VIRGINIA DENTAL
Journal
VOLUME 95, NUMBER 1 • JANUARY, FEBRUARY & MARCH 2018

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Dentists Helping Dentists

Annual Membership Issue

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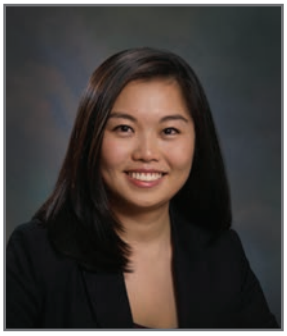
40 UNDER 40

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. WENHUI SUN

I'm a general dentist at Northern Virginia Dental Arts in Stafford, a brand new office near Quantico. I got my DMD at UConn and completed residency in Akron, OH. My husband and I live in Alexandria with our two dogs.

Virginia Dental ASSOCIATION

AADEJ American Association of Dental Editors & Journalists

VIRGINIA DENTAL JOURNAL

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

Volume 95, Number 1 • January, February & March 2018

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PRESIDENT'S MESSAGE

Dr. Benita Miller

Happy New Year! Welcome to our VDA Journal, devoted to membership. I don't know if you realize it, but our editor, Dr. Roadcap, is one of the most respected journal editors in the country and with good reason. Each Journal is filled with an informative mix of clinical and professional articles in a highly readable format. I am most amazed at Dr. Roadcap's personal reflections, which always seem to get to the heart of the matter so well. I know you will enjoy this membership journal!

We have had a busy quarter since our September meeting. More than 40 VDA members, staff, and VCU dental students met in early November for an exciting day of strategic planning for the upcoming year - lots of energy in the room! Under the expert facilitation of Dr. Bruce DeGinder, we began the morning by viewing Simon Sinek's Ted Talk "Start with Why" (2nd most viewed TedTalk of all time - https://youtu.be/IPYeCltXpxw).

When you start with "why", you ask what is your organization's purpose? What is its cause? Its belief? Why does your organization exist? From our strategic planning session, we reconfirmed our "why". For the VDA, we exist to make our members' lives better and improve oral health care in our communities. We do so by fostering meaningful relationships with our members so that we can anticipate our members' needs and be the "Go To" for all of us. We are THE organization for Virginia dentists. There is no other organization like us. We are listening, and we are acting. We are dentists helping dentists. We are dentists helping to improve the oral health of Virginians.

Everything we do stems from our purpose to help each other and our communities. We have so much to offer. And as our strategic planning session got going, we began to ask ourselves, how best can members easily access all these resources? We all know that http://www.vadental.org is the go-to digital resource, but with so many resources, are we giving members at various career stages the resources they need most? With input from our website focus group, we are in the process of updating the website to better group like information and help members navigate the site more efficiently.

Our website discussion also reinforced a behavior that many active members espouse, but those with less knowledge of the VDA may not be aware of. When you have a question that you can't solve - through searching the website or consulting peers - the VDA staff is at the ready. There is no concern or question too big or too small for our team at the VDA office to handle - addressing insurance concerns; how to handle an ethical dilemma; how to assess an insurance contract; how to access peer review if I have a disgruntled patient; or, how do I find out about loan refinancing options? My practice recently interviewed a potential new dental assistant, and we used the ADA's Center for Professional Success (through ADA.org) to find pertinent interview questions and guidance.

I will be the first to admit that I often waste time searching the internet for information that I could have quickly and easily accessed through the VDA or ADA websites or through a call to the VDA office. It takes a concerted effort to retrain your thoughts to turn to the VDA first, but hopefully it will quickly become second nature!

Our Insurance Workgroup also has been quite active, honing in on the most egregious actions taken by third party payers, and we will soon be addressing these concerns directly with those third party payers. Please consider contacting the VDA office with your insurance concerns and submitting information that will help us provide hard data to the Insurance Commissioner and third party payers. The greater the number of similar complaints/concerns, the greater weight they will carry in resolving these issues.

As we look towards 2018, we're preparing ourselves for the legislative session and the 15 (or more) new legislators in the General Assembly! That means developing new relationships and familiarizing these new legislators with the issues surrounding the practice of dentistry and oral healthcare in our communities. I hope to see many of you on January 19th for Day on the Hill. If you can't join us that morning, there are other ways to meet with your representative at a time that is more convenient for you and for her/him. The time you invest in forging a good relationship with your legislator will be critical in our advocacy efforts going forward. Laura Givens can help you with talking points and contact information.

Here are a few other quick updates. Please remember to:

- Update your ADA Find-a-dentist profile - the site is gaining traction with the public!
- Member get a member - this successful incentive continues - get a $200 discount on your membership when you get a new member to join.
- Take advantage of our flexible dues payment options especially monthly payments and auto renew.
- Make use of VDA Services endorsed vendors - the savings can exceed your annual dues and also gives back to the VDA.
- Young practitioners - be sure to explore your options with ADA student loan refinancing and contact the VDA for analysis of an insurance contract you may be considering.
- Join us at the New Dentist Conference (open to all members) - March 2-3 at the Omni Charlottesville for an excellent program and great networking!

This New Year is full of possibilities. I hope you will look to the VDA to help you convert any upcoming challenges into possibilities, so that you can operate in an environment of abundance and success. Along those lines, let me leave you to ponder, what is your "why"? What inspires you?

WE'RE HERE TO HELP

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TRUSTEE'S CORNER

NO MORE BUSINESS AS USUAL

Dr. Kirk Norbo, ADA 16th District Trustee

As the ADA moves forward, it has become obvious that the “business as usual” mentality that has worked for the over 150 years that our association has been in existence is no longer a recipe for success. This is not to say that much of our governance structure and policies are not well-grounded but the ADA must focus more of its attention on innovation if it is to reverse the trend that all associations are facing today. The days of depending on membership dues to finance all the programs and services the ADA has a reputation for providing are numbered.

In the 2017 November-December edition of *Harvard Business Review*, Linda Hill and George Davis wrote an article titled “The Board’s New Innovation Imperative”. I urge you to read this article because many of the principles they address can be applied to our dental practices. They outline the situation, the challenge and the solution when it comes to bringing innovative changes to boardrooms. This move toward more innovation in corporate governance can also be implemented by member dentists as they look at ways to stay competitive in the marketplace. The situation today is that boards are searching for innovative plans that will make them more competitive in much the same way that dentists are constantly looking at improving their practices by adding new technology and procedures, addressing third party payer issues from different perspectives and restructuring their management systems. The challenge for the ADA when it comes to governing innovation is to first come up with a current risk agenda. There needs to be a way to assess the level of risk that would be associated with each innovative idea that may be implemented, so this risk agenda must be accurate and up-to-date. Dedicating enough time and expertise to innovation are two of the other most important challenges. Most boards are guilty of not providing the time or expertise to the area of innovation and I would argue that most dental practices don’t commit the time or search out the expertise necessary to make innovative changes. So what are the solutions to the challenges facing any group wishing to move in an innovative direction? According to the authors of this article, boards should be composed of diverse members, there should be active interchange in place to stimulate new ideas and challenge existing governance methods. Most importantly, there should be an emphasis on “embracing and encouraging risk”. As the authors of this article point out, “Standing still or waiting to see how things turn out are not considered serious options in today’s often tumultuous environment”. It is refreshing to see the ADA move in this innovative direction while making ongoing risk assessments for programs and ideas as they are vetted.

My hope is that the movement toward more innovation will not be limited to the ADA in our tripartite system but will also receive careful consideration at the constituent and component levels. If organized dentistry is going to thrive in the upcoming decade and on, changes must occur. The Business Innovation Committee is one of the governance additions the ADA has made to strengthen this movement toward fostering new ideas. This committee is currently considering some exciting business plans that could provide new sources of non-dues revenue and ultimately lead to long term financial stability. The other big project the ADA has undertaken is being called the “Business Model Project” (formerly the "frog" project). At this point, it is still in the define phase to determine if it is a viable business venture. This project is moving forward very rapidly and its day to day business is being managed by Bill Robinson who is the ADA Vice-President of Member and Client Services. I am chairing a Governance Team that is tasked with making strategic decisions surrounding this business venture. It is important to maintain confidentiality in these early stages of the Business Model Project as long as possible to minimize the chance of competitive offerings coming to market more quickly than ours. As promised in Atlanta, I expect to be able to share significant details of the project in the first quarter of 2018.

The complexities of our profession continue to escalate, and as they do, it is imperative that all of us search for new ideas to govern our profession, deliver better care to our patients and ward off threats from ill-intended parties. Taking risks to improve our profession are, in many instances, uncomfortable and unpopular but if we choose to take an easier, more complacent path the future of dentistry could be seriously jeopardized.

I hope you and your families had a nice holiday season and best wishes for a happy and healthy 2018!

40 UNDER 40

DR. JAMIE CLARK

I attended VCU and did a GPR residency in Seattle. I'm currently practicing dentistry at Rockbridge Area Health Center in Lexington. It allows me to help underserved populations and seek adventure in the great outdoors!

DO YOU AUTO RENEW?

Did you know that the VDA offers three ways to pay your dues?

- Lump sum with an annual automatic renewal
- Lump sum with no auto renew
- 12 payments with an annual auto renew

And don't forget, the VDA accepts credit cards or ACH payments for members on auto renew plan

Membership renewal should be easy and Virginia is a leader in offering flexible payment options. As you gear up to renew your membership for 2018, **consider signing up for the auto renew plan!**

Still have questions? We have answers!
Contact Sarah Mattes at mattes@vadental.org
or Jill Kelly at jkelly@vadental.org

VDA Virginia Dental ASSOCIATION
www.vadental.org

MESSAGE FROM THE EDITOR

Dr. Richard F. Roadcap

"The American health care system is set up as if the mouth was separate from the body." Thus begins Chapter 3 of *Teeth: The Story of Beauty, Inequality, and the Struggle for Oral Health in America*, by Mary Otto. The chapter is titled "Emergencies" and it chronicles the hundreds of thousands who visit an emergency room each year in search of dental care. The opening paragraph concludes by saying "…the patients' needs are seldom met."

Mary Otto, who formerly wrote about health care issues for the *Washington Post*, became well-known to the dental profession in 2007, when she reported on the death of 12 year-old Deamonte Driver from a brain abscess which began as a dental infection[1]. The death of a child, who lived only a few miles from the nation's capital, may have spurred the inclusion of pediatric dental care as an essential benefit in the Affordable Care Act. Deamonte's name was invoked many times in congressional hearings that led to the reauthorization of the Children's Health Insurance Program (CHIP) and later the passage of the ACA.

I had the pleasure of hearing Ms. Otto speak at the Virginia Oral Health Coalition summit in November, and as an autograph hound, asked her to inscribe and sign my copy of *Teeth*. It was a diverse audience: hygienists, assistants, clinic administrators, policymakers, and a good turnout of VDA members. Her remarks were measured, a nod towards the varied backgrounds of those in attendance. At the first recess, a line formed for autographs and photo opportunities, and I of course took advantage.

If dentists are hoping for a pat on the back in *Teeth*, they'll be disappointed. Many of us will find the book infuriating at times, and intriguing at others. She's quick to grant sainthood to dental therapists, DHATs, and hygienists practicing apart from dentists, and slow to give credit to dentists' public service and organized dentistry's public health advocacy. Yet, many of the criticisms we've heard from within our profession, and there were none I'd not heard before. For example, we're portrayed as obsessed with cosmetics, driven by profit, and deaf to the pleas of the needy. Two months prior, I'd heard Dr. Gordon Christensen, perhaps the most popular CE speaker in America, say "Dentistry used to be a profession with a little bit of business. Now it's a business with just a little bit of profession." Ms. Otto may have kindred spirits among our ranks.

The outline for *Teeth* revolves around three themes: the estrangement (perhaps permanent) from medicine, the history of American dental education, and the ever-present dilemma of access to care. She recounts how Drs. Chapin Harris and Horace Hayden, the founders of the first US dental school (now the University of Maryland), sought to make dental training an integral part of medical school and were turned down. It's known as the "historic rebuff". They persevered, and began the first formal dental curriculum, holding classes in instructors' homes and a church. Medicine and dentistry grew even further apart in the early 20th century, with physicians promoting the "focal infection theory", a belief that teeth were responsible for nearly all illnesses. Countless millions of teeth were removed before pioneers like Edmund Kells confronted the medical establishment and helped put an end to this folly. Other prominent figures, such as William J. Gies, the Columbia professor of biochemistry who founded our present system of dental education, and Dr. Alfred Fones, who first trained young women to serve as dental hygienists, are profiled.

Dentistry's greatest shortcoming, according to Ms. Otto, is its response to the access-to-care problem. She records the story of Deamonte Driver's short life in painstaking detail, from his life with grandparents in a Prince Georges County, Maryland trailer, to his death in a Washington, D.C. hospital after six weeks of futile attempts to treat a brain abscess. His circumstances might be termed a perfect storm. In what former MSDS President Dr. Arthur Fridley called a "system in complete disarray", there were no heroes. The state bureaucracy, the profession, third-party payers, and even the child's mother share the blame. Unfortunately, the author often depicts organized dentistry as a bystander, failing to recognize the tireless efforts of the ADA and component societies in this arena.

Ms. Otto believes medicine and dentistry may never reconcile. She may be right; for the forty plus years of my practice, I've heard that the professions should integrate and communicate, and I can't say I've seen much movement. I take exception to her characterization of medicine as prevention-based, and dentistry as procedure-based. There's no mention in *Teeth* of municipal water fluoridation in Grand Rapids, Michigan (in 1945), a process which the Centers for Disease Control hails as one of the ten greatest achievements in 20th century public health[2]. She comments on actor James Dean's missing teeth, but fails to mention Dr. H. Trendley Dean, the pioneer researcher who found that fluoride in water prevented tooth decay.

Robert Burns (translated from the Scots language) said, "Oh, would some Power give us the gift/ To see ourselves as others see us!" If *Teeth* were a polemic about the evils of the dental profession, it would be easy to dismiss. But her attention to detail, and her compelling portraits of villains and protagonists make it a good read. To her credit, she profiles many competent and caring dentists. Ms. Otto's book deserves a place on your bookshelf or a download to your Kindle®. Its pages may help us see that our patients' needs are met.

1 http://www.washingtonpost.com/wp-dyn/content/article/2007/02/27/AR2007022702116.html

L-R: Dr. Richard Roadcap, Mary Otto

2 https://www.cdc.gov/mmwr/preview/mmwrhtml/mm4841a1.htm

GUEST EDITORIAL:

MAKE A CHOICE: SUPPORT THE VDA

Dr. Stephen Radcliffe; Chair, Virginia Dental Services Corporation

When I joined the Board of the Virginia Dental Services Corporation (VDSC) approximately six years ago I wasn't sure what to expect. It seemed as though we would be preaching to the choir in our quest to market the various products and services that are offered. However, I now wonder if we are even speaking the same language.

Most of the VDA membership does not seem to know what the VDSC is or what it does. A little primer: The Virginia Dental Services Corporation is the for-profit subsidiary of the VDA, and our sole mission is to raise non-dues revenue for the benefit of the VDA. The VDSC promotes the endorsed vendors to members under the VDA Services brand. Our Board of Directors researches vendors of various products and services before endorsing them for use by our member dentists. We do receive unsolicited proposals from some vendors, but our portfolio contains many that we sought out as partners.

Our problem seems to be an inability to reach our target market and demonstrate the value proposition of using the VDA Services Endorsed Vendors. Over the years, we have put notices in our annual dues statement, we have continuously placed ads in the *Virginia Dental Journal*, our logo appears on the VDA website, and our vendors place ads and articles in the Journal and on our website. We have sponsored the Virginia Meeting and MOM projects, and even distributed revenue to the Components. And yet, looking at the utilization of our vendors by the membership presents a dismal picture. Some of our programs have participation rates in the tenths of one percent of our membership.

Most of you would probably be surprised to learn what is required of our endorsed vendors. The contract they agree to specifies many different ways that we expect them to support our Association. They agree to attend the Virginia Meeting and they pay to exhibit there. They are required to advertise in our *Journal* and to send direct mail advertising to our members. Most of them willingly go above and beyond what they are required to do. They teach CE courses, sponsor component events and after the VDA building burned down, they donated to the VDA Foundation to replace supplies lost in that devastating fire. They support our Association and we should support them.

There is often special pricing (discounts) for our members, but even when there is not a stated discount we believe there is value in what they offer.

Sometimes the value is the intrinsic value of supporting an organization that is supporting you on a day-to-day basis. Clearly there are commodity products that we use and someone can always sell that for a lower price, but is that discount vendor supporting your Annual Meeting? Are they supporting the excellence of our Journal with their advertising dollars? Are they enabling you to practice in the manner you are accustomed to?

We are members of organized dentistry and that implies an understanding of the important role our organization plays in determining how we practice. It is our united voice that is heard at the state and national legislature and it is our voice that advocates for our patients. Of course we want to support that mission.

The VDSC has made the strategic decision to try and hone our marketing program and garner more support among our membership. You, the dentists, are who we are trying to reach. Many of the products and services we offer represent buying decisions in which most dentists are actively involved. The VDSC Directors, your colleagues, are asking you to consider the programs that our Endorsed Vendors offer. Help us to support the VDA by utilizing the VDA Services Endorsed Vendors – Help Us, Help You!

YOU'RE A MEMBER OF THE VDA...

NOW JOIN US ON FACEBOOK

Shannon Jacobs, VDA Director of Communications

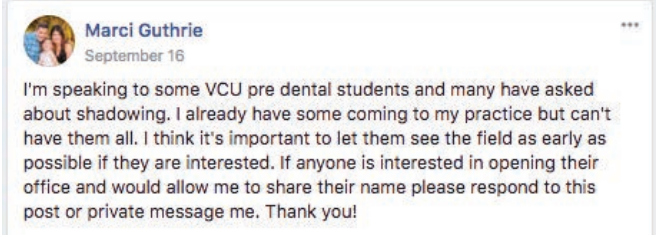
If you're anything like most Americans you spend, at least, a little time on Facebook each day. Maybe more than we should, right? Facebook is great for keeping up with family and friends or that band you're really in to. But did you know that Facebook is being used by the VDA to help *YOU* solve everyday problems in your dental practice?

How is that possible you ask? Easy...we've gathered over 350 (and counting) dentists who live and practice in Virginia and are willing to help you solve problems you might encounter on an everyday basis. That's right, you can post questions directly to the group and receive answers quickly, sometimes within minutes. You can also help answer questions other members have, simply by commenting on their post. We know you have many skills and expertise so sharing those with your peers is a great way to give back to the profession of dentistry.

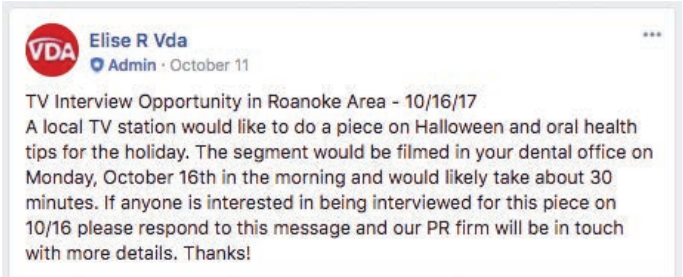
We also use the group to keep you current on issues in dentistry as they happen. If there are new laws or regulations going into effective, we'll be sure to post it. Who couldn't use another reminder on these changes...sometimes?

Take a look at some 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!

Dr. Bigelow needed some help identifying an implant screw. VDA members came to the rescue and helped solve the mystery within minutes.



Dr. Guthrie put a call out for members who would be willing to host a dental student. Plenty of members were eager to help out.



Occasionally, the VDA will alert members to opportunities available to them. In most cases we need a quick response, so we post these types of things directly to our Facebook group. If you're not in the group, you could be missing out on some great marketing opportunities.

As things change with laws and regulations we'll post the information to the Facebook group to keep you up-to-date.

JOIN THE GROUP AT: https://www.facebook.com/groups/VDAmembersonly

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NFPA 99 AND THE DENTAL OFFICE

Jonathan L. Wong, DMD and Gerhard Gschwandtner, P. Eng

CURRENT TRENDS IN DENTISTRY

Sedation and anesthesia are becoming increasingly prevalent in dentistry. In the past, patients did not expect to have anesthesia or sedation unless their visit was to the oral and maxillofacial surgeon. Today, patients are requesting sedation and anesthesia for their care or for the care of their family members. Many dentists are also requesting anesthesia support from anesthesia providers including physician anesthesiologists, dentist anesthesiologists, and nurse anesthetists. Other dentists are providing their own anesthesia and sedation in what is sometimes called the operator-anesthetist model. Unfortunately, with the increasing demand for anesthesia services, there has also been an increased focus on morbidity and mortality in dental offices. The public is becoming more aware of such issues, as they have been widely publicized, even making national headlines.

"Many code items are developed to address issues that have killed or severely injured people in the past."

Outpatient sedation and anesthesia are nothing new. Dentists pioneered the techniques of anesthesia in an outpatient setting and were at the forefront of office-based anesthesia as well. Ambulatory surgical centers are commonplace and widely accepted as safe, convenient, and cost effective means of delivering surgical care. So why are dental offices under such criticism? Our medical colleagues have been increasingly vocal against the use of operator-anesthesia. However, several of the recent public tragedies have involved separate anesthesia providers. One of the possible concerns is the lack of safety checks in dental offices. One such check that is almost entirely overlooked is that of the medical gas system.

NFPA AND NFPA 99

The National Fire Protection Agency is a global nonprofit organization, established in 1896 and devoted to eliminating death, injury, property and economic loss due to fire, electrical and related hazards. It is widely known as a codes and standards organization that continually updates codes on a 3-5 year cycle in a process that is open and consensus based. Technical committee members are typically volunteers. As one member stated, "Many code items are developed to address issues that have killed or severely injured people in the past."

NFPA 99 is the Healthcare Facilities Code. It is updated every 3 years. NFPA 99 is the national code (American National Standards Institute or ANSI) for all medical and dental gas installations in the United States. It is also adopted by reference in the International Plumbing Code and International Fire Code, which are the basis for a majority of state and local building codes (these vary by locality). Many dentists and healthcare professionals mistakenly believe that the NFPA 99 is merely about fire safety. NFPA is actually about life safety and prevention of medical gas mistakes. NFPA 99 contains the minimum requirements for piped gas systems, equipment, material, alarms, installations, testing, verification and maintenance. The requirement applies to all healthcare facilities in the U.S., including hospitals, outpatient facilities, dental clinics and dental offices. Since at least 1996, NFPA code has required dental offices providing sedation and anesthesia to be compliant with these minimum standards.

NFPA 99 defines 3 categories (previously called levels) of medical and dental gas systems. These categories define the specific minimum requirements for each system. The assessment of which category a facility or dental office falls under is based on a risk assessment and not by facility type or occupancy permit. Facilities offering deep sedation and/or general anesthesia must comply with Category 1 Standards. Facilities offering moderate sedation are designated Category 2. A traditional dental office offering only anxiolysis, or minimal sedation, would be Category 3.

These designations do not change whether such services are only offered on a non-routine basis. The designations do not change even if fewer than 4 individuals could be incapacitated at the same time. There is a popular misconception that dental offices do not need to comply with NFPA 99. This misconception may stem from NFPA 101 Life Safety Code, which relates to occupancy and applies when 4 or more individuals could be incapacitated (under or recovering from sedation / anesthesia) at the same time; an office is not exempt from following the NFPA 99 guidelines.

NFPA 2018 EDITION

The NFPA released the NFPA 99 Healthcare Facilities Code 2018 Edition in November of 2017. According to the NFPA, they worked with the ADA and dental specialty groups to develop the new code. (http://www.ada.org/en/publications/ada-news/2016-archive/august/ada-looks-out-for-dentists-in-work-with-fire) The NFPA recognized the lack of knowledge and adoption of code standards across the industry; therefore, NFPA 99 includes a new chapter, "Dental Gas and Vacuum Systems." The new edition makes it much easier for dental offices to comply with the standards because it segregates dental air and dental vacuum systems, which are currently not being built to anything but NFPA 99 Category 3 standards, thus preventing unnecessary costs of expensive medical air compressors to drive dental handpieces. It allows dental offices to use simplex surgical and waste anesthetic gas

12 Continued On Page

40 UNDER 40

DR. MINH-AN LA-PHAM

Dr. La-Pham is a Herman Ostrow School of Dentistry of USC graduate. She was practicing in southern California and just recently moved to Virginia with her husband and dog. The CAD/CAM proponent currently works in Loudoun County.

LETTER TO THE EDITOR:

DON'T SLICE YOUR FINGER

Henry Botuck, DDS

OSHA and CDC are concerned about continued instances of needle sticks and puncture wounds among health care professionals. OSHA's bloodborne pathogen standard requires that there be absolutely no hand-passing of exposed sharps from one person to another. NEVER!

We (should) know that we don't pass syringes when the needle covers have been removed. And we (should) know that to replace the needle cover we need to use the one-handed scoop method, so as not to endanger the other hand.

And we (should) know that we don't hand-pass scalpels from one person to another. NEVER! If you need the scalpel, then YOU must pick it up from the table or tray. And, YOU must lay it back down. But, picking up that flat scalpel handle from a flat surface sometimes can be awkward. Wouldn't it be great if you could just reach out and easily pick up the scalpel while keeping your eyes focused on the area you want to incise and not worry about cutting your fingers?

Yes, it is possible! I went online to see what some physicians are doing in the OR in order to comply with the mandate. One of the things I saw was a specially designed disposable sterile tray that has sloping inner walls and a deep vertical groove in the center where the scalpel rests.

You would find this a great help if you needed to pick up the scalpel multiple times during that surgery. It is possible to blindly place the scalpel into the tray and have it slide down the sides into the groove with the handle remaining on edge, not flat. There is a cutout in the central portion of the groove so that the scalpel handle can be grasped between thumb and forefinger, again blindly, to pick up the scalpel. The groove is deep enough so that your fingers cannot touch the blade portion when you reach into the tray to retrieve the scalpel.

The beauty of this is that it is not only easier to grasp the handle of the scalpel, but you don't need to take your eyes off of the area that you are concerned about. And, you don't need to refocus your eyes while waving that scalpel in the patient's face. Go online and look for "transfer tray for surgical sharps". There are many iterations of this product: "Bladesmart Sharps Transfer Tray", "Sharpstop Sharps Transfer Tray", "Bard Parker Hands Free Transfer Tray", etc. Check them out!

Bladesmart Sharps Transfer Tray

If you do much surgery, it can make your life easier---- and safer!

