VIRGINIA DENTAL
Journal
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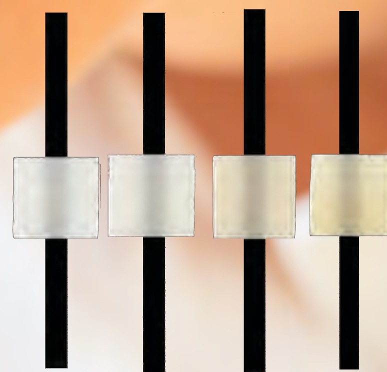

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A feature of the *Virginia Dental Journal*, "40 under 40" will introduce you to VDA members under forty years old in forty words or less.

40 UNDER 40

DR. NIELS OESTERVEMB

I spent 2 years doing a GPR and a Fellowship before buying Smiles of Virginia Family Dental Center in Winchester. The added knowledge and experience enables me to offer all procedures in house including implants, cosmetics, sedation and orthodontics.

Virginia Dental ASSOCIATION

American Association of Dental Editors & Journalists

VIRGINIA DENTAL JOURNAL

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

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PRESIDENT'S MESSAGE

Dr. Benita Miller

I am so excited and honored to serve as your President, and I hope you know how hard I will work to be an effective and accessible leader. We have been blessed with strong leadership over the years, and Dr. Vince Dougherty is no exception. He has done a fantastic job of strengthening our community, helping member dentists see the value in all the VDA has to offer, and helping to turn the tide in our membership. He is a wonderful mentor and inspiring leader, and I am so appreciative of all the time and hard work he has given over the years and especially this past year! Thank you so much, Vince! I'm going to do my best to carry on your initiatives.

We are an incredibly diverse group of men and women, and our demographics are continually evolving - we are new graduates just starting out; we are mid-career coming into our own; we are peak career hitting our stride; we are nearing retirement ready to enjoy some free time and transition to the next adventure in life. Our diversity is one of the most wonderful aspects of our profession! And we all have in common a vision of being professionally and personally successful and making a difference in our community.

The vision of the VDA is Representing and Serving Member Dentists by Fostering Quality Oral Health Care and Education. My vision for you is that you see the VDA as your home - your one-stop for all your professional needs - where you feel safe and welcome - where you feel we have your back - where you feel a strong sense of community. I want the VDA to be your "3rd place." I recently learned that Starbucks wants to be your 3rd place - home, work, Starbucks, but it really should be "home, work, the VDA!

The VDA is a place you instinctively go for whatever your professional needs, and they will vary depending upon your stage in school or in practice. Our Website has a wealth of information and resources at your fingertips - business resources, clinical resources, dental benefit information, peer review options, CE and volunteer opportunities, leadership training to name a few. We are working hard to continually improve the accessibility of information on the website - so go there as much as you can! It should be an automatic go-to place. Make sure you read the *The Chatter* and the *Virginia Dental Journal* to keep up to date on pertinent information and news! We have an amazing and caring Executive Director and team at the VDA office, and they all go the extra mile in service to our members. They continually look for ways that the organization can be more effective and efficient. Their expertise and help is just a phone call away, and you should take advantage of that. The VDA is here to help YOU - to be a better clinician, a better team member, a better practice leader - to help you achieve professional and personal success.

So what is the best way to benefit from all the VDA has to offer? It is to Engage. That leads me to my second hope for you, that every VDA member will engage in at least one meaningful activity over the year. Engagement is a catchy term. But what does it really signify? Engagement adds value because the more you engage, the more you benefit from that engagement. It's a lot like volunteering at a MOM project or seeing a patient through Donated Dental Services. How many of you have felt that you received so much more than you gave after such an endeavor, and it compels you to keep volunteering? Dentists are givers. We do all we can to make our patients' lives better. The more we engage, the more we feel a part of our patients' well being and feel that we are making a difference for them. The same is true of your engagement with VDA activities, resources, and community. So as Sheryl Sandberg has written in *Lean In* - get involved - you'll get so much more than you would have expected!

I encourage you to explore your areas of interest and learn more. We have so many opportunities to be involved. Sarah Mattes, our membership advocate, will be emailing you an interest survey. When you see that email, please fill it out! We hope to help you identify areas of interest where you can engage, in as little or as much time as you want.

Here are a few ways you can be involved:

- **Membership:** We want to continue our goal to increase membership by 5% and decrease non-renews by 5%. Make a connection and get a new member to join - think where we would be if everyone recruited just one new member!
- **Social and networking opportunities:** Go to component meetings. Look out for ways to make new members feel welcome and a part of the group.
- **Volunteer opportunities:** through MOM projects, Donated Dental Services, and Give Kids a Smile. We are the most dedicated advocates for optimal oral health care, and we need to continue to find solutions to access to care challenges.
- **Advocacy:** Keeping strong relationships with our legislators is critical; however, it takes time to develop and maintain these relationships. It can be as little as a morning, such as participating in Legislative Day on the Hill or as much as an ongoing effort, such as being a contact dentist for a legislator or hosting a fundraiser for your legislator. You can read more about some legislative issues on the horizon in my interview by Dr. Roadcap. We always need to be prepared for a legislative initiative, and fortunately we have the most dedicated and effective lobbying team imaginable. Our success in the General Assembly is due in large part to their expertise, to our commitment to what's best for our patients, and to our good relationships with our legislators. In those circumstances, we need everyone to engage in a big way. We can all help! We will all benefit! As you would expect, none of this success comes without a cost, but the return on investment is tremendous. It's what keeps our profession from becoming a trade. What we all need to do is contribute to our VADPAC. It's never too late to give or to increase your level of giving.
- **Mentoring:** Become an Ambassador! Your impact on a new dentist is immeasurable. You can help that dentist to become part of our community, help them be included and get involved, and help with their leadership development. I wouldn't be here if it weren't for my mentors who asked me to come to meetings, who called me to get involved on a local and on a statewide basis. They helped me see that I could contribute and make a difference in my profession.

We need to "tell our story". It defines who we are as an individual, as an association, and as a profession. We are a living, breathing organization of people who care for each other and our communities and our profession. We need to develop a written document that's available on the website and with open access for all. It's important that the public, that our legislators, that our member dentists know all the great work we do for our profession and our community. We tend to run quietly under the radar, and that been fine in the past. Now, however, we have a number of other stakeholders claiming to be the advocates for oral health care in America, and so it is critical that our voice

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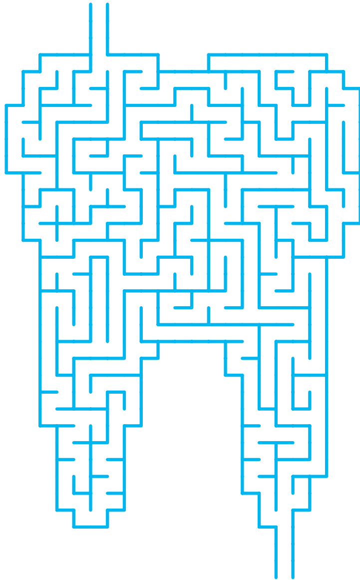

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is heard and that we remain known as the organization that truly advocates for quality oral health care.

The number one concern we hear from our members is centered around dental benefit plans, including decreasing reimbursement rates. I would love for us to have an in-house insurance consultant; ideally, someone who has previously worked with an insurance company and knows how they think, someone who could help with insurance questions and gather data from our insurance concerns. Use of that data will give us more traction when contacting the insurance commissioner or our legislators. We plan to explore the benefit and feasibility of having a full time in-house insurance consultant. This could prove to be one of our most valued benefits for our members. In the interim, we also plan to facilitate a meeting between the VDA, the Bureau of Insurance, and third party payers in an effort to work through some of these dental benefit issues.

With all the issues coming before us, we want to continue to strengthen our lines of communication between VDA leadership and component leadership and vice-versa so that we are all on the same page all the time.

I think back over the years from when I was a new dentist. How the profession has changed! The constant is the VDA. I have made lifelong friends at home and all over the state. No other organization has helped me reach my professional potential. We certainly have some serious challenges to our profession but with these challenges come great opportunities to strengthen our core and our values and make our profession stronger. Leadership is more than just having a leader. It's about inspiring others to lead. We're all in this together. This is OUR profession and YOUR VDA. We need to operate in an environment of abundance, not one of scarcity and doubt. We need to work together to strengthen our profession and to move it forward for our next generation. Young dentists out there - you are our future! You have a special energy that's wonderful to see! We need your engagement and your solutions to present and future challenges!

Thank you to all of you for allowing me to serve. Here's to a wonderful year together!

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Dr. Terry Dickinson, VDA Executive Director, Business Manager
Date: September 25, 2017

AN INTERVIEW WITH VDA PRESIDENT, DR. BENITA MILLER

Virginia Dental Journal: Why does Dr. Benita Miller want to be president of the VDA?

Dr. Benita Miller: I have always been one of those people who likes to be involved. It's just my nature. As far back as high school and college, I was involved in leadership roles. Although it seems like yesterday, I was asked to be a member of the first New Dentist committee for the VDA. A number of presidents have come out of that original committee and ones to follow. I was raised with the core belief that "to whom much is given, much is expected". We all have a responsibility to use our skills to strengthen our profession and move it forward. Our VDA is a wonderful community, and we want to mentor our younger members and prepare them for leadership.

VDJ: If you could change one thing in organized dentistry, what would it be?

Dr. Miller: I wish that every one of our dentists could appreciate the value of all that the VDA has to offer. It seems that no matter how hard we try to communicate that value, it just doesn't seem to reach everyone. When I first joined the ADA/VDA/RDS, our component meetings were packed, and our group was very involved. It would be great to see the pendulum swing back to more involvement on a local level. There's so much value to that face to face interaction.

VDJ: Name one event in your life that confirmed the value of membership to you.

Dr. Miller: I don't know of any one particular event as much as a host of events that confirmed the value of membership to me. One would be members who took an interest in me, and from those initial interactions, life-long friendships have grown. Another is the ability to give back to my community through MOM projects and Donated Dental Services. I also love being able to give back to my profession through involvement in local and statewide activities.

VDJ: Membership in organized dentistry, as measured by "market share", continues to decline. What will you do as President to stem the tide?

Dr. Miller: Actually, over the past year through a lot of hard work by a lot of people, we've turned a corner! We have increased the number of new members and decreased the number of non-renews. Two components increased membership by our goal of five percent, and five more components have increased membership by 1-3 per cent. We're starting to see an upward trend that is very encouraging. We want to continue the efforts of the Council on Membership, the Non-Renew Task Force, our VDA staff, and of our members in general who are working so hard to recruit and retain new members. We've officially rolled out the Ambassador program, and I encourage all who are interested to become an Ambassador and mentor a new dentist. Keep in mind you don't have to wait until you are an "older" dentist to be an Ambassador – anyone interested in mentoring a new dentist can be involved!

VDJ: What legislative issues will the VDA face in 2018? How will you address these?

Dr. Miller: There are two possible legislative initiatives on the table. The medical director of the Lenowisco and Cumberland Plateau Health Districts needs help finding dentists to staff the existing health clinics in these districts. A coalition in Southwest Virginia is pushing for the creation of a mid-level provider to man these clinics instead of a dentist. In an effort to help provide a solution, we have met with the Health Director and also with the Secretary of Health and Human Services to ask that funds originally allocated to dental care be re-allocated to this area so that there will be adequate long-term funding for dentists to staff these clinics. If the Secretary is not able to re-allocate those funds, then we will proceed with a legislative initiative to add this funding as a line item in the state budget. The other possibility addresses a recent vote by the Board of Dentistry to create an alternative pathway to licensure allowing PGY-1 graduates (at least one year of a post dental school education at a CODA approved program) to be licensed in the state of Virginia without ever having taken a clinical exam. Six other states allow this alternative to a clinical exam. Our VDA policy supports the present Virginia statute that requires passage of a clinical exam in order to be eligible for licensure. A requested change in the statute by the Board of Dentistry will come before the General Assembly in 2019, so that gives us a year to work with our legislators to communicate our message. We will need lots of "boots on the ground" from our members to help with both of these issues!

VDJ: You're a specialist in periodontics. What is your opinion of court decisions that may challenge the nine recognized dental specialties?

Dr. Miller: The ADA has long been the organization that sets the standards by which our specialties have been recognized, and it is to the benefit of our profession that the ADA remains the benchmark by which these standards are established. The ADA is updating the specialty recognition process, and a commission consisting of 9 general practitioners, 9 specialists, and 1 public member has been formed to address this need. Hopefully potential specialty organizations will apply or re-apply for recognition in the future.

VDJ: The ADA has proposed an Objective Structured Clinical Examination (OSCE) for licensing dental graduates, thereby eliminating live patient exams. What is your opinion of this proposal?

6 Continue Reading

5 Continued From

Dr. Miller: I like it! First of all, the OSCE has been used for a number of years for other health profession licensure, including medicine. The test is a standardized method of assessing your clinical judgment in a variety of situations, in contrast to subjective performance on a live patient (an assessment that is much more prone to variability and chance on a given day). The dental OSCE can include mannequins, radiographs, dental models, photographs, and haptic feedback devices as some of the methods of testing. The ADA is developing one standardized exam that will be offered to all state boards for use by 2020. The dental OSCE allows us to move away from live patient exams and maximize dental license portability throughout the country while also providing the most accurate assessment of a graduating student's capability for dental practice. I encourage everyone to go to ada.org and search OSCE FAQ for more information.

VDJ: The average dental student in the US graduates with educational debts of $250,000 to $300,000. What would you say to a new graduate to justify the expense of ADA membership?

Dr. Miller: How can you afford not to? It's the best money I've ever spent. Fortunately the dues are graduated in the first few years of membership, allowing new dentists to benefit from all the ADA and VDA has to offer. For full dues paying members, the tangible benefits alone, such as student loan refinancing, use of endorsed vendors, savings on CE costs more than offset the cost of full dues. The ADA Center for Professional Success provides business and practice management resources at your fingertips –saving you valuable time and money and helping you be as financially and professionally successful as you can be. The intangible benefits are priceless – networking, making life-long friendships, leadership development, making a difference in your community. There's no doubt in my mind that being a member of the ADA/VDA/RDS has helped me reach my potential in a way that I never could have otherwise.

VDJ: Do you have mentors? Who are they?

Dr. Miller: I have been blessed with some very special mentors and supporters over the years. First and foremost are Anne Adams and Charlie Cuttino, who got me involved both locally and statewide, and who are two of our closest friends. Ron Tankersley, Tom Cooke, and Les Webb have also encouraged and me professionally and personally, and Terry Dickinson has been an inspirational mentor and role model. I've been surrounded by an amazing support group including Linda Simon (RDS), our VDA staff, my long-time friend and practice partner Claire Kaugars, my family, and most importantly my husband Mike.

VDJ: What do you hope to be doing five years from now?

Dr. Miller: Sitting on a beach, watching the sunset! Just kidding! While I hope to be having some R&R, I plan to continue doing what I love to do for as long as I can. Over the years, we've developed close relationships with a number of our patients; I can't imagine not seeing them on a regular basis. I hope to keep learning and growing – it's what keeps life interesting. Our daughter is very interested in a career in dentistry as are a number of children of fellow dentists/ friends. We would love to be around to mentor all of them!

Editor's Note: Dr. Miller was interviewed September 16,2017, at the Virginia Meeting in Hot Springs.

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TRUSTEE'S CORNER

INDIVIDUALIST OR COLLECTIVIST?

Dr. Kirk Norbo, ADA 16th District Trustee

The ADA recently completed a business review of the association to determine its long term financial sustainability. The company, Frog Design, Inc. (https://www.frogdesign.com/) was hired as a consultant to do this business assessment and come up with a plan to assure the ADA's viability. I think one of the most interesting findings was that our members can be classified into two groups: individualists and collectivists.

