then you can encourage your patients to leave reviews. This is where acquiring reviews can get dicey – some dentists even offer rewards such as free whitening or discounts for positive reviews. Is this a gentle nudge to spread the good word about a practice, or a bribe? Regardless of your own standpoint, all dentists must take care to uphold the authenticity of their practice, and all reviews must be genuine. Nevertheless, bad apples inevitably leave reviews as well. A single disgruntled patient can write a horrible review, and sometimes even random people will post fake negative reviews on your page. Fortunately, you can often leave a response to your reviews, and you can contact a moderator if someone who was never your patient leaves a review.

Do you use social media to grow your practice? There are absolutely both pros and cons to utilizing social media pages to expand your practice. In the end, practices built on word of mouth, referrals, and local advertisements grow strong patient bases. Still, the rise of technology has changed the way that many new patients find their dental home. If you have a new practice or want to expand, make sure to consider the advantages and disadvantages of social media in your practice!

AWARDS AND RECOGNITION

Dr. Harry Simpson
(second from left)

50 YEARS OF SERVICE
Boys & Girls Clubs of the Virginia Peninsula

L-R: Drs. Joseph Bernier-Rodriguez, Robert Argentieri, Paul Olenyn, Avi Gibberman

VDA FELLOWS
Virginia Dental Association

NEW BRAND FAMILY

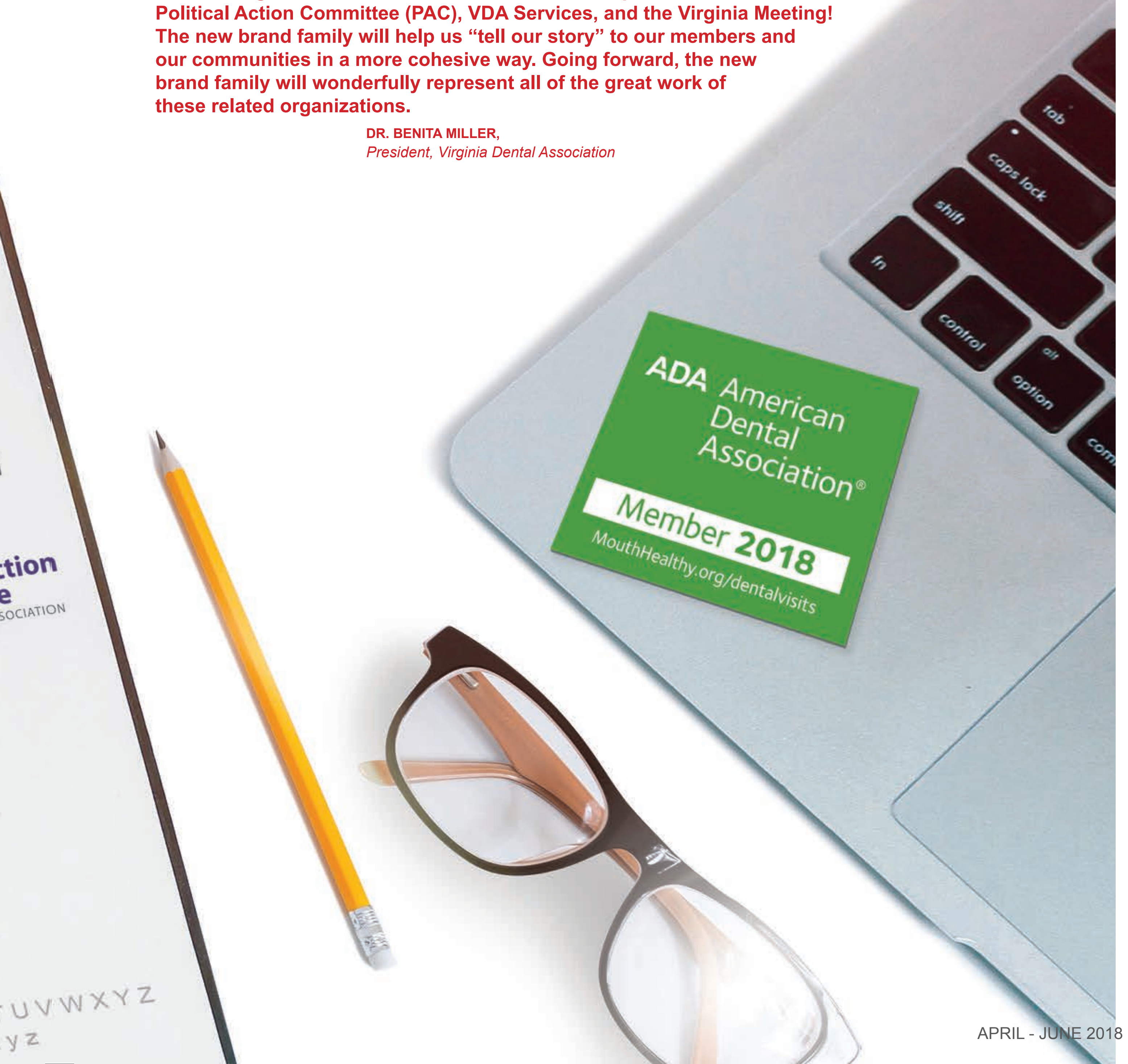
PROVIDES POWERFUL MESSAGE ON THE IMPACT OF ORGANIZED DENTISTRY IN VIRGINIA

With a large association, it is not uncommon for the organization to have many areas of interest and expertise in addition to related organizations, subsidiaries and offshoots from the original body. The VDA is no exception and throughout the years a foundation, a for-profit subsidiary, a very successful annual meeting and a political action committee that is highly respected in the halls of the Virginia General Assembly have all become an integral part of the work of VDA Members, staff and volunteers. In 2017, the VDA did a survey of all of these related entities and determined that while all do amazing work; time had led to a divergence in branding that caused each group to appear to be unrelated.

The lack of a cohesive brand diluted the work of all of the organizations comprehensively and caused confusion among members and the public. To benefit all audiences, the VDA embarked on a brand family redesign to create a unified look and feel across all of these amazing organizations.

We have a great new, unified look for our VDA components, VDA Foundation, Political Action Committee (PAC), VDA Services, and the Virginia Meeting! The new brand family will help us "tell our story" to our members and our communities in a more cohesive way. Going forward, the new brand family will wonderfully represent all of the great work of these related organizations.