11 Continued From Page

scavenging vacuum pumps instead of the previously required duplex systems. In addition, the 2018 edition allows portions of the dental office to be designated at different category levels. Therefore, an office can have several operatories that are Category 3 where procedures are performed under local and a Category 1 operating room. The standards explicitly address dentistry and certain nuances such as nitrous scavenging and waste anesthesia gas scavenging.

Another interesting verbiage in the 2018 standard is that previous systems were not "grandfathered" in. Instead, NFPA 15.1.5 states, "An existing system that is not in strict compliance with the requirements of this code shall be permitted to continue in use as long as the authority having jurisdiction has determined that such use does not constitute a distinct hazard to life."

NFPA 99 AND YOUR DENTAL PRACTICE

New dental offices should be aware of these new standards. The major dental equipment suppliers often offer design services, but are not well versed in medical gas systems. Local building inspectors often do not inspect dental offices for compliance unless the office specifically states that they offer certain sedation and anesthesia services. Professional engineers may be needed to design the gas system and mechanical closet. The use of certified medical gas installers, inspectors, and verifiers is required for all categories. The use of such prevents catastrophic gas line crossovers and debris from installation preventing function of valves and manifolds.

Existing offices should understand these issues when introducing new sedation and anesthesia services. An existing Category 3 system is not adequate for adding sedation and anesthesia services, just because the system is already present at the dental office. This also applies when having outside or independent anesthesia providers to the office to assist in treatment of patients. In addition, offices providing sedation and anesthesia without the proper independent third party certification of their gas system, may, at the very least, be responsible for notifying the authority having jurisdiction of such. As one state level AHJ and professional engineer stated, "This however does not relieve the building owners, contractors, architects, engineers, material suppliers, and anyone involved including the dental practitioners in the construction of the medical gas systems from complying to this code."

Editor's Note: Dr. Jonathan Wong is a certified Dentist Anesthesiologist. Gerhard Gschwandtner is a Professional Engineer, Credentialed Medical Gas Verifier, and Certified Healthcare Safety Professional.

ETHICS: COMMUNICATION

OUR ETHICAL RESPONSIBILITY

Blakely N. Pond; Class of 2020, VCU School of Dentistry

We communicate every day with patients, staff, family, friends, and strangers not only by what we say but also by what we do. We probably rarely think of our communication as ethical or unethical or as a gauge for others to decide if we are someone with ethical character. But in fact, our communication says it all. With a quick search on Google, you can find that ethics can be defined as "moral principles that govern a person's behavior or the conducting of an activity". So, the way we conduct our communication, verbally and nonverbally, does point towards our ethical qualities.

Before even embarking on ethics, we know good communication is necessary for good practice. We often learn the importance of communication in terms of building rapport and relationships and avoiding lawsuits. We know that patients who have good relationships with their dentists are less likely to pursue a lawsuit in negative circumstances. This alone is enough to encourage us to learn how to communicate effectively. But let's dig deeper! When we decided to pursue dentistry, we made a commitment to uphold ethical standards set forth by our profession. The principles of dental ethics, as described by the ADA in the "Principles of Ethics & Code of Professional Conduct", includes patient autonomy, nonmaleficence, beneficence, justice, and veracity. Our ability to communicate is intertwined in each of these principles.

Patient autonomy is the right of the patient to self-govern. It gives the patient the right to be involved in the decisions of their care. In order for patients to do this, you have to first communicate with and educate them regarding their dental needs and treatment options. It is our responsibility to make a professional recommendation to the patient, but we should present all possible treatment options in a manner that the patient understands and allow them to make the final call. We cannot accomplish this without communication.

Next, nonmaleficence, or do no harm, and beneficence, to do good, come into play. These principles of ethics encompass tasks such as knowing when to refer, keeping up with current knowledge and skills, and competent and timely delivery of care. In order to complete these tasks, you need to have a full understanding of the patient's medical and dental history, desires, finances, and more. This is impossible without ethical communication. Patients do not always understand why so much information is required for dental procedures. We have to communicate that this information is needed in order to avoid harming patients and to offer the best care for their circumstances. Ethical communication also is seen as we discuss topics such as lifestyle changes. We want patients to understand that we are educating them for their best interest. Understanding and discussing lifestyle changes are also important in our discussion of the last two ethical principles, justice and veracity.

Justice is treating everyone fairly and offering care without bias and prejudice. Justice encourages us to be culturally competent and to treat every patient equally, regardless of religion, race, socioeconomic class, or other factors which may cause us to discriminate. Of all ethical principles, nonverbal communication is most important when applied to justice. Patients can tell when someone is not genuine. Our words can say one thing but our faces, tone, and posture can say more. As in our discussion regarding lifestyle changes, justice encourages us to understand and accept a patient's lifestyle which then leads us to offer recommendations that are suitable and feasible for that patient. This is achieved by communicating with the patient.

Veracity is truthfulness and includes the ability to communicate truthfully without deception. Veracity can be seen as we offer patients treatment options and consider the pros and cons of each. We want our ethical communication to be open and transparent during this time as we answer questions and help the patient come to an understanding of their care. In addition, our ethical communication encourages us to communicate in an appropriate language, with appropriate aids, and using terminology that the patient can understand.

So, you might ask, this ethical communication sounds great, but what does it look like? It is patient, kind, empathetic, and selfless. It is what we say and also how we say it. It is our smiles, eye contact, handshakes, and posture. It is our confident but gentle voices and, even more, our listening ears. It is our attention and our time. It is presenting all options in a manner that the patient understands clearly and allowing them to be the decision maker. It takes into consideration the patient's religion, culture, lifestyle, and finances. It is being transparent and honest. Ethical communication is what we strive for in all interactions. It opens doors that allow us to be creative in meeting patients where they are and caring for their needs. It is an essential part of the commitment we made to hold ourselves to the highest ethical standards of this wonderful profession.

40 UNDER 40

DR. AMAN SABHARWAL

Dr Sabharwal received his DDS from the Medical College of Virginia and completed his AEGD from Temple University. He practices all phases of dentistry with special interest in implantology and prosthodontics. His multi-specialty family practice is located in Ashburn.

LETTER TO THE EDITOR:

DENTISTS SAVE LIVES

Dr. Marvin E. Pizer*

I write this paper as a tribute to a health profession that has served humanity for many years – dentistry. The dentist is a doctor who has good general knowledge of the entire body – but an authority on head and neck, especially the mouth face and adjacent structures. Many of the life-threatening diseases appear on the face and the oral cavity initially before systemic involvement. The dentist will refer the patient to the correct medical specialty and treat the oral disease as needed.

Listed are the many skills the dentist employs to detect life-threatening diseases:

1. A medical and dental history on new patients and once yearly on regular patients. The dentist with the first two years of basic sciences in dental school, followed by principles of medicine the last two years, will make the listening dentist cognizant of serious pathology and refer the patient to the specialist of choice.
2. A complete head and neck examination, especially the oral cavity and neck, can be revealing sites of pathology.
3. Intra-oral and extra-oral radiology may reveal malignant disease and significant vascular changes.
4. Biopsy procedures performed by many dentists can reveal life-threatening diseases.
5. The oral and maxillofacial pathologist who makes the final diagnosis on tissue from biopsy is also a dentist.
6. If the tissue is biopsied by a dentist and pathology reported is malignant, then this surgery may be operated upon by an oral and maxillofacial surgeon (also a dentist).
7. After significant surgery, the patient may need plastic and reconstructive surgery. This is also accomplished by oral and maxillofacial surgeons (all dentists).
8. Dentists treat life-threatening infections of the oral and maxillofacial regions.
9. Dentists do research on malignant disease.
10. Dentists treat sleep apnea.
11. Dentists treat fractures of the mandible and facial bones.
12. Dentists treat medical emergencies in their offices and in military combat, or other locations when needed.
13. Life-threatening systemic diseases frequently present their manifestation orally and the dentists are often the first health profession to visualize, recognize, and refer the patient to a competent physician.

The present definition of dentistry by the American Dental Association is “The evaluation, diagnosis, prevention, and/or treatment (nonsurgical, surgical, or related procedures) of diseases, disorders and/or conditions of the oral cavity, maxillofacial area and/or the adjacent and associated structures and their impact on the human body, provided by a dentist within the scope of his/her education, training, and experience in accordance with the ethics of the profession and applicable law.”

*Formerly:

The American University, Washington, D.C.: Professor of Research; Adjuct Professor, Medical Physiology; Director, Pre-Professional Health Program; Chairman, Pre-Medical Advisory Committee

Virginia Commonwealth University School of Dentistry, Richmond:
Clinical Professor, Oral and Maxillofacial Surgery

Emeritus Staff, Alexandria Hospital, Alexandria, Va.

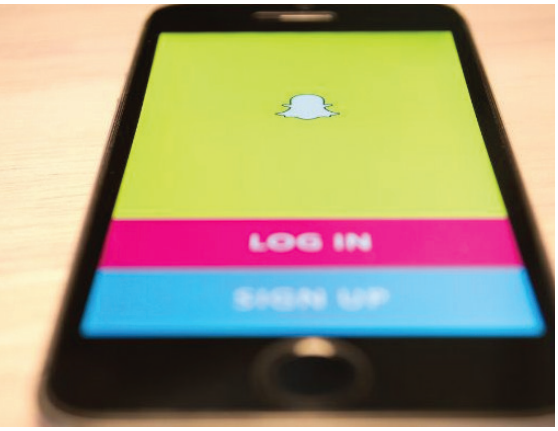
40 UNDER 40

DR. JO K. CRONLY

I have two rewarding jobs that I love- one as a mom and the other as a pediatric dentist at Children’s Dentistry of Virginia in Midlothian. I enjoy educating parents in preventative care and fostering smiles through fun dental visits.

WHAT YOU CAN LEARN FROM A RECENT HIPAA SCANDAL

Amelia Williamson DeStefano



In September, two medical staffers at Jacksonville Naval Hospital were found to have mishandled newborn patients; the misconduct was discovered in their Snapchat posts, which featured them “mishandling a newborn, making obscene gestures and calling babies ‘mini Satans,’” according to the *Washington Post*.

Around the same time, DentistryIQ editors received a message from a dental professional complaining that a dental hygienist at his or her practice had posted pictures and “sarcastic comments” about a patient on a personal Facebook page. The article received a strong response on social media, indicating that the issue of HIPAA compliance and staff social media accounts is of ongoing concern to dental professionals.

The consequences of a HIPAA breach are severe. Here are what three experts say you should learn from the Jacksonville scandal:

Dianne Watterson, MBA
I had a situation several years ago where a staff member posted some highly offensive remarks about a patient in the chair. She didn’t use the patient’s name, but it was time stamped, so other people could identify to whom she was referring.

Every dental practice needs a code of ethics on social media practices and their employees. Here’s what I recommend:

1. Employees will not ever share sensitive or identifying information about patients that could be in conflict with HIPAA regulations. It is strictly forbidden to insult patients over social networks.
2. Employees will not make disparaging remarks about management or coworkers over any social medium. It is impolite to badmouth people on a public forum. Posting made during an emotional moment may be regretted later.
3. Make sure postings are well-thought-out before sending. If there is any doubt whatsoever about whether or not to post, it is usually better not to post.
4. Keep in mind that anything you post could be read, copied, and shared with others many times. Even privacy settings do not prevent readers from copying and resending things that you post in private.
5. Employees are expected to maintain social media posting etiquette, which includes being civil and refraining from posting crude, inflammatory, or off-color remarks.
6. Remarks you make on social media sites are a reflection of you, and you are a reflection of the practice. Disparaging remarks about our practice or coworkers could place your job in jeopardy.

Linda Harvey, RDH, MS, LHRM
These professionals actions displayed blatant disrespect for human dignity and strike an emotional chord in all of us. Sadly, this case will be remembered for a long time for all the wrong reasons.

Could something like this happen in dentistry? Have you ever voiced displeasure with your daily schedule, a difficult coworker, or uncooperative patient on social media? How often are you posting treatment-related pictures on social media?

Posting a picture of the day's schedule where you can read patients' first and last name, phone number, and scheduled treatment constitutes a HIPAA breach. So does posting pictures of patients and other comparable images without written authorization according to the Privacy Rule. These pieces of patient information constitute "individually identifiable information" also known as protected health information (PHI).

Bear in mind, written authorization must be obtained using a HIPAA-compliant form. Verbal or implied consent is not legally sufficient under HIPAA. To learn what constitutes an acceptable "authorization," refer to 45 CFR 164.508 of the Privacy Rule.

What can dental professionals learn from this medical tragedy? The biggest takeaway is to be sure you know and understand HIPAA's privacy and security requirements. A privacy breach can result in criminal or civil fines and penalties. A former UCLA research worker found out the hard way when snooping in patient records landed him in prison for four months.

Not sure where to seek the best information? Start with the US Department of Health and Human Services website to review key aspects of these laws. Be sure to visit their FAQ page for interpretation on specific privacy questions.

Rebecca Boartfield and Tim Twigg
Compliance challenges, whether they be HIPAA, OSHA, charting, or employment related, can be damaging to your finances, emotion, and reputation. From an HR perspective, this situation highlights the need to review personnel policies.

Personnel policies help establish the ground rules and can protect against litigation. These written policies should cover several areas of applicable behavior, such as unprofessional conduct, cell phone use, and cameras on phones, as they relate to proprietary and confidential information. If something like this scandal occurred and you had nothing to show establishing that you were taking every measure to ensure appropriate conduct with your employees, then a prosecutor would likely paint you as a negligent employer.

Policies can show a good-faith effort on the employer’s part to follow the rules and keep employees from being inappropriate. While policies are important, they can’t necessarily stop all inappropriate behavior from occurring. When something does happen, even something little, it's important to take action immediately. Does the problem warrant suspension? Termination? If not, at the very least, establish documentation showing that the individual was counseled of the behavior and warned of consequences should it happen again. Of course, this should be signed by the individual in question to be completely thorough.

In short, never assume something like this can't happen to you. Take the necessary steps to protect yourself and follow up quickly and appropriately.

Editor's Note: This article first appeared in the *Apex360* e-newsletter. Reprinted with permission of DentistryIQ and PennWell Corporation.

A GLIMPSE INTO MEMBERSHIP

Sarah Mattes Marshall, Membership Advocate

This first year as your Membership Advocate, my formal title, has been a whirlwind of activity. I've really enjoyed getting to know you all and helping those of you who have reached out to directly access the many resources available through both the VDA and the ADA. I'm a researcher by trade and the cousin in my family that keeps everyone connected, so this position plays to both my strengths and interest.

To follow up on my email before the Virginia Meeting, below is a brief overview of our priority membership activities.

In late-September, we launched the Membership Survey, which was an effort to understand what you as members depend on most from the VDA, how you may be interested in serving the organization and how best to communicate with you. So far, about 8% of you have responded and we're working to tabulate the data and connect respondents with the resources you asked for. As part of the Strategic Planning Session in early November, we established a goal to get 20% of the VDA membership to complete all 9-questions (it should take less than 5 minutes). I would encourage each of you to fill it out and send it in to me, which you can do using the paper copy on the next page.

While our results are still preliminary, I can tell you that CE is a standout among the things you want most from us and we are constantly working to improve the education we provide to our members. Additionally, over 40% of you indicated that you are interested in mentoring students in dental school. I'll be following up with you so I can match you with some students eager for your expertise and guidance.

Just from this small amount of information, I can already see the impact this will have on how we support you and show the value of membership.

OUR OUTREACH EFFORTS SO FAR

One of membership's stated goals is to go upstream to develop meaningful relationships with dental students, residents and new dentists. So far, we've hosted a number of events and received instructive feedback on what they like (and don't like) when it comes to networking and CE. We had a great turnout at the New Dentist Reception at the Virginia Meeting. It was incredible to see so many students, recent grads, and not-so-recent grads coming out to connect with each other.

On that note, this March, we'll host the 2018 New Dentist Conference in Charlottesville, Virginia. If you're less than 10 years out of dental school and available March 2-3, I strongly encourage you to register at http://www.vadental.org/newdentist. This event is the best way to get CE tailored to your career stage and to network with your peers. It's a bit less overwhelming than the annual meeting and is a great way to jumpstart your engagement with our organization.

I've spent a lot of time in my first year working on ways to engage early career dentists and to welcome new members into our community. As we move into 2018, I plan to continue that theme with our mid- and later-career members. I'd like to learn what you need most from the organization and identify opportunities to partner in our shared goal of building a strong foundation for dentistry in the Commonwealth.

BUILDING A STRONG INFRASTRUCTURE FOR OUR ORGANIZATION

In September, the Virginia component staff (including me – shout out to Component 7!) met to talk about how each of our regions can collaboratively support membership and specifically the Ambassador Program. Following that meeting, three of our components will soon be setting up new websites using the template the ADA provides. I'll also be supporting our components as they implement the ADA's national membership database. While this database does not necessarily impact you on a day-to-day basis, Aptify helps the organization as a whole connect its members with the most relevant resources. Working on the same database means that I can provide more effective support to our components, giving them more time to build relationships in your area and less time record-keeping.

In my role as Executive Director for the Shenandoah Valley Dental Association, I will soon (second user in the country!) have access to the ADA's new marketing and email tool (like Constant Contact, but free) and am excited to provide more streamlined and polished communications for my component. I don't yet know whether this will be something that will help other components like mine, but I am committed to identifying and sharing the best the ADA has to offer within our state.

It's been less than a year since I started at the VDA and I can't remember enjoying a job more. I truly appreciate the opportunity to work for all of you. If there's something you need or you'd like to chat about how the VDA can improve itself, please don't hesitate to contact me.

40 UNDER 40

DR. LINDSEY NORTH

Fast-paced day, smiles, emotion—never a dull day in pediatric dentistry! My journey included VCU, residency in Chicago, and working in Charlottesville. Now I am embracing the zaniness at Dr. Richard Byrd & Associates Forest Hill location in Richmond!

Virginia Dental Association

WE NEED TO HEAR FROM YOU!

Dear VDA Members:

In my role as Membership Advocate for the VDA, I'd like to do a better job of engaging you with the work we do and the resources we provide.

The VDA is proud of the fact that there are many valuable aspects to membership and many ways to hear from us. However, we recognize that some may be more attractive to you than others. To streamline how we connect with you and how we connect you with the resources you value most, we've developed a means by which you can tell us your preferences.

Ways to complete the survey:

Online: https://goo.gl/3pzoKy
By Mail: Mail to Sarah Mattes at the address below
By Fax: Fax paper survey to 804-288-1880

If you have any question about this survey or about membership, please contact me at mattes@vadental.org.

Best,

Sarah Mattes
Membership Advocate, Virginia Dental Association
804.523.2189 (Direct)

Fold on dotted line and tape/staple to return your survey via mail (postage required).

USPS
Postage
Required

Attn: Sarah Mattes Marshall
Virginia Dental Association
3460 Mayland Court, Ste 110
Henrico, VA 23233

VDA MEMBERSHIP SURVEY

Please DO NOT complete this survey if you have previously responded online.

1. Please enter the information indicated below.

Name: _____

Preferred Email Address: _____

Preferred Mailing Address: _____

Career Stage (circle one):

New Dentist (0-4 yrs out of dental school)
Growing Dentist (5-10 yrs out of dental school)
Mid-Career Dentist (11-25 yrs out of dental school)
Senior Practitioner (26+ yrs out of dental school)

2. Please select your component:

1 - Tidewater Dental Association
2 - Peninsula Dental Society
3 - Southside Dental Society
4 - Richmond Dental Society
5 - Piedmont Dental Society
6 - Southwest VA Dental Society
7 - Shenandoah Valley Dental Association
8 - Northern Virginia Dental Association
I'm a student

3. Aside from legislative representation, what do you want MOST from the VDA? (circle ONE)

Practice Management Resources
CE/Education
Networking
Information on key industry and association issues
Problem-solving resources
Regulatory information
Other _____

4. How would you want to volunteer with us? (circle ALL that apply)

Leadership (i.e. serving on or chairing a committee)
Advocacy (i.e. Day on the Hill, Candidate meet and greets)
Volunteer - Missions of Mercy
Volunteer - Donated Dental Services
Volunteer - Give Kids A Smile
Member Mentoring (i.e. Ambassador Program)
Student Mentoring (i.e. Practice Visits, student shadows)

5. How do you prefer communication from the VDA? (circle TWO)

Email
Text Message
Phone
Face-to-face
Newsletter (The Chatter)
Virginia Dental Journal
Social - Main VDA Facebook Page
Social - VDA Members-Only Facebook Group
Social - Twitter
Other _____

6. Select the TWO VDA Services products you'd be most likely to employ. (circle TWO)

ACG - Wealth Management and retirement planning
Association Gloves/Supplies - Gloves, masks and disposables
B&B Insurance - Full Service Insurance Agency
Best Card - Credit Card Processing
Care Credit - Patient payment plans
Demandforce - Marketing and communications
iCoreConnect - Secure HIPAA compliant email
Leadership by Design - Practice Transitions
MedPro - Malpractice Insurance
Paychex - Payroll and HR Services
ProSites - Website design
Solmetex - Amalgam separators
TSI - Collection service
US Bank - Personal and business credit cards
Wellness Template
Bank of America - Practice Financing

7. What type of CE are you MOST interested in? (circle all that apply)

Practice Management
Insurance
Patient Relations
Marketing
Talk to an expert (lawyer, financial advisor)
HR Topics
Oral and Maxillofacial Surgery
Oral and Maxillofacial Pathology
Restorative Dentistry
Implant Dentistry
Prosthodontics
Endodontics
Pediatric Dentistry
Treatment Planning
Equipment and Materials
Technology
Leadership
Other _____

8. What types of social events are you most likely to attend? (circle all that apply)

Activity based - indoor (i.e. bowling, laser tag)
Activity based - outdoor (i.e. ropes course)
Non-dental Educational (i.e. museum, historical site)
Dental speakers - issue based
Happy Hour
Formal Dinner
Family event (i.e. BBQ or picnic)
Other _____

9. How would you prefer to process you membership? (circle ONE)

Annual auto-renew split up over 12 mostly automatic payments
Annual auto-renew with one lump sum payment
Annual lump sum payment with no auto-renew

WHAT CAN THE VDA DO FOR ME?

WE SPEND A LOT OF TIME EXTOLLING THE BENEFITS OF MEMBERSHIP, BUT HERE ARE SOME OF THE BENEFITS YOU MIGHT NOT KNOW ABOUT

RELATIONSHIP MANAGEMENT

Want to meet other dentists to find jobs, find people to join or buy your practice, build you referral base and don't know where to start? The VDA gives you access to thousands of members across the state and will help make introductions.

VOLUNTEER OPPORTUNITIES

Want to donate your time to mentor students and new members, serve in leadership positions, advocate for dentistry and oral health, or serve the most vulnerable members of your community? The VDA will match you with the opportunities you find most rewarding.

RESOURCE PATHWAY

There's a lot of great resources and relevant news at the national, state, and local levels. The VDA promotes these offerings through letters, emails and social media, when you need them the most.

For more information about the benefits of VDA membership, contact Sarah Mattes Marshall, Membership Advocate at 804.523.2189 or mattes@vadental.org

VDA STRATEGIC PLAN:

SETTING THE COURSE FOR THE FUTURE

Dr. Joseph Bernier-Rodriguez

Evaluating the current setup, sharing new ideas, and brutal honesty with colleagues regarding the VDA were several of the highlights at the 2017 Strategic Planning meeting. Being a diverse group of practitioners, the VDA is able to pull from a variety of experience and viewpoints. The reality is that the dental landscape is changing at a fast pace. The Internet, mobile apps and social media are now commonplace, allowing dentists to obtain information on demand. As a result, standard membership benefits offered by professional groups are becoming obsolete. Print media is becoming an anachronism, replaced by digital publications and email. Face-to-face meetings are becoming more costly, while alternatives for continuing education on demand proliferate from both commercial and nonprofit sources. Social and professional interactions with friends and colleagues, once limited to an annual meeting, now take place throughout the year in various media.

Taking into account socioeconomic factors, there is even greater pressure on the VDA to innovate. Time out of the office has become a valuable commodity as the cost of doing business rises and consumer demand for services declines. Younger generations prize other forms of engagement beyond their careers — time spent with family, volunteerism in community organizations and expectations for greater work/life balance — leaving the VDA with a more competitive landscape in which to attract and retain motivated members.

On Saturday November 4, VDA officers, the Board of Directors, component leaders, former VDA presidents and VCU dental students met in Richmond to discuss these challenges and to create a strategic plan that will address these issues. It was an amazing opportunity to interact with a number of different people from throughout the Commonwealth.

2017 VDA Strategic Planning Session

This year's overriding theme was "What can we do for you?" through efficiency and simplicity. The attendees wanted to craft something "concierge-like" that could be utilized by all dentists. The concepts of "What", "How" and "Why" were used to drive the discussions. Those in attendance were broken into two groups and several goals were discussed:

1. Fostering meaningful relationships through the anticipation of members' needs.
2. Fostering engagement/community with communications.

The following strategies were developed to address the goals:

1. To have a person at the VDA who knew dental benefits more than anyone else in the state of Virginia.
2. To transform the VDA website into a single stop resource that provides the membership with pertinent information they may acquire on demand (i.e. Dental benefits, dental transitions, continuing education, board of dentistry, OSHA and HIPAA).

Although change is not simple, the VDA leadership is energized. The VDA membership can be confident that there will be many additions that will make their practices more efficient.

40 UNDER 40

DR. STEPHEN HAUPT

I practice in Virginia Beach. Doctors Shiflet, Cox, and Morgan have been great mentors, and I enjoy working with them and their staff. I volunteer at Park Place Clinic and in my free time I enjoy playing golf and tennis.

PATHOLOGY PUZZLER

Dr. John Svirsky

CASE 1:

A sixty five year old white female presented to a general dentist with the chief complaint of left sided swelling. A Panorex was taken(Figure 1) and revealed an approximately 16 cm by 6 cm expansile multilocular radiolucency of the left mandible. The patient's past medical history was uneventful. The patient was referred to the Virginia Commonwealth University Oral and Maxillofacial Surgery Department (VCUOMS).

Which of the following would be included in a differential diagnosis?

Based on the clinical appearance, location and expansion, this would most likely be an ameloblastoma. We are not sure how long the lesion was present. Other thoughts would be a central giant cell granuloma, odontogenic myxoma and odontogenic keratocyst or odontogenic cyst. Ameloblastomas, giant cell granulomas, and myxomas can be expansile. Odontogenic keratocyst and odontogenic cysts typically grow through the medullary bone without expansion.