Collectivists can be defined as dentists who join the ADA because they believe in the collective welfare of the group. They feel that it is important to be part of a larger group that oversees our profession. It is their duty to be a member and expect all dentists to join. The success of our profession lies in our ability to stay unified. Collectivists believe that strength in numbers is essential for dentistry to maintain its professional status.

Individualists look at the ADA from a different perspective. These members continually ask what the ADA is doing for them. They assess the value of an association membership primarily against personalized benefits they receive in exchange for their dues. Many of these dentists are strongly entrepreneurial in nature and are more focused on the business aspects of their practices than collectivists. This is not to say that collectivists aren't good business people, but they have a common interest in preserving the welfare of the dental profession.

The reason this distinction in member traits is so important is that there seems to be a correlation as to who is more likely to be a lifelong ADA member. You probably guessed by now that collectivists are the more stable members when it comes to longevity. Individualists are more likely to drop membership and seem to have more of the "what have you done for me lately" mentality. Taking this into consideration, frog has proposed some business ideas that specifically target individualists.

So where do you stand? Do you consider yourself more of a collectivist or individualist? I would venture to guess that if you are a collectivist, you would never think twice about paying your ADA dues each year. On the other hand, if you have more of an individualist stance, more thought goes into the value of membership and ultimately whether to pay your dues. This analysis is in no way criticizing your personal beliefs or reasons why you are a member but rather what entices dentists to join and more importantly remain members for their entire careers. Based on these two member profiles, frog has recommended that the ADA focus its attention on the needs of individualists since they are more likely to drop membership. There is obviously a large overlap of the needs and expectations the association must fulfill to keep collectivists and individualists satisfied so there is no concern that the collectivists will be neglected if the individualists are the targeted group. As we move forward, our hope is to attract dentists motivated by individual benefits with a focused value proposition to grow membership without undermining advocacy for the collectivists.

These are challenging times for the ADA and all associations for that matter. It has become clear from frog's detailed look at the association's business practices that member dues will not be able to keep pace with the expenses required to deliver services that members have enjoyed. Non-dues revenue must account for approximately 65% of ADA income if the association is to remain on solid ground. This realization has led the Board of Trustees to consider some business proposals that will help generate more non-dues revenue. The mindset of the ADA leadership and staff is very optimistic about the long term sustainability of our association and is willing to make some revolutionary decisions to assure our future success. Stay tuned as we transition into 2018. Great things are ahead and I look forward to having your support as the ADA continues to grow.

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MESSAGE FROM THE EDITOR

Dr. Richard F. Roadcap

Thornton Wilder's three-act play, *Our Town*, takes place in the mythical Grover's Corners, New Hampshire. The narrator, or Stage Manager, is a central figure connecting all parts of the production from beginning to end. While discussing all the changes around town, he comments, "You'd be surprised, though – on the whole things don't change much around here."

Such has been the relationship between general dentists and specialists for most of my career. We have the nine ADA recognized specialties (http://www.ada.org/en/education-careers/careers-in-dentistry/dental-specialties/specialty-definitions), as approved by the Council on Dental Education and Licensure:

- Dental Public Health
- Pediatric Dentistry
- Orthodontics and Dentofacial Orthopedics
- Endodontics
- Oral and Maxillofacial Surgery
- Oral and Maxillofacial Pathology
- Oral and Maxillofacial Radiology
- Periodontics
- Prosthodontics

Dental specialists limit their practices to the confines of their advanced training, and general dentists have a (reasonably) clear understanding of which specialty is most qualified to provide treatment that is beyond the generalist's training and abilities. Yet, there is a great deal of overlap among the specialties, and between treatment provided by general dentists and specialists. For example, most general dentists perform biopsies, as do oral surgeons, periodontists, oral pathologists, and pediatric dentists. I don't know of any general dentist who holds themselves out as qualified to provide pathology reports on tissue specimens, as this procedure is almost always performed by an oral pathologist, or a pathologist physician (M.D.). And among specialists, we see procedures performed that are most commonly rendered by other specialists: oral surgeons doing endodontic procedures; periodontists extracting teeth; pediatric dentists providing orthodontics; and prosthodontists placing implants.

It's my opinion that the advent of osseo-integrated implants over twenty years ago did much to blur the lines between generalists and specialists, and the lines between the ADA-recognized specialties. Implants, as we all know, are multidisciplinary, incorporating the science of general practice, oral surgery, periodontics, prosthetics, and even endodontics, whose diplomates are called upon to render judgment on whether or not a particular tooth can be salvaged.

Just when we thought we had an understanding of life in Grover's Corners, along comes the American Board of Dental Specialties, http://dentalspecialties.org/member-boards/ representing four groups whose efforts at ADA recognition have fallen short:

- Implantology/Implant Dentistry
- Oral Medicine
- Dental Anesthesiology
- Orofacial Pain

Litigation against state dental boards in California, Florida, and Texas has led to court decisions in favor of ABDS member groups, on the grounds that state-enforced practice acts recognizing only the nine ADA-recognized specialties have violated the plaintiffs' rights under the First (freedom of speech) and Fourteenth (due process) Amendments to the US Constitution. What the ADA House of Delegates has declined to do, the federal courts have undertaken as their mission. A specialty seeking recognition must garner the approval of the House, following recommendation by the CDEL and the ADA Trustees.

Where does this prospect for change leave general dentists, who want no more than the best available specialty care for their referrals? As it stands now, we're in a quandary. Would our patients be better served, when implants are placed, by a specialist in implantology than the care rendered by an oral surgeon or a periodontist? Does the standard of care require that every patient with occult symptoms and pain that defies diagnosis be sent to a doctor with advanced training in orofacial pain? Our patients often fail to comprehend the nature of specialty care when referred, confusing one (ADA-recognized) specialty with another and as a result, fail to act upon our recommendations. All general dentists have encountered the situation whereby a referral to a board-certified specialist resulted in treatment being rendered by another general dentist, who according to the patient's friends and relatives, "specializes" in just that procedure. Of course, there was no evidence that the attending was touting himself or herself to be a recognized specialist; only that they were willing to undertake the procedure that the referring dentist chose not to.

I entered dental school in 1973 (that's right, do the math). Both then, and now, the cornerstone of dental care delivery and dental education has always been the highly-trained, versatile general practitioner. Some well-heeled foundations believe an ever-so-lightly trained "mid-level" can solve our nation's dental care needs, but that's a subject for another time. If additional specialties are recognized, there will be winners, losers, and some confusion before referring doctors know what can be expected. I can't say if new specialties will be an asset to the profession or not. It's hard to predict the outcome of changes in healthcare standards. Some say the practice of medicine has too many specialties, but others say it was inevitable given the demands placed on their profession.

I can foresee a day when specialists are allowed to perform an expanded range of functions formerly the province of general dentists. The endodontists to whom I refer now have only temporary filling materials in their office, not an amalgam or resin in sight. In the future, will they be closing the access with an FDA-approved "final" restoration, with the blessing of the ADA and their specialty organization? Will orthodontists (or their staff members) place sealants, fearing the onset of decay before the patient's next recall? Will oral surgeons not only place implants, but also restore them with one of the all-in-one kits now available? Relationships among generalists and specialists could become less collegial, at least for an interim period.

Meanwhile, back in Grover's Corners, as the Stage Manager says, "In our town we like to know the facts about everybody." I do expect the profession and organized dentistry will continue to place the interests of patients and the public ahead of parochial concerns. The ADA has already formed a commission of nine specialists, nine general dentists, and one public member to study the issue of new specialty designations, and to make recommendations. The ADA's website comments on prospective specialty groups, saying "Not all areas in dentistry will satisfy the requirements for specialty recognition. However, the public and profession benefit substantially when non-specialty groups develop and advance areas of interest through education, practice and research. Acknowledged by the profession, the contributions of such and their endeavors are encouraged." As a late-career dentist, were the changes enacted tomorrow, there'd be little impact on me. But, for young and mid-career doctors, there's much drama ahead.

LETTER TO THE EDITOR

YES, YOU **DO** NEED TO SWEAT THE LITTLE STUFF!

Henry Botuck, DDS

I'm referring to the issues of safety, and infection prevention. Sterilization and disinfection are the unsung centerpieces of your practice. If your staff takes shortcuts and/or disregards what they think are minor steps in infection prevention and office safety, it is not only the patients who might suffer, but it is YOU who will be in the crosshairs for condemnation. When the lead story on the 11:00 p.m. news involves the patients or staff members who contracted some illness in your office, it could destroy your practice. You and your staff have to realize that minor shortcomings can easily combine and morph into major lapses: "the perfect storm", if you will. And if your lack of diligence allows this to happen, you deserve to lose whatever time, money, and reputation it costs you. You are the captain of the ship. You get the glory *and* the shame!

When was the last time that you *actually observed* your assistant performing **all** of the steps in the sterilization process, and **all** of the steps in disinfecting the room after the patient exits? Occasionally you need to check to see that no shortcuts are being taken, especially if there has been a change of personnel in the past few months. When a new staff member is trained, you almost always can count on some step or concept being lost.

It would benefit the office to have the infection control and safety protocols down in writing--- and in detail. Step by step, how to clean up after each patient, and what to wear when doing so. What materials to use, and how to use them. What to throw away, and where to dispose of different kinds of trash. Step by step, how to clean instruments before sterilization. Step by step, how to package and sterilize instruments. How to store them, etc., etc. Then, when you get a new staff member or need to call upon a temporary employee, the recipe is right there in front of them to follow. No missed steps!

To compile it, outline the topics and have your staff fill in the steps …… in minute detail. Have everyone discuss the steps, add or subtract some, and finally agree on what the end product will be. Then place copies of the "bible" in the treatment rooms and sterilization area for ready reference. Because everyone has had input, they will be more inclined to adhere to the protocols. Everyone now "owns" it, and should know and understand the reasons behind each step. Knowing "why" underlines the logic of what is being done, and how each step fits into the overall picture. This is a one time major project that is well worth the effort. You just need to adjust the protocols when new equipment or materials are introduced. Keep it on your computer so that it can be easily modified.

If you feel that you, personally, don't have the time to stay on top of things, then appoint an "Infection Control Coordinator" from amongst your staff. His/her duty would be to keep current on the topics of infection control and safety, and make sure that everyone adheres to the protocols. (The recommendation for creating such a position comes from both the Centers for Disease Control (CDC), and the Organization for Safety, Asepsis, and Prevention (OSAP).

Make sure that the topics of infection prevention and safety are discussed periodically to keep them fresh in everyone's mind. This is another job for the Infection Control Coordinator. In fact, it would pay for you to subscribe to the newsletter put out by OSAP. It is the only organization that concerns itself with keeping you and your auxiliaries up to date on infection prevention in the dental setting. Go to osap.org to see their newsletter and the other materials that they offer. Then subscribe. Your patients' health, your staff's health, and the health of your practice will benefit.

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VIRGINIA BOARD OF DENTISTRY UPDATE

Karen S. McAndrew, DMD, MS

LEARN

It may not be the most exciting aspect of clinical practice and patient care, but we all must verse ourselves in the information posed at the Board of Dentistry meetings. The website clearly states the mission of the Virginia Department of Health Professions "… is to ensure safe and competent patient care by licensing health professionals, enforcing standards of practice, and providing information to health care practitioners and the public." Understanding the role of the Board of Dentistry and guidelines is paramount to the practice of every dental practitioner involved in dentistry and patient care. The Board of Dentistry met on Friday, September 15, 2017 for their quarterly forum open to the public.

As with every meeting, the agenda began with open comment from members of the community. Dr. Karen McAndrew provided opening comments to the BOD on behalf of the VDA asking them to please delay the vote on licensure credentials. There is current ongoing research on this important topic and the VDA supports a clinical examination as the pathway to licensure. Dr. David Sarrett, Dean of the VCU School of Dentistry also requested a delay in voting to take this item to the state legislature until further clarification could be obtained on PGY1 status under CODA (Council on Dental Accreditation) standards. After suggestions by Dr. John Alexander to postpone the vote, the BOD ignored the VDA recommendation, the recommendation from the Dean of the VCU School of Dentistry, and the ADA, who has not finished evaluating this topic and formulating a recommendation. The request to postpone the BOD vote until more information could be presented and discussed on the issue of licensure, fell on deaf ears as the Virginia BOD voted 7-3 to move ahead and propose legislation in the 2019 session to permit licensure by PGY1. This means that a clinical exam would not be required to obtain licensure in the state of Virginia for individuals who may have taken a year of advanced training after dental school, and it is unclear as to the credentials of this PGY1 training.

With the new academic year, the BOD welcomed Dr. Alexander, president, Dr. Parris-Wilkins, Vice President, and Dr. Petticolas, Secretary-Treasurer and minutes of previous meetings were passed. Several important topics were discussed at this September 15 meeting. Paramount was the Opioid crisis in Virginia. All practitioners are encouraged to visit the VDH (Virginia Department of Health) website for information and regulations regarding the prescribing/monitoring of opiods. The Advisory Panel on Opioids, headed by Dr. Alexander, reviewed emergency regulation that is needed and ongoing monitoring and updates to dental pain management. Ms. Yeatts was instrumental in her explanation of ongoing legislation and regulation of this emergency crisis.

Updates and regulations were presented for routine SRTA testing. A proposal was made and being reviewed for adding SRTA to ADEX for the Hygiene clinical exam. ADEX (American Board of Dental Examiners) are routinely calibrated and changes to testing regulations are routinely defined. There was recognition that standardization for continuing education needs to be implemented and well understood for the new guidelines on remote supervision for dental hygienists. Any dentist interested in using remote supervision must comprehend and implement Virginia code 54.1-2722 relating to the practice of dental hygiene: remote supervision.

During the open comment session Dr. Jacques Riviere spoke on the topic of specialty recognition and the need for regulating the understanding of specialty training for the safety of the public. The BOD affirmed the regulatory language to follow what is currently stated in 54.1-2718. The BOD will be clarifying the language while following existing 54.1-2718 of the Code of Virginia.

Administration of Sedation Guidelines were reviewed and necessary language was implemented and adopted into guidelines for practicing dentistry. The ADA firmly stands behind its efficacy guidelines in adult conscious sedation. The AAP/AAPD and ADA are in support of the importance of capnographic measuring in the monitoring of the moderately sedated patient and AAOMFS has required capnography for monitoring its moderately sedated patients since 2014. All practicing dentists who administer sedation must follow ADA protocol and training and meet all requirements of the Virginia Department of Health Board of Dentistry.

DAII was another topic for discussion among BOD members. While few have pursued this path within the dental profession, guidelines are changing as to the requirements for obtaining dental assisting II status. The BOD plans to amend the requirements for DAII training and implement a competency-based program. Those interested in the DAII pathway to patient care should make themselves familiar with the upcoming regulation changes.

On another positive note, Ms. Sandra Reen, Executive director of the BOD, recognized a surplus of revenue and will be entertaining ways to utilize the overage. There will also be an upcoming change to renewal date for licensure occurring in 2019 on the birth date of the renewer. This is expected to reduce financial expenses for maintaining licensure. Keep posted on ongoing discussions regarding the definitive dates for this change.

Without a doubt, dentistry is one of the most rewarding health service professions. Stay tuned for more exciting changes on the impact to the profession and stay current with the dynamics of dentistry. Visit the BOD and the Virginia Department of Health websites regularly. It certainly is an exciting time to be in the profession and the BOD bridges practice with safety as we are all honored to be on the same caring team.

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

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ETHICS: WHEN IS "GOOD ENOUGH" NOT GOOD ENOUGH?

Dr. Dana H. Chamberlain

One of the perks of being on the Ethics Committee is being offered the "opportunity" to write an article on the subject for the *Virginia Dental Journal*. My research began with the ADA's "Principles of Ethics and Code of Professional Conduct with Advisory Opinions", a truly ponderous tome that took me three or four attempts before I could get through it without falling asleep. However, it did turn out to be a valuable and worthwhile exercise.