DR. BENITA MILLER,
President, Virginia Dental Association



WELCOME NEW MEMBERS

Karen Clendenen, VDA Membership Associate

TIDEWATER DENTAL ASSOCIATION

Dr. Dumbuos Asigri – Virginia Beach – NY-Lutheran Medical Center, Dept. of Dental Service 2015

Dr. Leslie Lang – Suffolk – Midwestern University 2013

Dr. Kevin Leong – Portsmouth – University of Maryland School of Dentistry 2016

Dr. Kristen Maddux – Virginia Beach – Virginia Commonwealth University School of Dentistry 2011

PENINSULA DENTAL ASSOCIATION

Dr. Alexander Royzenblat – Chesapeake – University of Detroit Mercy School of Dentistry 2001

SOUTHSIDE DENTAL SOCIETY

Dr. Huiyan Guan – North Chesterfield – State University of New York at Buffalo School of Dental Medicine 2016

Dr. Naga Sucharith Tadepalli – Colonial Heights – Temple University 2017

RICHMOND DENTAL SOCIETY

Dr. Daniel Bartling – Richmond – West Virginia University School of Dentistry 2014

Dr. Thomas Dix – Henrico – University of Texas Health Science Center-San Antonio Dental School 2016

Dr. Gail Kim – Richmond – University of Pittsburgh School of Dental Medicine 2016

Dr. Sean Pack – Mechanicsville – University of Detroit Mercy School of Dentistry 2011

Dr. Afia Rasul – Richmond – University of Maryland School of Dentistry 2012

Dr. Hannah Rustin – Richmond – Medical University of South Carolina James B. Edwards College of Dental Medicine 2016

PIEDMONT DENTAL SOCIETY

Dr. David Irby – Gretna – Virginia Commonwealth University School of Dentistry 2016

Dr. Ching-Wen Wang – Lynchburg – Roseman University of Health Sciences 2017

SOUTHWEST VA DENTAL SOCIETY

Dr. Jae Park – Christiansburg – Creighton University School of Dentistry 1998

SHENANDOAH VALLEY DENTAL ASSOCIATION

Dr. Jeremy Jordan – Charlottesville – Virginia Commonwealth University School of Dentistry 2015

Dr. Amanda Magid – Charlottesville – West Virginia University School of Dentistry 2016

Dr. Zachary Paukert – University of Texas Health Science Center at San Antonio 2006

Dr. Jennifer Yau – Charlottesville – Virginia Commonwealth University School of Dentistry 2016

NORTHERN VA DENTAL SOCIETY

Dr. Mona Abdel-Wahab – Arlington – Howard University College of Dentistry 2011

Dr. Gursimran Bhangra – Ashburn – State University of New York at Buffalo School of Dental Medicine 2017

Dr. Leah Byars – Sterling – New York University College of Dentistry 2017

Dr. Shringar Chopra – Vienna – Howard University College of Dentistry 2005

Dr. Ashraf Eid – Stafford – University of Maryland Baltimore College of Dental Surgery 2017

Dr. Justin Hughes – Alexandria – Virginia Commonwealth University School of Dentistry 2013

Dr. Darin Iverson – Arlington – University of California at Los Angeles School of Dentistry 1995

Dr. Golnaz Jalali – Arlington – Virginia Commonwealth University School of Dentistry 2011

Dr. Joy Jang – Reston – University of Southern California School of Dentistry 2004

Dr. Carolyn Jones – Great Falls – University of Maryland Baltimore College of Dental Surgery 1999

Dr. Kambiz Khalilinejad – McLean – Boston University Goldman School of Dental Medicine 2017

Dr. Jean-Claude Kharmouche – Sterling – Boston University Goldman School of Dental Medicine 1993

Dr. Nishal Patel – Leesburg – Virginia Commonwealth University School of Dentistry 2015

Dr. Kristin Robertson – Alexandria – Virginia Commonwealth University School of Dentistry 2013

Dr. Pablo Ruck Troncoso – Woodbridge – NY-Lutheran Medical Center, Dept. of Dental Services 2017

Dr. Ahmed Saadula – Fairfax – Howard University College of Dentistry 2016

Dr. Zainab Shaghati – Springfield – University of Maryland Baltimore College of Dental Surgery 2018

Dr. Peter Shim – Woodbridge - University of California at Los Angeles School of Dentistry 2015

Dr. Adam Ta – Falls Church – Virginia Commonwealth University School of Dentistry 2006

Dr. Nino Tsintsadze – Alexandria – University of Maryland Baltimore College of Dental Surgery 2017

EVERYTHING YOU NEED TO KNOW ABOUT LIFE AND RETIRED MEMBERSHIP

Sarah Mattes Marshall, VDA Membership Advocate

As 2017 came to a close and everyone was gearing up to pay their 2018 dues, I received several calls from retired and/or life members with questions about their membership status. Some of them had no idea that they were just one form away from free dues until we talked!

In the likely event that there are more of you out there, and others nearing these milestones, I thought it might help to define the various stages and associated fees.

LIFE MEMBERSHIP

Members who are 65 or older and have at least 30 years of consecutive membership with the VDA OR 40 total years split among several state associations.

There are two types of life membership:

- Active Life Membership - Members who meet the requirements for life membership, but are not yet retired. This provides a 25% discount off the price of full active dues.
- Retired Life Membership - Members who meet the requirements for life membership and are no longer in practice. Member dues are FREE.

RETIRED BUT NOT YET A LIFE MEMBER

If you've retired but haven't attained life membership, you still qualify for a 75% discount off of full active dues.

TAKING ADVANTAGE OF THIS BENEFIT:

Whether you qualify for life membership or not, if you've retired or about to retire and want to receive the appropriate discount to your dues, contact me (mattes@vadental.org or 804.523.2189) for a Retired Affidavit form. More information on membership, check out this resource from the ADA: https://goo.gl/8Y1s85

In parting, I want to challenge each of our retired members to reach out to me directly about volunteer opportunities listed below. We value the knowledge and experience you bring to the table and are looking to create more opportunities for you to share that information within our dental community and across the commonwealth.

RETIRED? THE NEEDS YOU!

REMAIN ACTIVE IN THE DENTAL COMMUNITY, STEWARD FUTURE GENERATIONS AND CONTRIBUTE TO THE CONTINUED SUCCESS OF YOUR BELOVED PROFESSION!

BECOME A MENTOR

Dental students and practicing dentists are looking to connect with and learn from experienced professionals.