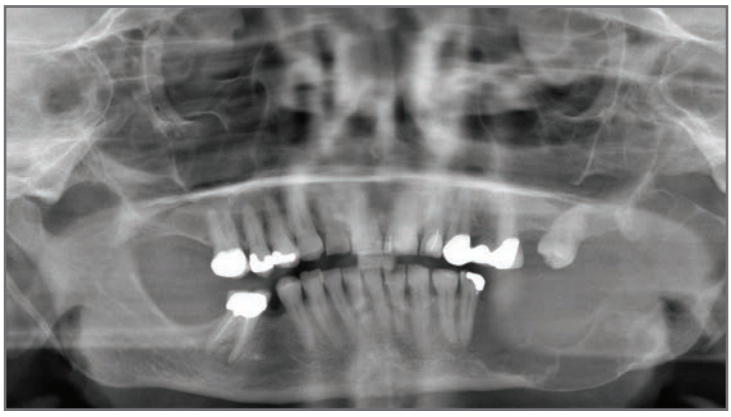


Figure 1

CASE 2:

This case was submitted on a 63 year old white male with an incidental lesion found on radiograph (figure 2). The lesion was an approximately 2 ½ cm by 2 cm lesion of the right mandible. Tooth number 28 shows some root resorption and both teeth were vital. There was a hint of cortication at the base of the lesion. Based on the location I would use the basic differential diagnosis for a radiolucent lesion of ameloblastoma, central giant cell granuloma, and odontogenic keratocyst. There was minimal to no expansion. In this case I would have gone for odontogenic keratocyst first, and then ameloblastoma and central giant cell granuloma. This location works for all three of the lesions. The teeth were vital, which ruled out a periapical pathosis.

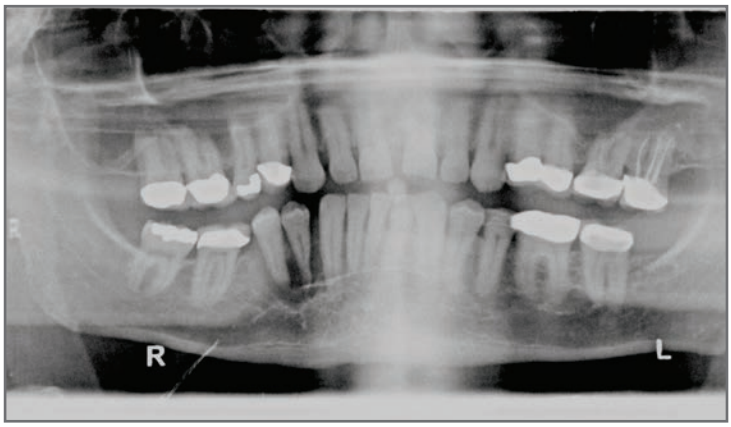


Figure 2

CASE 3

This is another example of a lesion with vital teeth that does not have cortication. The lesion appears between the roots of teeth numbers 20-22 (figure 3) and measures 1.7 cm by 1.6 cm in greatest dimensions. I would use the same differential diagnosis and add lateral periodontal cyst. However I have never seen a lateral periodontal cyst affect three teeth.

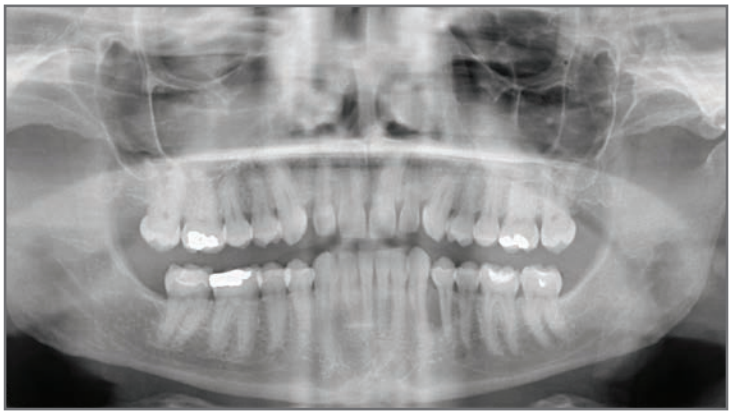


Figure 3

XX Continue Reading

XX Continued From

PATHOLOGY PUZZLER

Dr. John Svirsky

CASE 1:

The size of the lesion really makes ameloblastoma the most likely diagnosis. I have never seen any of the cystic lesions mentioned reach this size. At the VCUOMS the patient was biopsied and pus came out. With this finding, a drain was placed which hopefully will allow the patient's bone to fill in. This lesion turned out to be an infected odontogenic cyst. This is another case of a lesion, which appeared to be a tumor, not reading the textbook.

This case was submitted by Dr. Allison Robeson, a general dentist practicing in Tappahannock.

CASE 2:

This lesion, which looked reasonably benign in appearance, was ultimately diagnosed as ameloblastoma.

CASE 3

The histology in this case was ameloblastoma.

What is interesting in these three cases is that the one that classically appeared to be an ameloblastoma was not and the two that were not typical for ameloblastoma turned out to be that entity. That is why histologic examination is so important.

PEDIATRIC ABSTRACT:

MARGHALANI AA, EMILIE GUINTO B, MINHTHU PHAN B, VINEET DHAR B, TINANOFF N. EFFECTIVENESS OF XYLITOL IN REDUCING DENTAL CARIES IN CHILDREN. PEDIATR DENT. 2017;39(2):103–10.

Background: Xylitol, a sugar alcohol used as a sugar substitute, has often been reported to have anti-cariogenic properties. This five-carbon sugar alcohol is not readily consumed by oral bacteria and has been associated with a less acidic environment in the mouth when compared to the consumption of regular sugars. Since there has been more of a push to prevent caries, with methods such as fluoridated dentifrice and water, sealants, and dietary counseling, it has been a topic of interest to investigate the use of xylitol as a caries preventive measure. Previous studies have been clouded with bias and ineffective and inconclusive study designs.

Purpose: The purpose of this study (a systematic review) was to perform a meta-analysis of both randomized and non-randomized clinical trials to see if xylitol truly is successful in reducing caries incidence in 0- to 18-year-olds. These studies were also examined closely for variation and bias.

Methods: The following question was designed using PICOS (population, intervention, comparison, outcome, and study design): "In children, does xylitol use for at least 12 months compared to a control group reduce dental caries in controlled clinical trials?" DMFS/T scores were compared before and after the intervention with xylitol use, and this comparison was made in both primary and permanent dentitions. Articles were searched using PubMed, Web of Science, and Cochrane Center Register of Controlled Trials. Only articles published from 1995 to 2016 in English were included in this search. Further articles were obtained from reviewing reference lists of these articles. Once all of the articles (210 in total once duplicates were removed) were evaluated for specific inclusion criteria, 10 studies were fit for review. Each study was evaluated closely for risk of bias and was classified as low risk, unclear risk, or high risk of bias. The data was gathered and a statistical analysis was performed.

Results: Ten studies fulfilled the inclusion criteria of this review, five of which were nonrandomized. Xylitol exposure ranged from 2-5 times per day and different methods were utilized, including gum, dentifrice, lozenges, and wipes. Of the 10 studies, 8 reported the dosages of each xylitol intervention (ranging from 2.5 – 10.67 g). All 10 studies were determined to be at high-risk of bias in certain areas, including random sequence generation, blinding of participants/personnel, and funding. After the data was combined, there was a total of 2,733 subjects exposed to xylitol, and 3,232 control subjects. A review of this data revealed reduced caries rates in the experimental population, but this data had a very low quality of data. Even after removal of outliers, a smaller reduction of caries rate was revealed, but the quality of the data remained very low. The randomized studies showed the smallest reduction in caries rate. It was also demonstrated that caries rate was reduced more (54% reduction) when larger doses of xylitol were being consumed (greater than 4 g) than with smaller dosages (less than 3g, reduction of 17%).

Conclusions: Although there are conflicting results, it is still recommended that xylitol can be used as a caries preventive measure. The studies used in this review were heterogeneous (with differing dosages and forms of xylitol being used). This, in combination with high risk of bias that was identified in all of the studies used in this review, leads to a likely decreased statistical value of the pooled data. However, the results of this review have led to the discovery of a potential importance of xylitol dosage and caries reduction. This review resulted in two major conclusions:
1) The systematic review determined that there is a small caries reducing effect associated with xylitol consumption. This effect was identified in randomized control trials, but the quality of the evidence was very low. This causes uncertainty in the use of xylitol as a preventive measure for caries.
2) It appears that the dosage of xylitol that is consumed has an effect on the efficacy of reducing caries. The reduction rate was significantly higher when more than 4 g of xylitol was consumed.

DR. COLE STAINES;
Pediatric Dentistry Resident, Virginia Commonwealth University.

PEDIATRIC ABSTRACT:

WONG S, ANTHONAPPA RP, EKAMBARAM M, MCGRATH C, KING NM, WINTERS JC. **QUALITY OF LIFE CHANGES IN CHILDREN FOLLOWING EMERGENCY DENTAL EXTRACTIONS UNDER GENERAL ANESTHESIA**. INT J PEDIATR DENT. 2017; 27(2):80-86

Introduction: Early Childhood Caries is the most common childhood disease. Children with untreated dental decay can exhibit pain, changes in eating habits, sleep disturbances and changes to behavior. Extensive dental decay and severe pain can lead to emergency extraction of teeth under general anesthesia. Dental extractions under general anesthesia (DEGA) is considered a preventable hospitalization. After DEGA, these patients are typically referred to community dental clinics; follow up at these clinics has been poor in the past. This can lead to continuous dental extractions with DEGA on an emergent basis. Early Childhood caries can have a negative impact on the quality of life (QoL) of children and their families. Previous studies have demonstrated that comprehensive dental treatment under general anesthesia has improved QoL.

Purpose: Assess oral health related changes in oral health- related quality of life (OHRQoL) of preschool aged children that were treated with DEGA emergently for untreated dental caries.

Materials and Methods: Approval for study was granted from the Ethics and Research Governance Department of Princess Margaret Hospital. This study was conducted in Australia. During a 12 month period, 221 preschool children who underwent DEGA were recruited into the study. The study included 112 males (50.7%) and 109 females (49.3%) with a mean age of 4 years. Before DEGA, parents were given ECOHIS questionnaire (Early Childhood Oral Health Impact Scale) which asked about the child's oral health and well-being in the previous 3months. The ECOHIS includes a CIS (Child Impact Section) and FIS (Family Impact Section). DEGA was rendered to these patients on the day of the acute swelling or within 30 days for non-acute. Each patient then presented for a 2 week follow up they received the same ECOHIS questionnaire. The following data was collected: number of decayed, missing (due to caries), and filled teeth, gender, age, ethnicity, language spoken at home, primary source of water, area of residence.

Results: The two week follow up was completed by 126 caregivers, 59 females (46.8 %) and 67 males (67%) with a mean age of 4.02 and mean DMFT score of 8.27. The ECOHIS, CIS (child impact score) and FIS (family impact score) decreased significantly following DEGA. The ECOHIS score demonstrated a 32% change at 2 week follow up; the CIS had a 34% change at follow up and the FIS score exhibited a 29.7% change at two week follow up. Additionally, after DEGA there was a decrease in pain, issues sleeping, irritability and difficulty eating and sleeping, and parents being upset.

Discussion: The DMFT score for this group of chidren in this study that required DEGA was 8.27 and the Australian national average for this age group is 1.51. Children that have DEGA have a delayed access to primary dental treatment for various reasons. The ECOHIS scale is a preferred method of assessing QoL due to the options it provides parents but has its limitations in the FIS score. Other studies have shown significant reduction in ECOHIS scores with comprehensive dental treatment under GA. Overall the results of this study demonstrate how untreated dental caries can negatively impact the QoL of children.

BRANDY EDMONDS, DDS;
Pediatric Dentistry Resident, Virginia Commonwealth University

PEDIATRIC ABSTRACT:

WUNSCH PB, KUHNEN MM, BEST AM, BRICKHOUSE TH. **RETROSPECTIVE STUDY OF THE SURVIVAL RATES OF INDIRECT PULP THERAPY VERSUS DIFFERENT PULPOTOMY MEDICAMENTS**. PEDIATR DENT. 2016; 38(5):406-11

Purpose: The purposes of this retrospective study were to determine: (1) how asymptomatic grossly carious restorable primary molars and those with reversible pulpitis were treated over a four-year period in a university-based practice; and (2) successful treatment modalities of indirect pulp therapy (IPT), formocresol pulpotomy (FCP), and ferric sulfate pulpotomy (FSP).

Methods: Subjects for this study were selected by screening through an axiUm query (electronic patient records) using the following criteria: date range equals January 2010 through June 2014; treatment clinic equals pediatric dental practice; and current dental terminology (CDT) procedure code equals either D3120 (pulp cap-indirect) or D3220 (therapeutic pulpotomy). A total of 2001 teeth in 884 patients were included in the final analysis. A second axiUm query was done to identify further nerve treatment such as pulpectomies or extractions, and those were identified as treatment failures.

Results: After one year, IPT had success rate of 99.3 percent, 98.9 for FCP, 87.2 for FSP. By two years the success rates were 98.8 percent for IPT, 85.9 percent for FCP, and 75.6 percent for FSP. At the three-year follow up, the survival rate for IPT was 96.2 percent, 65.8 percent for FCP and 62.9 percent for FSP.

Conclusions: Over a four-year period of time, a trend toward an increase in the use of IPT over the therapeutic pulpotomy was noticed between 2010 and 2014 at a university-based pediatric dental practice. Pulp IPT showed a significantly greater survival rate compared to FCP or FSP.

DR. REHAM ALNAJJAR;
Pediatric Dentistry Resident, Virginia Commonwealth University

PEDIATRIC ABSTRACT:

DAVIDOVICH E, MELTZER L, EFRAT J, GOZAL D, RAM D. POST-DISCHARGE EVENTS OCCURRING AFTER DENTAL TREATMENT UNDER DEEP SEDATION IN PEDIATRIC PATIENTS J CLIN PEDIATR DENT. 2017; 41(3): 232-235

Background: Deep sedation in dentistry is sometimes required for treating children with uncooperative behavior. The first 24 hours after discharge, post sedation events may occur in sedated patients. Awareness of post sedation behavioral and psychological side effects is important for both dental providers and parents.

Purpose: To assess immediate post sedation events of children during the first 24 hours after dental treatment under deep sedation.

Methods: This study was a retrospective questionnaire survey completed with Institutional Review Board approval at the post-graduate dental clinic in the Pediatric department at the Hadassah School of Dental medicine in Jerusalem, Israel. Parents were asked by phone about post discharge events during the first 24 hours following treatment. Children between the ages of 1 and 16, who were treated under deep sedation with intravenous drugs (propofol alone or combined with either midazolam or ketamine). Eligibility criteria for the study were ASA Class I or II with uncooperative behavior related to cognitive impairment, developmental delay, or young age. Treatment complexity was defined as simple (examination, radiographs, prophylaxis, sealants, class I & II restorations) and Complex (stainless steel crowns, strip crowns, pulp therapy, dental extractions, and biopsy). The phone questionnaire inquired about restlessness, crying, sleepiness, dizziness, insomnia, fever, nausea, vomiting, pain in the oral cavity, extraoral pain, incontinence, lack of appetite, & memory of the dental visit.

Results: The study population was 54 children with a mean age of 6.1±4.3 years old, 29 boys, and 25 girls. Children were divided into 2 age groups: 32 children under age 6 years and 22 children aged 6 years or older. Thirty-nine children were treated with propofol alone and 15 were sedated with propofol in combination with midazolam or ketamine. The complexity of treatments in the young group was 9.4% simple and 90.6% complex; the older group contained 18.2% simple and 81.8% complex. At least one postoperative complication was noted in 81.3% of the younger group and in 86.4% of the older group. Sixty-three percent of patients had sleepiness after discharge with 46% remembering the dental visit. Crying (44.4%), Restlessness (35.2%), and lack of appetite (29.6%) were routinely reported. Complications of statistical significance included 59.1% of older children reported pain in the oral cavity versus 18.8% of the younger group. Older children (18.2%) reported dizziness as a complication while no younger patients reported dizziness. Patients who received sedative combinations had a higher incidence of nausea and vomiting 26.7% than the propofol group (5.1%).

Conclusion: Sleepiness is the most common post discharge event seen in children receiving dental treatment under deep sedation. After deep sedation, children still may recall the dental visit, and display crying, restlessness, and lack of appetite. After treatment, older children reported more pain in the oral cavity than younger children.

BRETT HENDERSON, DMD;
Pediatric Dentistry Resident, Virginia Commonwealth University

PEDIATRIC ABSTRACT:

MEI ML, LI Q, CHU C-H, LO EC-M, SAMARANAYAKE LP. ANTIBACTERIAL EFFECTS OF SILVER DIAMINE FLUORIDE ON MULTI-SPECIES CARIOGENIC BIOFILM ON CARIES. ANN CLIN MICROBIOL ANTIMICROB. 2013;12(1):4. DOI:10.1186/1476-0711- 12-4.

Background: Silver diamine fluoride (SDF) has proven to be an effective treatment option for the management of dental caries and incipient lesions.

Purpose: The purpose of this study was to investigate the mechanism of action of silver diamine fluoride.

Methods: The authors utilized a computer-controlled artificial mouth to study the effects of 38 percent SDF on both dentin carious lesions and in vitro cariogenic biofilms. The authors selected five known cariogenic species of bacteria for the study. They included Actinomyces naeslundii, Lactobacillus rhamnosus, Lactobacillus acidophilus, Streptococcus sobrinus, and Streptococcus mutans. These five species were used to form carious lesions on dentin blocks through the formation of a biofilm. These blocks were treated with 38 percent SDF (test group) or sterile distilled water (control group). The blocks were incubated in the computer-controlled artificial mouth for 21 days, with measurements occurring every seven days. The biofilms were assessed via scanning electron microscopy, confocal laser scanning microscopy, and measuring colony forming units (CFUs) on selective media plates. The dentin blocks were assessed via Knoop microhardness testing, energy dispersive spectroscopy, and Bio-Rad Fourier transform infrared spectroscopy.

Results: The assessment of the biofilm revealed 38 percent SDF inhibited the growth of the cariogenic bacteria and fewer CFUs in the test group compared to the control group ($p < 0.01$). The control group was also noted to have a confluent biofilm compared to minimal detection of bacteria in the test group. The assessment of the dentin blocks revealed the relative microhardness at 25-50 µm was higher in the test group when compared to the control group ($p < 0.05$). It was also noted that the weight percentages of phosphorus and calcium were higher in the test group than the control group.

Conclusion: The authors concluded that 38 percent SDF reduces the demineralization process and thereby arrests dental caries. The high concentrations of fluoride and silver ions result in the inhibition of growth of biofilms, which attenuates the process of demineralization.

NICHOLAS LUKE, DDS;
Pediatric Dentistry Resident, Virginia Commonwealth University

PEDIATRIC ABSTRACT:

NELSON T, CHIM A, SHELLER BL, MCKINNEY CM, SCOTT JM. PREDICTING SUCCESSFUL DENTAL EXAMINATIONS FOR CHILDREN WITH AUTISM SPECTRUM DISORDER IN THE CONTEXT OF A DENTAL DESENSITIZATION PROGRAM. JADA 2017;148(7):485-492.

Background: Autism spectrum disorder (ASD) is one of the most common developmental disabilities. According to the Centers for Disease Control and Prevention, the incidence of ASD is 1 in 68 children, not related to ethnicity, nationality, or socioeconomic status. It is estimated to be 5 times more prevalent in boys than girls. Studies have shown that children with developmental disabilities are more likely to have unmet oral health care needs compared to typically developing children. Dental care can be difficult for children with ASD due to their communication and sensory modulation impairment. Basic behavior guidance techniques (BGTs) such as tell-show-do, positive reinforcement, distraction, and voice control that are effective with typically developing children may not be as effective with this population. Challenging behaviors that are characteristic to ASD may prevent children from receiving routine dental care. In effort to overcome such barriers to care, dental behavior guidance strategies have begun including approaches that are used in educational settings. Previous studies have shown promising results from the treatment programs that use desensitization and exposure approaches, however research designs have varied widely. The objectives of this study were to evaluate the effectiveness of a dental desensitization program for children with ASD and to determine the association between a child's age, medical diagnosis, parent-rated severity, communication ability, and self-care skills and his or her ability to tolerate a minimal threshold examination (MTE).

Methods: A retrospective review of clinical behavior data and pre-visit questionnaires was completed for 168 children diagnosed with ASD who attended the Center for Pediatric Dentistry at the University of Washington in Seattle, from January 2012 through January 2015. Primary independent variables included treatment and behavior variables. Treatment variables included history of therapy, number of therapies received, and history of protective stabilization, sedation, or anesthesia for dental care. Behavioral variables included caregiver-rated ASD severity, level of challenging behaviors, social abilities, communication skills, and self-care skills. The primary outcome of interest was the patient's ability to receive an MTE, defined as an examination with an intraoral mirror while seating in a dental chair. The secondary variable was the number of dental visits required to achieve an MTE. Frequencies and percentages for categorical variables were completed. Association between the ability receive an MTE and all variables of interest was analyzed with modified Poisson regression using a 2-tailed statistical significance level of $P < .05$.

Results:

- An MTE was achieved for 77.4% of all children within 1 to 2 visits and 87.5% in 5 visits or less.
- Over 95% of the children with ASD severity rated as mild to moderate were able to receive an MTE. In comparison, 77% of those who were rated as severe achieved an MTE.
- There was statistically significant relationship between moderate and severe ASD.
- History of protective stabilization, sedation, or general anesthesia was not associated with ability to receive a dental examination.
- Other statistically significant predictors of successful dental exam included ability to be involved in group activities, verbal communication, understanding of language, mimicking or echolalia, and ability to perform the self-care skill of dressing.

Conclusions: The study revealed that desensitization can be an effective method of teaching dental skills to children with ASD. The results indicate that children with characteristics indicative of a milder presentation of ASD were more likely to benefit from dental desensitization.

GAIL KIM, DMD; Pediatric Dentistry Resident, Virginia Commonwealth University

40 UNDER 40

DR. JESSICA MOORE

Dr. Jessica Moore is the co-owner of a large practice in Charlottesville. Her team provides outpatient anesthesia services and traditional dentistry for children, adolescents, patients with special health care needs, and other underserved populations.

PEDIATRIC ABSTRACT:

SUM FHKMH, ZHANG L, LING HTB, ET AL. ASSOCIATION OF BREASTFEEDING AND THREE-DIMENSIONAL DENTAL ARCH RELATIONSHIPS IN PRIMARY DENTITION. BMC ORAL HEALTH. 2015;15, ARTICLE 30. DOI:10.1186/S12903-015-0010-1.

Background and Purpose: Breastfeeding is the ideal modality of feeding newborns and infants. Some of the many benefits of breastfeeding include providing nutrients and antibodies, reducing the chance of obesity and type II diabetes in adult life and reportedly higher scores in intelligence tests. There also seems to be a potential relationship between breastfeeding and oral health. The development of the facial bones is associated strongly with genetic factors but is also known to be affected by environmental factors. Breastfeeding and oral parafunctional habits are included amongst those environmental factors. The effects of non-nutritive sucking habits such as pacifier use or digit sucking have been widely reported on with their effects usually including anterior open bite, reduced overbite, increased overjet and posterior crossbite. There is, however, limited literature on the effect of breastfeeding on occlusion. Some studies show that children who are breastfed exclusively show higher percentages of straight terminal planes as compared to children exclusively bottle-fed- indicating a lower chance of developing anterior open bite and posterior crossbite in breastfeeding children. The purpose of this study is to evaluate the association of breastfeeding on intra-arch and inter-arch dental relationships in primary teeth.

Methods: A cross-sectional study was carried out in three main territories of Hong Kong. Ten kindergartens agreed to participate in the study with 1014 children participating. Parents were asked to sign consent forms to participate in the study. Non-asians, patients with orofacial cleft, facial deformities, congenital defects and systemic diseases were excluded from the study. Questionnaires were completed by the parents collecting information on the duration of breastfeeding, history of non-nutritive sucking habits and socioeconomic status (income and family background). An oral examination was completed by the same examiner for all patients done in the school setting. Centric occlusal relationship was evaluated with an orthodontic ruler. The dental arch was evaluated based off of incisal relationship, primary canine relationship, primary molar relationship, overjet, anterior crossbite, anterior openbite, overbite, intercanine width, intermolar width, posterior crossbite.

Results: Of the 851 children accepted into the study, about a quarter were purely breastfed for more than 6 months, less than one third had never been breastfed and a majority were breastfed less than 6 months. Most children had never sucked their thumb or used a pacifier. Significant association was found between duration of breastfeeding and incisal relationship- children who purely breastfed had a lower chance of developing class II incisal relationship compared with class I. Duration of breastfeeding had no significant difference in developing class III incisal relationship compared with class I. Children who experienced pure breastfeeding had lower chances of developing increased overjet. No association was found between primary canine or primary molar relationships or anterior crossbite. No association was found in the extent of overbite in the primary dentition. No significant difference was seen between duration of pure breastfeeding and openbites. Duration of breastfeeding was significantly associated with intercanine width- children who purely breastfed had higher chances of greater intercanine width development. Duration of pure breastfeeding was also associated with greater mean intermolar width. No association was seen between crossbite development and breastfeeding

Discussion: This study looked at the association of breastfeeding on the three-dimensional dental arch relationships in the primary dentition. Pure breastfeeding for more than 6 months benefitted dental development in anterior sagittal and transverse directions. This study supported the idea that children who purely breastfed had higher rates of development of a normal occlusion. Children who had purely breastfed for more than 6 months had a lower chance of forming class II incisal relationships and having increased (over 3.5 mm) overjet than those who never breastfed. No association was found between primary canine, primary molar relationships or anterior crossbite. In the vertical dimension, no association was found between breastfeeding and anterior open bite or overbite. In the transverse dimension no association was found between breastfeeding and posterior crossbite. Some of the limitations of this study are that information on breastfeeding was obtained using questionnaires relying on parental memory- potential recall bias. Another limitation is that as a cross sectional study the cause and effect of breastfeeding and three-dimensional dental arch relationships cannot be determined and only the association can be assessed.

Conclusions: Breastfeeding was found to have a positive correlation with dental arch development in primary dentition in the anterior sagittal and transverse dimensions.

MANPREET DHILLON, DDS; Pediatric Dentistry Resident, Virginia Commonwealth University

40 UNDER 40

DR. IBRAHIM HARON

Dr. Haron is an Emory University graduate who practices at Northern Virginia Oral and Maxillofacial Surgery Associates as well as INOVA hospital. Putting a smile on his patients' face is his number one goal.