There are five principles,

- Patient Autonomy (Self-Governance)
- Nonmaleficence (Do No Harm)
- Beneficence (Do Good)
- Justice (Fairness)
- Veracity (Truthfulness)

To each is attached the elements of the Code of Professional Conduct that apply ("Thou Shalt" and "Thou Shalt Not"). In addition there are a set of advisory opinions for each, interpretations of the code that have arisen in response to specific situations.

I also read the "Ethics Handbook for Dentists" from the American College of Dentists (another sleep-inducing tome) and Atul Gawande's charming and enlightening book *Better: A Surgeon's Notes On Performance* as well as a few, intimidating, but well-written, journal articles on ethics.

Merriam-Webster's dictionary defines ethics as "a set of moral principles", "a theory or system of moral values" and "rules of behavior based on ideas of what is morally good". It goes on to differentiate between morals and ethics. Morals describe one's "values as to what is right and what is wrong" and "connote an element of subjective preference". Ethics, on the other hand, "refer more broadly to moral principles as applied to correct behavior within a relatively narrow area of activity", such as dentistry, and tend to suggest "aspects of universal fairness".

If morals have elements of subjective preference and by extension can be modified by religious or cultural traditions, where are we to find aspects of "universal" fairness? We may not have to dig too deep. Christianity touts its "Golden Rule", a code of reciprocity that admonishes us to treat others as we would like to be treated. We Christians can be guilty of arrogantly thinking that this concept is unique to Christianity, but the reality is that statements to this effect prominently exist in virtually every religion, belief system and set of cultural traditions. Perhaps this is a good place to start our ethical decision making. Is this the kind of dentistry I would like to receive?

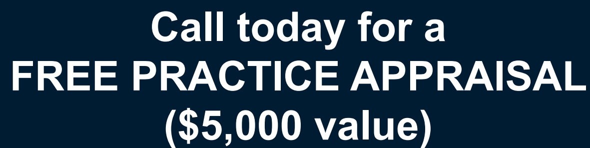
Our journey in "Ethics in Dentistry" began in school as our instructors hammered us on every step to every procedure to "get it right". This year I went to my 40th MCV class reunion. As I noticed some of our professors celebrating their 45th or 50th reunions (or even beyond), it occurred to me that the ones I have come to appreciate the most were the ones I tried to avoid in the clinic because they were so demanding. I recall an incident when the instructor (I believe it was Dr. Hugh Douglas) was evaluating an impression. He commented that it might be considered acceptable. He then handed it back saying that "since this is an 'academic exercise' perhaps we should do it again". I have thought about that a lot over the years as I have evaluated an impression or a preparation or restoration and asked myself, "If this were an academic exercise, would he suggest I do it over?" Dr. Douglas was certainly one of those instructors whose influence I have grown to appreciate more even as I silently cursed him for the thousands of dollars I have given up in remakes.

I don't think anyone would argue against excellence being the goal. It is a term frequently seen in promotional materials for various speakers and "institutes". But, what about "good enough"; is there a place for that? I think the answer may be "It depends". The "Ethics Handbook for Dentists" from the American College of Dentists clearly states "Good enough" is not good enough. However, in the very next sentence, it continues, "It must be the 'very best' service under the circumstances." Anyone who has practiced dentistry for more than a week can tell you about circumstances, such as mission work in situations with limited instrumentation and poor lighting. I had a patient with a prior injury that created scar tissue on one corner of his mouth that wouldn't stretch, limiting access. Patients also present with challenges like significant gag reflexes, large protective tongues, flood tides of saliva and severe tremor disorders to name a few. The "very best" we can do under these circumstances is not likely the very best we could do in ideal situations; but, couldn't it, perhaps, be considered "good enough"?

Many youth organizations that stress character development, such as Scouting and Little League, emphasize striving to do, not necessarily the best, but your best. I like to think of myself as a reasonably competent dentist, maybe even above average. However, I doubt that many of our colleagues that see my work would confuse me with the likes of Drs. Pete Dawson, John Cranham, Baxter Perkinson, Frank Spear or any of the others in my pantheon of dental heros. Listening to our heroes and reading publications like the AACD (American Academy of Cosmetic Dentistry) Journal can be humbling, if not ego-deflating. We do so, not just to see what others can do, but because it inspires and guides us to improve what we can do. Dr. G. V. Black said "Every professional person has no right to be other than a continuous student."

As I look back over this rambling treatise, I struggle to find the point. Maybe it's that I agree with Dr. G. V. Black. The dentistry I provided 40 years ago was adequate for its time. The dentistry I am providing this year is better, but can still be improved. All of us are ethically bound to strive to make our "good enough" better. Our patients deserve nothing less.

Editor's Note: Dr. Chamberlain, a member of the Ethics and Judicial Affairs Committee, practices in Marion.



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HOW TO CREATE HIGH-CONVERTING DENTAL PRACTICE WEBSITES

Melissa Mickelson, Senior Marketing Manager, ProSites

Is your dental website helping you attract new patients from the Internet? If you answer is “no,” or “I’m not sure,” this article is for you.

Most companies create a website to simply share information about what they do, which is a step in the right direction, but your dental website cannot simply stop at informing people of the services you offer. It must be designed and written in such a way that helps visitors make the decision to reach out and initiate contact with your practice.

We’ve compiled the top dental website best-practices to help you learn which small changes to your website can have a big impact:

- **Have a compelling design.** Your online visitors will decide in less than three seconds if they want to stay or leave your website. Make sure people immediately see you as an up-to-date, valuable resource by having a professional design with images that resonate with your target audience. If you haven’t updated your website in the last few years, now may be the time to see if there’s a newer option that you should consider.
- **Write engaging content**. Once visitors decide they want to stay on your website, you’ll want to provide them with educational content that serves several purposes:

    A. Educate visitors on the services you offer.
    B. Help visitors understand why you’re different and why they should choose you.
    C. Communicate your expertise and credentials.
    D. Utilize keywords to help your rankings online.

    It’s important to come across as being very thoughtful and organized. Make sure your content is arranged in such a way where there’s one main topic per page.

- **Strong calls-to-action and forms.** Every website page should end with a strong call-to-action to tell the visitor what you want them to do. Include an appointment request form or a contact us form to make it easy for potential patients to send you their information and initiate contact with your practice.
- **Keep forms short.** If you have a form on your website, make sure to only ask the need-to-know questions to increase the likelihood of people completing the form. If you can, stick to the basics, such as name, phone number, and email.
- **Be mobile-friendly.** More people are on smartphones today than ever before, and it’s critical for your website to appear correctly (and quickly) on a mobile device. Mobile-friendly websites have enlarged text, smaller images for quick load times, and thumb-friendly buttons to make it easy to navigate around the website.

Article written by Melissa Mickelson, Senior Marketing Manager at ProSites. ProSites is endorsed by VDA Services for their website design and online marketing solutions including search engine optimization (SEO), social media, and pay-per-click advertising. VDA members receive 25% off the standard website set-up. For more information, or to start a free trial, call (888) 932-3644 or visit www.ProSites.com/VDA.

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</DATA BREACH>

INFORMATION SECURITY IN THE AGE OF THE DATA BREACH:

PCI NON-COMPLIANCE CAN BE COSTLY

Jennifer Nieto, President RJ Card Processing Inc, d/b/a Best Card

Every few months it seems like there are more revelations of large scale data breaches that expose the personal or financial information of millions of Americans. In 2017 there have been breaches of Arby's, Verifone, Dun & Bradstreet, Saks Fifth Avenue, Intercontinental Hotels Group, Chipotle, Kmart and Verizon[1] that have resulted in credit card numbers or personal information being obtained by malicious characters.

The following graphs, compiled by the Identity Theft Resource Center[2] (a non-profit advocacy group), states that the healthcare industry is one of the largest targets for data breaches. By far the largest threats to data security are hacking, skimming and phishing.

- **Hacking** normally involves obtaining credentials to install malware that can monitor and extract sensitive information.
- **Skimming** is the process of attaching a physical device in the card processing environment to duplicate and steal the data.
- **Phishing** is the practice of sending fraudulent emails or phone calls purportedly from a reputable company to get individuals to reveal information such as passwords, personal information or credit card numbers.

To address these issues, the credit card industry has responded with a set of guidelines called **Payment Card Industry (PCI) Compliance** to ensure that any business that accepts credit cards has implemented secure procedures to protect transmission of card information. PCI Compliance is a requirement for any business that accepts credit cards, but the actual requirements that your business must meet is determined by the equipment and the method of communication used in processing.

As part of PCI Compliance, every business must complete an annual **Self-Assessment Questionnaire (SAQ)** unique to the processing environment. For example, a stand-alone credit card terminal that attaches over an analog phone line has a very simple SAQ that focuses on in-office procedures to protect credit card data. This is because the terminal encrypts all information at the point of entry and then sends the information over an analog phone line which are much more difficult than IP connections for hackers to actively monitor. If your office uses a credit card processing terminal that connects over the internet or through your computers, not only will you have a more demanding SAQ that will ask about your network security, you will also be required to perform quarterly external PCI network scans to ensure that your network is secure from tampering.

PCI Compliance will usually be handled by your credit card processor even if they use an industry-approved PCI subcontractor. However, it is the merchant's responsibility to make sure that their business has completed all the required steps to achieve compliance. While some credit card processors are very proactive in helping dental offices attain compliance, many don't view it as their responsibility. When Best Card reviews statements from dental offices to prepare cost comparisons, approximately 60% of dental offices are being charged monthly or quarterly PCI Non-Compliance fees. Best Card averages 90% PCI compliance for our dental offices and charges approximately 25% of the annual cost other processors do for PCI compliance.

Having worked with thousands of dental offices for their PCI compliance, below are some helpful tips for any dental office to avoid PCI issues, maintain security, and identify calls from scammers trying to get information.

18 Continue Reading

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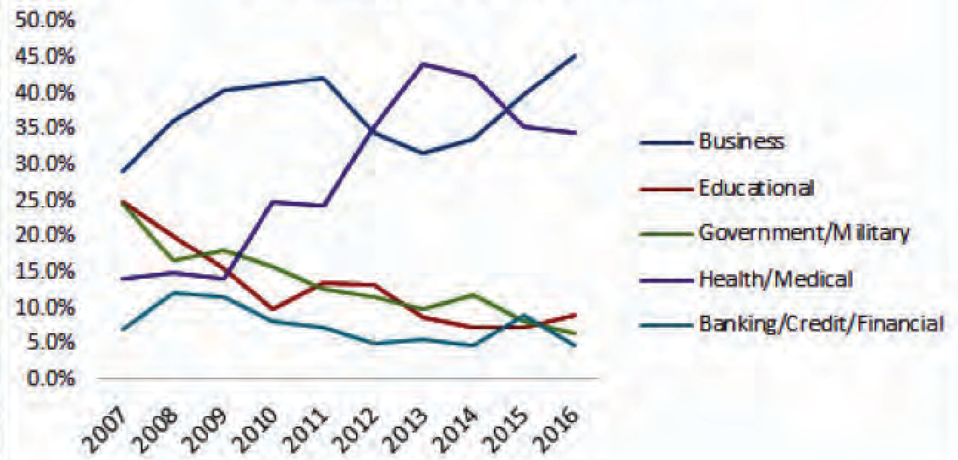
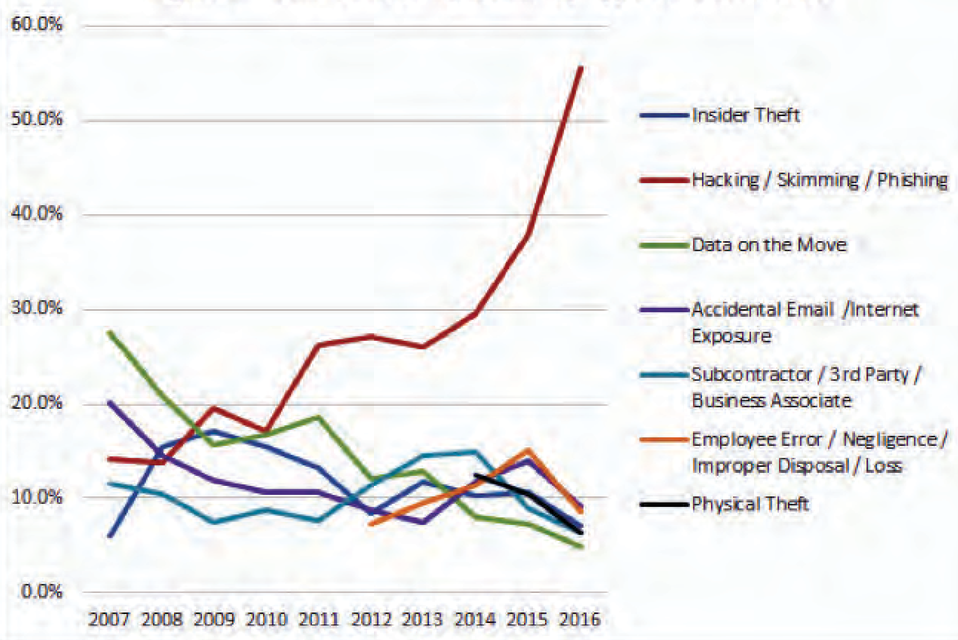
1 Daitch, Heidi. "2017 Data Breaches – The Worst Breaches, So Far." Identity Force. N.p, 11July 2017. Web. 14 July 2017

2 "Identity Theft Resource Center." ID Theft Center. N.p., 19 Jan. 2017. Web. 14 July 2017.

17 Continued From

- If your office stores physical credit card numbers, be sure to **keep all card information locked up when not in use** and to shred any card numbers once no longer required for business or legal reasons.
- If you have your office phones connect over IP (instead of analog phone lines), your router must separate phone activity from the rest of your office internet activity. While this should be common practice, many internet service providers such as Comcast, AT&T, etc. have not updated the firmware on the routers that they offer to businesses to be compliant with this practice. Currently you can receive a waiver for this vulnerability to achieve PCI compliance, but beginning January 1, 2018 these routers will no longer be compliant without an update.
- Change passwords to systems if you have an employee leave. Former employees might login remotely and run fraudulent refunds to their own credit cards.
- Never store card numbers on a computer unless they are being stored in an encrypted format (where you cannot see full credit card number) by a PCI approved software/gateway/processor.
- **Be very careful when giving access to your passwords** or allowing others to remotely login to your office computers. We have had offices that have called us after "Microsoft" called and said that they immediately needed to login to their computers. This is a common scam used to compromise your network and install malicious programs.
- We have had offices call us because "PCI" called and demanded to see a copy of their PCI Scan report. Any PCI compliance steps would be handled in conjunction with your processor, **there are no "PCI police" that would call you by phone.** Giving away this information would essentially give a roadmap to hack your office network.
- **There are many unscrupulous credit card processing companies** that will call and say that your equipment or your network is not PCI compliant. They may even say that they need to do an "update" to your terminal and give you something to sign. Unless this call is coming from your credit card processor and they can provide your merchant number, this is an underhanded solicitation. The caller will have no information on the integrity of your systems unless you give it to them. These companies will try to scare you into signing a new agreement that usually has expensive costs and punitive contract terms.
- **MasterCard has begun issuing credit cards that begin with a two (previously all MC began with a five) and some terminals need an update to accept these new cards.** At Best Card, most of our terminals/online software systems auto-updated but we did have to re-download our VX520 terminals. **MasterCard wanted updates completed by 6/30/17 and can assess non-compliance fees of $2,500 per occurrence in the first 30 days,** escalating to $10,000 in the next 60 days and up to $20,000 per occurrence for subsequent violations, but Mastercard will send a warning before assessing fines. If you get sales calls saying you are non-compliant and may get fined, there might be some truth to this and you should check with your present processor.





Data security and PCI compliance are an ever-changing part of the business environment, but with reasonable preparations and updates it should be very manageable! If you have any questions about PCI compliance or the credit card processing industry in general, feel free to reach out to Best Card at (877) 739-3952. **If you have a recent statement from your credit card processor and would like a detailed, no-obligation cost comparison, you can send the statement via email to CompareRates@BestCardTeam.com or fax to 866-717-7247.** Best Card is the endorsed credit card processor of the Virginia Dental Services as well as 25+ dental associations nationwide.