SERVE AS AN AMBASSADOR

Help new members become involved in our organization and access its many resources by becoming an ambassador.

REPRESENT THE VDA

Its hard to make time for advocacy during a 40+ hour work week. Consider serving as a representative for the VDA in our legislative and regulatory outreach.

Contact Sarah Mattes Marshall, Membership Advocate, to get involved. 804.523.2189 or mattes@vadental.org

IN MEMORY OF DR. CAROL NIBLEY BROOKS

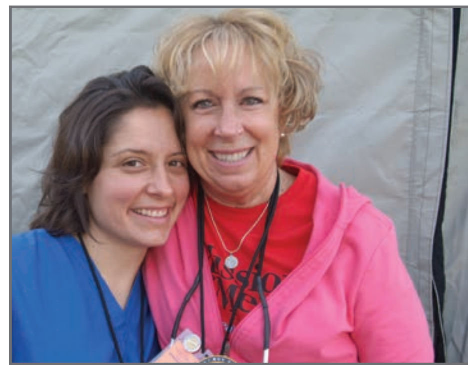
Dr. Robert Barnes

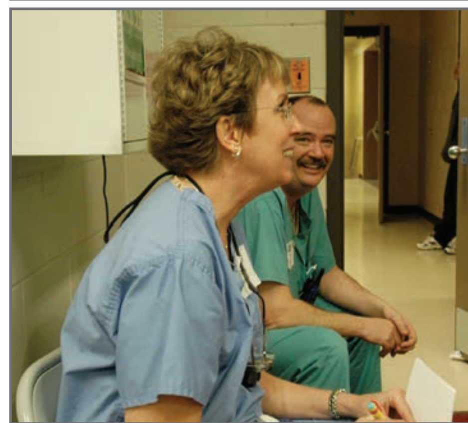
When I was asked to contribute to a memorial for Dr. Carol Brooks a flood of memories entered my mind. I had the privilege of knowing Dr. Brooks from her position as hygiene faculty at Virginia Commonwealth University School of Dentistry through her VCU pre-doctoral education in the 1990s (I was her group leader in the 1990s) to her position as a peer on the faculty at the School of Dentistry. When I was the full time faculty administrator of the VCU Jamaica Project, Carol made it very clear that she wanted in on the Project and her contributions to that effort were considerable, carrying through even to today! She participated as a student and later as faculty in the project, using her experiences in Jamaica as a foundation for ideas when asked to help organize the Mission of Mercy Project by the Virginia Dental Association. She was instrumental in setting up a system that ultimately proved to be a roadmap for other state dental societies when establishing similar projects.

In addition to her contributions to public health dentistry, Carol served as a mentor to both the undergraduate dental student as well as residents in the AEGD program she administered at VCU. She was constantly available to students, taking time in her full time faculty schedule to listen to students, giving them guidance and helping them focus on the right stuff. She could be found at the Dental School on weekends working with the D1 and 2 students, helping them perfect their preclinical skills. Students knew that they could depend on her for good advice.

When Dr. Brooks passed away a void appeared in the school and state dental world that will be difficult to fill. Carol always liked to use positive reinforcement when dealing with students and frequently used the expression “good job” to do so. When I reflect on her contributions to the school, state, and national dental worlds I think that statement could be elevated to another level: “great job” Carol, you will be sorely missed.

Editor’s Note: Dr. Barnes is Adjunct Clinical Professor, Virginia Commonwealth University School of Dentistry





IN MEMORY OF:

Name	City	Date of Death	Age
Dr. Frederick S. Krochmal	Vienna	March 13, 2018	75
Dr. David D. Peete	Arlington	February 20, 2018	97
Dr. John J. Sweeney	Glen Allen	February 11, 2018	77
Dr. Wallace B. Lutz	Edinburg	February 1, 2018	78
Dr. John W. King	Midlothian	December 24, 2017	67
Dr. James J. Andre	Manakin Sabot	February 20, 2018	92

BRIDGING THE GAP

Sarah Mattes Marshall, VDA Membership Advocate

Sometimes, life just gets in the way.

The VDA wants to make you aware of several options available to members that can help you both retain your membership when times get tough and access the resources you need. Below is information on the types of waivers available to members as well as several practice transition resources.

TEMPORARY AND PERMANENT WAIVERS

Often an unexpected, yet temporary, health or financial setback will keep you from being able to pay your full dues invoice. If this is the case, contact me at the state members office (mattes@vadental.org or 804.523.2189) or your local component for a waiver. Depending on your situation, we may be able to offer you a 25%, 50%, 75% or 100% waiver for the current membership year.
If your temporary issue becomes permanent, the VDA can work with you to submit a permanent disability waiver.

PRACTICE TRANSITION RESOURCES

In either of these situations, you'll need ready access to resources to help keep your practice running or sell it to a qualified candidate. We have several resources to aid you in that process:

- You can post a FREE classified ad to the our website or in our *Journal* to find a short or long-term replacement or to sell your practice http://www.vdaclassifieds.com
- You can pose a question to the VDA Members-Only Facebook page and other members can point you towards other helpful resources
- VDA's endorsed practice managment consultant, Leadership by Design, specializes in dental practice transitions and offers a 10% discount to VDA members. Their information is available in our Member Center on vadental.org.
- If you want to talk to a peer who's gone through a similar experience, let me know and I can connect you with another member.

Whether you're at the beginning of your career or just a few years from retired status, please know that we value your voice and participation in our organization and would like to serve as a resource. Whether that's helping you transition your practice or finding new ways to put your expertise to work within your community, we're here to help you navigate what is surely an uncertain time.

YOUR VOTE REALLY COUNTS

Shannon Jacobs, VDA Director of Communications

It's that time of year again...time to get to know the elected leadership candidates and the positions for which they are applying. Below you will find statements from each candidate. We feel it is important for voting members to understand the responsibilities of each position. To that end, we have provided a brief description for each position below.

- **VDA President:** Presides at all meetings of the Association and acts as Chair of the Board of Directors, appoints members at-large of standing committees, special committees and/or task forces where specified in the Bylaws or VDA Policy, appoints all members of the reference committees of the House of Delegates and performs such other duties as the Board of Directors shall deem advisable as outlined in parliamentary authority. The president keeps the Board of Directors fully informed of all activities of the Association and makes a report to the House of Delegates at the Annual Membership Meeting on the activities of the Association. ***Term of office one year.***

- **ADA Delegate:** Attend all the regular sessions of the House of Delegates, the District caucuses, and such other meetings as the chair of the Delegation shall designate. ***Serves a three year term.***

- **ADA Alternate Delegate:** Attend all the regular sessions of the House of Delegates, the District caucuses, and such other meetings as the chair of the Delegation shall designate. ***Serves a two year term.***

Now that you know what each job entails, take a look at the candidates and their abilities to fill those roles. Biographical information for each candidate will be available on the VDA website.