PEDIATRIC ABSTRACT:

HARRISON R, BENTON T, EVERSON-STEWART S, WEINSTEIN P. EFFECTS OF MOTIVATIONAL INTERVIEWING ON RATES OF EARLY CHILDHOOD CARIES: A RANDOMIZED TRIAL. PEDIATR DENT 2007; 29(1): 16-22

Background: This study focused on addressing rates of early childhood caries in South Asian immigrant children. The oral health of young South Asian immigrant children from low-income families has been reported as poor in comparison with their native-born counterparts; these findings have been consistent in South Asian children in Western Canada.

Standard educational practices are often ineffective as they are not adapted to a family's specific needs and disregard a parent's readiness to change their behavior. Motivational interviewing (MI) is a more patient-centered, collaborative form of intervention which has been found to facilitate behavior change. In MI, the patient's intrinsic motivations are engaged through the use open-ended questions, affirmations, reflections, and summary statements.

Purpose: The goals of this study were twofold: 1) to assess the effect of motivational interviewing on the prevention of early childhood caries, and 2) to improve the efficiency of data analysis through the use of Poisson regression.

Methods: This research was conducted by the University of British Columbia, the University of Washington, and the Progressive Intercultural Services Society (PICS). The participants were 240 South Asian children, six to eighteen months old, and their mothers. They were enrolled over a period of 2 years and randomly assigned to either the control group, which received traditional oral health education, or the experimental group, which received a MI intervention. The participants were further divided into 2 groups by age: 1) 6-12 months and 2) greater than 12 months.

In the control group, mothers viewed an 11-minute video, "Preventing Tooth Decay for Infants and Toddlers" and received a pamphlet on infant oral health with specific ECC prevention strategies tailored to the South Asian community. In addition to receiving the control intervention, mothers in the MI treatment group received the following: a 45-minute counseling session; two brief follow-up telephone calls at 2 weeks and 1 month after initial contact; four follow-up telephone calls up to 6 months after the initial contact; and two postcard reminders.

A visual examination was conducted to assess the patient's caries in the form of a "knee to knee" exam. The patients' parents completed two questionnaires: 1) a modified Evens instrument and 2) the Readinesss Assessment for Parents concerning Infant Dental Decay (RAPIDD). Both the exam and the questionnaires were completed at initial enrollment, and at the 1 year and 2 year follow-ups.

Results: The Poisson regression indicated a protective effect of MI (hazard ratio [HR]=0.54; 95% CI=0.35-0.84). After 2 years, the MI treatment group had a DMFs rate approximately 46% lower than the control group. Additionally, the study found that children had increased DMFs rates if their mothers had: 1) pre-chewed their food; 2) been raised in a rural environment; and 3) a higher family income (P<.05).

Conclusion: Motivational interviewing is an effective means of promoting oral health behavior change among mothers and preventing early childhood caries in high risk children.

DR. VICTORIA ONESTY;
Pediatric Dentistry Resident,Virginia Commonwealth University

PEDIATRIC ABSTRACT:

HANSEN RN, SHIRTCLIFF RM, DYSERT J, MILGROM PM. COSTS AND RESOURCE USE AMONG CHILD PATIENTS RECEIVING SILVER NITRATE/ FLUORIDE VARNISH CARIES ARREST. PEDIATR DENT 2017; 39(4): 304-307.

Background: Silver nitrate/ fluoride varnish as well as silver diamine fluoride have been implemented as a treatment option to arrest dental caries. While silver products have been used in medicine for many years, they have more recently been adopted in dental education and clinical practice. Silver diamine fluoride received FDA approval in 2014 and has been available for use since 2015. Not only have silver products been used to arrest caries progression, they have also been proven to decrease incidence of caries formation in healthy teeth more effectively than sodium fluoride varnish treatment and serve as a replacement for pit and fissure sealants. While silver ion products have the potential to provide a solution for the need for greater access to dental care and the pervasiveness of childhood caries, there is still much to be learned about their cost effectiveness and use of resources.

Purpose: The purpose of this study was to evaluate the effects of cost of dental care and use of resources with the implementation of silver nitrate/fluoride varnish.

Methods: In this retrospective matched cohort study, Oregon Medicaid claims of children younger than 21 from January 2012-December 2014 were analyzed to compare pediatric patients treated with silver nitrate/ fluoride varnish to those pediatric patients not treated with silver nitrate/fluoride varnish. Exclusion criteria included children with prosthodontic treatment. The student's t-test was used to compare continuous variables, while a chi-square test was performed for categorical variables. Generalized estimating equation regression models were used to estimate dental services and costs.

Results: When compared with matched pediatric patients that were treated using conventional methods, children treated with silver nitrate/fluoride varnish used a greater number of dental services in the first year and in total over an average of twenty-eight months. Costs were similar between the two groups. When preventive and diagnostic costs were not considered, children treated with silver nitrate/fluoride varnish had lower costs than those children treated conventionally.

Discussion: The costs for pediatric patients treated with silver nitrate/fluoride were lower than those of children treated using conventional methods when diagnostic and preventive costs were excluded and the focus was turned to restorative and surgical costs. This lends support to a recent publication suggesting that pediatric patients treated with silver products would require less surgical treatment. These results are in line with reports that parents are not as concerned with discoloration associated with arrested caries as would be expected. As restorative costs are lower, parents were not frequently requesting that esthetic restorations be placed.

Conclusion: The use of silver diamine fluoride and silver nitrate/fluoride varnish are beneficial options for treating dental caries and provide the potential to improve the oral health of citizens in the U.S. and abroad. Since the use of these topical products is rather new to the field of dentistry, standardized protocols must be implemented.

DR. HANNAH RUSTIN;
Pediatric Dentistry Resident, Virginia Commonwealth University

SCIENTIFIC

INTEGRATION OF A PREVENTATIVE DENTAL CARE COORDINATOR WITHIN A LONG-TERM CARE FACILITY:

A PILOT STUDY TO DETERMINE EFFICACY IN TWO LONG-TERM CARE FACILITIES IN VIRGINIA

Frank P. Iuorno, Jr. DDS, MS; Patricia B. Bonwell, RDH, BSDH, MSH, PhD; Lyubov D. Slashcheva, DDS; Marcia Rhodes, RDH

BACKGROUND

Preventive and restorative dental care for residents in long-term care facilities remains underfunded, underutilized and mismanaged. [1] However, maintaining oral health is a key component to overall health and well-being. Federal and state regulations require long-term care facilities provide oral health services [2], but funding is usually not provided. This proves to be the largest impediment to the access to oral health care in long-term care facility facilities. [3] [4] Medicare and Medicaid commonly cover fees for infected devices, heart attack, aspiration pneumonia, and ventilator associated pneumonia of dental origin [5] all of which may be avoided with less expensive preventive oral care and dental restorative measures. [6]

The elderly US population is ever growing. Thirteen percent of the population was 65 years or older in 2010. This will increase to 19% in 2030 and over 20% of the population expected to be over 65 years old by 2050 (5% of which will be over 85). From 2010 to 2050, the population of people over 65 years old will increase 46% and the number of teeth at risk, will also grow from about 140 million in 1972 to 933 million in 2030. [3] [7]

Adult dental coverage is not an essential benefit as defined by the Affordable Care Act. [7] Funding for routine oral health care is not provided through Medicare coverage nor most state Medicaid programs. [7]

It is imperative to address these preventive oral health needs because of their impact on quality of life, systemic health and potential negative financial impact. Dental caries may contribute to malnutrition, infection, pain, bacteremia, and even airway compromise. Research has shown that persons with decayed teeth and visible plaque or tartar are more likely to develop pneumonia than those without decayed teeth and visible plaque. Current research belief is that pieces of calculus break off from teeth and become lodged in airway, prompting the development of certain lung infections from the presence of oral bacteria. [8] [6] [9] These findings support the need for proper oral hygiene and proper care of dental prosthetics. A decrease in the incidence of pneumonia in nursing home residents is attributed to proper oral hygiene. It has been estimated that an annual savings of $800 million in nursing home costs can be attributed to a decrease in nursing home acquired pneumonia through improved oral hygiene [10]. Epidemiologic studies demonstrate that prevention of dental disease may provide substantial medical cost savings associated with diabetes, pneumonia, coronary artery disease, stroke, dementia and other conditions. [5]

Inadequate daily oral care leading to extensive disease is common in long-term care facilities. [11] [12] Nurses and nurses' aides mainly lack time and training to provide daily oral care. [13] Often delivery of these preventive and restorative dental needs for residents is challenging and transportability is difficult. [14]Providing services within the resident's facility would be the most cost-effective way to deliver dental care.

The cost of providing routine dental services is low compared to nursing care, pharmacy and physician services. Using data from Apple Tree Dental, cost of providing routine and emergency dental care when delivered by a mobile, on-site delivery system was about $200 per resident per year. [15] Dental-related emergency room visits among adults over 65 years of age rose from 1 million from 1999-2000 to 2.3 million during 2009–2010. Total charges for dental ED visits were $1.6 billion and the average charge per visit was $749. Medicaid accounts for $520 million or about one-third of total dental ED charges. Although the average charge among elderly adults was almost twice as much as for younger age groups, elderly patients as a group accounted for only 4.5 percent of total charges. Children 0 to 18 years old accounted for 9.5 percent while adults 19 to 64 years old accounted for 86.0 percent. [16] A report published in the Journal of the American Dental Association (Sept. 2010) reviewed hospital admission data from 2007 and concluded the average cost of care per patient was $13,590. The average stay in the hospital was about 3 days. The total hospital charges in 2007, for dental abscess admissions, were $105.8 million (23,001 hospital days). The average cost of examining and removing an abscessed tooth in a dental office is $232, as an outpatient procedure. [17]

The Virginia Dental Association formed the Access to Care Task Force to study the issue of access to dental care in the elderly, specifically the long-term care facility population. The Task Force consisted of dentists, dental hygienists, representation from the Virginia Department of Health, Virginia Commonwealth University School of Dentistry, American Dental Association's Council on Advocacy for Access and Prevention's National Eldercare Advisory Committee, and the Virginia Health Care Association. It was determined that to effect significant change, proof that providing coverage for preventive needs would be more cost effective than providing coverage for emergent care was necessary. The pilot study was conceived and funding procured.

A well accepted measure of oral health in the long-term care facility population has been the Oral Health Assessment Tool (OHAT). OHAT scores have been shown to be a reliable and valid screening tool for long-term care facility residents. [18] This would serve as a tool to assess outcomes throughout the pilot study.

HYPOTHESIS:

1. Integrating a preventative dental care coordinator in a long-term care facility improves Oral Health Assessment Tool (OHAT) scores.
2. Integrating a preventative dental care coordinator in a long-term care facility decreases hospital admission rates for dental/oral health related disease.
3. Integrating a preventative dental care coordinator in a long-term care facility decreases the overall health care cost per long-term care resident.

MATERIALS AND METHODS

Facilities

Two long-term care facilities in Virginia were identified and agreed to participate in the pilot study for 12 months. Location A was a 180 bed facility, Location B was a 190 bed facility. Both facilities serviced mostly Medicaid and Medicare residents. No previously established dental monitoring systems were in place in either facility.

Both facilities were divided into specific care units based on residents' needs. Residents in the severe dementia units in each facility were excluded from the study as per the facilities' requests. To aid in the research process, the remaining patients in each of the facilities were randomly divided into control and treatment groups and each site served as both a treatment and control site. This approach aided in addressing confounding variables.

Consent for preventive treatment and collection of data was obtained either directly with patients in the treated group when applicable or via the facility director (or appropriate proxy) prior to starting the study and providing treatment. Further consent for specific treatment was obtained if treatment was rendered off-site with local dentists.

Staff and Training

A licensed dental hygienist and dental assistant were hired to deliver preventive dental care and coordinate more involved dental care for patients in both long-term care facilities. The oral health care providers who participated in this program received training on how to provide oral health care to medically, behaviorally and cognitively challenged residents. Educational videos created by the Cecil Sheps Center for Health Services Research at the University of North Carolina and Lucy Corr Village (Chesterfield, Virginia) were used. The ADA's multi module online CE series entitled "Dentistry in Long-term Care: Creating Pathways to Success" was also utilized for training.

Data Collection

In Locations A and B, sixty (60) patients and one hundred (100) patients were screened respectively. The 60 and 100 patients were then randomly assigned into treatment and control groups for each facility. For Location A, thirty patients were assigned to the treatment group and thirty patients were assigned to the control group. Location B, fifty patients were randomly assigned to each group.

Demographic information for each patient was then recorded, which included age, gender, race, mobility status, a Brief Interview for Mental Status (BIMS) [25] score and dental status (Dentate, Partially Edentulous, Edentulous).

Initial screenings were provided at the facilities by volunteer dentists and treatment plans formulated in accordance with Virginia state law. Screenings included medical history reviews, oral cancer screening exams, and modified Oral Health Assessment Tool (OHAT) scores (Figure 1). Both initial and final OHAT scores were recorded.

The number of hospital admissions for dental needs and illness stemming from dental needs were recorded throughout the pilot study for each facility in all groups. Cause of death was also noted for any patient who expired.

Treatment Rendered

Based on the initial assessment, a dental hygiene treatment plan was created and implemented by the hygienist and oral prophylaxis provided if agreed upon by the patient or guardian when possible. One of four daily mouth care cards (Figure 3) were posted in each resident's room/space displaying daily oral care recommended for each resident in the treatment group.

The hygienist and assistant provided daily oral health care and instruction to all participating residents. Included in this responsibility was training for nurses, CNAs, and other facility staff in oral health care practices that they could then implement with their patients.

The hygienist and assistant coordinated care with local dentists for residents in need of basic restorative care (simple fillings, prophylaxis) and extractions. All treatment administered by a dentist was paid for by the study funds and treatment fees recorded.

Routine chart review of all residents (control and treatment groups) was performed and any hospital admissions recorded. Resident expirations were also recorded and cause of death noted.

RESULTS

Demographic Data

Data collected from residents in both facilities can be found in Table 1. In Location A, there were sixty patients screened. Thirty were treated and thirty were in the control group. The average ages for the treated and control groups were 61.83 and 68.83 respectively. In Location B, 100 patients were screened and subsequently randomly divided into two groups of fifty. The average ages for the treated and control groups were 78.32 and 78.14 respectively.

Taken together, the average age for the treated groups was 74.76 and control group was 72.03. There was no statistically significant difference between these groups.

In both facilities, there was a fairly equal distribution of Caucasian and African American patients. Fifty-nine percent of those treated were mobile, while 41% were not able to ambulate outside of the facility without the use of a wheelchair and nurses aid for transfer.

Average BIMS score for patients treated was 9.97 and those in the control group scored 10.34. There was no statistically significant difference between the two groups.

A dentate patient was one who had all remaining permanent teeth with the exception of third molars. Partially edentulous was defined as a patient missing more teeth than just the four third molars. Edentulous patients were missing all permanent teeth.

Interestingly, in the treated group, 69% of patients seen in both facilities were dentate, 23% edentulous, with only 9% partially edentulous. In the control group, 68% were observed to be dentate, and 23% and 10% were edentulous and partially edentulous respectively.

OHAT Scores (Hypothesis 1)

Table 2 displays the OHAT scores at the beginning of the study (OHAT, T1) and those taken at the end of the year (OHAT, T2). There was no statistically significant difference between OHAT scores of the treated and control group at T1; however, at T2, there was a statistically significant difference between the treated and control groups.

Hospitalizations (Hypothesis 2)

This data is summarized in Table 3. In the treated group for both facilities, there were 36 hospital admissions throughout the 12 month study period, one of which was related to oral pain (prior to coordinator's treatment). Twelve patients expired.

In the control groups, there were 24 patient admissions, two of which were because of dysphasia/oral pain and 24 patients expired through the 12 month study period. There were two admissions for pneumonia, the etiology of which was undetermined. There were no apparent deaths directly linked to oral health etiology.

Financial Summary (Hypothesis 3)

The pilot study financial summary is recorded in Table 5. Altria, Dental Trade Alliance Foundation (DTAF) and the ADA State Public Affairs (SPA) grants were procured for a total of $145,000.00 income. Wages for the hygienist and dental assistant constituted the bulk of expenses along with supplies, equipment and training. Of note was the cost of delivering care to residents treated in the study. In total, $5,115.00 was spent to deliver care to residents in need. Only extractions, prophylaxis and simple restorations were performed. Not every resident in the treatment group needed treatment outside of the facility. Some residents were edentulous and others needs could be met with preventive treatment rendered on-site. There were a total of 80 residents in the treated group for an average cost per resident of $63.94.

DISCUSSION

Daily oral health care for the older adult population has shifted from primarily providing denture care to providing more brushing and flossing and utilizing other dental therapy to maintain the health of natural dentition [19] (Donaldson, 2011). This change is primarily because of an increase in the number of older adults retaining more of their natural dentition. The number of

30 Continued On Page

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older adults who have retained some or all of their natural dentition is increasing as the rate of edentulism in the U.S. has declined significantly from 20.3% in 1972 to 13.9% in 2001. [20]

This pilot study was conducted to determine the potential efficacy of having a full-time Community Dental Health Coordinator in a long-term care facility to coordinate care for residents, thus decreasing the need for urgent or emergent dental care which is known to be very costly. Despite the dental/oral health treatment provided, along with materials needed, and staff and other costs being covered by funding for this study (with no financial outlays to either facility), there were still other unforeseen barriers to accessing dental care. In many instances, there were logistical barriers that prevented transportation. Other impediments centered on the bureaucracy of each facility.

Excellent relationships were established between the preventative dental care provider/coordinator and the physicians at each facility. In all instances, the physicians were able to have residents medically ready for dental treatment (premedicated with antibiotics, titrating INR, etc), and this never posed hindrances to access to coordinated dental care.

Transportation was often an impediment, but rarely a complete block to dental treatment. Again, this pilot study provided funds for transportation and if needed, funds for a nurse to accompany the resident for transport to an outside office for care. When transportation became an issue, it had more to do with logistics from the administrative side of the facility.

Findings from this study show that utilizing a full-time preventative dental care provider/coordinator definitely improves OHAT scores. A decrease in OHAT scores translates to better oral health and decrease in potential emergent/urgent dental visits which are known to be costly. Since there were two admissions related to oral pain in the control group, we can state that at an average cost per admission of approximately $16,000.00, a total of $32,000.00 could have potentially been saved. This would have justified cost of one full-time presence of a preventative dental care provider covering both facilities.

Providing care for residents to maintain oral health was found to be approximately $65.00 per resident in this sample. These costs included transportation (when needed) and professional fees, which could be covered under the Incurred Expense program which is operational in many states. Under normal circumstances, these fees would not be covered by the patients' state-funded insurance programs and would likely be deducted from the monthly stipend allotted to the facility. It cannot be stressed enough that the cost of providing routine preventive care including extractions, simple fillings and cleanings is overall less than providing coverage for emergent/urgent visits and potential hospital admissions for oral pain.

Since this study began, Virginia has started a new training program for Community Dental Health Coordinators (CDHCs). These individuals are trained to recognize dental disease, coordinate care with community dental providers, educate the public on dental disease prevention and provide limited preventive services with a projected annual salary of $30,000.00 - $40,000.00 per year.

Future study on the implementation of CDHCs in long-term care facilities to justify the cost of providing coordinated care, thus eliminating the need for emergent dental care, is worthwhile. This could not only save money for patients, facilities and insurers, but also increase the overall quality of life for long-term care facility residents.

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TABLE 1

9.Facility	Groups	Number Patients	Age Range (Ave/Stnd Dev)	Gender	Race	Mobile (%)	BIMS (Ave/Stnd Dev)	Dentition ^
Facility A	Treated	30	39-86 (61.83/11.63)	17Female 13Male	16White 14African American	23Yes (76%) 7No (23%)	0-15 (9.96/4.24)	22D (73%) 7E (23%) 1PE (3%)
	Control	30	48-92 (68.83/13.37)	14Female 16Male	17White 12 African American 1Hispanic		0-15 (11.57/3.98)	19D (63%) 7E (23%) 4PE (13%)
Facility B	Treated	50	57-103 (78.32/14.41)	31Female 19Male	26White 24 African American	24Yes (48%) 26No (52%)	0-15 (9.98/4.65)	33D (66%) 11E (22%) 6PE (12%)
	Control	50	44-100 (78.14/11.92)	37Female 13Male	27White 23 African American		0-15 (9.60/4.49)	35D (70%) 11E (22%) 4PE (8%)
Both Facilities	Treated	80	39-103 (74.76/14.14)	48Female 32Male	42White 38 African American	47Yes (59%) 33No (41%)	0-15 (9.97/4.47)	55D (69%) 18E (23%) 7PE (9%)
	Control	80	44-100 (72.03/14.73)	61Female 29Male	44White 35 African American 1Hispanic		0-15 (10.34/4.39)	54D (68%) 18E (23%) 8PE (10%)
			p-value = 0.23				p-value = 0.61	

^(D=Dentate, E= Edentulous, PE=Partially Edentulous) * = Statistical Significance

TABLE 2

Facility	Groups	OHAT (T1) (Ave/Stnd Dev)	OHAT (T2) (Ave/Stnd Dev)
Both Facilities	Treated	5.91/3.78	6.01/3.65
	Control	5.38/3.45	4.52/3.20
		p-value = 0.35	p-value = 0.03*

*Statistically significant

TABLE 3

Facility	Groups	Hospital Admissions	Expirations	Admissions Related to Oral Disease
Both Facilities	Treated	36	12	1
	Control	24	24	2

TABLE 5

Income		
Grants	Altria	$40,000.00
	DTAF	$25,000.00
	ADA SPA	$80,000.00
Total Income	**$145,000.00**	

Expense	
Wages	$126,772.89
Administrative Supplies	$280.42
Dental Supplies	$5,488.94
Licenses and Permits	$15.00
Dental Treatment	$5,115.00
Miscellaneous Program Expenses	$218.99
Equipment Purchased	$4,776.29
Travel & Training	$3,200.63
Total Expense	**$145,868.16**

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FIGURE 1

Resident Name:			Facility:		Exam Date:	
Category	**0=Healthy**	**1=Changes**	**2=Unhealthy**	**Score**	**Action Required**	**Action Completed**
Lips	Smooth, pink, moist	Dry, chapped or red at corners	Swelling or lump, white/red/ulcerated patch; bleeding/ulcerated at corners		1=intervention 2=refer	
Tongue	Normal, moist, pink	Patchy, fissured, red, coated	Patch that is red and/or white, ulcerated, swollen		1=intervention 2=refer	
Gums & Tissues	Pink, moist, smooth, no bleeding	Dry, shiny, rough, red, swollen around 1-6 teeth, one ulcer or sore spot under denture	Swollen, bleeding around 7 teeth or more, loose teeth, ulcers and /or white patches, generalized redness and/or tenderness		1 or 2=refer	
Saliva	Moist tissues, watery and free flowing saliva	Dry, sticky tissues, little saliva present, resident thinks (s)he has dry mouth	Tissues parched and red, very little or no saliva present; saliva is thick, ropey, resident complains of dry mouth		1=intervention 2=refer	
Natural Teeth Yes No	No decayed or broken teeth/roots	1-3 decayed or broken teeth/roots	4 or more decayed or broken teeth/roots, or very worn down teeth, or fewer than 4 teeth with no denture		1 or 2=refer	
Denture(s)	No broken areas/ teeth, dentures worn regularly and labeled	1 broken area/tooth, or dentures only worn for 1-2 hours daily, or no name on denture(s)	More than 1 broken area/tooth, denture missing or not worn due to poor fit, or worn only with denture adhesive		1=ID denture 2=refer	
Oral Cleanliness	Clean and no food particles or tartar on teeth or dentures	Food particles/tartar/debris in 1 or 2 areas of the mouth or on small area of dentures; occasional bad breath	Food particles, tartar, debris in most areas of mouth or on most areas of denture(s), or severe halitosis		1=intervention 2=refer	
Dental Pain	No behavioral, verbal or physical signs of pain	Verbal and/or behavioral signs of pain such as pulling of face, chewing lips, not eating, aggression	Physical signs such as swelling of cheek or gum, broken teeth, ulcers, "gum boil", as well as verbal and or behavioral signs		1 or 2=refer	
Nutritional Problems	Able to chew and eat normally	Difficulty chewing but still able to eat, soft mechanical diet	Unable to chew eat effectively		1=intervention 2=refer	

Follow Up

OHAT to be repeated	Hygiene care plan	Referral
[ ] Annually [ ] Every 6 months [ ] Date_____	[ ] Referral to hygienist [ ] Fluoride varnish recommended [ ] Preventive maintenance	A) Referral to dentist required Y N B) Referral made: date _____ C) Referral refused by resident/family/guardian Y N

Insurance	Compliance	Screening Dentist's Name/Signature
[ ] Private Pay/Ins [ ] Medicaid [ ] Medicare	[ ] Patient is transportable to office and will comply with treatment [ ] Patient is transportable but needs sedation or anesthesia for treatment [ ] Patient is not transportable and needs hospital-based dentistry	_____ _____ _____

40 UNDER 40

DR. BRAD LENTZ

I'm fortunate to practice in a beautiful, new office in Lynchburg. I'm a Pennsylvania native, educated at the University of Pittsburgh. I love spending time with my wife and 3 kids, and watching my Pittsburgh sports teams!