HONORING OUR VETERAN

A HUMAN INTEREST STORY

Charlotte Hawley, RDH

It seemed like your average dental appointment. A visit to the periodontist yielded an evaluation and concentration on the reason for referral, a crown extension procedure. Who would have known that this chance meeting with Dr. Abe Shait and his wonderful dental team would result in fulfilling the longtime dreams of his new patient and an honored WWII veteran?

Mary Mealy, Dr. Shait's dental assistant has the gift of gab. One day she comes flying into my operatory and announces – "Hey Char, wait until you hear this guy's story. You are going to love him!!"

What an incredible story he had to tell. James Jalbert was a World War II bomber pilot who flew over 58 missions for the Army Air Corps. Nicknamed "Moose" in the service, his plane was fondly called *Daisy Mae*…. He held a rank of first lieutenant..

He drove himself to his dental appointment, using only a walking stick to steady his gate. How lucky were we that this true American Hero chose us (or maybe there are no coincidences).

Dr. Shait, at one point, asked Mr. Jalbert what he thought of the World War II Memorial in Washington, D.C. James stated he had never seen it and probably never would in his lifetime. The little twinkle in his eyes faded.

Dr. Shait, rallied his staff and declared this could be remedied. Then he stated he was a man with a van (the Shaits had just replaced their old one) and a plan!

As many times as I have shared this story, I still become teary eyed. Dr. Shait told our World War II hero he would be glad to take him to D.C. to the Memorial. James's jaw dropped open and his mantra was, "You would do that for me? You would do that for me?" The twinkle had returned along with a pure love for his new friend and new adventure.

Two weeks later, on a Monday, July 24, 2017, Dr. Shait closed the office, personally drove to James's home and the journey began.

As Dr. Shait escorted our hero with our private guide, Joe Gaziano, a retired Army veteran himself, around the World War II memorial, Mr. Jalbert became an instant "Rock Star".   This was a place where religion, race or age did not matter. One shy guy in his twenties timidly asked if he could shake his hand. "Yes, please come meet him, he won't bite." He leaned over and said, "Thank you for my freedom sir." His fans were swarming around him like bees to honey.

The heat did not deter him from picnicking under a shade tree in front of the memorial. James said, "Until today I thought no one cared any more… but they do care". Salutations included "Thank you for keeping me safe, thank you for serving our country and thank you for being here today."

We headed over to Arlington Cemetery where Mary had secured a driving pass. After witnessing a full military funeral with a caisson, we asked James how many missions was the average for a pilot. His only response was "some only had one".

Heading home he thanked us for a trip of a lifetime – I heard Dr. Shait say, "If you ever need to go anywhere, any time, I will get you where you need to be." Mary then asked would he rather be back in his cockpit in his bomber plane *Daisy Mae* or riding down I-95 with Dr. Shait., James didn't miss a beat and said he'd rather be piloting his plane, he said, "Dr. Shait you know you're a tailgater."

How fortunate in our great dental profession that we have a chance to meet many people and hear these stories, and everyone has a story. It can be the simplest acts of kindness that make a difference. All it takes is to take the time to listen like Dr. Shait did to James's story. Every time a patient walks through your doors, it's an opportunity for a random act of kindness. Charity begins at home and our patients are part of our family.

September 11, 1920 is Mr. Jalbert's birthday…. maybe there are no coincidences.

Editor's note: Dr. Abraham Shait is a periodontist practicing in Richmond, with his wonderful team Ms. Mary Mealy (dental assistant) and Mrs. Charlotte Hawley (dental hygienist).

The Daisy Mae Crew July 5, 1944. Lieutenant James Jalbert (left rear)

Left to Right: Mr Michael Hawley, Dr Abe Shait, Lieutenant James Jalbert, Ms. Mary Mealy , Mrs. Charlotte Hawley at posing during their trip to the WWII Memorial in Washington, DC.

SCIENTIFIC

SEVERE POSTOPERATIVE HEMORRHAGE FROM A FREE PALATAL GRAFT SITE:

AN ANATOMICAL EXPLANATION

Janina Golob Deeb DDS, MS, Danielle McCormack DDS,
Daniel M. Laskin DDS, MS, George R. Deeb DDS, MD

ABSTRACT
Severe hemorrhage is an uncommon complication following periodontal surgery. This case report describes severe bleeding from the donor site of a free palatal graft in an edentulous patient and provides an anatomical explanation for its occurrence.

INTRODUCTION

Because of the excellent vascular supply, hemorrhage is a relatively common complication following many surgical procedures in the oral cavity. Such post-surgical bleeding can range from mild and easily controllable to severe, requiring hospitalization. Extensive hemorrhage following most periodontal procedures is rare due to primary closure of the surgical site. (Druckman et al. 2001, Padya et al. 2012). However, in areas of densely attached mucosa, primary wound closure is not always possible due to the inability to mobilize sufficient adjacent tissue. This is particularly true for free palatal grafts. Harvesting of the free palatal graft leaves a large open wound with uncovered connective tissue in the donor site. Such areas are not only susceptible to persistent oozing of blood, but there is also the risk of injury to the greater palatine artery or vein during the procedure, leading to more severe hemorrhage. We report a case in which severe alveolar atrophy resulted in the donor site being located in the area of the neurovascular bundle and unrecognized vascular injury resulting in extensive postoperative bleeding.

REPORT OF CASE

A 62-year-old edentulous female presented to the Department of Graduate Periodontics at VCU School of Dentistry for placement of a free palatal graft on the labial aspect of two anterior mandibular implants to deepen the vestibule and increase the amount of keratinized tissue. The patient's medical history was positive for hypertension, hyperlipidemia and degenerative arthritis controlled with medications. She was currently taking pravastatin, Lotrel (amlodipine-benazepril) and meclizine for vertigo as needed. She denied smoking and reported occasional social drinking. She had undergone several dental surgical procedures in the past, most recently placement of the two mandibular implants, with no history for postsurgical complications. Oral examination revealed an extremely atrophic maxillary alveolar ridge and a flat palatal vault (Figure 1). Because of the resultant limited amount of available donor gingiva at a single site, it was decided to take bilateral grafts.

Local anesthesia was obtained with bilateral greater palatine and nasopalatine nerve blocks in the palate and infiltration in the mandibular recipient site using 4% Septocaine with 1:100,000 epinephrine. The donor sites were also infiltrated bilaterally for hemostasis. The recipient site was prepared by making a horizontal split thickness vestibular incision and repositioning of the mucosa inferiorly. Next, the rectangular-shaped palatal grafts were outlined bilaterally, extending anteroposteriorly from the palatal rugae to the area anterior to the greater palatine foramen and horizontally from below the alveolar crest toward the base of the palatal vault. The palatal grafts were then carefully dissected from the underlying connective tissue. The grafts were adjusted and attached to the recipient site with chromic gut sutures (Figure 2). Minimal bleeding was encountered during the operation. Following placement of the grafts, the patient's upper denture was inserted to protect the palatal donor sites.

Two hours later, the patient called and reported extensive bleeding from her mouth. She was urged to immediately return to the clinic. Upon arrival, she presented with a large "liver clot" in her mouth (Figure 3). The denture and clot were removed and the mouth was irrigated and suctioned. This revealed a small area of non-pulsating oozing of dark red blood, consistent with venous bleeding, from the right donor site. Local anesthesia was obtained and the bleeding was controlled with local hemostatic measures. Both donor sites were then covered with collagen tape saturated with

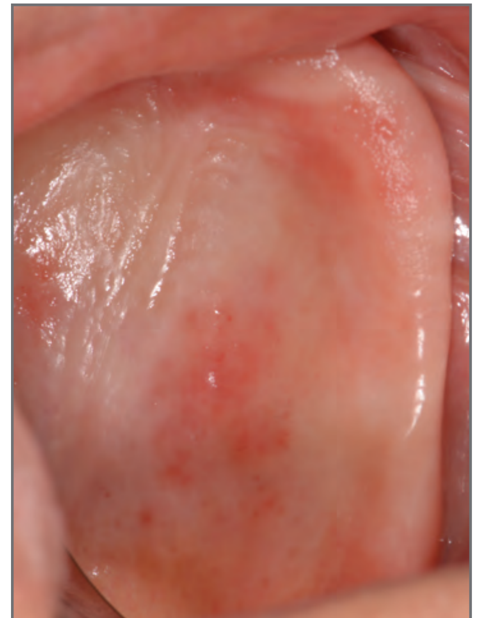


Figure 1: Free palatal graft donor site before surgery. Note the severe alveolar process atrophy and the flat palatal vault.

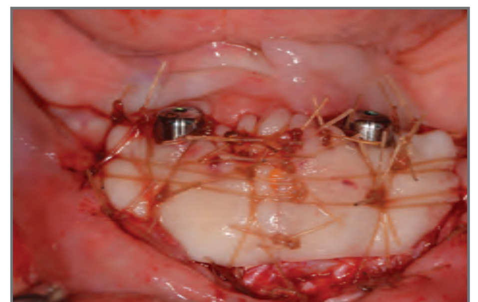


Figure 2: Free palatal grafts sutured to the recipient site.

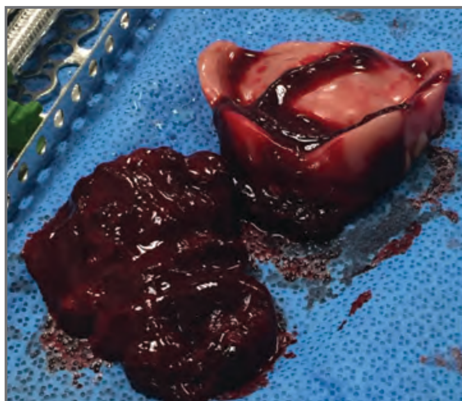


Figure 3: View of upper denture and liver clot 2 hours following surgery.

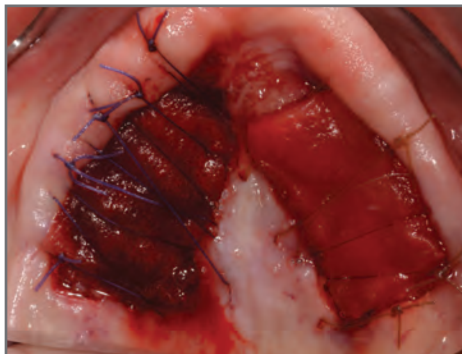


Figure 4: Hemostatic dressings soaked in thrombin and secured with mattress sutures.

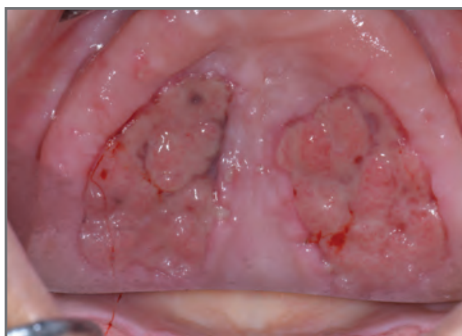


Figure 5: Appearance of the palatal donor sites following removal of dressings 1 week postoperatively.

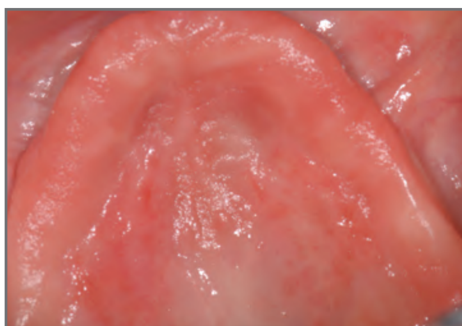


Figure 6: Palatal donor sites 7 weeks following surgery.

thrombin (Figure 4). The patient was advised not to wear the upper denture.

At the follow-up visit 24 hours later there was no evidence of further bleeding. The sutures and dressings were removed at one week (Figure 5) and the sites healed without further complications (Figure 6).

DISCUSSION

Free palatal grafts are commonly used for root coverage, and for providing keratinized mucosa. This is usually done in dentate patients in whom the graft site is on the alveolar process, away from the greater palatine neurovascular bundle. However, the situation is different in the edentulous patient, particularly when there is severe atrophy of the alveolar process. In such instances the graft site is directly over the neurovascular bundle and this needs to be taken into consideration during surgery in this area. The finding of non-pulsating, dark blood oozing from the right donor site supports the premise that there was unrecognized damage to the greater palatine vein during graft procurement.

Placing a denture or splint over the palatal donor sites can protect the area and make the patient more comfortable. However, the severe alveolar atrophy in this patient resulted in an inadequate peripheral seal of the denture. In addition, the presence of the mandibular implants, and the lack of a lower prosthesis, made it impossible for occlusion to help stabilize the upper denture. Thus, micro-movement of the denture may have been responsible for dislodging the initial clot and the resultant hemorrhage.

CONCLUSION

Excessive bleeding is an uncommon complication following removal of a free palatal graft because the donor site is generally on the alveolar process above the neurovascular bundle. However, in the edentulous patient, particularly when there is severe alveolar atrophy, there is a greater risk of injury to the neurovascular bundle during the procedure.

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Druckman RF, Fowler EB, Breault LG. (2001) Post-surgical hemorrhage: formation of a “liver clot” secondary to periodontal plastic surgery. J Contemp Dent Pract 15(2), 62-71.

Pandya D, Manohar B, Mathur LK, Shankarapillai R. (2012) “Liver clot” - a rare periodontal postsurgical complication. Indian J Dent Res 23(3), 419-22.

Editor's Note: Dr. Janina Golob Deeb is an Assistant Professor in the Department of Periodontology at Virginia Commonwealth University. Dr. Danielle McCormack is a graduate student in the Department of Periodontics at Virginia Commonwealth University. Dr. George R. Deeb is an Associate Professor in the Department of Oral and Maxillofacial Surgery at Virginia Commonwealth University. Dr. Daniel M. Laskin is Professor Emeritus in the Department of Oral and Maxillofacial Surgery at Virginia Commonwealth University.

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There was no funding obtained for this case report.

CLINICAL RELEVANCE

Scientific Rationale: In normal conditions in the dentate patient, when a free palatal graft is harvested, there is generally sufficient space left between the lower border of the graft and the greater palatine neurovascular bundle. However, in the edentulous maxilla with severe alveolar process atrophy, the donor site may be directly over this area. Failure to take this into consideration during the dissection can lead to vascular injury and excessive bleeding.

Principal Findings: This report describes a case involving an edentulous patient with severe alveolar atrophy in whom unrecognized damage to the greater palatine vein during harvesting of the graft resulted in severe postoperative hemorrhage.

Practical Implications: In harvesting free palatal grafts in edentulous patients, or those with a flat palatal vault, clinicians need to be aware of the altered relationship of the donor site to the greater palatine neurovascular bundle in planning the graft site and its surgical removal.