Finally, mark your calendar for July 18, 2018 so you don't forget to vote for your candidates. With a contested race for ADA Alternate Delegate, every vote counts!

DATES TO REMEMBER:

July 18, 2018 - Voting Opens (Online)

September 20, 2018 - VAM Onsite Voting 3:00 p.m. - 5:00 p.m.

September 21, 2018 - VAM Onsite Voting 8:00 a.m. - 2:00 p.m.

September 22, 2018 - VAM Onsite Voting 8:00 a.m. - 1:00 p.m.

September 22, 2018 - Voting Closed 1:00 p.m.

September 23, 2018 - Election Results Announced

MEET THE CANDIDATES

2018-2019 LEADERSHIP CANDIDATES

ONE POSITION AVAILABLE

President Elect

DR. ELIZABETH REYNOLDS - CANDIDATE FOR OFFICE OF PRESIDENT ELECT

At least once a week a patient will ask me “When did you know you wanted to be a dentist?” My response is always the same: “For as long as I can remember; my father was a dentist. I watched him go to work every day and saw how much he loved it.” My father graduated in 1930 and practiced until he was 80. He was in the state House of Delegates for 20 years and prided himself on representing the best interests of the dentists because he believed in dentistry and he believed in dentists and he believed in the Virginia Dental Association. That is the legacy I would be honored to continue.

I have served various capacities within the local, state, and national organization. I began working in organized dentistry when I arrived in Richmond and Drs. Anne Adams and Benita Miller invited me to my first Richmond Dental Society meeting. Through their mentorship and their guidance I was able to meet amazing individuals who taught me the value of the tripartite and what it meant to the dental profession. I began my involvement by serving on the RDS Board of Directors and as chair of several RDS committees; I then served as chair of the VDA Council on Sessions and I currently chair the Council on Membership. I have been involved nationally on the Council on Ethics, Bylaws, and Judicial Affairs and as a delegate to the ADA. I have been blessed to work with people within the organization who have made organized dentistry what it is and who want to continue to make it better and larger and maintain its relevance in today’s dental world.

Though the practice of dentistry has certainly changed over the past eighty years, the basic tenets haven’t changed. I truly feel that every dentist in the Commonwealth has the same basic goals: we want to protect and serve our patients, we want to compensated fairly, and we want to be in charge of our professional destiny. We cannot do this alone. We need the Virginia Dental Association. I see the membership numbers dropping, the insurance companies encroaching on our amazing profession, and the potential influx of inappropriately trained technicians who want to perform irreversible procedures on our patients. We owe it to our patents to protect them, and we owe it to our members to protect them. I feel the best way to do this is through maintaining the VDA’s reputation and working to make it a stronger and more influential organization. It is and should continue to be the organization which supports its members in their practices and throughout their professional lives. I feel I have the experience, the desire, the dedication, and the energy to work with you to continue to propel our association so that it indeed continues to “have the backs” of the dentists in the Commonwealth. I respectfully and humbly ask for your vote as the Virginia Dental Association President Elect.

MEET THE CANDIDATES

2018-2019 LEADERSHIP CANDIDATES

FOUR POSITIONS AVAILABLE

DR. DAVID ANDERSON - CANDIDATE FOR OFFICE OF ADA DELEGATE

Anyone who has served on the delegation realizes what an honor and privilege it is. It is the extra benefit and great joy it generates to have a voice in how our profession is portrayed, administered and advanced. Taking your concerns to the House is a pleasure.

We are now at a crossroads. Student debt is at an all time high. For profit schools are producing more dentists than ever. Fewer and fewer graduates can practice as they desire. These are just a few of the challenges we face. Problems require someone who has been there working for our profession. This is why I ask for your continuing support and vote.

DR. VINCE DOUGHERTY - CANDIDATE FOR OFFICE OF ADA DELEGATE

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

I have the will, the confidence, and the passion for the position. I promise to represent you in the best way possible. Serving as ADA Delegate, as Past President of Northern Virginia Dental Society and Virginia Dental Association, I have acquired leadership and decision making skills to act confidently on your behalf. I am currently serving as a board member at the VDA as Immediate Past President.

There are many threats against our great profession, including the ability to practice quality dentistry while delivering exceptional patient care. Another critically important issue is insurance interfering with the doctor-patient relationship. As Immediate Past President of the VDA, I feel I have the knowledge to make informed decisions. I will cast any vote based upon the following question: "Does this strengthen the doctor/patient relationship?"

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

DR. SAM GALSTAN - CANDIDATE FOR OFFICE OF ADA DELEGATE

I am running for ADA Delegate. I have had the pleasure of serving two terms as ADA Alternate Delegate and one term as Delegate. I am presently serving the VDA as President-Elect, and have learned a great deal about how the ADA and the VDA function, and am ready and prepared to dedicate the time, effort and knowledge necessary to best represent our members. It has been a great honor and privilege to serve organized dentistry in the past, and also a great responsibility that I take very seriously. We are presently (and will continue so in the future) going through some significant changes in organized dentistry, and we need some steadiness and experience to help best guide us. I can help provide this necessary leadership. I appreciate the support that many of you have shown me in the past, and I will continue to do my best to live up to your expectations in the future, and to best serve our organizations. I would greatly appreciate your vote this year for ADA Delegate. If elected I will continue to serve you faithfully.

DR. ELIZABETH REYNOLDS- CANDIDATE FOR OFFICE OF ADA DELEGATE

First, thank you for giving me the opportunity to represent you over the past three years as an ADA Delegate. I am, and continue to be, both impressed and awed by the incredible members of this organization and their unparalleled commitment to it on the local, state, and national levels. Over the past few years I have had the opportunity to work on the Council of Ethics, Bylaws, and Judicial affairs, which was a life changing event, and I now am honored to serve on two ADA Foundation subcommittees. My involvement in the Foundation has reinforced my belief in and my respect for the ADA by showing me first hand that there are so many means through which the ADA serves its members in times of need. I love knowing that this organization cares as much for its members as they do for it! This involvement has also given me the chance to develop and nurture relationships with delegates from around the country. These relationships allow our delegation to build coalitions which assist us in getting your voices heard in the ADA and in establishing the 16th District as a force with which others must reckon!