FIGURE 3

Daily Mouth Care

Resident's Name: _____

Resident with Denture(s) and Natural Teeth

Mouth Care

- Remove and rinse Dentures(s)/Partials(s)
- Check inside of mouth (cheeks, lips, tongue) for anything unusual and report any findings.
  -Lumps, Bumps, Sores
- Use gauze, toothette or a rag to clean gums and roof of mouth
- Use dental floss (use a floss aid if necessary, best if done before bed)
- Brush teeth (2 times a day is best, just before bed is beneficial)
  -Gently massage gums around teeth with toothbrush bristles at a 45 degree angle, then brush the tooth surfaces
  - If cannot be done over a sink, use a kidney basin along with a cup of water to swish/rinse/spit.
- Brush tongue from back to front. Let toothbrush air dry
- Use a mouth rinse that is **Alcohol Free**
- Place Dentures(s)/Partials(s) back in mouth

Denture Care

- Take Dentures(s)/Partials(s) our at night and **soak** in a **clean** denture cup
- Check Dentures(s)/Partials(s) and report any problems (Chips, breaks, don't fit)
- Brush denture with liquid soap, NOT toothpaste, then rinse before placing back in mouth

* Special Instructions/Comments

_____

Resident with Only Natural Teeth

Mouth Care

- Check inside of mouth (cheeks, lips, tongue, teeth) for anything unusual and report any findings.
  - Lumps or bumps
  - Sores
  - Chipped or broken teeth
  - Bleeding Gums
- Brush tongue from back to front
- Use a Fluoride mouth rinse that is **Alcohol Free**
- Rinse toothbrush and store to air dry

Tooth Care

- Floss teeth daily (use floss aid as needed, best if done before bed)
- Brush teeth (2 times a day is best, just before bed is beneficial)
  - Gently massage gums around the teeth with toothbrush bristles at a 45 degree angle, then brush the tooth surfaces
  - If cannot be done over a sink, use a kidney basin along with a cup of water to swish/rinse/spit

* Special Instructions/Comments

_____

Residents with NO Denture(s) and NO Natural Teeth

Mouth Care

- Check inside of mouth (cheeks, lips, tongue, teeth) for anything unusual and report any findings.
  - Lumps or bumps
  - Sores
- Use gauze, toothette or rag to clean gums and roof of mouth
- Brush tongue from back to front
- Use a Fluoride mouth rinse that is **Alcohol Free**
- For those who cannot reach a sink, use a cup of water and a kidney basin for them to rinse and spit

* Special Instructions/Comments

_____

Resident with Denture(s) and NO Natural Teeth

Mouth Care

- Remove and rinse Dentures(s)/Partials(s)
- Check inside of mouth (cheeks, lips, tongue) for anything unusual and report any findings.
  - Lumps or Bumps
  - Sores
- Use gauze, toothette or a rag to clean gums and roof of mouth
- Brush tongue from back to front. Let toothbrush air dry
- For those who cannot reach a sink, use a cup of water and a kidney basin for them to rinse and spit
- Use a mouth rinse that is **Alcohol Free**
- Place Dentures(s)/Partials(s) back in mouth

Denture Care

- Take Dentures(s)/Partials(s) our at night and **soak** in a **clean** denture cup
- Check Dentures(s)/Partials(s) and report any problems (Chips, breaks, don't fit)
- Brush denture with liquid soap, NOT toothpaste, then rinse before placing back in mouth

* Special Instructions/Comments

_____

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Richmond

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◄ Connor Johnson
VCU School of Dentistry Class of 2019

"I was thrilled to be part of the VDA's strategic planning this year. It feels good to know that, even as a student, the VDA welcomes my perspectives and insight."

◄ Dr. Leslie Webb
Richmond

"The VDA gave me the opportunity to network with denitsts throughout the state. It keeps me aware of the external forces affecting dentistry and is an effective team to influence these forces in a positive way.

Dr. Jeena Devasia ►
Fairfax

"My recent use of the ADA's refinancing program allows me the flexibility to invest in CE and networking opportunities that strengthen me as both a clinician and individual."

Dr. Erika Anderson ►
Burke

"As a native Virginian who did not attend VCU School of Dentistry, my membership has been invaluable. The professional relationships I've built strengthen me as a clinician and as a person"

◄ Dr. Bruce DeGinder
Williamsburg

"There are so many intangible benefits that we don't realize are there until we have unusual circumstances arise in our own lives or with our practice."

◄ Dr. Bradley Hammitt
Orange

"I have always enjoyed providing care for those in need, and through the VDA's support of the MOM Projects, I can volunteer time and dentistry to help the underserved in Virginia."

Dr. Shvan M. Kareem ►
VCU School of Dentistry Class of 2019

"I met some inspiring individuals at the Virginia Meeting. The Real World Tour also provided me with great advice for my future goals."

Dr. Kelly Peaks ►
Chantilly

"I recently attended the Virginia Meeting. The VDA team provided an engaging environment for dentists of all ages to hear about new advancements and exchange ideas."

◄ Dr. Thomas Glazier
Richmond

"For me, the VDA is about RELATIONSHIPS! If it were not for the VDA, I would not have found my mentors and partners in private practice. "

◄ Ashley Pater
VCU School of Dentistry Class of 2019

"I was recently invited to a CE dinner event through the RDS. This opportunity allowed me to gain insight into the profession and network with local leaders."

Call today for a FREE PRACTICE APPRAISAL ($5,000 value)

Practices for Sale

Exceptional Opportunity in Yorktown

This practice is collecting over $750K in revenues a year with a solid hygiene program. The practice is in a great location with excellent visibility in a retail complex. The office has 4 treatment rooms, 3 of which are equipped. The practice is digital and has a PPO/FFS patient base. Opportunity ID: VA-4905

Great Growth Potential in Fairfax

This general practice, which is grossing $550K, is an excellent opportunity to grow in a great area of Fairfax. The 4 treatment room office is equipped with digital X-ray and Dentrix Software. This opportunity would make a great merger or a satellite office. Opportunity ID: VA-4897

Profitable Shenandoah Valley Practice

This great opportunity is located approximately an hour from NOVA in a beautiful Shenandoah Valley setting. The practice is mainly FFS accepting one PPO and is grossing $850K. The 5 treatment room office is completely renovated with new equipment. The real estate is also available. Opportunity ID: VA-4896

Substantial Cash Flow in Loudon County

This is a great opportunity to purchase a practice that is grossing $2M. The facility is all digital with up to date equipment and modern, tasteful decor. The 7 treatment room office is located in a multi-use building with excellent visibility. Opportunity ID: VA-4863

Didn't find what you were looking for? Go to our website or call to request information on other available practice opportunities!

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AGENDA

THE Virginia MEETING®
A Program of the Virginia Dental Association

Thursday, September 20

Continuing Education Courses
Dr. Darin Dichter: Treatment of Worn Dentition

Exhibit Hall Open 4:00-6:00pm

Social Events:
Pierre Fauchard Breakfast
Putting Tournament
Opening Reception (in Exhibit Hall)
Ping Pong Tournament
ACD Dinner

Registration and Room Reservations open in April!

Friday, September 21

House of Delegates & Reference Committees

Continuing Education Courses:
Mr. Larry Oxenham: Lawsuit protection, tax reduction & estate planning
Dr. Randy Huffines: Prevention of high caries risk patient
Mr. Andrew Miller: Reaching new patients in digital world
Ms. Teresa Duncan: Insurance Changes
Dr. Mel Hawkins: Local Anesthesia/Pharmacology
Dr. Juan Yepes: Oral Radiology/Oral Pathology in Children
Ms. Karen Davis: Oral Cancer
Bank of America: Dental office finance

Exhibit Hall Open 10:00am-5:00pm

Social Events:
AGD Breakfast
VDA Fellows' Lunch
16th District Meeting
Putting Tournament
Closing Reception (in Exhibit Hall)
New Dentists' Reception
President's Party

Saturday, September 22

Continuing Education Courses:
Dr. Mel Hawkins: Local Anesthesia/Pharmacology
Dr. Randy Huffines: High caries risk patient
Mr. Andrew Miller: Reaching new patients in digital world
Ms. Teresa Duncan: Management issues
Dr. Juan Yepes: Trauma in Primary/Permanent Dentition
Dr. Barry Taylor & Dr. Caroline DeVincenzi: THC and oral health

Social Events:
ICD Breakfast
Annual VDA Golf Tournament
VDAF Annual Celebration

Sunday, September 23

House of Delegates & Annual Business Meeting






#VirginiaMeeting

Visit www.vadental.org/events/virginia-meeting or call (804) 288-5750 for more information.

TO JOIN, OR NOT TO JOIN,

that is the question!

Dr. Elizabeth Reynolds - Chair, VDA Council on Membership

Why should I join? **What does the ADA do for me?**

Aren't there better things I could do with my money?

I can join other organizations and I feel certain they will better represent me.

ADA? Why?

As I write this, my ADA renewal date is rapidly approaching. Around this time each year I find myself pondering both my membership and my profession. The question that plagues me is similar to Hamlet's age old adage, "To be, or not to be." or in our case, "To join, or not to join."

By the time you read this many of you have already renewed your membership, however, the questions above might still ring true. Hopefully, I can help answer some of those questions for you.

ADVOCACY

Let's start with Advocacy. What? What is that? Why does it matter? And I already get the benefit from that without even joining, right? So why would I join?

We as dentists practice in what has become a complicated, litigious, political climate. When my father graduated from dental school in 1930 I can assure you that he never anticipated that we would be in this environment. He worked hard, was compensated fairly, and did his absolute best to serve and protect his patients. He did not need to concern himself with convincing a third party that sealants are actually a better service than waiting for the tooth to decay, or that restoring the tooth before it breaks is actually a better option than waiting for it to break and then having to perform heroic measures to save the tooth. He did not have others dictating his treatment and his fees. And, heaven forbid, if the treatment did not go as planned, he did not worry that his patients would blame him and sue. That is where we are now. We need someone to help support and protect us in this third party arena, and we do that through hiring the most amazing people to lobby for us at both the state and national levels. Chuck Duvall and Tripp Perrin are our state lobbyists extraordinaire. What do they have to say about VDA membership?

> "The VDA membership has been a shining example of how advocacy is effectively done. However, now is not a time to rest on our laurels – in fact it is high time to redouble our efforts as there is a great deal of political uncertainty across the Commonwealth and the profession is continuing to evolve quickly. We need members to consistently engage with their local legislators and remain vigilant in protecting our patients and the profession."

What about members of the state legislature? Does it matter to them when our lobbyists ask for support on a bill such as the non-covered services bill? Senator Siobhan Dunnavant, representing the 12th District in the Virginia Senate, is a practicing OBGYN and hence has first person knowledge of medical lobbyist representation in government. When asked about the importance of membership and representation in the state senate, here is what she had to say:

> "You've worked extremely hard because you have a passion for helping people and this passion drives you and other dentists to stay actively engaged in what happens at all levels of Virginia's government. Trust me, I realize how hard it is to balance all of the urgent demands it takes to be at the top of your profession and find time to give back. However, little is more important for the VDA than YOU taking the time to advocate for policies aimed at both enhancing the oral health of the citizens of Virginia and preserving the all-important doctor-patient relationship. I can tell you that the VDA is one of the most-respected professional organizations in the Capitol. Use the respect you've earned and continue to educate members of both parties on issues you and your patients care about. Keep up the good work!"

What about nationally? Do our ADA membership numbers matter? Let's hear from Mike Graham our ADA lobbyist, (touted by the Center for Public Integrity as one of the top five lobbyists in the country).

> "In the 1950's, the American Medical Association (AMA) membership was around 75% and the vast majority of physicians were the employers/owners. Today, the AMA's membership is less than 25% range and the majority of physicians are employees."

Let's continue working our way to the top with some insight from Congressman Paul Gosar, one of four dentists in Congress:

> "Since coming to Congress in 2011, I have worked hand-in-hand with the ADA on key federal issues. Health care is now highly regulated both occupationally (licensing, OSHA, employment rules), through insurance, and through Medicare, Medicaid and Obamacare. There are constant fights being played out in DC where one group or another is trying to undermine the practice of dentistry. It requires constant vigil to protect our standing, protect our ability to choose what is best for our patients, and protect the free market so patients can choose and we can make a living. The ADA is the leader, and our go-to for updates, information, data and assistance when we need help in the trenches. For example, the ADA has been actively helping me get co-sponsors in the Senate to get my successful McCarran Ferguson bill signed into law. Your support of the ADA allows the ADA and ADPAC to help me and others who support dentistry. Without their assistance, dentists would not have a strong, well-respected organization in DC. "

Okay, I will belong, but do I really need to contribute to those PACs? I already spend so much money just on my membership…

I KNOW!!! I used to feel the same way! It took my actually going to Washington to meet with our senators and congressmen for me to appreciate how much they respect us as a group and as a profession. Our PAC money goes directly to candidates who support our profession, and those candidates are split almost evenly between republicans and democrats. As Dr. Bruce Hutchison likes to say, we are the "tooth party". What have we done here in Virginia to maintain our profession? Well, first, there is the non-covered services bill which was a landmark decision in our state, paving the way for other states to defeat this as it arose. The defeat of this bill prevented insurance companies with which you participate from dictating what you may charge on non-covered services, i.e., whitening. Secondly, there is potential legislation to help ensure that Mid-level Providers (high school graduates with a year or two additional training) do not get a foothold here in our state. We are constantly monitoring the Medicaid legislation to ensure that the reimbursement for the Smiles for Children program is not cut or put under a managed care plan. Our PAC dollars make a difference! (And do you know about the 12 month dues payment option? You can include your PAC dollars in that as well! That certainly makes the amount more manageable -and palatable!)

So, what else is the ADA/VDA doing specifically for me?

LOAN RESTRUCTURING PROGRAM… WHAT IS THAT?

The ADA heard what its younger members were saying: they needed help with their debt. The loan restructuring program has afforded many of our younger members the ability to take their debt and restructure it so that it is affordable for them to go into associateships or potential partnerships. This not only offers an opportunity for these members to practice as they would like, perhaps in a smaller practices or back in their hometowns, but also could potentially help the older members who are looking to sell their practices- now maybe these younger members can afford to buy them!

FIND-A-DENTIST CAMPAIGN… WHAT IS THAT?

The ADA understands that one of the primary concerns of its members, regardless of their number of years in practice, was a concern for "busyness." Dentists need more people in their chairs. The initiation of the Find-a-Dentist campaign has addressed this concern and the initial numbers look good. The ADA House of Delegates believes so strongly in this program that they voted to fund it for a second year as a member benefit. Be sure to read the article in this *Journal*, and go online to update your profile so you don't miss out!

ETHICS… I KNOW WHAT IT IS… SO WHAT?

We have always been a self governed profession. At the very basic level, the difference between a profession and a trade is that, "a professional is a practitioner who, though his/her personal commitment, and though enforcement by their peers, puts the public and their clients' good ahead of their own personal gain." We as dentists are held to basic ethical tenets. We regulate these ourselves and we put our patients' welfare ahead of our own. The ADA is the body which allows us to maintain this self regulation. Every ADA dentist has agreed to abide by the ADA Principles of Ethics and Code of Professional Conduct. This constantly evolving document holds us accountable to our patients and to our profession. Without this we become no more than a trade organization. I am proud that as an ADA dentist I can let my patients know that I am committed to upholding the self imposed, self regulated ethical standards.

I truly feel that the bottom line is that every dentist here in America has the same basic desire that my father had when he graduated in 1930: to protect and serve his patients, to be compensated fairly, and to be in charge of the destiny of his profession. Unfortunately in 2018 this is not a given. We must work hard to maintain the foundations which those dentists before us established. The external noise and influences are loud and powerful and we as a group must be louder and more powerful. So to join or not to join, that is a question but the answer, at least to me, is obvious: I will join. And I will happily write my membership check and I will happily write my PAC checks and I will trust that the ADA has my best interest at heart, and if I feel that perhaps I have a difference of opinion, I will get involved and let my opinion be known. I just know that I cannot do it on my own, and I know that I don't feel it is fair to ask organized dentistry to do it for me. I want to a part of my destiny, and I want to help protect my profession. **Don't you?**

MEDICARE BASICS:

WHAT YOU NEED TO KNOW AS YOU APPROACH AGE 65

Larry Bedsole, Jr.

Enrolling in Medicare can seem like a daunting task. There are the types of plans to consider, supplemental plans, calculating your expected out-of-pocket costs, reviewing prescription coverage needs and being mindful of deadlines to ensure you maintain coverage throughout the process. Thankfully, there are many guides to help you and you can rely on the expertise of insurance agents to help navigate this process. As you are starting to ponder enrollment in Medicare, consider some of this basic information to help you get started.

MEDICARE PARTS AND PREMIUMS

Medicare is comprised of four basic "Parts" which can be supplemented with additional coverage. Below is a brief description of each part and premium cost information for 2017.

- **Part A Hospitalization** - Most people do not pay premiums for Part A if you have paid income taxes for 40 quarters or more.
- **Part B Physician and Doctor Services** - Part B includes most doctor services while you are a hospital inpatient, outpatient therapy and durable medical equipment. The standard Part B premium amount is $134.00 (but it can be higher depending on your income).
- **Part C** - More commonly referred to as Medicare Advantage, Part C allows consumers to purchase Part A and Part B coverage through a private insurer (such as an HMO or PPO). If you choose to purchase Part C coverage, you will not enroll for Part A and Part B through the Social Security Administration (SSA) as you would enroll via a private insurer.
- **Part D Prescription Drug Benefit** Part D plans premiums vary based on the plan you choose. Careful consideration of prescription drug needs and costs will help to determine what Part D plan is appropriate.
- **Supplemental Policies** –Various policies and premium cost based on type of supplemental coverage selected.

ENROLLMENT PERIODS

You will only enroll in Part A and Part B once, while annual decisions can be made on Part C, Part D and any supplemental policies. Same basic enrollment information is listed below:

1. Initial enrollment period for **Part A** (hospitalization) and **Part B** (physician services) -- Starts three months before your 65th birthday with coverage taking effect the 1st day of the month in which you turn 65.
2. Special enrollment period for **Part A** and **Part B** (for people who are covered by an employer group health plan at 65) -- Enroll in Medicare anytime during employment or when the group coverage ends.
3. Initial enrollment period for Medicare **Part C** (better known as "Medicare Advantage") -- May coincide with either initial enrollment or special enrollment period for Part A and Part B.
4. Initial enrollment period for **Part D** (prescription drug coverage) -- May coincide with initial or special enrollment period for Parts A and B. Or if you have creditable coverage through a retiree plan, it is not necessary to enroll in Part D when you enroll in Parts A and B, however if you lose that creditable coverage you should enroll in Part D before such coverage ends.
5. Open enrollment period for Medicare **Supplemental Policies** -- Starts on the first day of the month in which you turn age 65 and have initiated and enrolled in Part B (physician services) of Medicare. This period lasts for six month and during that window, Medicare supplement carriers must accept you for coverage regardless of your health status. It is important to note that the ACA prohibition against denying people with pre-existing conditions does not apply to Medicare supplement insurers.

Annually, there is an Open Enrollment period for **Part C** (Medicare Advantage Plans) **Part D**, and **Medicare Supplemental Plans**. From October 15th to December 7th, Medicare policy holders are able to make changes or enroll in a new supplemental plan for the following year. During this time, carriers must accept you for coverage in Medicare Advantage and Supplemental plans, regardless of your health status. All changes and additions made during this open enrollment period will be effective on January 1 of the following year.

Anyone enrolling under Medicare should first download a copy of the Medicare and You guide which you can find online at www.medicare.gov. The guide is a great way to start learning more about this important health coverage. You may enroll online in Parts A and B of Medicare by logging onto www.medicare.gov. If you have any questions regarding coverage or the enrollment process, you can contact the Social Security Administration at 1-800-772-1213. You can also contact your local Social Security Administration office to schedule an appointment to enroll or just to have your questions answered. To find your local SSA office and other resources please visit www.ssa.gov.

Once you have enrolled in both Part A and Part B of Medicare through the Social Security Administration, it is "strongly" recommended that you purchase a private Medicare Supplement plan that will help pay for additional medical costs during retirement. When considering what supplemental policy might be a good fit, reaching out to your insurance agent to discuss different plans can help guide you through this important process. At B&B Insurance, we have helped many VDA Members navigate what supplemental plan will best help cover some out of pocket costs not covered by Medicare. Typically, we recommend Part F through Blue Cross/ Blue Shield (either with Anthem or Carefirst depending on your home address). Some people may want to consider enrolling under a Medicare Advantage Plan (Part C) which combines the Medicare Supplement and Part D (prescription drug benefit) under one plan through the same insurance carrier. As you can see, there are many important decisions to be made when moving to Medicare. Learning as much as possible and seeking out the guidance of an expert when you need it can put you on the path to a smooth Medicare transition.

Larry Bedsole, Jr. is the President of B&B Insurance Associates, Inc. (a VDA Services Endorsed Vendor) in Burke, Virginia. A licensed life and health insurance agent, Larry has been working closely with VDA Member dentists on all of their insurance needs since 2001. You can reach Larry at 877-832-9113 ext. 220 or via email at larryjr@bb-insurance.com.

WHAT YOU NEED TO KNOW:

FROM THE DECEMBER 2017 VIRGINIA BOARD OF DENTISTRY MEETING

Dr. Ursula Klostermyer and Dr. David Black

During the public comments Dr. Edward Snyder discussed his concerns with an out-of-state company, the Smile Direct Club. "Smile Direct Club" (a company not owned by dentists) uses patient-taken photographs (commonly known as "selfies") and patient-taken impressions (of questionable quality) to fabricate clear aligners to modify patients' malocclusions. Dr. Snyder's concerns are that the treatment will happen without in-office supervision of the cases. He questions the quality of care and is concerned about the health of our patients. "Smile Direct Club" had their legal counsel present to defend their procedures.

The Board commented finally that this topic is out of their jurisdiction unless there would be in-state patient complaints. Should there be any patient complaints, please report them to the Board of Dentistry. Then, the Board could take action.

Dr. John Wittrock, a former faculty member at VCU School of Dentistry, is concerned that dentists do not retain the clinical knowledge they have gained through university training and continuing education. He thinks that CE courses do not teach enough and there is no examination afterward. He requests software to be developed to test dentists regularly. He stated that this has concerned him since 17 years ago, when he first complained to the Board. The Board discussed whether our current CE requirements are sufficient to prove competency, but no decision was made.

David E. Brown, D.C., Director of the Virginia Department of Health Professions, was concerned that both hygienists and dentists were fined the same amount for similar concerns. He made the point that with the discrepancy in income between the hygienists and dentists, possibly some adjustment in those amounts would be appropriate. A 50% fine reduction for hygienists was suggested.

Dr. Brown had concerns about a fair assessment regarding the Board's costs to doctors being the same for doctors who only got a reprimand and not a sanction, and those who needed a more lengthy study and had sanctions imposed. He suggested the Board study that issue to see if there was equitable treatment for reprimands only.

Neal Kauder, of VisualResearch (http://www.vis-res.com/), supported the above statement that more consistency would be needed regarding monetary penalties and introduced how boards of other professions had dealt with that problem. It would follow, therefore, that similar sanctions should impose similar fines. The Board voted to hire his firm as an independent contractor to perform a study and report back to them.

Elizabeth Carter, Ph.D., Director of the Healthcare Workforce Data Center of DHP, reported regarding the Virginia Dentistry and Dental Hygiene Workforce report 2017. It is a thorough report and can be found online, http://www.dhp.virginia.gov/hwdc/findings.htm. Additionally, she reported on the status of the dental law exam and there were concerns about how to construct a defensible exam, and the Board referred it back to the regulatory legislative committee.

Elaine Yeatts, Agency Regulatory Coordinator for DHP, reported that the Board had previously voted and approved to change the renewal schedule for licenses from the usual renewal month, March, to the licensee's birth month starting in 2018.

Good news! Next year there will be a one-time license fee reduction. This will reduce the fee for a dentist from $210.00 to $142.00, and for dental hygienists, it will go from $55.00 to $37.00.

The Board voted to refer the "PGY1 pathway for licensure" to the legislative regulatory committee. Virginia dentists: Let the Board of Dentistry know what you think about this topic during the public comment times. We will keep you advised of any opportunities on the Virginia Regulatory Town Hall.

Your voice counts!

Editor's Note: This information is presented for the benefit of our readers, and is deemed reliable but not guaranteed. Licensees are advised to read and comprehend all Virginia Board of Dentistry policies and regulations.

40 UNDER 40

DR. PATRICIA DARY

I'm a general dentist at Reston Dental Care. I also work part time with The Mobile Dentist, serving seniors across the DC area. I strive to provide my patients with high-quality and personable care and I truly enjoy the art and science balance of dentistry.

IS IT HARVEST TIME?

THE INS AND OUTS OF IMPLEMENTING A TAX-LOSS HARVESTING STRATEGY TO REDUCE TAX LIABILITY

J. Saunders Wiggins, CFP, AIF

Have you ever heard that an investment loss is a good thing? Sounds counterintuitive, right? You will be interested to know that there are particular circumstances when an investment loss may be beneficial for your situation and used to your advantage. The U.S. tax code allows investors to offset capital gains with capital losses through the sale of investments that have decreased in value, or, in other words, to "harvest" investment losses. Benefitting from investment losses involves taking advantage of a strategy known as tax-loss harvesting.

Opportunistic tax-loss harvesting is a good way for investors to increase their returns indirectly. Typically, in a well-diversified portfolio, some holdings lose value while others perform well and increase in value. Tax-loss harvesting allows you to offset gains acquired by selling investments that performed well and increased in value during the year with the losses created by selling investments that performed poorly and thus decreased in value. When this is done, investors are said to "realize" the loss. These "realized losses" may be used to offset realized gains from the current year. And, if after offsetting realized gains you still have realized losses, the remaining realized losses may be carried forward to offset future gains.

Let's look at an example portfolio. Suppose you invested $10,000 in Fund A and $10,000 in Fund B. Five years later, your Fund A investment is worth $15,000 and your Fund B investment is worth $5,000. If you sell your entire position in both Funds (Fund A & Fund B), you will realize a capital gain of $5,000 on Fund A and a capital loss of $5,000 on Fund B. The gain and the loss you realize would offset each other and thus, you would not owe any tax.

It is important to note that if capital losses exceed capital gains in the equation, an individual may use only $3,000 of losses ($1,500 each, if married filing jointly) per year to reduce their taxable income. When net capital losses exceed the cap amount of $3,000 in the initial year, excess losses can be carried forward to future years.

Going forward, each year that capital losses exceed capital gains, the investor could claim up to $3,000 as a loss and continue doing so until the net loss amount is reduced to zero.

TAKING ADVANTAGE OF MARKET CORRECTIONS

Even though 2017 is shaping up to be in the top five of the least volatile years in recent history (1960-today), intra-year stock market corrections are quite common. In the last 17 calendar years, the S&P 500 has seen a decline of at least 10 percent in 12 of those years. Investors may be able to use these market corrections as an opportunity to harvest losses.

The main risk to the tax-loss harvesting strategy is the opportunity cost of being out of the market. Many intra-year corrections see a subsequent market rebound. Investors want to avoid the possibility of being out of the market to realize a loss, and therefore missing significant market gains during a rebound.

WASH-SALE RULE

There is an important detail to understand prior to implementing a tax-loss harvesting strategy. This detail is known as the wash-sale rule. With this rule, the IRS prohibits investors from selling an investment at a loss, and within 30 days, prior to or after this sale, buying a "substantially identical" stock or security. This would demonstrate a clear attempt to dodge taxes by manipulating the tax code.