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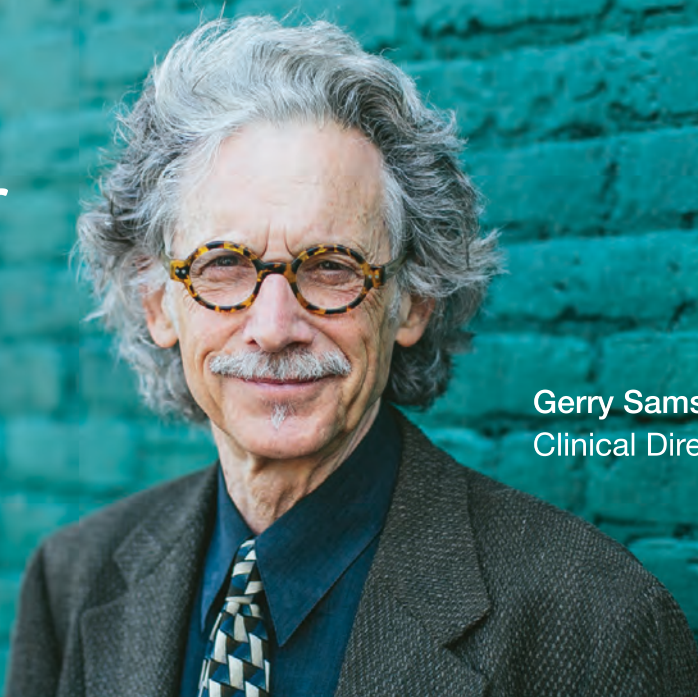


Gerry Samson, DDS
Clinical Director

www.springandsprout.network

PATHOLOGY PUZZLER

Dr. John Svirsky

Figure one is a four year old African American male who developed lesions every three months. According to the mother they seemed to be triggered from a "virus or head cold." The process would take up to four weeks to heal. They were told it was the result of a primary herpes virus and the sores were in his mouth and even down his throat (pictures not available for mouth sores). He was unable to eat or brush his teeth and when he did there was pain and bleeding. PediaSure was given to maintain nutritional status. "My son was miserable, and multiple physicians were unable to diagnose the cause. The lesions would get worse with each outbreak." The lesions at first remained only oral and then moved to face and eventually his body. He was tested for food allergies, HIV, herpes, and sexually transmitted diseases. At age 9 he had another outbreak (Figures 2-4) that started out like the others. With this outbreak he developed small blisters on his body. He went back to the clinic and was told it was contagious and to stay away from others. The patient and his mother had to move to a hotel but by the time they got there the blisters doubled in size and the patient complained of breathing problems. He was taken to the local hospital and admitted. Due to the severity he was transferred to a children's hospital where he was initially diagnosed with mycoplasma pneumonia. After a week and multiple consultations, fevers reaching 107 degrees, throat swelling and oxygen therapy, he was diagnosed with...

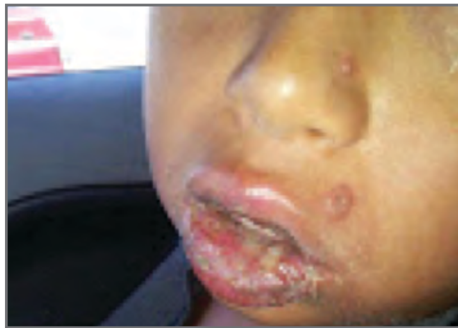
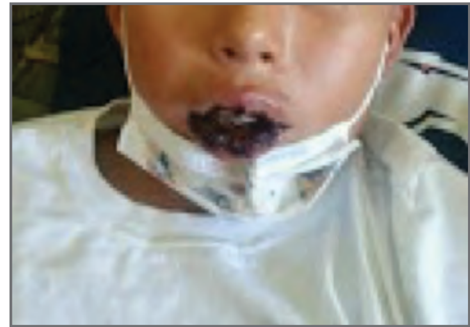


Figure 1



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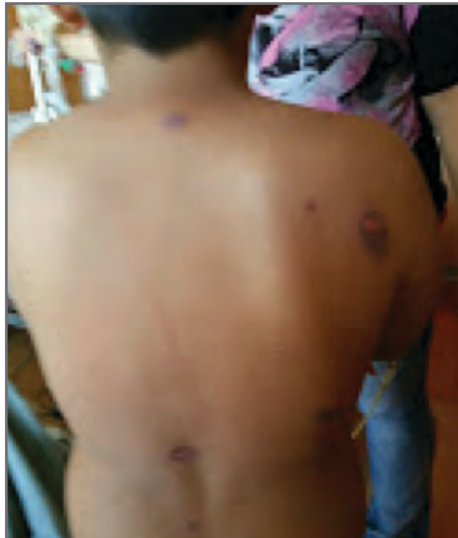

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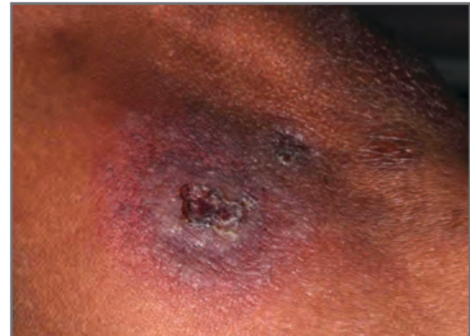


Figure 4

24 Continue Reading

Continued From 23

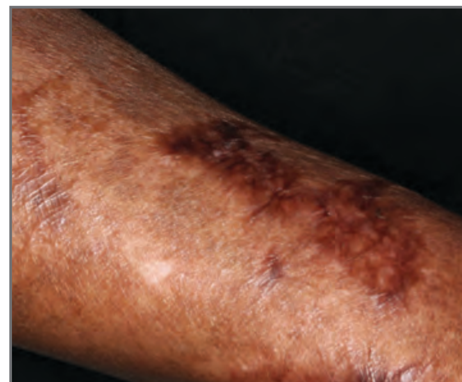
PATHOLOGY PUZZLER

Dr. John Svirsky

This case turned out to be erythema multiforme secondary to a virus (Herpes). Due to the severity of his condition with skin lesions the most likely diagnosis was erythema multiforme major (EMM) also known as the Stevens Johnson Syndrome. This presentation was not typical since the disease kept increasing in severity with each outbreak without drug causation. Erythema multiforme major is typically a drug reaction that is not dose related. EMM classically shows skin, mucosal, eye and genital lesions. EMM has approximately 7% mortality and the skin lesions that occur may show scarring (example of scarring post EMM figures 5-6). This case though severe did not have eye or genital lesions. Post herpetic erythema multiforme is not uncommon but usually does not result in the severity shown in this case. Now that it was diagnosed and known to be a viral cause, this patient will be protected from further outbreaks with prophylactic antiviral drugs.

An additional case of erythema multiforme minor that presented with explosive onset and extensive oral and lip lesions is shown (figures 7-10). The treatment for this case was systemic steroids and palliative mouth rinses. Patients typically respond quickly to Prednisone and within two days are out of pain. Without treatment the condition can last two to six weeks.

Figure 5



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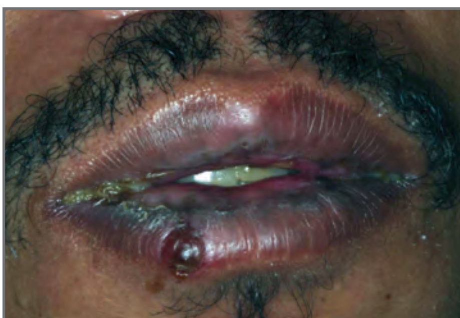

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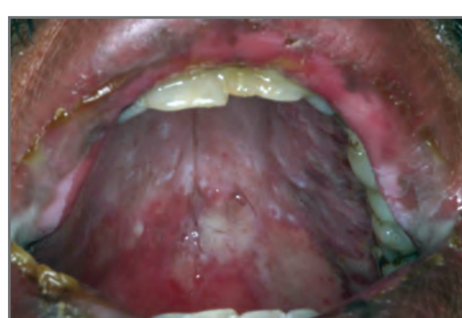

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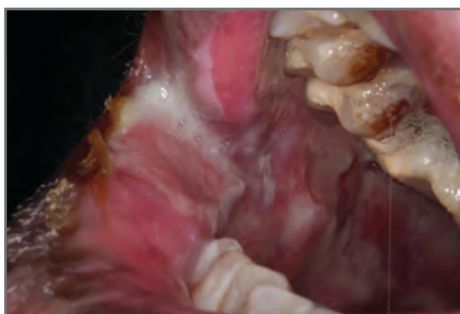

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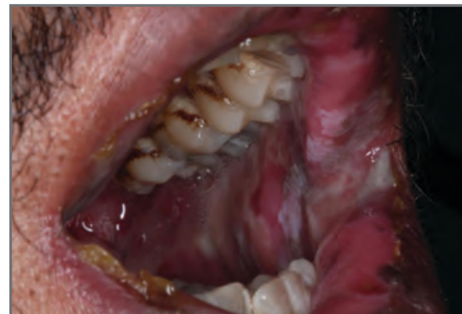


Figure 10

Patient Name:________ Date:______
Address:________

Rx **Prednisone 20 mg tablets**

(Under 130 lbs dispense 30 ten mg tablets and use 40 mg/day in am with food for 3 days followed by 30, 20, & 10 mg in the morning with food for 3 days each.)

Disp: 24

Sig: Take three tablets (60 mg) in morning with food for four days; Followed by 2 tablets (40 mg) in the morning with food for four days;

MD:________
Signature:________

Patient Name:________
Address:________ Date:______

Rx **Magic Mouthwash**

(1 part viscous lidocaine 2% + 1 part Maalox + 1 part diphenhydramine 12.5 mg per 5 ml elixir)

Disp : 240 ml bottle

Sig : Rinse and expectorate 5 ml prn
- up to 4 times/day

MD:________
Signature:________

ORAL SURGERY ABSTRACT:

CHRISTENSEN J, MATZEN LH, VAETH M, WENZEL A, SCHOU S. EFFICIENCY OF BUPIVACAINE VERSUS LIDOCAINE AND METHYLPREDNISOLONE VERSUS PLACEBO TO REDUCE POSTOPERATIVE PAIN AND SWELLING AFTER SURGICAL REMOVAL OF MANDIBULAR THIRD MOLARS: A RANDOMIZED, DOUBLE-BLINDED CROSSOVER CLINICAL TRIAL. J ORAL MAXILLOFAC SURG. 2013; 71(9): 1490-1499

Active efforts are being made to reduce the prescription of opioid pain medications after routine surgical procedures due to the growing epidemic of opioid addiction sweeping our nation. A multimodal approach to acute pain management should be utilized to curtail overall post-operative opioid medication consumption after invasive procedures such as dental extractions. The authors of this study examined post-operative pain and swelling after the use bupivacaine and methylprednisolone during extraction of mandibular third molars.

A randomized, double-blinded, crossover clinical trial was performed that involved four treatment combinations. A total of 126 patients (mean age 25.0 years) underwent extraction of partially impacted right and left mandibular third molars with each extraction performed at least 4 weeks apart. Treatment groups included 1) first operation: lidocaine and placebo, second operation: bupivacaine and methylprednisolone; 2) first operation: bupivacaine and methylprednisolone, second operation: lidocaine and placebo; 3) first operation: lidocaine and methylprednisolone, second operation: bupivacaine and placebo; 4) first operation: bupivacaine and placebo, second operation: lidocaine and methylprednisolone. Measured outcomes included self-reported pain and swelling(on Visual Analog Scale), number of days taking analgesic tablets, number of days taken off work and measured maximal mouth opening at 2 and 7 days postoperatively.

The authors used 2% lidocaine with 1:100000 epinephrine and 0.5% bupivacaine with 1:200000 epinephrine. They injected 2 mL of local anesthetic for inferior alveolar nerve and lingual nerve blocks, 1 mL for buccal nerve and 1 mL for buccal infiltrations. Methylprednisolone was administered in 16 mg tablets and patients were instructed to take two tablets the day before surgery, one tablet the morning of surgery and one tablet in the evening on the day after surgery. Surgery was performed by 1 of 3 providers and post-operative pain was managed with 600 mg of ibuprofen.

Results showed that patients who received bupivacaine reported lower pain scores at 2, 4, 6, 8 and 12 hours after surgery compared to those that received lidocaine, but that no significant difference was observed after 24 hours. Pain was also significantly lower 4, 6, 8 and 12 hours and 2 days after surgery when methylprednisolone was administered compared with placebo. Swelling was reported to be significantly more pronounced 4, 6, 8, and 12 hours after surgery when administered bupivacaine compared with lidocaine. As expected, a significant reduction in swelling was reported as well as significantly less trismus when methylprednisolone was administered compared to placebo. No statistically significant differences in days taken off work or number of analgesic tablets consumed were observed between the 4 treatment groups.

The authors conclude that bupivacaine combined with methylprednisolone provided the greatest reduction in postoperative pain and swelling when compared with the use of lidocaine and placebo, lidocaine and methylprednisolone or bupivacaine and placebo. This multimodal approach to treat acute surgical pain has the potential to reduce the amount of narcotic pain medication required after a procedure such as third molar extractions.

DR. BALRAJ KANG; Resident, Department of Oral and Maxillofacial Surgery, VCU Medical Center

ORAL SURGERY ABSTRACT:

ABRAMOWICZ S, RAMPA S, ALLAREDDY V, LEE MK. THE BURDEN OF FACIAL CELLULITIS LEADING TO INPATIENT HOSPITALIZATION. J ORAL MAXILLOFACIAL SURG. 2017; 75(8): 1656-1667

This retrospective analysis of the Nationwide Inpatient Sample (NIS) aimed to present national estimates of hospitalizations attributed to facial cellulitis and conduct an exploratory analysis on identifying factors associated with outcomes such as hospital charges, length of stay, disposition status, and occurrence of infectious complications.

The study utilized the NIS for the calendar years 2012 and 2013 and the International Classification of Disease, Ninth Revision, Clinical Modification diagnosis (ICD-9-CM) code of 682.0 as the primary diagnosis field of NIS as reason for hospitalization. All patients included were at least 18 years old. Variables examined were hospital charges, length of stay (LOS), disposition status, and occurrence of infectious complications. Descriptive statistics and a multivariable linear regression model were used to examine association between independent variables and patient disposition and infectious complications.
From 2012-2013, 74,480 hospitalizations involved facial cellulitis in adults at least 18 years old in the United States, most of which were women. The mean age was 47.5 years old. Most patients were Caucasian (68.8%) followed by African Americans (12.2%) then Hispanic (9.2%). Although African Americans had a 33% higher likelihood of discharge to home with Home Health, most patients were discharge to home versus being sent home with Home Health or Skilled Nursing Facility (SNF). They found that increasing age was associated with odds of discharge to another facility. The South had the largest number of cases (40.5%), followed by Midwest (22.2%), West (19.0%), Northeast (18.3%). Average LOS was 3.3 days and the average hospital charge was $20,432 in 2013 and in one year alone totaled 245,200 in-hospital days and $1.5 billion. Variables associated with decreased odds of bacterial infections as cause of facial cellulitis were age, and black or Hispanic race. Women with at least one comorbidity had higher odds of mycoses. Statistically relevant predictors of increased LOS were age, race, insurance, location of infection and sepsis. Not surprisingly they concluded that the presence of comorbid conditions predicted worse outcomes.

VANCE PATRICK HALL, DMD;
Resident (PGY-3), Department of Oral and Maxillofacial Surgery, VCU Medical Center

SCIENTIFIC

ORAL SURGERY ABSTRACT:

SALOMON D, HEIDEL E, KOLOKYTHAS A, MILORO M, SCHLIEVE T. DOES RESTRICTION OF PUBLIC HEALTH CARE DENTAL BENEFITS AFFECT THE VOLUME, SEVERITY, OR COST OF DENTAL-RELATED HOSPITAL VISITS? J ORAL MAXILLOFAC SURG. 2017; 75(3): 467–474

This study is an analysis of the impact of legislation in one state that reduced the adult public dental insurance coverage to treatment of emergencies only, eliminating coverage for preventive dental care. Specifically, this study aims to quantify the effect of this legislation on the volume, severity, and treatment costs as it relates to odontogenic infections. In 2012, the Illinois legislature passed the “Save Medicaid Access and Resources Together (SMART) Act”. This law in effect limited covered dental treatment only to emergency extractions of a single tooth for adults over 21 years of age. The design of this study is a retrospective cohort study that analyzed patients admitted to the University of Illinois Hospital one year prior (Cohort 1) and one year following (Cohort 2) the enacting of this legislation. The study population included patients with sole odontogenic complaints admitted at one hospital that presented to the Emergency Department (ED) or as a direct transfer from an outside hospital for this reason. The authors looked at variables that included age, gender, insurance status, Oral and Maxillofacial Surgery (OMS) consultation, imaging, treatment, treatment location, hospital admission length, and inpatient care level. The authors found that emergency department visits increased 48%, surgical intervention increased 100%, and hospital admission days increased 128%. They also found a significant increase in likelihood for OMS consultation, incision and drainage, and longer hospital stays. The cost of each hospitalization also increased approximately 20%.