I recognize that the dental profession continues to face significant challenges and I feel the ADA must remain dynamic and dedicated to this amazing profession to keep it relevant. I have enjoyed being involved and seeing what happens from the inside out. I am grateful for the opportunity, and I feel as though my energy and enthusiasm can help make a difference. I would love to the opportunity to continue to represent you and I hope that you will support me with your vote for ADA Delegate this year.

MEET THE CANDIDATES

2018-2019 LEADERSHIP CANDIDATES

FIVE POSITIONS AVAILABLE

DR. DANI HOWELL - CANDIDATE FOR OFFICE OF ADA ALTERNATE DELEGATE

Dentistry is a great profession, a profession that I am very proud to have joined; but the profession is in a climate of change with obstacles still on the horizon. Being at the beginning of my career, I find it imperative to take an active role in protecting and shaping the future of this profession. I will have the opportunity to complete a vacated term this fall and am seeking election to a full term as ADA Alternate Delegate. Through my undergraduate studies, I have a strong understanding of policy making and many of the protocols used in the ADA House of Delegates. I am faced with many of the same difficulties as other new dentists and can offer a voice for those concerns. Additionally, I believe my understanding of organized dentistry and leadership experience in dental school and at the component level qualify me for this position. Thank you for your support and I look forward to the opportunity to serve on the delegation.

DR. JUSTIN NORBO - CANDIDATE FOR OFFICE OF ADA ALTERNATE DELEGATE

Over the past several years I have had the pleasure of serving as an ADA alternate delegate from the 16th district. I have witnessed first hand how well respected our district is at the ADA level and it has been a wonderful experience serving on the delegation. I have gained much knowledge and experience in the tripartite through my involvement at the ADA, VDA, and Northern Virginia Dental Society levels. I have a strong willingness to serve and will continue to be committed to the duties and responsibilities of the delegation.

It would be an honor to continue to serve as ADA alternate delegate and contribute my thoughts, opinions, and ideas to the ADA House of Delegates. I feel as though I understand the challenges and concerns from ADA members, especially from younger members, and I will strive to help steer the ADA in such a way to help its members succeed.

DR. JANINE RANDAZZO - CANDIDATE FOR OFFICE OF ADA ALTERNATE DELEGATE

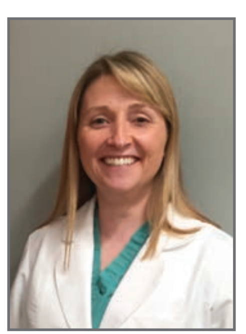
I feel I would be a good candidate for this position because I have been practicing dentistry for 20 years and I have lived in many different locations and have been exposed to many dental offices and styles of working in dentistry. My time on active duty in the US Army has also shaped me into good leader and has helped me be successful in working with people of many different backgrounds and experiences.
I have been running a successful dental practice for 10 years and am lucky to have a long standing team that I have the pleasure of working with every day. They have been instrumental in my success and growth over the years. I have reached a time in my career that I am able to volunteer my time and experience to organizations that I feel are doing a great job for their constituents, and I hope to continue the great traditions of the ADA.

MEET THE CANDIDATES

2018-2019 LEADERSHIP CANDIDATES

FIVE POSITIONS AVAILABLE

DR. CASSIDY TURNER - CANDIDATE FOR OFFICE OF ADA ALTERNATE DELEGATE



I am running for the office of ADA Alternate Delegate. I have been a VDA member for the past 10 years and I have had the privilege of serving in multiple leadership positions on a local, state, and national level.

As I have served in these different positions I have seen the benefit of being actively involved in organized dentistry. I recognize the importance of organized dentistry and the role it plays in protecting our profession from external organizations that are looking to influence the practice of dentistry. These external organizations are trying to dictate the way that dentistry is delivered to better serve their interests and not necessarily the interests of the patients or the dentists that are delivering the care. The ADA needs to be a strong voice for dentistry as we continue to face challenges to our profession. I would be honored to serve as a VDA Alternate Delegate to the ADA and support the ADA in its mission to be America's leading advocate for oral health.

DR. JAMES WILLIS - CANDIDATE FOR OFFICE OF ADA ALTERNATE DELEGATE

For several reasons, I am seeking an initial term as ADA Alternate Delegate. I have served on the Component 8 (NVDS) delegation to the Virginia House of Delegates since 2010. I am the current President of Component 8 (NVDS) and serve on the VDA Board of Directors as director of Component 8. I am very comfortable representing opinions of member dentists from my area and am quite comfortable presenting that opinion on the VDA floor of the House of Delegates. I have served as Chairman of Community Outreach Committee for NVDS and in that capacity have been the Chairman of the NVDS Mission of Mercy (MOM) for several years. I am committed to excellence in dentistry and have a passion for doing everything I can to champion the concerns of density as well as to ensure that dentistry is a well-respected and trustworthy profession in the eye of the public. I do not take lightly the honor and responsibility of the positions I hold and I would count it a privilege to represent our member dentists on the national level. I commit to making myself available to you and to take your concerns seriously and to do my best to reach our goals. I am grateful for this opportunity and I thank you in advance for your consideration.

DR. BRENDA YOUNG - CANDIDATE FOR OFFICE OF ADA ALTERNATE DELEGATE

I wish to run for the position of ADA Alternate Delegate. I have been serving on the Virginia delegation since 2014 and feel there is so much more to accomplish. Our profession is going through many changes with the growth of corporate dentistry, mid-level providers and insurance company interferences. We need to protect our profession through participation in organized dentistry. I enjoy being an active voice in this process. We have great leadership in our current ADA House of Delegates. These members are fighting to protect our livelihood, support our future students and help us continue to serve the public. I would like to be active in this pursuit. Please allow me to continue serving as your ADA Alternate Delegate. Thank you for your support.

FIVE OVER FIFTY

REFLECTIONS FROM FIVE RETIRED LIFE MEMBERS WITH OVER 50 YEARS OF MEMBERSHIP

I came to Virginia, courtesy of Uncle Sam, in 1957. After spending two years at Fort Belvoir, I opened a solo practice here in Northern Virginia. Though it was not the case then, I am pleased to say that our organization now welcomes women and minorities, not only as members, but also in leadership roles. We are stronger for it.