Investors want to avoid being out of the market after selling a position at a loss and then waiting the 30 days in cash for the wash-sale time period to expire. A more proactive approach is to have a strategy that allows the investor to continue to have market exposure. This could be as simple as selling a U.S. large cap stock and then purchasing a broad market index, such as the S&P 500 Index mutual fund to keep market exposure and avoid being in cash during a market run-up.

Let's review this on a deeper level. An investor holds XYZ Healthcare stock in his/her portfolio, but XYZ is down 15 percent. The investor decides it is time to liquidate holdings of XYZ in his/her portfolio but realizes that if he/she does so, he/she will no longer have any exposure to the healthcare sector. The investor's financial advisor suggests the purchase of iShares U. S. Healthcare exchange-traded fund (ETF) to maintain some exposure to healthcare for the 30 days. Once the 30 days are up, the investor could sell the ETF and re-purchase the XYZ stock. On a cautionary note, this could result in a short-term gain if the "placeholder" investment has a gain in the 30 days it is held.

Keep in mind that it is generally ill-advised to base investment decisions solely on tax considerations. It is significantly more important to decide whether a particular buy or sell decision fits into your overall investing plan.

Traditionally, tax-loss harvesting is done towards the end of the calendar year so it can play a role in portfolio rebalancing efforts. Portfolio rebalancing is the process investors use to attempt to bring their asset allocation back in line after market moves have knocked their portfolio out of balance.

With input from your financial adviser and your CPA, the team of advisors you trust can help determine if tax-loss harvesting is an appropriate strategy for your investment portfolio. Obviously, engaging a tax-loss strategy requires you to have losses that you can realize in the first place. Typically, when the stock market sees a significant drop – like the drops that occurred during the great recession and again in 2015 – is a good time to consider the possibility of using a tax-loss harvesting strategy.

Editor's Note: ACG is not a tax adviser. The information contained in this article is general in nature and for information purposes only. Call ACG or your tax professional if you have questions.ACG Advisory Services, Inc. www.acgworldwide.com, info@acgworldwide.com, (804) 323-1886

FOUR WAYS TO JUMPSTART YOUR PRACTICE'S MARKETING IN 2018

Kelsey Leavey

You're not alone if you feel like every time you master your marketing duties, something new comes along.

The online world has transformed the ways dental practices market to potential patients. And in this rapidly changing world, it can be difficult to keep tabs on every new trend.

Before diving into a few marketing tactics, you might consider to promote your practice, let's talk about measurement. The only way to know what's working and what's not is to track and analyze your efforts on a regular basis.

Start by setting goals. Each of your marketing activities should be measurable, such as the number of impressions, clicks to your website or even leads in the form of contact inquiries or scheduled appointments.

Setting goals can be intimidating, and are typically unique to each individual business. If you're unfamiliar with goal setting, start with benchmarking by looking at your historical data. Whether you have access to three months of past data or even a year, you should be able to identify your average impressions on each social platform, clicks from various sources to your website, leads coming from social media each month, etc. – these are your benchmarks. Once you've identified these, you can set reasonable goals for improvement.

For example, if on average you've been receiving 1000 impressions on Facebook each month, a reasonable goal might be to increase impressions by 10% — success would mean that your content on Facebook would now generate at least 1100 impressions on a monthly basis. For more guidance on setting digital goals, visit https://sproutsocial.com/insights/social-media-goals/ and save the guide from Sprout Social.

Continue to collect data on each of your marketing activities on a monthly or quarterly basis, and see how your results stack up against the goals you've set. Once you've analyzed the data, you can tweak the tactics that aren't meeting your practice's needs.

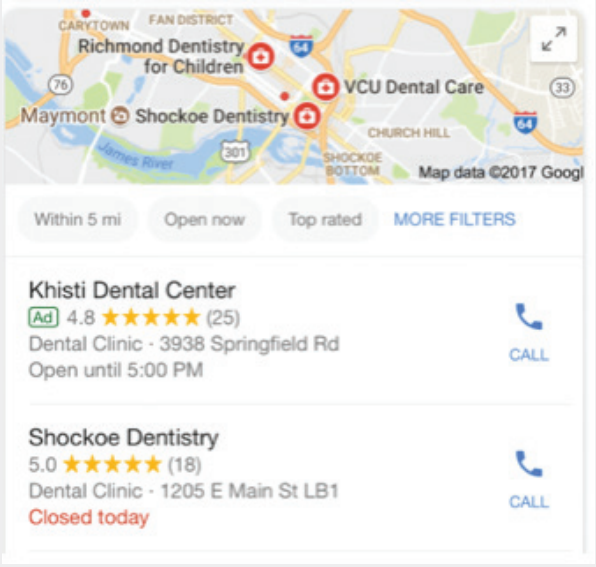
Without further ado, here are four ways to reach new patients online.

1 SEARCH ENGINE OPTIMIZATION

Location, location, location. Google now is using location data to serve users location-specific search results. This means if someone searches for "local dentists," they'll likely find search results specific to where they're located at the time of their search. And instead of showing traditional results, like websites first, the top organic search results include a map of area businesses matching the search criteria.

What you can do: Take control of your Google My Business (GMB) listing, and keep it updated. Gaining access is relatively easy if you have the right credentials. If a GMB listing does not exist for your practice, you can verify ownership for free – Google will send a postcard with a security code to your business' address. If you already have access to your GMB listing, keep it updated with holiday hours, photos and important information for current and potential patients. And you can track how many people call your office, request directions and find your website through the online dashboard.

Applicable metrics to track: website clicks, office calls and requests for directions.



2 SOCIAL MEDIA

Customer service through Facebook messenger? According to Facebook, 20 million businesses with company pages are active on Messenger, a messaging service owned by the platform. With 1.2 billion people using Facebook Messenger each month, it's likely your customers expect (or will expect soon) your business to be responsive via Messenger when they have questions or issues.

What you can do: Be prepared to answer questions quickly through social media. Start by developing policies for responding to incoming messages that protect patient information, then delegate the responsibility to a trusted team member who has experience dealing with customer service. By responding quickly to inquiries, your practice can gain the coveted "very responsive to messages" badge on your profile and potentially reduce the number of inbound calls that tie up the front office.

Applicable metrics to track: inbound messages, average time it takes to respond to each message.

3 VIDEO 2.0

One hundred million hours of video are watched every day on Facebook. And that's just Facebook. Video content is one tool businesses and organizations are using to differentiate themselves in a cluttered social media landscape. Traditionally, video production has been reserved for large organizations with large budgets; consumer expectations about video is different.

What you can do: Repurpose video content that you're using for other marketing purposes (commercials, website content, etc.), to share on social media. Social media videos should be quick (30 seconds or less) and created with shorter attention spans in mind.

Start your videos with the information you want to viewers to remember instead of saving it for the end; this provides information to users as they scroll through their feeds.

Video content in many cases doesn't need to be produced by a professional. If it isn't in the budget to hire a video crew, use the camera on your phone to create content.

(Social media platforms are experimenting with video content that disappears within 24 hours. Facebook, Instagram and Snapchat all have this capability, through a feature called Stories.)

Here are a few ideas to get you started: tell your practice's story and what sets it apart; share useful information to help new patients with onboarding; or give viewers insight on what can be expected when someone visits your office.

Applicable metrics to track: video views, number of viewers who watched more than 10 seconds or who watch more than 50 percent of your video.

4 DIGITAL ADVERTISING

Advertising can help reach new audiences. It's probably frustrating to hear that without a social advertising spend in your marketing budget, it can be difficult to reach new audiences. Fortunately, there are advertising options that fit any budget. One of the best and most cost-effective ways to reach new audiences is by using the social advertising platforms available to most businesses. Facebook, Instagram, Twitter, LinkedIn, Google and Snapchat allow you to advertise to users on their platforms and across the internet.

What you can do: Before diving into social advertising, think about the type of patient you are looking to attract. Knowing your audience can help guide your messaging and where to advertise. When you're ready to start advertising, you can target people based on a variety of options such as zip code, income level, age, gender and number of children. Being specific about your audience targeting ensures that you aren't wasting your advertising budget on audiences your message won't resonate with.

Applicable metrics to track: cost per click, cost per thousand impressions (CPM), impressions.

While you may not be able to execute on all four of these marketing activities at once, think about how these pieces might fit into your overall marketing plan for the new year. And don't forget about setting goals and tracking the success of each individual tactic. This will give you the knowledge to continue what's working and stop wasting your time on activities that don't provide your practice with any return.

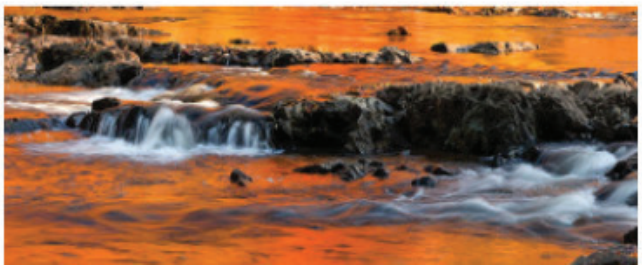
Editor's Note: Kelsey Leavey is a public relations and social media specialist at The Hodges Partnership, a strategic communications firm based in Richmond that excels in public relations, content management and social media. She works with clients to tell their stories through traditional and digital media.

Metric	Channel			
	SEO	Facebook Messenger	Video	Digital Advertising
	Clicks to website	Number of inbound messages	Video views	Cost per click
	Calls to your office	Average response time	Number of viewers who watched more than 10 seconds	Cost per thousand impressions (CPM)
	Directions requested		Number of viewers who watch more than 50% of your video	Impressions (the number of people who have seen your advertisement)

New Dentist Conference

March 2-3, 2018

The Omni Charlottesville Hotel
Charlottesville, VA



REGISTRATION FEES

$179	VDA Members
$79	Students
$299	Non-Members

9
CE Credits Available

CE COURSE AGENDA

Friday, March 2, 2018
1:30pm - 4:30pm

Implant Dentistry:
The Art and Science of the Team Approach
Dr. Kanyon Keeney

Implant dentistry has provided a new paradigm in treatment with potentially exquisite clinical outcomes. The implant treatment team, however, faces many challenges in making excellence in this treatment modality a profitable business model. This course includes practical advice for implant doctors to implement immediately, with the goal of the ultimate win/win for the patient and doctor. That would be successful treatment outcomes, fewer visits and fewer complications for the patient and greater satisfaction, profitability, and efficiency for the implant team.

Saturday, March 3, 2018
9:00am - 12:00pm (Part One)
1:15pm - 4:15pm (Part Two)

How to Not Fail Miserably in Private Practice
Dr. Chris Salierno

We have been trained to be outstanding clinicians, not savvy business owners. Many of us are afraid or, or simply ignore, the business end of our profession. We're unsure of how to read a profit and loss statement or motivate our staff. Leading a successful practice doesn't have to remain a mystery. This course will discuss the most common mistakes we make that can slowly and silently ruin our offices. You will leave armed with tools for best practices and practical tips.

GET THE DETAILS AND REGISTER TODAY AT:
http://www.vadental.org/newdentist

REGISTRATION DEADLINE: THURSDAY, FEBRUARY 15, 2018

Questions? Contact Sarah Mattes Marshall at 804-523-2189 or mattes@vadental.org

The Virginia Dental Association is an ADA CERP Recognized Provider.
ADA CERP is a service of the American Dental Association to assist dental professionals in identifying quality providers of continuing dental education.
ADA CERP does not approve or endorse individual courses or instructors, nor does it imply acceptance of credit hours by boards of dentistry.
Concerns or complaints about a CE provider may be directed to the provider or to ADA CERP at www/ada.org/cerp.

ADA C·E·R·P® | Continuing Education Recognition Program

YOUR VOICE CAN STILL BE HEARD

Bruce Hutchison, Chair, ADPAC; Chair, VADPAC

Friday January 19 was our annual VDA Day on the Hill. Dentists from across the state gathered in Richmond to meet with their state Delegates and Senators to discuss issues important to dentistry. I hope you were there. This is our opportunity to let our legislators know what is important to us and to the patients we serve. The General Assembly will pass laws this year (just as in years past and years to come) that may affect how you and I practice dentistry. Many of these bills don't seem to affect us, but often they contain subtle issues that, long-term, mean a lot to how we deliver dental care in Virginia. Our exceptional staff at the VDA, along with our lobbyists, scour every single bill in the General Assembly for those "little things" that could affect us, or our patients, both directly and indirectly. They help identify potential "threats" so that we, the dentists of Virginia, can contact our legislators to help them make the best decisions for our patients.

Do you like how dental insurance companies are turning up the pressure and "bullying" dentists into falling into place? Do you see it and feel it? I'll bet you do. More denials than ever, questioning your diagnosis, asking for ridiculous amounts of supporting evidence to approve a procedure, recommending directly to your patients that they seek the care of a "cheaper" dentist, changing the fees on a service they don't even cover (isn't this illegal in Virginia?) and on and on. Do you see that pressure escalating? Then there are the Federal governmental regulations. Do you see more of those coming down the pike? More hoops to jump through just to stay in business? Is that good for Virginia? I'm sure you could list even more things that bother you every day. The dentistry part starts to be the easy part. It's regulations, requirements, government intrusion, and insurance companies making doing business as a dentist more difficult, making the delivery of quality dental care more difficult and expensive. What can you do?

The best solution is to be active, to make sure you educate your Delegate and Senator as to what is important to you and your patients. They aren't dentists. They are lawyers, bankers, teachers, etc. We have only one dentist in the Virginia House of Delegates, Dr. Todd Pillion. For the most part, they don't understand dentistry at all. Certainly not well enough to make decisions that affect us and our patient care. We must take the time to get to know our legislators and to educate them. They don't want to make bad decisions. They will vote on bills that affect us. Without education from the dentists, they will make the best decision they can make based on the information they have at hand. That information does not come from the dentists, unless you, or I, deliver it.

Does your future as a dentist matter to you? Do you want to continue to practice in a profession that still has some freedom to it? Absolutely. Then get involved. Get to know your legislators. This year, 2018, there will be 15 (or more) new delegates out of 100 serving the state of Virginia. That's 15% totally new. Do you know who your delegate is? Is he or she one of these new delegates who have no contact dentist yet? Do you want to be their contact dentist, their source of all information concerning dentistry? You have the opportunity to get to meet him/her and develop that relationship. Once you become "friends," they will feel comfortable speaking with you, listening to you, and believing you. Friends trust friends. Dentistry has a great story to tell, and that is about the best dental care in the world. We need to keep it that way. We must be involved to assure it does. Help make your legislator a better legislator, be their "go to" guy or gal on dental issues. They will appreciate the help, you will have a better future, and your patients will get the care they deserve. That's win-win-win.

Hopefully you were in Richmond to help make a difference for our patients. THANK YOU or making a difference for our profession. But if you weren't, it's not too late to get involved. Be sure you get to know your local Delegate and state Senator. They need the information that you can provide to make the very best decisions for our patients (their constituents).

And… don't have the time to get involved? Then support VADPAC. Your Virginia Dental PAC helps support candidates who support dentistry. Like it or not- money makes a difference. It's expensive to run for office in Virginia. Candidates must raise a lot of money. They notice who helps them. It makes a difference. It helps get a foot in the door or an ear willing to listen to our story. But we must tell a good story- and we have the best story to tell. Again, dentistry in Virginia as the best in the world…with your help, we will keep it that way.

Make your voice heard. Contact your representatives and let them know what is important to you. They will appreciate the help, and you can still make a difference.

40 UNDER 40

DR. STEPHEN FINTEL

After dental school I completed a 1 year GPR in Roanoke VA, my hometown, and I currently work for a non-profit clinic in the same area. I enjoy all of the challenges and rewards dentistry has to offer.

VADPAC 2017 FINAL CONTRIBUTIONS

Laura Givens, Director of Legislative and Public Policy

Component	% of 2017 Members Contributing to Date	2017 VADPAC Goal	Amount Contributed to Date	Per Capita Contribution	% of Goal Achieved
1 (Tidewater)	32%	$45,500	$37,625	$289	83%
2 (Peninsula)	40%	$27,500	$26,245	$342	95%
3 (Southside)	**41%**	**$14,000**	**$19,370**	**$315**	**139%**
4 (Richmond)	**33%**	**$67,750**	**$71,425**	**$352**	**105%**
5 (Piedmont)	36%	$30,000	$25,415	$296	85%
6 (Southwest VA)	55%	$25,250	$23,415	$312	93%
7 (Shenandoah Valley)	40%	$30,000	$28,032	$314	93%
8 (Northern VA)	32%	$135,000	$102,305	$306	76%
TOTAL	**40%**	**$375,000**	**$333,832**	**$316**	**89%**

TOTAL CONTRIBUTIONS: $333,832

2017 GOAL: $375,000

CONGRATULATIONS TO COMPONENTS 3 AND 4 FOR MEETING YOUR GOALS!

We were just short of the goal in 2017. The challenge for 2018 is to surpass a goal of $375,000!

The 2018 Virginia General Assembly begins their session this month. How can we maintain influence in the halls of the General Assembly Building? ALL DENTISTS must participate in the process! VDA members must make sure that dentistry's voice is heard and insure that the interests of your patients are foremost in the General Assembly's eyes. If you haven't already contributed to VADPAC for the 2018 year, please make your contribution today! You can contribute when paying your VDA dues or find a contribution form on the VDA website at http://www.vadental.org/advocacy/vadpac. Contact Laura Givens at 804-523-2185 or givens@vadental.org for more information on how to become more involved in VADPAC efforts. YOU can make a difference by effectively advocating for your profession!

We would like to thank all 2017 VADPAC contributors for your generosity! Below are our highest level contributors.

WE WOULD LIKE TO THANK ALL 2017 VADPAC CONTRIBUTORS FOR THEIR GENEROSITY! BELOW ARE OUR HIGHEST LEVEL CONTRIBUTORS.

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GOVERNMENT RELATIONS

Tripp Perrin and Chuck Duvall, VDA Lobbyists

Editor interviews candidate Northam

On November 7th a political earthquake hit Virginia as the Democrats swept all three statewide offices and Dr. Ralph Northam is now Virginia's governor-elect. Dr. Northam is the current Lieutenant Governor and was a State Senator prior to that. He is a pediatric neurologist and has been a friend of the VDA throughout his career in public service.

The Lt. Governor-elect is Justin Fairfax – a former Federal prosecutor who has never been elected to any public office – interestingly his wife, Dr. Cerina Fairfax, is a general dentist in Fairfax and a VDA member! Mark Herring was re-elected to the Attorney General position.

The biggest news of the night was not only the significant margins by which the statewide candidates won but the fact, as of this writing, that the Republican majority in the House of Delegates is in real danger. Nobody honestly expected the Democrats to pick up more than 8 seats in the chamber that currently has a makeup of 66 Rs and 34 Ds, however; the massive Democratic turnout combined with a large anti-Trump vote has the Ds picking up at least 15 seats – this would give Rs the narrowest of margins at 51-49, however; at least 2-3 seats are still in play due to recounts and legal challenges – including one in Newport News where the Republican holds only a 10 vote lead. In the end the Republicans could hang on to the majority; there could be power sharing if it is 50-50 tie; or the Ds could take the Speaker's gavel back for the first time in nearly two decades. Additionally, the Senate of Virginia could be up for grabs if the Northam team is able to persuade a Republican Senator to come into the administration – current makeup is 21Rs and 19Ds. The Governor-elect would look for a district in which he thinks the Ds could win in a special election. Stay tuned.

So, what does all of this mean for the VDA membership?

- We have a lot of new friends to make (and old ones to keep) and some education to do in nearly every corner of the Commonwealth.
- Our key committees in the House will look vastly different – Appropriations and Health, Welfare and Institutions. Both lost several members from the Republican caucus and, as a result of the gained seats, the Ds will pick up several more seats – likely with a one vote majority to either party.
- The approach the VDA has taken through the years to assign specific members to legislators has never been more important and we need redouble those efforts. RELATIONSHIPS are the name of the game and we need to build them with these folks quickly. If you know any of the newly elected Delegates, please contact Laura Givens at 804-523-2185.

Bottom line – we have a lot of work to do and our approach has worked well in the past. We are going to need every member across the state to step up and be involved in the process. Your lobbying team will keep you updated as things unfold and we look forward to seeing ALL OF YOU at Day on the Hill.

MEDICARE JUST GOT A LITTLE EASIER:

THREE THINGS TO KNOW

Jennifer Garvin, ADA News

Reprinted with permission

Baltimore — Thanks in part to significant advocacy efforts from the ADA, the Centers for Medicare and Medicaid Services announced Nov. 16 plans to rescind certain Medicare Part D and C requirements for providers.

This means that dentists no longer need to enroll or opt out of Medicare to continue to provide dental care and prescriptions for Medicare Advantage and Part D drug plan beneficiaries. However, the agency has not rescinded the two-year opt-out period for providers, meaning dentists who acted in good faith and chose to opt out of the program are still prohibited from accepting payments for services covered by Medicare Part B or Medicare Advantage plans. It also means that their patients' claims will also be denied.

According to the CMS website, the opt-out period remains two years and "cannot be terminated early unless the physician or practitioner is opting out for the very first time and the affidavit is terminated no later than 90 days after the effective date of the physician or practitioner's first opt out period."

For opt-out affidavits signed on or after June 16, 2015, CMS says the opt out will "automatically renew every two years." The agency says that dentists who file a valid opt-out affidavit after June 16, 2015, and do not want to extend their opt-out status at the end of the two-year period, may cancel by notifying in writing all Medicare contractors with which they filed an affidavit at least 30 days prior to the start of the next two-year opt-out period.

The ADA realized this conflict as early as 2015 and has asked CMS to instruct Medicare contractors to allow dentists who have opted out to terminate the opt out and enroll as either an ordering and referring or as a Medicare provider, but the agency has declined to change the length of the opt-out period.

For more information, including a listing of all physicians and practitioners that are currently opted out of Medicare, visit CMS.gov.

COUNCIL ON GOVERNMENT AFFAIRS REPORT

INSURANCE ISSUES WORKGROUP

Dr. Roger Palmer; Chair, VDA Council on Government Affairs

At our Committee Meetings in January 2017, the VDA Council on Government Affairs received a number of complaints from members regarding various insurance company policies. We formed a subcommittee with Dr. Mike Morgan doing most of the research about these complaints.

We requested input from our members and compiled an extensive list of complaints about insurance companies. We have had several meetings to discuss these issues and have engaged the services of a consultant. In addition, our lobbyists, Chuck Duvall and Tripp Perrin have given us invaluable advice.

Listed below are the specific issues that were brought to our attention. Some of these issues are being addressed by the ADA, some of them we will try to address by directly contacting the individual company (ies), some may be addressed by legislation and some can't be solved because of existing laws.

- Crowns being denied because of no radiologic evidence despite a narrative being submitted. This has happened with cracked teeth even with a narrative.
- Periodontal scaling and root planing being denied because of no radiologic evidence despite there being 6+ mm pocket depths and narratives submitted.
- Insurance companies have been asking for the return of fees paid ("claw-backs") because the insurance was cancelled. We had complaints that this was being done over a year after the treatment was rendered but could not get documentation.
- Contract provisions that prevent collection for non-covered services unless the provider has obtained written consent from the patient prior to treatment that the service would not be covered. An example of this would be a crown that was denied because it does not meet the insurance company's carefully crafted definition and the insurance company notifies the patient that they are not responsible for payment because the dentist's claim did not meet their definition of necessity.
- A directory listing should be required for participating providers. If the insurance company treats a provider's claims as in network and benefits from the fee reduction, they should be required to list the provider in their provider directories.
- Substitute benefit such as payment for base metal crown only. A significant percentage of women are allergic to base metal crowns.
- Limitations on provider's fee where the provider's out-of-pocket lab expense exceeds the contracted allowable fee.
- Deemed participation by group. This is a practice whereby all providers within a group will be deemed participating if any one provider has signed an individual participation agreement.
- Delta of California and Tricare: They are advising patients to seek treatment at other "less expensive" practices, i.e. PPO vs Premier. The Council has reached out to Delta of Virginia on this issue. Delta of Virginia is NOT doing this and is aware of the VDA's concern. This serves as an example of how we feel we should proceed. The ADA has written Delta letters protesting this policy.
- Silent PPO: This is where a patient has an insurance card but it is actually administered by another company. We should contact the offending company (ies) and attempt to resolve this so that it is clear what company is paying the claim and the fee schedule. This should be clearly stated on the patient's insurance card. To date, 14 states have already enacted laws addressing this.
- Insurance Companies: Should clearly state in their patient information that they have the right to pay for a different treatment other than what the dentist and patient agreed upon solely based on cost. "Least expensive acceptable treatment" option.
- Insurance companies are "downcoding" or "bundling" fees. Some companies treat a separate Buccal and Occlusal restorations as a single class II restoration at a reduced fee. It is illegal for us to do the opposite and call a class II restoration two class I's.
- Insurance companies should be required to supply their participating dentists with a current table of allowances.
- Some companies are extending the length of time between radiographs. In some cases, bitewings are only paid for every 24 months. Also, the replacement time for crowns, bridges, partial dentures and dentures is being extended from the traditional five years to seven or even ten years. This effectively extends our "warranty" far beyond any dental laboratory guarantee. We are trying to research this area. The ADA no longer compiles this type of information.
- Some of our members have received letters from insurance companies asking them to justify why their billings are outside the "norms" for that particular company. In addition, some of our members have been audited and insurance companies have asked for large amounts of fees returned based on just a few charts being audited. We have scheduled a meeting with one of the largest carriers in our area to discuss this.

It is our feeling that we should proceed with the above items by first contacting the individual companies that are engaging in these practices and then proceed with either regulatory or legislative solutions. We have also contacted the ADA to see if they have suggestions regarding the above listed issues.

We are asking the members of the VDA to send in any additional complaints and comments about insurance practices that they feel are unfair to us and our patients. We need actual EOB's showing clearly what the problem is. The EOBs should be totally redacted to remove all identifying information about the patient and the dentist. We have developed a form to send with the EOB. Please send us actual cases that clearly define the problem.

DOWNLOAD THE INSURANCE ISSUE FORM:
https://goo.gl/DBzqnH

ADA'S FIND-A-DENTIST CAMPAIGN TAKES OFF IN VIRGINIA

Elise Rupinski, VDA Director of Marketing and Programs

In April 2017, the ADA launched a three-year, $18 Million advertising campaign authorized by the 2016 House of Delegates. The online campaign uses targeted ads to encourage specific consumer segments to visit an ADA Member Dentist in order to maintain their oral health. In addition to the funds designated through the national campaign, the VDA's PR Task Force elected to participate in the matching funds program, increasing the ad spend in Virginia and providing more exposure for member dentists. For every dollar that the VDA spends, the ADA is matching that with two additional dollars so we are really maximizing the reach of this important campaign.