Based on the results of this study, it can be concluded that there are significant negative public health effects of eliminating basic dental care coverage. Previous studies have shown that preventive dental treatment in an outpatient setting is more effective as well as cost efficient (admitted hospital patients cost ten times as much to treat as patients treated in an outpatient setting). ED treatment for Medicaid patients has previously been shown to be much greater than the outpatient setting, but this is the first study to review hospital-associated costs and treatment of admitted Medicaid patients. Accessing affordable and preventive oral health care clearly has a tangible benefit for society to invest in prevention. This study highlights the value that outpatient dental care provides to the medical system by reduction in the enormous hospital associated expenditures due to lack of dental care.

BRYAN WHEELER, DMD; Resident (PGY-4), Department of Oral and Maxillofacial Surgery, VCU Medical Center

ORAL SURGERY ABSTRACT:

LIEBLICH S, ISRAEL H, BENNETT J, VISWANATH A. ANALGESIC EFFICACY AND SAFETY OF EXPAREL (BUPIVACAINE LIPOSOME INJECTABLE SUSPENSION) IN SUBJECTS UNDERGOING THIRD MOLAR SURGERY: PRELIMINARY RESULTS OF A RANDOMIZED CONTROLLED STUDY. J ORAL MAXILLOFAC SURG. 2016; 74(9): E42-E43.

Pain associated with third molar extraction is a common adverse effect and can significantly interfere with everyday living for 1-3 days following the procedure. A common pain management regimen includes a combination of NSAIDs and prescribed narcotics. With the opioid addiction and abuse increasing every year, it is important for practitioners to investigate other means of post-operative analgesia. EXPAREL® (liposomal bupivacaine) is a prolonged-release formulation of bupivacaine used for surgical site infiltration, and has been used for postsurgical analgesia in over 1.5 million patients undergoing various surgical procedures.

In this prospective, randomized, double-blind, placebo controlled study, EXPAREL was evaluated for its analgesic benefit in 60 subjects undergoing bilateral maxillary and mandibular third molar removal, with ≥ 1 mandibular third molars fully or partially bony impacted compared to 30 patients who received placebo normal saline infiltrations. Both groups were prescribe rescue oxycodone 5-10mg PO qh4 upon request. Using a 0-10 numeric pain scale, analgesia was assessed at 24, 48, 72, and 96 hours. Opioid utilization through 48 hours (morphine equivalent dose, mg), time to first rescue, and subject satisfaction were also assessed. Adverse events through day 30 and vital signs immediately before and following the procedure were recorded for all subjects who were randomized and treated. The groups had significant differences in their pain scores at all 4 time assessments with the EXPAREL group reporting significantly lower pain scores at all time points. In addition, the EXPAREL group used significantly less opioid pain medication; however, time to first rescue pain medication as well as patient satisfaction was similar in both groups. The results demonstrate that further studies are warranted to investigate the potential of liposomal bupivacaine anesthetic for prolonged pain management following 3rd molar removal and other invasive dentoalveolar procedures.

LAUREN KAPLAN, DDS; Resident (PGY-1), Department of Oral and Maxillofacial Surgery, VCU Medical Center

ORAL SURGERY ABSTRACT:

BATAINEH A, AL-SABRI G. EXTRACTION OF MAXILLARY TEETH USING ARTICAINE WITHOUT A PALATAL INJECTION: A COMPARISON BETWEEN THE ANTERIOR AND POSTERIOR REGIONS OF THE MAXILLA. J ORAL MAXILLOFAC SURG. 2017; 75(1): 87-91

One of the consistent challenges during routine maxillary dental extractions is that of patient tolerance of obtaining palatal anesthesia. This study assessed the efficacy of solely buccal infiltrations with 4% articaine (no palatal injections), as well as if there was any difference between anesthesia and pain tolerance between anterior and posterior maxillary extractions. This was a prospective controlled study which used a split mouth protocol during which patients served as their own control. A total of 48 patients were used in the study (27 men, 21 females), ages 28-84. A total of 96 teeth were extracted (one anterior, one posterior per patient). Each received 1.8cc of 4% articaine with 1:100,000 epinephrine as a buccal infiltration adjacent to each tooth indicated to be extracted. Anesthesia was assessed using a pinprick test, and pain/discomfort during the extraction was recorded using Visual Analog Scale (VAS). Statistical analysis was completed using descriptive statistics, paired-sample t test, and independent sample t test. A total of 87 teeth (90.6%) were able to be extracted without an additional palatal injection, and 90% of the patients reported the extraction pain/discomfort as only mild on VAS at both the anterior and posterior regions.

As shown in previous studies, buccal infiltrations using 4% articaine can be effective in providing adequate anesthesia during routine dental extractions. Of note, the study does specify that the buccal infiltration did not provide adequate palatal soft tissue anesthesia, and recommends additional palatal infiltrations if significant palatal soft tissue manipulation is indicated. The study also showed that there was no statistical difference in pain perception between anterior or posterior tooth extraction.

This study provides a local anesthetic technique that could be applied to patients with poor pain tolerance, or with significant anxiety regarding palatal injections. Of note, this technique is not to be used if significant palatal soft tissue manipulation is to be completed.

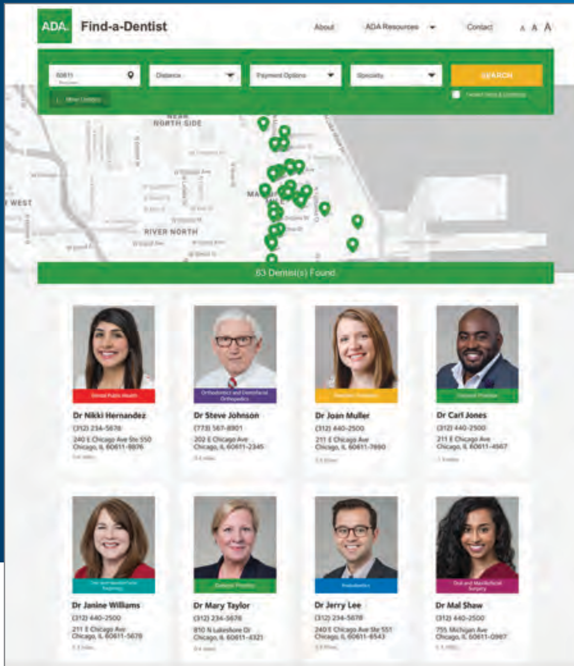
CHARLIE BOXX, DDS; Resident (PGY3), Department of Oral and Maxillofacial Surgery, VCU Medical Center

ORAL SURGERY ABSTRACT:

RODRÍGUEZ SÁNCHEZ F, RODRÍGUEZ ANDRÉS C, ARTEAGOITIA CALVO I. DOES CHLORHEXIDINE PREVENT ALVEOLAR OSTEITIS AFTER THIRD MOLAR EXTRACTIONS? SYSTEMATIC REVIEW AND META-ANALYSIS. J ORAL MAXILLOFAC SURG. 2017; 75(5): 901-914

Alveolar osteitis remains one of the most common postoperative complications after dental extractions. The methods of preventing alveolar osteitis (AO) after dental extractions has been a topic of debate for many years. The most widely used definition of AO was proposed by Blum in 2003, “postoperative pain that increases in severity in and around an extraction site which increases in severity at any time 1 to 3 days after extraction accompanied by a partially or totally disintegrated blood clot within the alveolar socket with or without halitosis.” This study was a systematic review and meta-analysis of a total of 18 randomized clinical trials between 1979 to present after selecting for appropriate inclusion criteria such as systemic antibiotic use and other factors. One purpose of the study was to measure the incidence of AO after third molar extractions in patients treated with versus those treated without chlorhexidine. The second purpose of the study was to compare efficacy and effectiveness of chlorhexidine rinse or gel in any formulation against placebo rinse and gel formulations. Half of the randomized control trials used chlorhexidine rinse and half of the randomized control trials used chlorhexidine gel of various concentrations. The overall result of the study was that use of chlorhexidine in some form either pre-operatively, intra-operatively or post-operatively prevented development of AO after third molar extraction. Not a single adverse reaction was reported throughout all clinical trials and the number needed to treat (NNT) was extremely small demonstrating 7-11 patients must be treated with some form of chlorhexidine to avoid 1 case of alveolar osteitis. In addition, chlorhexidine gel was found to be moderately more efficacious than the chlorhexidine rinse. The majority of the research that was included focused on mandibular third molars with the exception of two randomized control trials that focused on maxillary and mandibular third molars. It should be noted that only third molars were included in this study due to alveolar osteitis occurring approximately 10 times more commonly with third molar sites than other teeth. It is possible that chlorhexidine would also be an effective treatment regimen in regards to other extraction sites but further research would be required in this area. The study was also unable to reach a conclusion on the best dosing regimen for rinse and gel formulation and the efficacy between gel and rinse use. Other areas for study could include comparison of pre-operative versus intra-operative versus post-operative use. In conclusion, use of chlorhexidine rinse or gel in any formulation used either pre-operatively, intra-operatively, or post-operatively was found to be effective and efficacious in preventing alveolar osteitis in patients who have undergone third molar removal.

DANIEL HAWKINS, DMD; Resident (PGY-2) Department of Oral and Maxillofacial Surgery, VCU Medical Center

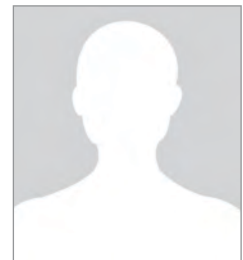


5 Minutes Today, More Patients Tomorrow with the NEW **ADA Find-a-Dentist®**

Exciting news! The ADA is launching a new consumer advertising campaign to bring more patients to you. Over the next 3 years, the ADA is investing $18 million on paid search and digital ads that drive prospective patients to the **NEW ADA Find-a-Dentist®** tool. Don't miss out on new patients — update your profile today at **ADA.org/findadentist**. It only takes 5 minutes.

The best way to stand out in search results is to make sure your profile has the information patients look for most:

- Photo
- Business address
- Office hours
- Practice email
- Payment options
- Insurance types
- Languages spoken



Which dentist would you choose?

Profiles with photos show up near the top of the search results and get **11 times more clicks** than those without. Don't be photo shy — upload a photo today!

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ADA American Dental Association®

ADA FIND-A-DENTIST®

FREQUENTLY ASKED QUESTIONS

WHAT IS THE UTILIZATION (OR SEE YOUR ADA DENTIST) CAMPAIGN?

Resolution 67, which was adopted by the ADA House of Delegates during the 2016 Annual Meeting, authorized funding for the "See Your ADA Dentist Campaign," the ADA's largest investment in consumer marketing to date. In this three-year campaign, the ADA will be spending $6 million annually on search and digital advertising to direct consumers to make an appointment with an ADA dentist.

WHAT IS THE PURPOSE OF THIS CAMPAIGN?

In a survey conducted by the Health Policy Institute, their data showed that although 77% of adults say they intend to go to the dentist, only 33% actually go. Also, despite the rebounding economy over the past several years, ADA dentists continue to report that they had the capacity to see more patients. The purpose of this campaign is to address the busyness gap by driving more referrals to ADA member dentists.

WHAT IS THE GOAL OF THIS CAMPAIGN?

We have two major goals:

1. For members: from now until the end of 2017, the goal is to have 50,000 dentists update their Find-a-Dentist profile. That way, the tool will by well-populated when we begin to focus our marketing efforts on consumers to use Find-a-Dentist to search for providers.
2. For consumers: our goal for the social and digital advertising campaign is to generate 218 million advertising and search impressions, and 776,000 clicks to Find-a-Dentist by the end of 2017.

WHAT ARE THE BENEFITS FOR MEMBERS?

The Find-a-Dentist enhancements are designed to make dentists' practice information more accessible to potential patients so they can more easily search by geography, payment/benefit plan and specialty and connect to book an appointment with them, thus addressing the "busyness" gap.

WHAT ARE THE NEW FEATURES IN FIND-A-DENTIST?

The new tool includes:

- A new drop down list of dental benefit companies
- New search criteria for patients looking for doctors who treat special needs, cancer, and high anxiety patients

HOW LONG DOES IT TAKE TO UPDATE A FIND-A-DENTIST PROFILE?

On average, it takes only 5 minutes.

CAN PATIENTS BOOK APPOINTMENTS WITH THIS NEW TOOL?

Patients are unable to book appointments using the current tool, but the ADA is investigating new technology vendors who could offer this functionality.

WHO IS THE TARGET AUDIENCE FOR THIS CAMPAIGN?

In 2016, the ADA conducted extensive consumer research that identified seven consumer "personas," which are research-based, semi-fictional profiles that represent a cluster of people who exhibit similar characteristics, attitudes, behaviors and traits. Out of these seven personas, we have identified two personas with the best opportunity to increase their dental visits. These personas represent 36% of the US adult population, or nearly 20 million people. Most of them have dental benefits and sufficient income to afford care, so in this campaign, we are providing them with the motivation to visit the dentist more regularly.

WHAT IS THE STRATEGY FOR ACCOMPLISHING THIS GOAL?

We have developed a marketing plan designed to increase visits to ADA dentists. Because a high percentage of the target personas fall within Gen X and Millennials, the plan focuses on digital and social media strategies, which are much more targeted and cost efficient than traditional TV, radio and print/magazine plans.

The four parts of the plan include:

1. Paid Search: To ensure that when our target consumers search for a dentist on Google and other search engines that the ADA Find-a-Dentist tool comes up near the top. This will begin in summer 2017.
2. National Digital and Social Media Advertising: The target personas are younger and more accustomed to sourcing information on digital devices, such as phones, tablets and computers, so our media buy will be 100 percent digital. This national overlay also includes ad placements on Facebook in addition to websites and apps. The campaign will begin in summer 2017.
3. State and Local Support: Matching funds will be provided to state and local societies to amplify the message in their respective areas for greater reach and penetration. The ADA's ad agency will manage these media buys, which can be scheduled to run between June through December.
4. Member Resources: ADA members will receive to use in marketing their practices and talking to their patients. Three toolkits will be available in March, June and September, and will include customizable digital and social assets, print materials, and other resources specifically developed for member use.

Bookmark **ADA.org/findadentist** and visit today for resources to help you communicate with patients.

ADA American Dental Association®

ORAL SURGERY ABSTRACT:

LANG M, GONZALEZ M, THOMAS B.T. DO ANTIBIOTICS DECREASE THE RISK OF INFLAMMATORY COMPLICATIONS AFTER THIRD MOLAR REMOVAL IN COMMUNITY PRACTICES? J ORAL MAXILLOFAC SURG. 2017; 75(2): 249-255

The role of perioperative antibiotic use in the extraction of third molars is controversial. This study examined the association between antibiotic use and postoperative inflammatory complications in outpatient, community-based third molar extractions. The authors defined inflammatory complications as either surgical site infection ("visible frank purulence of the extraction site at any point postoperatively or unanticipated pain or edema warranting operative intervention or antibiotic use") or alveolar osteitis ("new-onset or increasing pain more than 36 hours after the operation and clinical examination showing loss of the blood clot with exposed bone, irrigation of the site or gentle probing reproducing the pain, and marked pain relief with application of an anodyne dressing"). Structured as a prospective cohort study, a total of 105 oral and maxillofacial surgeons with data from 2954 patients met study inclusion criteria. Among the providers, 42 different antibiotic prescribing patterns were practiced. Because of this diversity, authors converted the predictor variable of antibiotic use to a binary variable, in effect dividing the patient population into those who received any type/form/dose of antibiotic and those who did not.