DR. HENRY BOTUCK
Northern Virginia Dental Society

After spending 40 years in Pediatric Dentistry, I've spent my retirement with my wife, Lois, volunteering for more than five organizations and serving on numerous boards. While I owe my community spirit to dentistry, my wife and I owe our good health to our active routine and look forward to continuing our service for a long time.

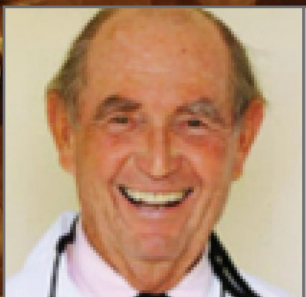
DR. BARRY EINHORN
Tidewater Dental Association

I have a large and wonderful family, I've been all around the world, I've spent my leisure time sailing boats and crafting furniture, and I've been active in the ADA, VDA, and Richmond Dental Society. Dentistry supported all of these adventures and I feel fortunate to have chosen it as my profession.

DR. EDWARD "RIP" RADCLIFFE
Richmond Dental Society

In my opinion, one of the most important dental innovations for the practice of general dentistry is the air turbine, which came on the market at a pivotal time in my career, between my graduation from the MCV School of Dentistry and beginning my private practice. I consider myself one of the most blessed in our profession by having the opportunity to practice for a number of years with my son, Dr. Ralph Howell, as well as his daughter, Dr. Dani Howell. Dentistry is a wonderful profession and the VDA has always been there with their support.

DR. LEROY HOWELL
Tidewater Dental Association



I am the luckiest dentist and all my classmates would join me in agreement, having enjoyed such wonderful technology over the past 60 years. We certainly were the first to enjoy the turbine dental drill, and now the digital age with x-rays, the wonderful world of implants. My grandfather started practice in Warrenton in 1875 and was an expert in gold foils. While not done anymore, they're still recognized as the ultimate in dental restoration. I've enjoyed following his patients, some more 100-years-old, still with these beautiful implants. So, I am indeed fortunate.

DR. WILLIAM ALLISON
Northern Virginia Dental Society

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JOBS - DENTIST

5796 - Full Time/Part Time Associate Dentist (Virginia Beach)
Our modern and comprehensive dental practice is looking for an enthusiastic part-time General Dentist to join our team. We are a fun and friendly modern office with a wonderful staff and patient base. Our practice believes in giving our patients fantastic customer service by working together as a team to diagnose, treat, and get to know our patients and their health needs. We are looking for a for someone who shares our vision and cares about the well being of the patient, someone who has strong personal ethics and prides themselves on quality customer service. If you enjoy providing high quality care in a fast-paced environment, educating patients, take pride in your role as a provider and would like to join our team, please respond by email with your resume.
Contact: Dr. Zahir, 757-353-7636, drshabana@gmail.com

5819 - Dental Associate
Seeking an associate in a small town in the beautiful Shenandoah Valley (Augusta County, VA). Our family and cosmetic solo practice is two generation family owned since 1960 and our doctor is ready to slow down. Recently renovated six operatory office with a large patient base is located in area with broad, clean industrial support. Seeking an experienced, compassionate, motivated and team-oriented person with eventual buy out possibility. Send CV today and join a great, experienced team as we are ready to hire the right person today.
Contact: Cheryl Layne, 540-255-5767, sdlr.dentistry@gmail.com

5825 - Associate Dentist with possible Partnership
Seeking a full time dentist in Chatham, VA (20miles north of Danville, VA and 40 minutes south of Lynchburg, VA). All digital, 8 operatory, established, growing practice. Great staff and positive work environment. Open Monday through Thursday 7:30am-5:30pm (no weekends or holidays). Very competitive base salary (daily minimum $750) with collections bonuses, PAID TIME OFF, benefit package including health insurance, and opportunity for future partnership. Established patient base, dentist will step into a full schedule. Please send resume to pwmillerdds@gmail.com Possible relocation/signing bonus is available.

5827 - Multiple opportunities throughout Virginia
Do you want unlimited earning potential? Have you always wanted to work side by side with colleagues to improve patient outcomes? Morrison Dental Group has locations throughout Central and Southeastern Virginia. We have offered comprehensive, general dentistry for over 26 years. MDG is looking for motivated, ethical doctors to join our amazing staff in Charlottesville, Richmond, Williamsburg, Hampton and Virginia Beach/Norfolk as we continue growing and expanding. Don't miss your opportunity of a lifetime. Contact Alison Morrison at: amorrison@morrisondentalgroup.com, 757-719-2237

5842 - Associate Dentist for Loudoun Co., VA
Are you a bright, motivated, goal oriented, Team player looking to become part of a cohesive, hard working, fun-loving Office? We are a busy, established and highly regarded dental practice in Loudoun County looking for a long term Associate to find their forever home. We pride ourselves on providing high quality, precision care in a fast-paced, warm and friendly environment. This is not a DSO job where you're just a number. Working with us requires a Team spirit, positive energy, willingness to work hard and have a great day every day! You will provide comprehensive treatment in all aspects of general and cosmetic dentistry, extractions, root canals, implants and more, using state-of-the-art equipment in a supportive and educational environment. Your daily focus will be providing excellent dental care and building long-lasting relationships with each patient. You will receive highly adept clinical support as you work along side our long standing clinical and hygiene Teams. We provide a competitive salary and Bonus structure, with a comprehensive benefits package to include: Medical insurance, Disability, 401K with Match, vacation time, CE assistance, and Corporate and Community Events. AEGD or GPR residency preferred, or two years private practice experience required. Military Veteran dentists encouraged to apply. If you want to become part of our amazing Team send your CV and cover letter to: dentistryinLoCo@gmail.com

5844 - Associate needed in beautiful southwestern Virginia
Associate needed in beautiful southwestern Virginia. Schools are wonderful. Many outdoor activities in the area including hiking, hunting, fishing. Close to Virginia Tech and Radford University. Salary base will be 30% of production with a minimum base salary of $7500 a month. Both are negotiable. Possibility for partnership buy in in the future. Great opportunity for new graduate looking for mentorship within a group practice. Established practice in wonderful community is busy with plenty of patients and a comfortable, laid back feel to the work place.
Contact: Tyler Burningham, 540-250-2765, tylerandann@yahoo.com