Specifically, from August through October, the campaign in Virginia has delivered 4,540,265 impressions and 19,196 clicks on member profiles, earning an overall Click Through Rate (CTR) of 0.42%. From those 19,196 clicks, there have been 240 conversions, which are defined as people that not only click on the ad but also complete a search to find a dentist in their area.

In order to make the most of this campaign, members are encouraged to update their profiles via the ADA's website, as those with photos and complete profiles will appear higher in the search results.

Every member can access this information by logging on to www.ada.org and clicking on their dashboard to find out profile clicks, email clicks and various other measures of activity on the Find a Dentist page.

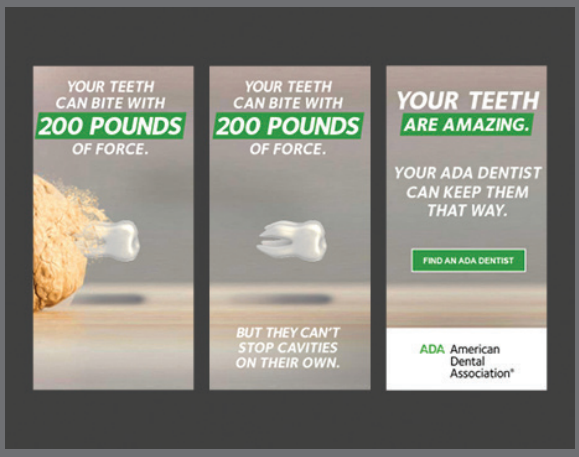
To help us better quantify the results, we asked the VDA's PR Task Force to pull their individual performance from the campaign. The PR Task Force members had an average of 10 profile views each. They also averaged over two website clicks per member and had various email clicks, phone clicks and even profile shares. The program is still in the beginning stages but the results are starting to show that the public is using the ADA's Find a Dentist to locate a provider in their area.

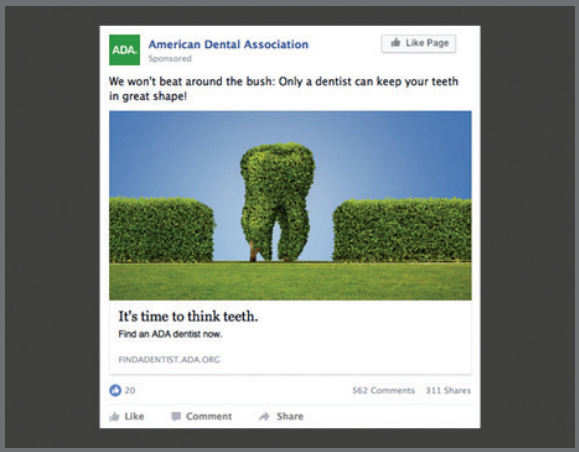
While you are logged in to the website to review your dashboard, please be sure to check the accuracy of all of the information listed about your practice. When VDA President, Dr. Benita Miller, checked her dashboard recently she noticed her practice's website address was not accurate. She made the update and it was displayed correctly on the Find-a-Dentist search in under 24 hours. Upload a photo, check your information and add in more details about your practice to get the best results from this new advertising campaign.

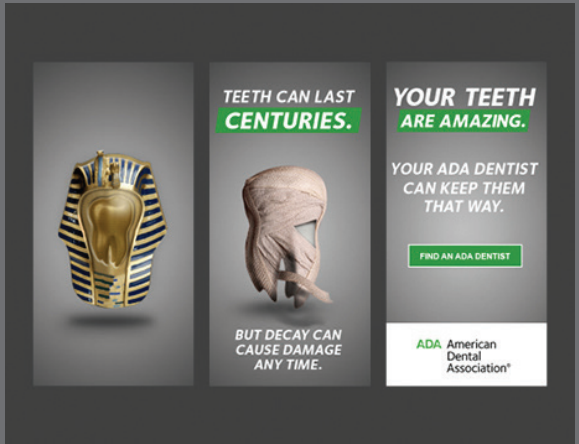
The VDA and ADA are working to address the 'busyness' problem for members and we believe this coordinated advertising effort could have a meaningful impact. By pooling resources and working on a national level, each member will get exposure far beyond what one could do individually. This is the ADA and VDA working to provide solutions for issues that are most pressing to you and the profession today. Thank you for your support and participation!

Editor's Note: If you have questions regarding the ADA advertising campaign, please contact Elise Rupinski at: rupinski@vadental.org or 804-523-2184

TAKE A LOOK AT SOME OF THE ADS USED IN THE CAMPAIGN







VIRGINIA BOARD OF DENTISTRY
DID YOU KNOW?

• PATIENT RECORDS
Did you know that if a patient requests their health record in accordance with §32.1-127.1:03 of the Code of Virginia you are required, within 30 days, furnish such health records regardless of whether the patient has an outstanding financial obligation?

18VAC60-21-90.C and D of the Regulations Governing the Practice of Dentistry

• SEDATION
Did you know that if you administer conscious/moderate sedation you must now have available to the areas where patients will be sedated, treated and recover, and maintain in working order, an end-tidal carbon dioxide monitor?

18VAC60-21-291.B(17) of the Regulations Governing the Practice of Dentistry

• SPORE TESTING
Did you know the Board of Dentistry has found a violation of the standard of care for failing to perform weekly spore testing of sterilization equipment in dental offices?

§54.1-2706(5) of the Code of Virginia

• DENTAL SPECIALTIES
Did you know that a general dentist who limits his practice to a dental specialty or describes his practice by types of treatment shall state in conjunction with his name that he is a general dentist providing certain services (e.g. orthodontic services)?

18VAC60-21-80.A of the Regulations Governing the Practice of Dentistry

40 UNDER 40

DR. CARTER REEVES

Second-generation dentist and family man provides cutting-edge care to the Ashburn area. He founded First Impression Dental with his college sweetheart, Dr. Liz Ramsey. Their joint practice personifies the love they share for the Loudoun community. Go Hokies!

SMILES FOR MASSEY

Karen S. McAndrew, DMD, MS

Often, we find our role within the community we serve by chance. Our life events point us in a direction that becomes our passion to make a difference. Many within our dental profession follow a path to serve others through a desire to make a difference and turn life events into a positive experience. All too often, these individuals pursue their mission without much deserved recognition.

Dr. Chip Anderson has endured the loss of his daughter Ariana at the age of 3 to Acute Myeloid Leukemia (AML). He remembers the events as if they were yesterday. She was diagnosed and within a matter of days underwent chemotherapy treatment. Ariana passed away on March 5, 2001 and Dr. Anderson has made it his mission to advocate for better therapies for children and others suffering from all types of cancer. He created the “Smiles for Massey” campaign to honor his daughter and combat cancer.

Recognizing that members of the dental community have also been affected by cancer and the role that dental practitioners play in diagnosing and treating patients with oral cancers, Dr. Anderson recognized that he was in a unique position as a dentist (and orthodontist) to advocate for raising oral cancer awareness and provide patient education. He has been raising money for oral cancer research with new therapies continuously being developed that can now “target” specific areas and types of cancer. “Dr. Chip”, as many affectionately refer to him, has been an advocate for further cancer research and raising awareness for those affected and their families. That is why, when Dr. Jill Bussey reached out to Dr. Anderson and asked him to join the Massey Cancer Board, he knew it was a perfect fit to fulfill his commitment to the cause. Now, in his third term as a Board member to the Massey Cancer Center, Dr. Anderson has launched "The Smiles for Massey" campaign.

He announced the program, saying “As a member of the Massey Cancer Center Advisory Board, I am thrilled to announce the beginning of what I hope to be an excellent partnership between the Central Virginia dental community and the VCU Massey Cancer Center.”

The Smiles for Massey campaign has been established to raise funds for cancer research, with a portion of the funds raised supporting oral cancer research. We, as healthcare providers, are often on the forefront of oral cancer diagnosis, but after that we are often helpless to do much more. With the Smiles for Massey campaign we can join forces with the research community to help find ways to treat and hopefully cure this scourge of our society.

The Smiles for Massey campaign will ask dental practices to donate or pledge funds based on some category that you deem reasonable. My practice is going to be participating by donating $5,000. Our goal is to raise $50,000. I am asking you to join me in this effort by finding a way to share your support of Massey Cancer Center with your patients.” Many dentists have already joined in this campaign raising money and cancer awareness within their offices and contributing to Dr. Chip’s fund. To date, over $14,000 has been donated through many dental office campaigns and office fundraisers.

Smiles for MASSEY

Dr. Chip Anderson, Founder, Smiles for Massey

Dr. Chip invites the dental community to “Please join me in pledging your help in raising awareness and funds for the Smiles for Massey campaign. Together we will make a difference!” We need the assistance of the community to support this worthwhile mission and support Dr. Anderson, a man making a difference with his personal mission.

See Smiles for Massey donation site - https://www.teammassey.org/

40 UNDER 40

DR. JESSICA CLARK

As a Virginia Beach native, I am proud to be back home practicing Pediatric Dentistry. I purchased a practice from Dr. Townsend Brown, Jr. last year and am excited to continue the 35 year tradition of quality care for children!

VDA FOUNDATION:
MAKING VOLUNTEERING EASY SINCE 1996

We are proud to say that VDA members are among the most selfless, charitable people we know. Every day we get calls from members asking how they can help make a difference in Virginia.

In 1996 we formed the VDA Foundation to fulfill two needs:

1. The need of thousands of Virginians who experience pain, diffculty eating, embarrassment, and serious health complications, simply because they lack the resources to get comprehensive dental care and preventitive services.
2. The outlet for dentists and their staff to share their talents with those who need them the most.

We've made it extremely easy for you to volunteer and give back. So easy that over 28,000 VDA members, dental staff and students have already served one of the VDA Foundation's three nationally-recognized outreach programs.

VOLUNTEER IN PERSON

Missions of Mercy
Virginia Dental Association Foundation

Missons of Mercy (MOM):
Launched in 2000, the MOM program operates an average of six free mobile dental clinics annually across Virginia. Since its inception, over 65,000 patients have received care valued at more than $43 million. Over 27,000 volunteers have participated in the program.

VOLUNTEER FROM YOUR OFFICE

Donated Dental Services (DDS):
Started in 1997, roughly 600 volunteer dentists, as well as specialists and laboratories, tend to the essential and comprehensive dental care needs of some of Virginia's most vulnerable groups -- individuals who are disabled, elderly or medically-compromised and unable to afford services or access public aid.

VOLUNTEER FOR THE KIDS

give kids a smile!
ADA American Dental Association

Give Kids a Smile!® (GKAS):
An initiative proposed by the American Dental Association, Give Kids a Smile!® is a National Children's Dental Access Day designed to raise awareness and provide free oral health care to as many children as possible on the first Friday of each February. Efforts range from community outreach and education programs in schools to donated full-mouth restorations for children requiring extensive care.

HOW TO MAKE A DIFFERENCE RIGHT NOW:

- **MAKE A GIFT** - The average cost of dental treatment per person at a MOM Project is $55. Make a donation at www.vdaf.org or send a check to the VDAF to 3460 Mayland Ct., Suite 110, Henrico, VA 23233.
- **VOLUNTEER** - Volunteer at a MOM Project, as a DDS volunteer, or with a GKAS event. See project dates and locations and sign up to volunteer at www.vdaf.org.
- **SPREAD THE WORD** - Encourage your friends and colleagues to learn more about the VDAF and get involved.
- **HOST A FUNDRAISER** - Turn your birthday or block party into an event with a cause.

LEARN MORE AT WWW.VDAF.ORG

IT'S WORKING...

VIRGINIA'S CDHC PROGRAM

David Black, DDS

As a member of the VDA Board of Directors for the Piedmont Component, I listened with interest for the last couple years about the national program and more recently the program we have started in Danville/ Martinsville to train CDHCs. This new program has been in response the cry for more access to care in our state.

About two months ago I visited the CEO of New Horizons Health Care in Roanoke and explained the advantages of hiring a CDHC. They serve Medicaid clients and have a sliding scale for other low income patients without insurance. We talked about going out into the community and schools to help educate patients about the importance of dental care, and helping this population make and keep appointments in the center. This would not only help the patients, but also help the center with the broken appointment problems they often have with patients that have trouble getting off work or have transportation problems.

Parker Coulson is a Martinsville native who travels one hour each way, every day, to work at New Horizons. She started one month ago, and is feeling her way from trainee to a fully functioning member of their team. She is learning to improve her chairside skills, while strategizing with the doctors and office manager on how to make inroads into the social services world and the different community structures that will utilize her skills in helping our community understand and utilize dental services that are available to them. She has already started community outreach with a couple agencies in town, and has started working to coordinate with the Pediatric Department in their own clinic to schedule children already in the building to come to their Dental Department for check-ups without the need for additional visits.

I am excited and encouraged by Parker's enthusiasm and commitment to improving the health of the people of Roanoke. I also would challenge doctors all over the state to sponsor students, in this mostly online initial phase, and to help accommodate the students for the 500 hours of on-site experience they need to complete this program.

Parker also expressed appreciation to the VCU dental students on rotation in the Martinsville clinic for their help in gaining clinical skills that her class needed to be fully qualified for this job. She also worked at Wise and Grundy MOM projects, and you can understand what an experience that was for her training.

This is a great program, filling a need in all of our communities. Let's all pitch in and help make it flourish. Do what you can, and encourage our community colleges to add this to their curriculum.

CDHC - THE FIRST GRADUATES

Parker Coulson, CDHC

Being in the very first graduating Community Dental Health Coordinator (CDHC) program in Virginia has been a very enlightening experience. There were four of us in this first cohort. We all bravely stepped into a program no one in this state had even heard of. Not only were we busy learning exactly what a CDHC was, we were equally busy trying to educate others. The best way to explain what we do is to show local dentist offices and clinics how we can be a liaison between their offices and the clientele they're unable to reach through ordinary means. While we are certified to be dental assistants, we also know the ins and outs of how insurance and Medicaid are used, as well as how to reach out to local organizations (such as pre-schools, nursing homes, and church ministries) in order to bridge the gap between the community and the often intimidating dental office.

CDHCs understand the reasons why a person's dental care is often not their first priority. Parents, trying to put their children's needs before their own, can ignore symptoms until it is too late. Parents who are working three jobs just to keep the electricity on may not have the time or energy to see if their children are eating, or brushing, properly. When the situation becomes critical, leading to infection or rotting teeth, the Emergency Room is sometimes the only option. Possibly a referral will be given to see a dentist, but that now leaves the person with the conundrum of a prescription that needs to be paid for, an appointment that needs to be made (with often a very long wait), paying for the dentist they couldn't afford in the first place, possible transportation and child care issues, and now the patient gets to do it all while living with a painful infection.

L-R: Parker Coulson, Christine Coulson

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55 Continued From Page

The four of us each completed more than 500 hours in outreach opportunities that none of us were aware existed, in a community we have lived in for most of our lives. For the first half of those hours, we worked in the Martinsville Piedmont Dental Clinic, assisting third and fourth year dental students from Virginia Commonwealth University. Every one of them was so helpful and showed patience with us while we learned how to assist. It was here, however, that we learned the gravity of our community's overall dental health. With a full schedule that was booked up to a year in advance, patients were desperate once they finally got to come for their appointment. Often, there were requests to "just pull them all." We became very comfortable with extractions. The level of appreciation for their pain relief was “off the charts”. Patients were so thankful and would often hug us through tears.

Spread throughout our time at the clinic were outreach opportunities. We were blessed to work at the MOM Project in Wise. If we thought getting to the fairgrounds at 6:00 a.m. was early, I was stunned to find many, many people who had driven hundreds of miles for medical and dental care, having slept in their cars or tents in order to get in line before dark that morning – very humbling, indeed. We saw over 2,000 people receive care that weekend.

Dee Joyce, our fellow classmate, who has such a heart for community outreach, paved the way for us by opening doors of local dentists and reaching out to Liberty University, asking if they would consider partnering their medical outreach with our dental outreach. They have come to Martinsville for the past two years, intending to provide medical care. They had not gotten the turnout they had expected, and were considering not coming back if there did not appear to be a need this year. Dee recruited six dentists to volunteer, she arranged for the mobile bus to be on site, and personally drove to Richmond where she was provided with portable chairs, and all things dental. (Huge thanks to Tonya Adiches for donating so much!) While we worked all day as assistants, even setting up an extra dental chair outside under a tent, because our local dentists were willing to stay past their promised volunteer time, it was Dee who went above and beyond to make sure all the hygienists, assistants and the new class of CDHCs had all they needed. Because all patients had to be triaged through medical before they were ushered through to dental, Liberty’s medical outreach saw about 300 patients. I cannot say what a topnotch group of students that was. They were wonderful to work with, and they are very excited to come back again next year.

Those patients who were seen were so appreciative, although there were many that had to be turned away. One young lady told me she was in line at 4:45 a.m. for dental care. I was so thankful to be a small part of the success of that day, but it was very eye-opening to see how great the need is for education and navigation of this often-overlooked area of health.

I am proud to say I've accepted a job at New Horizons Dental Clinic in Roanoke, where I hope to be a blessing to those I help in the clinic, as well as those I hope to meet in outreach opportunities

PIEDMONT DENTAL CLINIC RECEIVES $600K HARVEST FOUNDATION GRANT AWARD

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The Piedmont Virginia Dental Health Foundation (PVDHF), the driving force behind the Community Dental Clinic, received a three-year grant from The Harvest Foundation in the amount of $603,195 for indigent dental care.

The Community Dental Clinic served nearly 5,000 individuals in 2016, and since the clinic opened in 2006, there have been more than 41,400 patient visits providing more than $9.3 million in dental services to unemployed and uninsured children and adults in Martinsville-Henry County. Emergency dental visits to SOVAH Health Martinsville, formerly Memorial Hospital of Martinsville and Henry County, have decreased by 31 percent over the past six years, according to information provided by PVDHF.

“The Community Dental Clinic provides a valuable service to Martinsville-Henry County,” said DeWitt House, senior program officer at The Harvest Foundation. “The clinic is well-organized, efficient, and provides a variety of dental care for the patients served. The staff and volunteers at the clinic do an amazing job and are committed to the continued success of the clinic. We are fortunate to have an organization of this caliber in our community.”

Dr. Mark Crabtree, president of the PVDHF Board of Directors, said the dental clinic is the only solution available for those in need who cannot afford care in a private, fee for service dental practice.

“We are grateful for Harvest’s substantial support of the Community Dental Clinic,” Crabtree said. “They have been a significant part of our efforts from the very beginning, and we owe our success to their generous funding. This significant three-year commitment makes it possible to continue providing dental care to those who have no other place to access quality dental care. This truly improves the health of thousands in our community.”

The Piedmont Virginia Dental Health Foundation works in partnership with the Virginia Commonwealth University School of Dentistry, providing externships to dental students who provide care in the community. The organization also partners with Patrick Henry Community College to develop the community dental health coordinator and dental assistant programs, as well as local dentists who volunteer their time at the clinic. Other partners include the City of Martinsville in addition to The Harvest Foundation.

To find out more about PVDHF and its services and programs, visit www.piedmontdental.org.

MOM PROVIDES DENTAL CARE FOR RICHMOND'S HOMELESS

Michael Rogers; Homeward, Community Engagement Coordinator

Homeward is the planning and coordinating organization for homeless services in the greater Richmond region.

Our mission is to prevent, reduce and end homelessness by facilitating creative solutions through the collaboration, coordination and cooperation of regional resources and services.

Recenlty, Homeward hosted its 11th annual Project Homeless Connect (PHC), an event that matches clients with volunteers in a partnership to connect adults experiencing homelessness to as many on-site services as possible in one day. The impact of PHC is multi-faceted: First and foremost, where there are usually lengthy barriers facing people trying to get the help they need to get off the streets, Project Homeless Connect provides immediate access to the services that help people resolve their homelessness. Secondly, service providers coordinate with each other at the event to make an even bigger impact in their community. Lastly, it introduces over hundreds of volunteers to the tangible needs of people in our community, thereby inspiring all of us to take action beyond this one day event.

This year we saw over 400 volunteers work with 552 people from our community get connected to services offered by nearly 50 providers in areas such as dental, health, housing, employment, and benefits.
The Virginia Dental Association Foundation's (VDAF) Missions of Mercy (MOM) and the VCU School of Dentistry and Dental Hygiene joined us again as annual partners providing dental care for 63 patients. Treatment included 63 oral exams, 27 cleanings and fluoride varnishes, 108 extractions and 92 x-rays. The services provided by MOM relieve dental symptoms and restore the dignity and confidence of PHC clients so that they can focus on their housing and additional service needs.

Homeless Connect Volunteers

Together with our partners like MOM we…

- For the eleventh consecutive year, coordinated vital services with the people who need them most
- Saw our neighbors experiencing homelessness take steps towards more stable housing
- Witnessed how the barriers to basic services many of us take for granted affects our most vulnerable community members

Yet, an important outcome exists beyond these stated results: we were all reminded of the humanity of people experiencing homelessness.

We can often overlook the human component of homelessness. The person going through homelessness can become an abstraction lost in news stories of the crisis of homelessness. Yet, the experience of every volunteer, service provider, and Homeward board and staff member helps us to understand that our neighbors who are experiencing homelessness today are not others. They are just like us without a safe and stable place to call home.

Project Homeless Connect exists primarily to remove the barriers between adults experiencing homelessness and the services that can help them overcome it; yet, PHC also promotes the connection of community members who have and do not have stable housing. PHC presented every participant with the opportunity to look into the eyes of a person that is not singularly defined as homeless, but justly qualified as neighbor, family member, coworker, and friend.

Homeward is grateful for the continued partnership with Virginia Dental Association Foundation to serve at this vital community event. We look forward to working together to serve our most vulnerable neighbors in the years to come.

For more information on Homeward please visit www.homewardva.org.

40 UNDER 40

DR. STEPHENIE BROWNING

Dr. Stephenie Browning earned her Doctor of Dental Surgery degree from Baylor College of Dentistry in Dallas. She has received numerous accolades and is a member of the American Dental Association, Special Care Dental Association, and Academy of General Dentistry.

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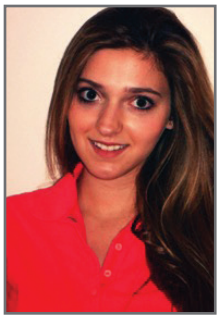


FINDING MENTORSHIP IN THE DENTAL PROFESSION

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

As a dental student halfway through my third year at VCU School of Dentistry, I have grown more and more comfortable with and excited about working with patients in clinic. Now that my classmates and I are treating patients full-time, we have quickly gained knowledge beyond what we studied in textbooks – we now attempt to apply everything that we have learned in our pre-clinical years to treating patients who often have high expectations of us. Although our peers, fourth year dental students, and faculty are incredibly helpful, sometimes students are in need of advice and assistance on a big-picture scale. In these instances, finding a mentor within dentistry is paramount for a dental student's professional path.

Many students are lucky to have grown up with a parent or family member who is a dentist, who perhaps has built a practice that a dental student can learn from or join in the future. However, there are also other students, like myself, who do not have any family members within the dental profession. Although VCU prepares us extremely well with clinical knowledge, we still need mentorship from seasoned dentists to answer our questions about both clinical dentistry and the business side of our profession. Luckily, we do have a helpful Practice Management course for third years and fourth years, in which guest speakers come and discuss important topics concerning associateships, practice acquisitions, and debt management.

Despite the resources our classes provide, students like myself are looking for mentors in dentistry. Sometimes, we find mentors within our practice groups in clinic. Although a student may be more comfortable with working with the same faculty for difficult procedures, I have learned that it is best to branch out and learn from anyone who is available, because each clinical faculty member has different insights into the task at hand. Our faculty are eager to help us and to also discuss with us greater issues within the profession.

Beyond our resources within school, dental students can find mentorship within organized dentistry. A few weeks ago, I attended the Richmond Dental Society meeting. At the meeting, I was able to meet both new graduates and experienced dentists. Many of the dentists present were happy to talk to dental students and answer our questions about the world beyond dental school. Attending events such as dental society meetings is an excellent way to find a mentor.

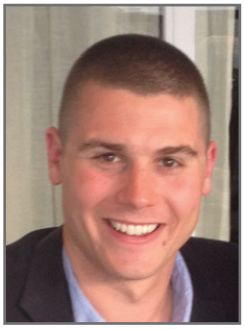
The Virginia Dental Association provides opportunities for dental students to get involved with organized dentistry and make connections for mentorship. One opportunity that takes place every year is "Day on the Hill". On January 19, 2018, dentists and dental students met with each other, local legislators, and lobbyists. Dental students enjoyed the opportunity to learn about upcoming legislation that may significantly affect our profession. Dentists involved with organized dentistry are incredible resources, because they are aware of how our field is constantly changing.

Another opportunity to find mentorship and advice for dental students and new graduates is the VDA New Dentist Conference on March 2nd-3rd, 2018, in Charlottesville. At the New Dentist Conference, attendees can engage in networking and participate in seminars about succeeding in private practice. Events such as these are fantastic ways to find mentorship and gain valuable information for life after dental school.

Although the future after graduation may seem intimidating, dental students should remember that many of our fellow dentists are happy to relay their experiences to us. The dentists that have gone before us were dental students once too, and the ones that I have spoken to would love to extend their help to us. Ultimately, dental students need to take advantage of the resources at our disposal, both at school and through connections within organized dentistry as well.

Editor's Note: If you don't currently mentor a student or new dentist, what are you waiting for? They don't know what they don't know. Pass on your knowledge and expertise to help perserve the future of dentistry.

40 UNDER 40



DR. ANDREW JANIGA

I recently completed the AEGD program with the Army, where I had hands-on experience with implants, CAD/CAM restorations, and periodontal surgeries. I am currently stationed at Ft. Lee. My family and I are enjoying our time in Virginia!