Of the total patient population, 75.2% received some form of antibiotic and had a total incidence of inflammatory complication of 5%, while 24.8% of the patient population received no form of antibiotic and had a total incidence of inflammatory complication of 7.5%. The absolute risk reduction for postoperative inflammatory complication was 2.5% in the antibiotic group, the relative risk of complication was 67% higher in the non-antibiotic group, and the number needed to treat was 40. After adjusting for additional differences between the two study groups, statistical significance between them persisted with a resulting odds ratio of 0.58 in favor of antibiotics.

The clinician must interpret these results with appropriate caution. Although the absolute risk reduction and relative risk measured between the groups support a significant difference between antibiotic recipients and non-antibiotic recipients with respect to postoperative inflammatory complication, the actual percentage of difference between the groups is small, and the use of antibiotics was acknowledged to result in an increase in mild transient adverse effects. Overall, further study needs to be completed in order to examine an optimized antibiotic type/form/frequency that minimizes inflammatory complications while also minimizing postoperative complication. Until such study is completed, the clinician may interpret the results of this study as supporting the use of antibiotics perioperatively for a small but significant reduction in the risk of postoperative inflammatory complications.

CHRISTOPHER RAY, DDS; Resident (PGY-1), Department of Oral and Maxillofacial Surgery, VCU Medical Center

ORAL SURGERY ABSTRACT:

GADY J, FLETCHER M. CORONECTOMY: INDICATIONS, OUTCOMES, AND DESCRIPTION OF TECHNIQUE. ATLAS ORAL MAXILLOFAC SURG CLIN NORTH AM. 2013; 21(2):221-6. DOI: 10.1016/J.CXOM.2013.05.008.

Coronectomy is the removal of only the coronal portion of a tooth. The main indication for this procedure is to prevent iatrogenic injury to the Inferior Alveolar Nerve (IAN) while removing a third molar. The frequency of IAN damage after extraction of a third molar ranges anywhere from 0.4% to 8.4%. The risk level can be determined preoperatively by considering the following radiographic factors: Darkening of the root, narrowing of the apices, deflection of the root, diversion of the IAN canal, narrowing of the IAN canal, and interruption of the white outline of the IAN canal. Multiple studies show statistically significant reduction in iatrogenic IAN damage by performing a coronectomy rather than extraction of third molars in high risk patients.

The success of a coronectomy depends on the survival of the retained root fragments with the successful formation of osteocementum and bone over the roots. Contraindications to the procedure include the following: Active caries into the pulp, periapical pathology, horizontally impacted teeth associated with tumors or large cysts, patients scheduled for future osteotomy, and systemic reasons including immunocompromised patients, radiation therapy, immunomodulating drug therapy, and poorly controlled diabetics. Risks of the procedure include infection, neurosensory disturbance coronal migration of retained root fragments requiring surgical retrieval, potential need for additional surgical procedures

A coronectomy is performed by first accessing the tooth in the same way that you would for a third molar extraction. A buccal trough is then created to allow access to the CEJ. Next, the crown is sectioned off with a fissure bur and elevator while being careful to minimize any mobilization of the residual roots. The remaining enamel is reduced so that it is at least 3mm apical to the crest of the alveolar bone. The site is cleared of all debris and any residual follicle, then irrigated copiously with normal saline. Finally, the tissue is reapproximated and closed primarily with sutures. It is worth noting that root canal treatment of the retained roots is contraindicated. Studies show that the infection rate is much higher for teeth in which root canal treatment was performed due to the increased time of exposure and increased risk of root mobilization. An immediate postoperative panoramic radiograph should be obtained for a baseline assessment of the retained tooth fragment. Postoperative follow up appointments should be scheduled for 10 days and 6 months.

The most common complication of a coronectomy is mobilization of roots during the procedure in which the root or roots must be removed to avoid a possible foreign body reaction and delayed healing. Other complications of this procedure are similar to those of a third molar extraction. The most commonly reported long term consequence is migration of the residual tooth roots. It has been shown that migration generally occurs within the first 6 months in a coronal direction anywhere from 2-4 mm on average.

The opinion of the authors is that a coronectomy is a safe and legitimate alternative to third molar extraction in specific situations. These situations include patients at high risk for IAN injury, patients older than 25, and anyone with a low tolerance to the possibility of postoperative neurosensory deficit.

MARK GARDNER, DDS; Resident (PGY-1), Department of Oral and Maxillofacial Surgery, VCU Medical Center

ORAL SURGERY ABSTRACT:

WARREN V, ET. AL. BUFFERED 1% LIDOCAINE WITH EPINEPHRINE IS AS EFFECTIVE AS NON-BUFFERED 2% LIDOCAINE WITH EPINEPHRINE FOR MANDIBULAR NERVE BLOCK. J ORAL MAXILLOFAC SURG. 2017; 75(7): 1363-1366

Effective local anesthetics rely on their ability to penetrate nerve membranes and prevent depolarization by blocking local voltage gated sodium channels. Pre-administered local anesthetics formulated with epinephrine exist predominantly in the ionized state, and require buffering for the absorption of their unionized form. This study assessed the outcome of pulpal anesthesia and pain on injection for buffered 1% lidocaine with 1:100,000 epinephrine versus non-buffered 2% lidocaine with 1:100,000 epinephrine. This was a randomized cross-over trial comparing the cold and electrical responses to pulp testing, and pain on injection in 24 patients until a positive pulpal response returned to the mandibular first molar and canine. Pulp test responses were measured by subjective patient responses of “yes” or “no,” and pain level was reported with a 10-point Likert-type scale. Twenty-three patients completed the study protocol, and served as their own controls, with follow up visits performed two weeks following prior administration of either buffered lidocaine 1% with 1:100,000 epinephrine, or non-buffered lidocaine 2% with 1:100,000 epinephrine.

Findings were consistent with the current consensus that effective local anesthetics better penetrate nerve membranes when buffered, increasing the available unionized form. Time to sensation return to canines and molars was not statistically different, while pain-with-injection levels were significantly lower for the buffered 1% lidocaine with 1:100,000 epinephrine formulation. General dentists can use this study to help guide their decision making regarding achieving pulpal anesthesia while minimizing pain experienced on injection for the patient. Utilizing buffered 1% lidocaine with epinephrine can help minimize pain on injection while producing similar pulpal anesthesia as 2% lidocaine with epinephrine, and can thus help prevent patient discomfort.

CHRISTOPHER LOSCHIAVO, DMD;
Resident (PGY-1), Department of Oral and Maxillofacial Surgery, VCU Medical Center

ORAL SURGERY ABSTRACT:

COCERO N, BEZZI M, MARTINI S, CAROSSA S. ORAL SURGICAL TREATMENT OF PATIENTS WITH CHRONIC LIVER DISEASE: ASSESSMENTS OF BLEEDING AND ITS RELATIONSHIPS WITH THROMBOCYTOPENIA AND BLOOD COAGULATION PARAMETERS. J ORAL MAXILLOFAC SURG. 2017; 75(1):28-34

Dental extractions are frequently needed in patients prior to liver transplant. Bleeding after such procedures is of concern due to the significantly decreased liver function leading to clotting dysfunction in this patient population. This study assesses the risk factors for bleeding in patients with chronic liver disease. This is a retrospective study, which includes 1183 extractions in 318 patients. Patients with a platelet count less than 40,000μL were given preoperative platelet transfusion, and patients with an INR of 2.5 or more were given fresh frozen plasma transfusion. Following extraction, the sites were sutured, fibrin sponges were applied, and tranexamic acid rinse was administered. Follow up to evaluate the sites were at post-operative days 1,3, and 7. Three groups of patients were selected. Group 1 included alcoholic cirrhosis. Group 2 included viral hepatitis. Group 3 included other liver disease such as autoimmune cirrhosis, primary biliary cirrhosis, sclerosing cholangitis, etc. No significant difference was found between the three groups. During the follow up time period, 12 severe bleeding events took place. The bleeding risk in patients with INR of less than 2.5 and PLT above 40,000μL was 0.4%. The bleeding risk for patients with INR greater than or equal to 2.5 was 40% (4 of 10 patients). The bleeding risk for patients with a platelet count of less than or equal to 40,000μL was 6% (2 of 34 patients). The bleeding risk for patients with INR greater than or equal to 2.5 and platelet count of less than or equal to 40,000μL was 100% (3 patients). In conclusion, the bleeding risk is low for dental extractions in patients with an INR of less than 2.5 and a platelet count of above 40,000μL. In patients whose lab values cannot be optimized to these levels, bleeding can be expected but managed with thorough planning.

JASON WOOD, DMD; RESIDENT
(PGY-4), Department of Oral and Maxillofacial Surgery, VCU Medical Center

40 UNDER 40

DR. ASHLEY D HOLMES

Dr. Holmes is a 2009 VCU/MCV graduate. She practices at Hendricks Family Dentistry in the Little Neck area of Virginia Beach. She enjoys working and making a difference in the community in which she lives.

ORAL SURGERY ABSTRACT:

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

The most commonly impacted tooth is the mandibular third molar, which is usually treated with surgical extraction. These surgical procedures can result in a reactive inflammatory response that can be controlled with proper postoperative care. Corticosteroids have been one of the interventions shown to help minimize surgical complications after mandibular third molar extraction. Dexamethasone has been shown to reduce pain, edema and other complications after third molar extraction. This study aimed to evaluate the effect of single-dose dexamethasone to lessen post-operative complications. The study utilized a split-mouth randomized controlled clinical trial to extract mandibular third molars in two separate procedures, giving either a placebo or a 0.1 mg/kg preoperative intramuscular injection of dexamethasone The investigators evaluated patient outcomes, including pain, discomfort, oral function limitation and daily activity limitation for which they collected using self-reported scales to report these variables. In comparing placebo versus dexamethasone injection groups, there were no significant differences in the angulation or depth of impaction of mandibular third molars.

Overall after dexamethasone injection, patients had a decreased inflammatory response, leading to decreased reporting of pain, decreased analgesic intake, less swelling, and fewer postoperative complications after third molar extraction. While prolonged use of corticosteroids can have adverse side effects, single intramuscular dexamethasone injection can help decrease postoperative pain, swelling, complications and analgesic consumption while potentially increasing patient satisfaction with treatment.

DR. MICHAEL MCADAMS;
Intern, Department of Oral and Maxillofacial Surgery, VCU Medical Center

ORAL SURGERY ABSTRACT:

BLOCK I, EMERY R, CULLUM D, SHEIKH A. IMPLANT PLACEMENT IS MORE ACCURATE USING DYNAMIC NAVIGATION. J ORAL MAXILLOFAC SURG. 2017; 75(7): 1377-1385

The purpose of this study was to measure and compare the accuracy and precision of dynamic navigation with freehand implant placement. Dynamic navigation is becoming more widely available and is currently available and used in the VCU Oral and Maxillofacial Surgery Department. This study, which was a prospective cohort study, enrolled patients who had implants placed over a 2-year period. The patients had implants placed either fully guided (FG) via dynamic navigation, partially guided (PG) with dynamic navigation (ie, osteotomies done under guidance but implant placement under direct vision), or freehand (FH) placement. Post-operative CBCT scans were obtained and the position of the implants were compared with the pre-surgical plan. Deviations from the virtual plan were recorded for each implant/surgeon. The study enrolled 478 patients, and 714 implants were placed by four experienced surgeons. The mean angular deviation, mean global platform position deviation, and the mean global apical position deviation was measured. Of the three, the angular deviation was the most important measurement improved by the FG implant placement. The FG dynamic placement had an angular deviation of only 2.97 +/- 2.09 degrees. The FH placement was the least accurate, with the mean angular deviation of 6.50 +/- 4.21 degrees. These results showed that dynamic navigation improves accuracy of dental implant placement and allows the surgeon to have more precise placement of dental implants.

TREVOR B. HOLLEMAN, DDS;
Resident (PGY-4), Department of Oral and Maxillofacial Surgery, VCU Medical Center

40 UNDER 40

DR. PATRICK B HOLMES

Dr. Holmes, a 2009 VCU/MCV graduate, is a board certified orthodontist practicing in Virginia Beach. He works with Klar Voorhees Orthodontics where building relationships with patients while creating beautiful smiles for a living is his dream come true.

DESIGNING YOUR TRANSITION CHAPTER

Dr. James R. Schroeder

Recently, a phone call came into my office from a delightful colleague inquiring about my transition program. At 82 years old, he had been considering for some time now that it was time to close or transition his practice. I arranged for a visit to his well-maintained office and met his two staff members who had been part of his practice for nearly a lifetime. The doctor and I sat down together and he began to describe an amazing career. Hearing him share the story of how he started his practice, the changes and challenges along the way, and the stories of his patients made me smile as I knew that these stories would give him great comfort in the next chapter of his life. I sat and listened to him talk about the past, then he slowly began talking about where he is today and his future, or what I like to refer to as his "next chapter". Sure, he had scaled back his efforts to bring in new patients, but even at this stage he still had an active patient base of approximately 700 patients. He thought he would just close the practice but it was important to him that he had a good home for his patients. After all, not only had he spent years helping these patients achieve and maintain good if not great oral health, but many of them grew up before his eyes. I often find that bringing a close to your practice is not only a financial and legal decision, but also carries with it a very emotional component. You're not only closing a business, you're ending relationships with people you have been connected to for a huge portion of your life.

Fortunately, I recognized that this particular colleague was going to be able to move through the transition process and make the important decisions that needed to be made relatively easy. I'm finding more often than not, that this isn't the case. When we wait too long, facing a crisis or find that we're simply not in ideal health, making these kinds of decisions can often be stressful not only to the doctor but for his family as well.

PLANNING FOR YOUR TRANSITION

Every partnership and solo practitioner should consider a plan before a crisis or their health demands action! It is more than a legal document or insurance policy but also a design of what happens next that is required in order to protect and sustain the practice - and the families involved. These may be difficult conversations but they are very valuable to assure the best outcomes. If you are within 5 years of retirement consider the following action items:

1. Interview and establish a relationship with someone who is current with the many opportunities or choices available in the closing or transition of the practice. Your location, patient base, facility, staff and equipment will all impact your options.
2. Do you want to continue to practice clinical dentistry or do you want to walk away immediately upon the transfer of ownership?
3. If your facility and equipment are beyond acceptable function, then exploring a chart acquisition can be very attractive option for you.
4. With your selected transition guide, select both an attorney and accountant who are experienced with best practices with these transactions. HIPAA and IRS regulations need to be carefully considered to avoid costly mistakes.
5. Define before you sign. This is a critical step that is often ignored. Often an associate is brought in with no outline of the steps to move into ownership. The relationship outside clinical dentistry is foggy and unclear and often gets worse. Clarity and alignment of expectations between the buyer and seller helps assure a win-win situation. No one wants to end a great career nor start a career on a bitter note of disappointment.

I am often brought into a transaction in the fourth quarter of a practice, after a couple years of the senior doctor attempting to navigate the process himself. It can be done, but more often than not a consensus is not reached and the potential win-win transaction disappears.

Now entering into my tenth year of clinical dentistry "retirement", I now coach physicians and dentists to view the closing of their practice as starting a new chapter. The chapter begins with designing the closing, or transition, of your current practice and ends with creating a healthy outlook for the future. When you take the time to intentionally design the closing of your practice in the best manner possible for you and your family, it will pave the way for peace of mind for yourself, your staff and your family.

DESIGNING YOUR PLAN

Select a trusted transition team and start brainstorming what options are available for your future. This will allow you to be informed and have control of your transition design. If this article stirs up some thoughts please feel free to call for a complimentary conversation on designing your transition. At some point in time, the reality is that we will all have a transition chapter. I encourage you to take the time now to shape your unique chapter.

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

40 UNDER 40

DR. ALEXANDRA L. WOOD

After graduating from VCU School of Dentistry in 2015, I returned home to Charlottesville, Virginia. I joined my Father's general dentistry practice. The practice employs my mother as a dental hygienist. You read correctly, I have become my mother's boss!

Thanks for Catching Memories

with us!