5846 - General Dentist
A caring and fast paced practice in Virginia Beach, VA is seeking an associate dentist with an overwhelming passion for dentistry. This passionate dentist needs to be willing to work 4 days/week, use 4-handed dentistry, and must have a desire to continually improve their craft with every procedure that they complete. This associate position may transition to a partnership, if desired and if the owner feels that the associate is able to continue offering the same care, professionalism, and precision that he has worked so hard to maintain over his 33 years in practice. Patient ages range from 3 to 99, with the dentist needing to be proficient in composite and amalgam, crowns and bridges, prosthodontics, extractions, and root canal therapy.
Contact: Marissa Maosi, 757-427-2212, marissa@wernickdentistry.com

5849 - Associate Dentist
A general dental practice with a generational history (since 1897), extremely loyal patients and expanding patient base, located in historic, downtown Smithfield, VA is seeking a part-time (2-3 days a week) dentist to help with our expanding patient load. We need someone who is self-motivated, caring and team oriented. Serious applicants must have good communication skills and chairside manners. We would like a general practice dentist that can provide all aspects of general dentistry including endodontics, restorative, implants, extractions and prosthodontics (fixed and removable). Our private practice is modern, paperless and fully digital with great support personnel. We provide great service to the entire family. Our office offers competitive benefits and in addition to a daily guarantee, the ablility to earn extra income through a compensation package based on personal productivity. If this interests you, send resume to miltoncook@smithfield-dds.com. Recent graduates are also encouraged to apply.

5854 - Pediatric Dentist - Charlottesville
We have an opening for a Pediatric Dentist at a busy dental practice located in Charlottesville, VA. The practice is a multidisciplinary practice, however, patients are primarily children. Our practice also has In-house general anesthesia and an In-house orthodontist. The practice has a culture of mission-minded dentistry with a focus on increasing access to care to the communities of Central Virginia. Our team will fill your schedule for you. This position is full-time, five days per week, no weekends. The compensation is offered as a % of Production, and annual pay is between $200,000 to more than $230,000, not including potential cash bonuses. The production calculation includes all

procedures, including prophy and fluoride. Our benefits package is very competitive: 100% Health Insurance coverage; 401(k) Matching; License/DEA Cost Reimbursement; Malpractice Coverage; CE stipend; Professional Organization Membership dues reimbursement; Lab Fees Paid by Practice We also offer a Sign-On Bonus. Charlottesville is a growing college town located in Central Virginia at the base of the Appalachian Mountains. Our town has a thriving, historic culture, with plenty of opportunity to enjoy outdoor activities, wineries/ breweries, and easy access to Richmond / DC / the Coast.
Contact: Dr. Jessica Moore, drmoore@cvillechildren.dental

5862 - Dentist-Norfolk VA
The Foleck Center is actively seeking a motivated, quality-oriented Associate Dentist for our multi-location practice in Hampton Roads, Virginia. The area boasts a 3-mile boardwalk, more than 18,000 acres of state parks, active city centers for dining and shopping, and a dynamic art scene. There's a little something for everyone! We are looking for a Dentist to become part of a practice that administers all aspects of dental care under one roof. We are proud that our patients do not have to constantly be referred out and wait for treatment to be initiated and sometimes delayed at another office. Dr. Foleck lectures internationally on implant dentistry, digital workflow with implant dentistry and on grafting techniques. We are a state of the art office with an in-house lab offering Emax and Zirconia crowns and bridges as well as some removable. From Cone Beam, to Cerec, to Biolase, (and of course digital radiography and charts) our office has always been on the cutting edge. If you are looking for a practice that will help you grow as a clinician and allow you to interact with other like-minded people, this is the place for you. Benefits include health insurance, malpractice insurance, 401K with a matching program, continuing education, dental insurance for associates and immediate family members, and two weeks vacation.
Contact: Tatjana Manojlovic, 757-623-0283, downtownoffice@thefoleckcenter.com

5875 - Pedodontist
Become part of a popular, high quality, practice that has a highly energized, dedicated team in our family friendly office. We are seeking a super kid friendly, patient focused, dedicated professional that can build upon our successes and who shares our passion in bringing the best pediatric dental care in a great community with significantly more potential for growth. A competitive salary package and incentives are offered. Immediate start is preferred and applicants are encouraged to contact us today at 757-488-8884. Our area has a lot to offer everyone, from the water to the mountains. Outdoor activities in the area include but not limited to fishing, boating, and hiking. The nation's history is all around. We are just a short drive to Washington D.C., Baltimore, and Nags Head. Come be on vacation every weekend.
Contact: Kathy Imbimbo (Office Manager), 757-488-8884, cdwsll100@gmail.com

5885 - Associate Dentist- Rustburg, VA
Busy General Dental Practice is seeking a Full Time Associate with potential to buy into the practice. We are seeking an applicant who is self-motivated, caring, and team oriented to help with our practice's expanding patient load. The newly constructed office is in Rustburg, VA approximately 10 minutes south of Lynchburg and in close proximity to Liberty University. Applicants should have good communication skills, chair-side manner and knowledgeable in all aspects of general dentistry. Our 11-operatory private practice is modern and fully digital with great support personnel. We provide great service to the entire family. If this interests you, send resume to wefixteeth5919@gmail.com. Recent graduates are also encouraged to apply.

5886 - Associate Dentist
Opportunity available for a dentist in a 20 plus year, high new patient volume, high demand, fast paced, growing established practice that is patient care driven, not insurance care driven. CDVA is currently going through renovations internally and externally. The ideal team member must be able to keep up with daily operational protocols, stay adaptable flexible to changes while maintaining quality of care. problem solving skills chairside, team player, procedures that are most common and pending treatment completion are gumgrafts, implants, sinus lifts, upper molar endo, composite restorations, Invisalign, veneers, dentures, extractions. Resumes to my attention: Edith Martinez-practice manager Job Type: Full-time
Contact: Edith Martinez, 703-968-7022
edithmartinez0729@gmail.com

5889 - P/T General Dentist
Seeking Associate General Dentist 1-2 days per week to join our upscale, modern dental practice located in beautiful Palmyra, Virginia; 1-2 days week. For more information, please call Dr. Jose Mera (804) 357-5354, mera.jose@yahoo.com

PRODUCTS AND SERVICES

5801 - Xray Unit and Endo Microscope for sale
Global Endo Microscope for sale, good working order, includes wall mount asking $6,000 or best offer. Pictures are available please email info@dunndentalgroup.com Progeny Preva Xray unit, manufactured in 2010. Additional new faceplate for control panel included. Good working order. We moved and didn't need this unit. Asking $3,000.00 or best offer. Pictures available email info@dunndentalgroup.com