WELCOME NEW MEMBERS

Karen Clendenen, VDA Membership Associate

TIDEWATER DENTAL ASSOCIATION

Dr. Christopher Gushue – Virginia Beach – Temple University The Maurice H. Kornberg School of Dentistry 2013

Dr. Daniel Winter – Chesapeake – West Virginia University School of Dentistry 2014

PENINSULA DENTAL ASSOCIATION

Dr. Ariel Atwood – Hampton – University of Nebraska Medical Center College of Dentistry 2017

Dr. Matthew Joosse – Williamsburg – University of Pennsylvania School of Dental Medicine 2009

Dr. Arya Namboodiri – Hampton – Virginia Commonwealth University School of Dentistry 2012

SOUTHSIDE DENTAL SOCIETY

Dr. George Davis, III – Chester – Virginia Commonwealth University School of Dentistry 1984

Dr. Eleni Tarasidis – Midlothian – University of North Carolina School of Dentistry 2016

RICHMOND DENTAL SOCIETY

Dr. Christopher Alexander – Glen Allen – Georgia Regents University 2017

Dr. Victor Amarteifio – Richmond – Howard University College of Dentistry 2017

Dr. Justin Armbruster – Danville – University of Kentucky College of Dentistry 2016

Dr. Christopher Collie – Virginia Commonwealth University School of Dentistry 2014

Dr. Katherine DeSilva – Richmond – New York University College of Dentistry 2017

Dr. Manpreet Dhillon – Glen Allen – Virginia Commonwealth University School of Dentistry 2017

Dr. Jillian Ferdman – Glen Allen – University of Pittsburgh School of Dental Medicine 2015

Dr. Mark Gardner – Richmond – West Virginia University School of Dentistry 2017

Dr. Megan Green – Richmond – Georgia Regents University 2016

Dr. Natasha Grover – Chatham – Virginia Commonwealth University School of Dentistry 2017

Dr. Alyssa Gutierrez-Ricci – Henrico - Virginia Commonwealth University School of Dentistry 2017

Dr. Stephen Haverkos – Richmond – University of Kentucky College of Dentistry 2017

Dr. Daniel Hawkins – Richmond – University of Pittsburgh School of Dental Medicine 2016

Dr. William Hefele – Ashland – Virginia Commonwealth University School of Dentistry 1990

Dr. Brett Henderson – Richmond – Medical University of South Carolina James B. Edwards College of Dental Medicine 2015

Dr. Magdalena Holz – Richmond – West Virginia University School of Dentistry 2014

Dr. Sameer Jain – Richmond – University of Texas Medical Branch Hospital 2017

Dr. Balraj Kang – Richmond – State University of New York at Buffalo School of Dental Medicine 2016

Dr. Lauren Kaplan – Richmond – Virginia Commonwealth University School of Dentistry 2017

Dr. Meng Lee – Richmond – Case Western Reserve University School of Dental Medicine 2017

Dr. Christopher Loschiavo – Richmond – Arizona School of Dentistry & Oral Health 2016

Dr. Denver Lyons – Richmond – Virginia Commonwealth University School of Dentistry 2017

Dr. Michael McAdams – Richmond – University of North Carolina School of Dentistry 2017

Dr. David Nichols – Richmond – University of Maryland Dental School 2017

Dr. Alaaaldin Radwan – Glen Allen – New York University College of Dentistry 2011

Dr. Christopher Ray – Richmond – University of Oklahoma College of Dentistry 2017

Dr. Amy Reichert – Richmond – Virginia Commonwealth University School of Dentistry 2016

Dr. Jennifer Rominger – Richmond – East Carolina University School of Dental Medicine 2017

Dr. Adam Sarnowski – Richmond – University of Florida College of Dentistry 2006

Dr. Kelly Schwabe – Richmond – Marquette University School of Dentistry 2017

Dr. Katrina Thatch – Richmond – University of Maryland Dental School 2017

Dr. Dan Tran – Richmond – Virginia Commonwealth University School of Dentistry 2016

Dr. Jessica Tucker – North Chesterfield – University of Tennessee College of Dentistry 2015

Dr. Molly Westbrook – Richmond – University of Maryland Dental School 2017

Dr. Chao Yi Zhang – Richmond – Virginia Commonwealth University School of Dentistry 2017

PIEDMONT DENTAL SOCIETY

Dr. Maryia Kvashenka – Roanoke - Virginia Commonwealth University School of Dentistry 2017

Dr. Daniel Moye – Lynchburg – West Virginia University School of Dentistry 2016

Dr. Zan Pervaiz – Falls Church – Howard University College of Dentistry 2017

Dr. Emma Schmidt – Lynchburg – Case Western Reserve University School of Dental Medicine 2014

Dr. Alyssa Stout – Roanoke - Virginia Commonwealth University School of Dentistry 2017

Dr. Kelsey Wright – Roanoke – University of Tennessee College of Dentistry 2017

SOUTHWEST VA DENTAL SOCIETY

Dr. Hayley Campbell – Gate City – Virginia Commonwealth University School of Dentistry 2016

Dr. DoBin Choi – Blacksburg – West Virginia University School of Dentistry 2014

Dr. Myrna Gamez – Christiansburg – NY-Lutheran Medical Center Dept. of Dental Service 2013

Dr. Spencer Starley – Big Stone Gap – Ohio State University College of Dentistry 2017

SHENANDOAH VALLEY DENTAL ASSOCIATION

Dr. Mario DeNicola – Harrisonburg – State University of New York at Buffalo School of Dental Medicine 2014

Dr. Danielle Dunn – Charlottesville – University of Michigan School of Dentistry 2017

Dr. Davinder Garcha – Charlottesville - Virginia Commonwealth University School of Dentistry 2017

Dr. Andrew Glassick – Charlottesville – University of North Carolina School of Dentistry 2009

Dr. Monisha Khanna – Harrisonburg – State University of New York at Buffalo School of Dental Medicine 2014

Dr. Amanda Knestrick – Penn Laird – West Virginia University School of Dentistry 2017

Dr. Michael McKinney – Staunton – Roseman University of Health Sciences 2017

NORTHERN VA DENTAL SOCIETY

Dr. Ignacio Blasi Beriain – Fairfax – University of Pennsylvania School of Dental Medicine 2012

Dr. Daniel Bostock – Falls Church – University of California at San Francisco School of Dentistry 2012

Dr. Dustin Bowler – Sterling – Columbia University 2012

Dr. Lydia Brett – Alexandria – Temple University The Maurice H. Kornberg School of Dentistry 2017

Dr. William Dang – Springfield – Midwestern University College of Dental Medicine Illinois 2017

Dr. Akbar Dawood – Herndon – University of Pennsylvania School of Dental Medicine 2003

Dr. Shashank Gattumeedhi – Winchester – New York University College of Dentistry 2017

Dr. Farzin Ghanavati – Alexandria – NY University of Rochester Eastman Dept. of Dentistry 2017

Dr. Valla Grayeli – Great Falls – Temple University The Maurice H. Kornberg School of Dentistry 2017

Dr. Lauren Gutta – Arlington – West Virginia University School of Dentistry 2017

Dr. Lauren Jain – Fairfax - Stony Brook University School of Dental Medicine 2013

Dr. Manjot Kaur – Burke – Howard University College of Dentistry 2017

Dr. David Matney – Falls Church – Virginia Commonwealth University School of Dentistry 1994

Dr. Nirali Mehta – Springfield – Midwestern University College of Dental Medicine 2017

Dr. Ashley Metz-Suska – Alexandria – University of Detroit-Mercy School of Dentistry 2013

Dr. Raymond Mikhail – Fairfax – Loma Linda University School of Dentistry 2007

Dr. Archana Nadig Kasi – Alexandria – Harvard University School of Dental Medicine 2012

Dr. Mariam Naeem – Dunn Loring – University of Pennsylvania School of Dental Medicine 2015

Dr. Nguyen T. Nguyen – Fredericksburg – Virginia Commonwealth University School of Dentistry 2017

Dr. Athanasios Ntounis – Fredericksburg – University of Alabama School of Dentistry @ UAB 2013

Dr. Raquel Pagan – Arlington – University of California at Los Angeles School of Dentistry 2017

Dr. Bhargav Patel – Springfield – Temple University The Maurice H. Kornberg School of Dentistry 2016

Dr. Alexandra Patil – Brambleton – University of Minnesota School of Dentistry 2016

Dr. Meghan Patsy – Leesburg – University of Kentucky College of Dentistry 2017

Dr. Matthew Puchta – Reston – University of Kentucky College of Dentistry 2017

Dr. Sowmya Punaji – Woodbridge - University of North Carolina School of Dentistry 2012

Dr. Alexander Sadak – Fairfax - Stony Brook University School of Dental Medicine 2014

Dr. Akram Sannaa – Arlington – Boston University Goldman School of Dental Medicine 2016

Dr. Michael Sims – Alexandria – Georgetown University 1983

Dr. Radwa Sobieh – Ashburn – OH-Miami Valley Hospital 2009

Dr. Jeanne Tchuenbou – Alexandria – University of Maryland Dental School, Baltimore College of Dental Surgery 2017

Dr. Montressor Upshaw – Alexandria – Meharry Medical College School of Dentistry 2008

Dr. Petra Von Heimburg – Alexandria – Northwestern University 1980

Dr. Brian Vu – McLean – Howard University College of Dentistry 2016

Dr. Syeda Zafrin – Woodbridge – Case Western Reserve University School of Dental Medicine 2017

IN MEMORY OF DR. JOHN P. MCCASLAND

Dr. Bill Callery

Dr. John P. McCasland died peacefully surrounded by family on August 17, 2017. He was 86 years old.

After graduating from Baylor Dental School in 1956, Dr. McCasland entered into the U.S. Army. During his military career he achieved the rank of Colonel, trained as a maxillofacial prosthodontist, and became Chief of Removable Prosthodontics at Walter Reed Medical Center. He was a member of many professional organizations, including being a Fellow and Founding Member of the American College of Prosthodontics, and was widely recognized for his pioneering work in the field of removable prosthodontics. He trained, mentored, and worked with many exceptional dentists during his career.

After retiring from the Army in 1976, Dr. McCasland joined the faculty of the Medical College of Virginia (MCV) as an associate professor. His career at MCV was notable for his tough love approach to teaching, tempered by a big heart driving his desire for his students to succeed not just in dentistry, but in life. He was exceptionally smart, hardworking, extremely humorous, and absolutely unforgettable.

Outside of dentistry, Dr. McCasland was an avid fisherman who enjoyed spending time with friends and family aboard his boat, the Laura/Liz. He was an accomplished golfer, participating in as many tournaments as he could and a regular attendee at meetings and continuing education courses. He rarely missed a chance for a meal!

Dr. John McCasland was a true dental professional, exceptional educator, and loyal friend. Everyone he ever met has their own "John McCasland story." He is fondly remembered by his many friends, colleagues, and students for the character he was. He will be sorely missed by all.

Editor's Note: Dr. Callery, a VDA member, practiced in Chester.

Dr. John P. McCasland

IN MEMORY OF:

Name	City	Date of Death	Age
Dr. Carol N. Brooks	Richmond	October 2, 2017	65
Dr. Richard C. Fisher	Springfield	October 2, 2017	96
Dr. Horace P. Johnson	Richmond	August 26, 2017	67
Dr. Wedo Nutaitis	Fairfax	March 21, 2017	91
Dr. Howard S. Tugwell	Norfolk	March 16, 2017	87

VDA BOARD OF DIRECTORS

ACTIONS IN BRIEF - NOVEMBER 3, 3017

1. Approved: A resolution to allow Terry Dickinson to negotiate a contract with Sklar Technology to offer IT service, at a discounted fee, as a membership benefit.

2. Approved: A resolution confirming the following ADA alternate delegate appointments (appointees are filling vacated terms):
   - Dani Howell to serve the last year of Richard Taliaferro's term.
   - Cassidy Turner to serve the last year of Frank Iuorno's term.

3. Approved: The 2018 Virginia Dental Association Foundation Board members: Barry Isringhausen (President), Robbie Schureman (Vice President) Graham Gardner (Secretary), William R. Harland, Jr. (Treasurer), Anne C. Adams, DDS, Nate Armistead, D4, Patrick W. Finnerty, Ralph L. Howell, Jr., DDS, Audra Y. Jones, DDS, David C. Jones, DDS, David L. Jones, DDS, David S. Lionberger, Esq., Derek Rickson, D3, Norma N. Roadcap, Juan A. Rojas, DDS, Carlos S. Smith, DDS, Robert Walker, D. Omar Watson, DDS, Edward J. Weisberg, DDS.

4. Reaffirmed: VDA Policy that to practice in Virginia a patient centered clinical exam must have been successfully completed

VDA OFFERS MEDIA OPPORTUNITIES

Elise Rupinski, VDA Director of Marketing and Programs

Throughout October, the VDA worked with its new public relations partner, The Hodges Partnership, to promote news stories about maintaining good oral health even through the candy filled Halloween season. On an individual level, not all members have the marketing budget to fund a comprehensive public relations and advertising campaign but that is where the VDA can provide member value by working to get oral health into the spotlight. Working together as an association, members of the VDA are all able to benefit from statewide efforts to promote the profession and the importance of visiting a VDA member dentist for care.

During this campaign, Hodges connected with reporters across the state to pitch the idea of having local dentists talk about oral health tips during the time of year when candy is in the spotlight. The target media outlets included local TV stations and daily newspapers that were provided with the opportunity to speak to a VDA member dentist in the weeks leading up to Halloween. Hodges and the PR Task Force worked together to develop a set of talking points to help members prepare for the interviews and feel more comfortable talking on camera.

Dr. Stephanie Vlahos from Salem stopped by the WDBJ studio in Roanoke for her interview on her way to the airport to fly to the ADA Annual Session in Atlanta. Dr. Vlahos reflected, "The interview process was quick and I felt prepared since I had reviewed the talking points and spoke with the producers at WDBJ." Dr. Vlahos said it took her about 15 minutes to prepare for the interview and she was at the station about a half an hour to film the three minute segment. After the segment aired, she heard from patients, family, friends and even a colleague who lives more than an hour away that they saw her on TV! Dr. Vlahos commented, "It was a fun experience and great to have the opportunity to represent the profession and talk about oral health at Halloween."

Dr. Stephanie Vlahos featured on WDBJ - See the video at: https://goo.gl/QkVy1T

The story was picked up by four stations across the state. A big thank you to the members who shared their time and expertise! We are hoping to provide additional media opportunities in 2018 and will announce interviews via the VDA's private Facebook Group.

AWARDS AND RECOGNITION

Thomas Wilson

HONORARY MEMBERSHIP
Virginia Dental Association

Dr. Kirk Norbo

EMANUEL MICHAELS
DISTINGUISHED DENTIST
Virginia Dental Association

Dr. Richard Taliaferro

LEADERSHIP
AWARD
Virginia Dental Association

Dr. Jeena Devasia

NEW DENTIST
AWARD
Virginia Dental Association

Dr. David Anderson

LEADERSHIP
AWARD
Virginia Dental Association

Dr. Alonzo Bell

LEADERSHIP
AWARD
Virginia Dental Association

Dr. David Black

LEADERSHIP
AWARD
Virginia Dental Association

Dr. Peter Cocolis

LEADERSHIP
AWARD
Virginia Dental Association

Dr. Jared Kleine

LEADERSHIP
AWARD
Virginia Dental Association

Dr. Kirk Norbo

LEADERSHIP
AWARD
Virginia Dental Association

Dr. Cynthia Southern

PRESIDENTIAL
CITATION
Virginia Dental Association

Dr. Gus Vlahos

LEADERSHIP
AWARD
Virginia Dental Association

AWARDS AND RECOGNITION

Dr. Roger Wood

LEADERSHIP AWARD
Virginia Dental Association

Dr. Samuel Galstan

PRESIDENTIAL CITATION
Virginia Dental Association

Dr. Karen McAndrew

PRESIDENTIAL CITATION
Virginia Dental Association

Dr. Tyler Perkinson

PRESIDENTIAL CITATION
Virginia Dental Association

Dr. Elizabeth Reynolds

PRESIDENTIAL CITATION
Virginia Dental Association

Dr. Richard Roadcap

PRESIDENTIAL CITATION
Virginia Dental Association

Dr. Daniel Laskin

UNIVERSITY OF ILLINOIS AT CHICAGO COLLEGE OF DENTISTRY DISTINGUISHED SERVICE AWARD

University of Illinois

No photo available

Joyce Morgan

DENTAL TEAM MEMBER AWARD
Virginia Dental Association

40 UNDER 40

DR. BROOKE GOODWIN

Brooke has the unique privilege of working for the Mennonite community in Dayton. The community-funded clinic also provides medical, pharmacy, and birthing services. She feels blessed every day to work with such a kind, hard-working, and inspiring group of people.

Members advertise for FREE with the VDA

VDA CLASSIFIEDS
vdaclassifieds.org

VDA Classifieds offers several ad types:
JOBS, Products and Services, Office Space For Sale and Practice Transitions

NON-Member Pricing: $50 a month per ad (web); $150 per issue (Journal)
VDA Members receive FREE ads on VDA Classifieds and in the *Virginia Dental Journal*

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Need Help? Contact the advertising concierge, Shannon Jacobs at jacobs@vadental.org or 804-523-2186

VDA CLASSIFIEDS

JOBS - DENTIST

5756 – Associate Dentist (PT)
Thriving dental practice is Fredericksburg needs a confident associate with the experience and confidence to handle diagnosis, treatment planning and procedure delivery on basic cases. The practice is very well staffed with seasoned assistants and dental hygienists so there is plenty of support. This is a perfect fit for a dentist interested in, and comfortable with, every high tech dental device imaginable. A short list includes the latest Cerec with integrated mill and 3D imaging. Intra-oral cameras in each of the 8 hygiene and treatment rooms. Most rooms have been recently updated. This is a journey. We are looking for someone to start off slow working a few days per week (part-time) with a quick ramp up to full time. More days will be added as the practice adjusts to scheduling two doctors. The practice is looking to expand hours and include more patient days. Please send a resume with a short note defining what type of engagement would be best for you. Resumes demonstrating best fit will be contacted for phone interview to be respectful of your time. If it makes sense to continue, we will schedule an onsite interview and practice tour. Look forward to hearing from you.
Contact: Tom Francis – 703-819-1505

5648 - Full Time Pediatric Dentist needed –Hampton, VA
We are seeking a full time Pediatric dentist to join our multi-specialty, General, Pediatric, and Orthodontic dental practice. We are a very busy, well established, and respected dental practice for over 30 years. We are located in Hampton, VA, and are centrally located to all of the major cities in Hampton Roads. We are within an hour drive to the beaches of the Atlantic, and also the mountains. You can visit our website at www.caring4kids.com and read our great reviews. We have all of the state of the art dental equipment, including chairs, hand pieces, and computer software. We are also completely digital. You will be fortunate to be working with a very experienced staff. We are proud to say they have been with us for over 20 years. We would like to give the right person an opportunity for great earning potential, and eventual partnership.

We would also like to list all of the benefits that you will be able to enjoy $ 225,000.00 - $ 300,000.00 (Salary with 30% of collection income over $ 55,000.00 each month) Oral Sedation Hospital dentistry, Vacation pay/Holiday pay, Paid Professional liability insurance, contributions toward CE expense, 401 K, Health insurance. **Please call Michelle at 757-896-5050 about any inquiries, or email your resume to mbunch@caring4kids.com**

5763 - General and Pediatric Dentist Opportunity
Unique Opportunity! Join an established practice that provides the highest quality dental care to patients using the most advanced, state-of-the art dental technology available. Join our dynamic team and be part of an innovative model of care featuring general dentistry, pediatric dentistry and orthodontics all under one roof. Currently seeking… General and Pediatric Dentist! At Gettysburg Dental Associates, we are pleased to announce the following opportunities: Full-time General dentist & Full-time Pediatric dentist our practice has continued to experience strong growth and we are seeking candidates with excellent clinical and personal skills who desire to provide our patients with the highest quality dental care. Our practice, established 35+ years ago, is currently staffed by: • Three full-time general dentists, • Two full-time pediatric dentists, • One orthodontist, and • Nine hygienists. The home of our general practice is on the main floor of our office, with the pediatric practice located on a separate floor…complete with its own reception room, play areas and saltwater fish tank. Our office is conveniently located in Gettysburg, Pennsylvania just 10 miles north of the Maryland border. This gives us the unique ability to serve families from both states, and makes Baltimore and Washington, DC easy commutes. The charming community of Gettysburg is full of history and most advantageously is a family friendly area. The area has many unique restaurants, outlet shopping, golf courses, a ski resort, lakes and great parks. It is also easy to enjoy the cities of Baltimore, Frederick, Harrisburg, Hershey, York and Washington, D.C. as they are all within easy driving distance. We are currently offering a $5,000 finder's fee for anyone (dentist or other) who refers a general dentist or pediatric dentist to our office who then becomes an associate. If you desire to work in an established, successful dental practice such as ours or would like additional information, visit our website at www.justkidsgettysburg.com. **Please email our practice administrator, Jennifer Gervasio, at jennifer.g@gettysburgdentalassociates.com or call 717-334-8193.** Looking forward to speaking with you, Eric Seidel, DMD, Partner Stephanie DeFilippo, DDS, Partner

5778 - Associate Dentist
Busy Hampton, VA office is actively looking for a full-time/part-time Dental Associate that provides excellent general dentistry. This candidate must be a friendly, outgoing and motivated General Dentist with at least 2 years of experience, a team player and ready to work! Great earning potential!
Regina Vanlear, 757-838-5999, familydentistry11@yahoo.com

5781 - Dentist
James A. Burden, D.D.S. & Associates is looking for a productive, goal driven Associate Dentists to join our team. We are seeking someone who wants to be part of a fast-paced cohesive team that likes to work hard and have fun. You will be providing comprehensive treatment to a steady flow of patients, to include restorations (fillings), crowns, bridges and build ups, extractions, removable prosthodontics, and hygiene exams. As a dentist, you will be able to focus your entire day on providing quality patient care, using state-of-the-art equipment. Working along side of you will be highly skilled assistants. Our front office is well trained to handle all of the administrative functions of the office so you only need to focus on the patient. You will also have the opportunity to receive management training and a possible partnership. What we offer: -Highly Competitive Salary -Benefits Package (including medical, 401k, vacation, sick time, CE assistance & more) -Well established and structured office -Relocation Assistance Requirements: -D.D.S. or D.M.D. from an American Dental Association accredited dental school -Current active unrestricted license to practice dentistry in Virginia (or the ability to obtain) -Educate patients on their oral health -Complete comprehensive full mouth exams and diagnose conditions -Assess treatment planning options and the ability to discuss with the patient -Maintain an awareness of office goals and work in conjunction with the team to achieve them -Keep abreast of continuing education and new developments in dentistry through continuing professional education Required Education -D.D.S. or D.M.D.
Contact: Sharon Steward, 757-229-1224, info@smilesofwilliamsburg.com

5788 - Associate Dentist to 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, and opportunity for future partnership. Established patient base, dentist will step into a full schedule. **Please send resume to pwmillerdds@gmail.com**

5792 - General Dentist Needed
Busy, state of the art general dental office seeking a full time General Dentist in Yorktown, VA. Residency and/or experience preferred.
Please email your resume to Robin at robin@levydentalgroup.com.

5793 - General Dentist - Hampton Roads
Morrison Dental Group is seeking an experienced general dentist (minimum of three years) for our growing practice in the Hampton Roads area of Virginia. Enjoy working in an established practice with room for growth. We believe 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. If this sounds like a great fit for you, please contact us by phone or email. We look forward to meeting you!
Alison Morrison, 757-719-2237, amorrison@morrisondentalgroup.com

JOBS - DENTAL STAFF

5785 - Dental Front Office Coordinator
General dental office is looking for an experienced office manager or office coordinator . This requires communication skills and minimum of 4 years experience. Candidate must have experience on dental insurance verification, processing dental insurance claims ,excellent customer service, treatment plan presentation and Dentrix knowledge. Please only reply if you have experience working in a Dental Office.
Contact: Office Manager, 757-962-7000, ezahir@gmail.com

5787 - Front Desk Assistant-Mechanicsville
Family Practice in Mechanicsville looking for front desk administrator to join our amazing team. Candidate must have previous experience in dentistry and at least 1 year working front desk. Candidate must be friendly, cheerful, organized and a team player. Duties will included but are not limited to answering phones, scheduling appointments, checking patients in/out, collecting co-pays, and treatment plan presentations. If you are looking to join an amazing team then this is the office for you.
Please email resume to tammy.progressdental@gmail.com.

PRACTICE TRANSITIONS

5750 - Associate Buy Out Richmond, VA General Practice For Sale
I have a long-established solo general dentistry practice in Richmond, VA in the near West End of Henrico County. We recently redecorated our entire office and are state-of-the-art including digital charting, digital X-ray, computers and TV in each of 6 operatories, Cerac Connect, Implant surgery motor and instruments, rotary endo, We have a very low BA rate because we confirm patients by computer. We are getting 45-65 new patients a month and have a high Google rating in our zip code. I am looking for a "warm transition" wherein I will work for the buyer for two years. **CV can be sent to WestEndDentist@yahoo.com along with a phone number to contact you.**

5761 – Williamsburg Practice For Sale
BEAUTIFUL WILLIAMSBURG PRACTICE, well-established with over 2100 active patients. Three modern treatment rooms, 1,200 square feet. The practice is grossing $400k and has been voted the best by the community. The selling doctor is looking for the right potential buyer for continued growth and tender patient care. Don't spend the money on a cold start-call today for more information.
Dr. Jim Schroeder, 804-897-5900, hrcoordinator.lbd@gmail.com

5789 - Dental Office for Lease
Appalachian Mountains-13 miles from Damascus, VA 24236 (Konnarock). Great stand alone building (approximately 1,800 sf) was built for a dentist in 1984 with 3 examination rooms. He practiced until he retired about 7 years ago. Recently purchased and repainted interior with chestnut lumber wainscoting. Beautiful building near the VA Creeper Trail, Whitetop Mountain, Mt. Rogers. and the Appalachian Trail. Equipped with some dental equipment including x-ray, vacuum and compressor, propane, O2, N2O lines, but I don't know how serviceable. There is a significant need in the isolated and economically disadvantaged area. The lease arrangements can be $1,200/ month (+utilities) or as low as $600/month (+utilities) for the first 2 years if you will accept Medicaid patients. **Call Gary Galbreath (540) 314-1099. (ggalbreath@swva.net)**

5742 - 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

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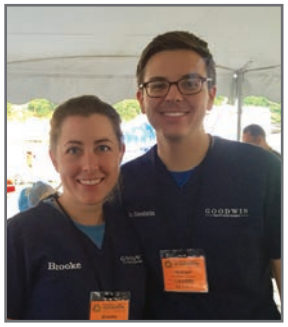

DR. WILL GOODWIN

In 2016, Will opened Goodwin Oral & Facial Surgery in Harrisonburg. Thanks to his amazing family, team, referring dentists, and answered prayers, the practice is thriving and he is able to focus on giving every patient a wonderful experience.