5884 - WaterlaseMD
A little used YSGG WaterlaseMD unit for sale. Contact for pricing, pictures of unit or any questions.
Contact: Charles 804-320-8894 office@capitaldentaldesign.com

PRACTICE TRANSITIONS

5805 - Dental practice for sale - Newport News Virginia
Dental practice for immediate sale! Established in 1961 in the central section of Newport News Virginia. A proven practice, with many loyal patients. Practice presents many excellent opportunities for continued future growth and expansion. The office is approximately 1500 ft.² with three operatories. Priced for a quick sale.
Contact: Chad, 757-879-0400, wcgreenlaw@hotmail.com

5808 - Practice for Sale 2019-2020
Active general restorative practice in Southside Danville Virginia. All digital office, 5 treatment rooms, 2300 square feet. Well trained and devoted staff. 2 hygienists, 2 assistants, 1 front desk manager. 4 days/week. Average gross 700K. Special services CAD/CAM (Planmeca E4D) dentistry, orthodontics and sleep medicine. Doctor will stay on to introduce and train as needed. No dentures. Website : www.thesmiledoctors.com Local amenities include proximity to VIR International Raceway, revitalized downtown, riverwalk trail, Anglers Park premier mountain bike system, Braves minor league team and nearby recreational lakes.
A T Silvers, DMD, 434-548-3023, maddog@gamewood.net

5838 - DUAL PRACTICE SALE - Williamsburg/West Point
OUTSTANDING OPPORTUNITY! Successful practice is all digital with Cone beam CT machine! Collections are over $715,000 with an abbreviated schedule of 3 days per week in West Point and 1 and 1⁄2 days in Williamsburg. Call for details for this one or two location purchase!
Contact: Jim Schroeder | 804-897-5900 | info@lbdtransitions.com

5860 - Practice Sale - Fairfax County, VA
Exceptional opportunity located in a general office building (mixed healthcare and businesses). Extraordinary practice provides high-quality general and restorative dentistry. Practice is paperless and fully digital. I/O cameras, digital x-ray, digital panorex, and all Adec treatment chairs. For details, contact Henry Schein Professional Practice Transitions Consultant Krista Butler, 919-622-8339, krista.butler@henryschein.com. #VA152

5861 - Practice for Sale - Fauquier County, VA
Wonderful location! Great starter or satellite location!! 2 ops in 1,000sf. Digital x-ray. Part-time general practice. Live, work, and play!! Revenue around $300,000. Real Estate available also. Approximately $200,000. #VA156
Contact: Henry Schein Professional Practice Transitions Consultant Donna Costa 1-856-988-7588 ext 3 donna.costa@henryschein.com

5865 - Practice for Sale - Virginia Beach
Great location. 8 opts. Collections approx. 1.2 mil. Modern office. Digital x-rays, panorex, trios scanner Easy transition for new owner. Priced to sell Call Lisa 757-839-2076, dlj@cox.net

5866 - Practice/Building For Sale
Active 8 year old practice for sale. Stand alone new building, 3200 square feet, all digital, five operatories with x-ray units, digital Pano, one hygiene full time Hygienist. Call for specific numbers and /or leave a message.
Contact: Dr. Michael Turck, 757-718-5153, mturck@cox.net

5882 - SEEKING PROSTHODONTIST – Richmond Area
OPPORTUNITY FOR PARTNERSHIP at top family dental practice! Outstanding productivity for full-time prosthodontist – productivity in the range of 900k and strong referral base. Current prosthodontist willing to remain in place to introduce new doctor to area dentists, referral specialists and existing patients under active care. This an exceptional and RARE OPPORTUNITY. Available July 1st
Call Jim for details 804-897-5900 or email info@lbdtransitions.com

5864 - Office Space For Sale/Lease/Rent
Excellent investment opportunity for sale, lease, or rent in busy area of Woodbridge, VA. Newly equipped 1-3 operatory dental office with purchase option available. Please email Kim at dentalbusiness22@gmail.com

JOBS - DENTAL STAFF

5859 - Dental Hygienist
Established dental practice in Chesapeake, VA seeking experienced part-time dental hygienist to join our team. We are a modern, fast-paced office where the well-being of our patients is the first priority. Fax resumes to (757) 548-4492 or email mchelle58@outlook.com

5874 - Registered Dental Hygienist needed!
Madison Family Dentistry is looking for a well rounded and hard working dental hygienist to join our team! We are a comprehensive dental office treating patients of all ages and offerimg all dental services. Candidates must be certified to administer local anesthesia and licensed to practice in Virginia. Benefits package includes Profit Sharing, paid holidays, 2 weeks paid vacation, 401K, 4 day work week, and more! New graduates are encouraged to apply. Please email your resume with three references.
Contact: Dr. Vega, 540-948-4488, drvega@madisonfamilydds.com

5876 - Full Time Dental Hygienist
Excellent opportunity for an enthusiastic, goal-oriented hygienist to join our successful team 5 days / week. The qualified candidate will have graduated from an accredited dental hygiene program. Experience preferred; however, recent grads will be considered and are encouraged to apply. Seeking a candidate who has an emphasis on quality patient care and education, is able to treat patients of all ages, and is capable of working efficiently in a busy office. Must be knowledgeable in current OSHA regulations and infection control practices. Current BLS certification required. Seeking candidates who are professional, team player, dependable, flexible, able to work well with others, have a pleasant personality and an excellent chairside manner. Outstanding customer service skills and positive attitude are a must! Salary will be based on experience. Days / hours are negotiable. If you are seeking a long term career opportunity in a thriving dental practice, we invite you to submit an application for consideration in joining our wonderful team!
Contact: Carrie, farsoltaniandds@yahoo.com

5881 - Dental Hygienist
Our award winning, patient-centered general dental practice needs a new hygienist to compliment the team. Great pay, benefits provided, incentive pay available for the dedicated RDH who wants to apply their skills in Charlottesville, VA. Give us a call today to find out more information.
Contact: Dr. Jeffrey E. Hodges, 434-293-8944, jhodges2250@gmail.com

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DR. AMER ALLAYMOUNI

I am a Diplomate of the American Board of Orthodontics. I graduated from the University at Buffalo, NY. Currently, I practice in Colonial Heights and Chester. Every day, I enjoy providing the best quality of care and creating beautiful smiles.

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