We had so much fun at The Homestead this year that we can't wait to do it again in 2018!

THE Virginia MEETING®
A Program of the Virginia Dental Association

September
20-23, 2018

AN INTERVIEW WITH THE DEMOCRATIC CANDIDATE FOR GOVERNOR

RALPH NORTHAM

FOR GOVERNOR — FOR VIRGINIA'S FUTURE

***Virginia Dental Journal*:** How can Virginia increase access to healthcare for more of its citizens in a fiscally responsible manner?

Dr. Ralph Northam: I think what we saw in Wise is a testament to the fact that individuals don't have access to healthcare. We have in the past proposed expanding Medicaid. Right now 400,000 working Virginians don't have access to healthcare. And the reason for this is the cost of healthcare has gone up faster than their salaries. The purpose of this Medicaid expansion was to give access to these working Virginians. Of these, 14,000 are veterans. So, a veteran who suffers from mental illness can end up in places like the emergency room or end up one medical or dental problem away from financial demise, so that's not a good place for anyone to be in.

VDJ: Our membership is made up mostly of small business owners – what policy proposals do you plan to pursue to help Virginia's small business owners prosper over the long-term?

Northam: I'm a small business owner myself. Our practice started out in Hampton Roads and now we have grown to 100 sub-specialists and over 250 employees. We need a tax code that's both fair and fiscally responsible. This will take bipartisan, comprehensive tax reform. Second, we need to emphasize workforce development. Jobs of the 21st century require an educational system that prepares a trained workforce for healthcare professionals, such as dental hygienists and dental assistants. Third, healthcare professions are heavily regulated, as you know. We must be careful not to burden small businesses with regulations for no good reason. We must not make it cumbersome for small businesses to operate. Lastly, one reason I became involved with healthcare policy was because I was frustrated with insurance companies in my practice. In practice, time is money, and dealing with insurance companies gets your blood pressure up. It's almost like the burden is on us as the practitioner rather than the insurance company. The extra staff we have to hire to deal with insurance companies drives up the cost of health care.

VDJ: What criteria will you use for making appointments to health regulatory boards? Will you allow input from professional associations?

Northam: First, the boards, like the Board of Medicine, Board of Nursing, and the Board of Dentistry are very important. Being a physician, I understand importance of these boards. I plan to communicate with dentists and the VDA and rely on your input on appointment to the boards. When it comes to appointments, I'll have an open-door policy. We want the most qualified professional people, and I want input from dental profession and the VDA on appointments.

VDJ: "Smiles for Children", Virginia's Medicaid dental program, has been recognized as a model for other states to follow. If you are elected Governor, would you have any plans to change or improve the program?

Northam: The only way I would make any changes would be to work with the VDA to make improvements and make the program more efficient. A lot of dentists are sole practitioners, and we want to make sure that patients can go to a dentist of their choice. I want to maintain an open line of communication with the dentists and the VDA. When we're all at the table, when can do what's best for the patients and the profession

VDJ: For both employers and individuals, the purchase of health insurance is often a daunting challenge. Do you have any proposals that would make that purchase more transparent, less costly and/or easier to understand?

Northam: It is a challenge for me as a healthcare provider, and I'm sure you too. We need to compare benefits to costs, we need transparency, and we need simple, straightforward policies. We need to walk employees through the process, and anything we can do to make this process less cumbersome will help. To a lot of people all they see is the cost, and they pick the lowest cost plan. That's why it's important to sit down with individuals and help them understand what they're getting. What happens is they walk into the office and we are on the receiving end as the practitioner having to explain it to them. And they are upset, so if we can make sure that the process is transparent on the front end it will save a lot of problems in our offices.

VDJ: Our membership is made up of nearly 3500 dentists that proudly employ thousands of Virginians in every corner of the Commonwealth and serve millions of patients annually – what ONE other thing should they know about you before going to the polls in November?

Northam: Yes, they need to know I'm a healthcare provider who has taken care of thousands of patients, both children and families. All Virginians should have access to medical care, and we should be sure that no family suffers financial demise from seeking care. Healthcare is a right, and we need to make sure we take care of patients and make sure that all Virginians have access to affordable medical and dental care. We also need to make sure we have an adequately trained workforce for the healthcare jobs of the 21st century.

Editor's Note: Candidate Northam was interviewed August 4, 2017.

AN INTERVIEW WITH THE REPUBLICAN CANDIDATE FOR GOVERNOR

***Virginia Dental Journal*:** How can Virginia increase access to healthcare for more of its citizens in a fiscally responsible manner?

Mr. Ed Gillespie: This is a priority for me. We have nine different healthcare policy working groups. I've involved Delegate O'Bannon and Sen. Dunnavant, both of whom are physicians, in our working groups. I want to involve healthcare providers, doctors, patients, and business owners in our access-to- health care policies. I will release our healthcare plan in the not too distant future. If we increase competition in the insurance marketplace consumers will benefit. Due to the exit of insurance companies from the Affordable Care Act exchanges, 50 localities in Virginia have only one insurance carrier. If we increase competition we reduce prices, and competition is good for the consumer.

VDJ: Our membership is made up mostly of small business owners – what policy proposals do you plan to pursue to help Virginia's small business owners prosper over the long-term?

Gillespie: Well, we want to make it easier to start and expand small businesses. For a long time in Virginia we have been focusing on Fortune 500 companies. We want to make it easier to open and grow a small business. I am proposing a 10% cut in the individual income tax, which will also benefit Subchapter S corporations and LLCs, which pay the individual income tax rate. Kathy and I know what it's like to take out a loan with your home as collateral. We want to make it easier to meet the challenges. I also want to reduce regulations that affect small businesses. Because of the man-hours involved, the burden of compliance is much greater on small businesses than large corporations. Local taxes are something we want to look at – they can be problematic, sometimes anti-growth. One example would be the BPOL (Business Professional Occupational License) tax. We want to help localities to reform their tax structure, and identify taxes that restrict growth. We can help them identify other sources of revenue that would offset any revenues lost from reform of these taxes.

VDJ: What criteria will you use for making appointments to health regulatory boards? Will you allow input from professional associations?

Gillespie: Yes, as a standard process we would seek input from professional associations. How these appointments are made is critically important. It's very important to make appointments on merit. Professional associations like yours have valuable insights. Input from a lot of different sources is helpful, but when we make appointments we'll be looking for recommendations from professional associations.

VDJ: "Smiles for Children", Virginia's Medicaid dental program, has been recognized as a model for other states to follow. If you are elected Governor, would you have any plans to change or improve the program?

Gillespie: This is a program that's very important for healthy children and families. I've read that just one visit a year helps reduce costs by 30% per person. Our healthcare policy working group has given it very favorable reviews.

VDJ: For both employers and individuals, the purchase of health insurance is often a daunting challenge. Do you have any proposals that would make that purchase more transparent, less costly and/or easier to understand?

Gillespie: This goes back to the first question – we know that greater competition would bring down costs. We've seen costs skyrocket under the Affordable Care Act, and patients have lost their choice of doctors. I don't know what's going to happen at the federal level, but at the state level we can offer choices, thereby increasing competition and bringing down costs.

VDJ: Our membership is made up of nearly 3500 dentists that proudly employ thousands of Virginians in every corner of the Commonwealth and serve millions of patients annually – what ONE other thing should they know about you before going to the polls in November?

Gillespie: I think the choices are very clear, in fact they've never been more clear. We've had economic stagnation for six years in Virginia. Virginia should be number one, but instead we're 39th out of 50. I honestly believe this election is not just about the next four years, but about the next 20-30 years. Do we want to be heavily regulated and taxed so Virginia looks like states to north, which are all in the bottom half of growth, or do want to look like states to the South that have more dynamic economies? At the end of next governor's term, will Virginia become the northernmost Southern state or southernmost Northern state? That's the choice we'll make in November.

Editor's Note: Candidate Gillespie was interviewed August 5, 2017.

VADPAC UPDATE

SEE WHERE YOUR COMPONENT IS AND WHAT YOU NEED TO DO TO MEET YOUR GOAL

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	$35,505	$322	78%
2 (Peninsula)	40%	$27,500	$25,945	$360	94%
3 (Southside)	41%	$14,000	$19,370	$337	139%
4 (Richmond)	33%	$67,750	$68,970	$345	102%
5 (Piedmont)	36%	$30,000	$23,580	$290	79%
6 (Southwest VA)	55%	$25,250	$23,115	$331	92%
7 (Shenandoah Valley)	40%	$30,000	$27,532	$314	92%
8 (Northern VA)	32%	$135,000	$94,780	$333	70%
TOTAL	**40%**	**$375,000**	**$318,797**	**$329**	**85%**

Total Contributions: $318,797

2017 Goal: $375,000

WE NEED YOUR CONTRIBUTIONS TO RAISE $56,203

VADPAC would like to recognize components 3 and 4 for surpassing their goals for the 2017 year. Thank you so much to all members who have generously contributed this year! We are nearing the end of the year, which means that there are only a few weeks left to submit contributions for 2017. We still have the potential to reach the goal and you can help with that- Have you made your contribution yet for 2017? You can view the current list of contributors in the VADPAC page on our website at http://www.vadental.org/advocacy/vadpac.

If you have not yet contributed, there is still time! A contribution form is also found on the VADPAC page of the website or you may call Laura Givens to make a contribution over the phone at 804-523-2185 or email her at givens@vadental.org to be sent a form. We need to have the collective support from VDA members. **Don't sit on the sidelines while your colleagues pick up the slack!**

Dues will be mailed in the next month or so for 2018 and we urge members to submit contributions when sending in your 2018 VDA dues payments.

Your VADPAC contribution helps the voice of dentistry to be heard on Capitol Hill and sends a strong message to our enemies – PICK A FIGHT WITH US AND YOU ARE IN FOR A REAL BATTLE!

Please contribute! Contact Laura Givens at givens@vadental.org or 804-523-2185 with questions.

VADPAC FUNDRAISER FOR DELEGATE CHRIS JONES IN SUFFOLK

Laura Givens, Director of Legislative and Public Policy

VDA members and guests gathered on August 24th to thank Delegate Jones for his hard work through the years. Dr. Dani Howell hosted the event at her home in Suffolk and Dr. Ralph Howell chaired the fundraiser. We are very fortunate to have Delegate Chris Jones representing the 76th district in the Virginia General Assembly, which covers part of the South Hampton Roads area. He has always been a thoughtful and tireless leader ever since taking office nearly 20 years ago. Delegate Jones serves as Chairman of the powerful House Appropriations Committee. In this role, he is one of the chief architects of Virginia's over $100 billion biennial state budget, which puts him in a very favorable position to put his legislative mark on the course Virginia's government will take for many years to come. VADPAC appreciates VDA member involvement in steering committees that made this and other fundraising events successful.

A REPORT FROM THE GENERAL ASSEMBLY

Dr. Todd E. Pillion

Serving others and improving the lives of those around me are important qualities that were instilled in me at a young age. I was blessed with a strong upbringing and a family that taught me the value of hard work on our family's farm. Now that I have children of my own, these are qualities that I have a new appreciation for, and strive to embody in my work as a pediatric dentist and member of the House of Delegates.

Prior to becoming a pediatric dentist, I practiced general dentistry in Abingdon after graduating from Virginia Commonwealth University. While completing my residency for a pediatric certificate in Buffalo, NY, I was called to active duty to support the 42nd Infantry Division in Tikrit, Iraq in Operation Iraqi Freedom. I later returned to complete the program and my tenure with the Virginia National Guard with the rank of Major.

As a Delegate, I recognize how Virginia's citizen legislature is vital to making our government more accountable and effective. Since we are not full-time legislators, many of us have careers and day jobs that support our families. I believe this helps keep our elected officials rooted and is one of the things that makes our government more efficient.

Since my election, I have been fortunate to work with many passionate people who are engaged in important work to make our communities a better place. Last year, I began meeting with local and regional stakeholders about how we can address Virginia's opioid epidemic. Experts from across the spectrum and many different backgrounds came together for solutions-based discussions.

In November 2016, the opioid epidemic was declared a public health emergency in Virginia. While the impact of the addiction crisis spreads across the state, communities in Southwest Virginia have been dealing with the challenges for decades. In fact, 2016 marked the deadliest year for opioid overdoses in Virginia.

Some of the measures put forth include developing educational standards for prescribers, new regulations and guidelines for prescribing opioids and buprenorphine, and reviewing ways to remove barriers to treatment for substance-exposed infants. Each bill passed the General Assembly unanimously and was signed into law. While it is still very early, officials have observed a decrease in the number of prescriptions for controlled substances in the first and second quarters of 2017, including for some of the most powerful opioids.

During session, I also strive to identify opportunities to partner with individuals or organizations on projects that can benefit constituents and the district. This year, a partnership with Kool Smiles, Inc. led to more than 4,600 toothbrushes being donated to elementary school-aged students in the fourth district. Before summer break, I had the chance to visit classrooms to distribute the donated items to students and discuss the importance of dental hygiene. Partnerships such as this are extremely rewarding as it bridges my work as a dentist and Delegate.

Most recently, I had an opportunity to volunteer with the annual Mission of Mercy event at the Wise County fairgrounds. Unfortunately, such events have become highly politicized over the years. I believe—and work to ensure—that these clinics remain patient-centered above all else. For any dental or medical provider who has not had the opportunity to volunteer at this event, I highly encourage you to consider doing so next year as it is an opportunity to provide badly needed care for some of Appalachia's most needy citizens.

As the General Assembly's only dentist, I strive to ensure the dental community has a strong voice in Richmond. I remain committed to working with our professional network across the Commonwealth to advocate for good ideas and sound policy that will improve the industry and health outcomes for the patients we serve.

Editor's Note: Dr. Pillion represents the fourth district in the Virginia House of Delegates.

MARK YOUR CALENDAR FOR JANUARY 19, 2018

Join us for one of the most important days of the year! Every January, dentists from around Virginia and VCU dental students gather in Richmond for the VDA's annual Day on the Hill.

This event gives VDA members the opportunity to join together to inform policy makers about the profession.

Any early breakfast will be at the Omni in downtown Richmond at no cost to you and our Day on the Hill is over well-before lunch.

Mark your calendar now for January 19, 2018. Block off your Friday morning- these few hours of your time will make a big difference for dentistry and your patients! We look forward to seeing you in Richmond. Contact Laura Givens at 804-523-2185 or givens@vadental.org with questions.

VIRGINIA BOARD OF DENTISTRY

DID YOU KNOW?

• PRESCRIBING OPIOIDS

Did you know that any prescription for an opioid for a patient with acute pain shall be a short-acting opioid in the lowest effect dose for the fewest number of days, not to exceed seven days unless extenuating circumstances are clearly documented in the record?

18VAC60-21-103 of the Regulations Governing the Practice of Dentistry

• STANDARD OF CARE

Did you know that one of the standard of care violations found by the Board of Dentistry in the area of implants concerns failing to assess and record a patient's periodontal condition prior to performing treatment with implants?

§54.1-2706(5) of the Code of Virginia

• HEALTH HISTORY

Did you know that you are required to take a health history on your patient at the initial appointment that is updated when analgesia, sedation or anesthesia is to be administered, when medically indicated and at least annually?

18VAC60-21-90.B(2) of the Regulations Governing the Practice of Dentistry

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DID YOU SEE IT?

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

Did you read the article in the Sunday Edition of the *Washington Post* on July 2, 2017? The article, “Dental Lobby Bares Its Teeth on Care Laws” calls attention to the fact that dentistry has been pretty successful, so far, in fighting the growth of mid-level (some call it low-level) providers in many states. From the article,

> *“Among the general public, dentists tend to have a Norman Rockwell appeal- solo practitioners who clean your teeth, tell your kids to cut down on the candy, and put their seal of approval on a range of minty toothpastes and mouthwashes. But lawmakers from Maine to Alaska see a different side of dentists and their lobby, the American Dental Association, describing a political force so unified, so relentless and so thoroughly woven into American communities that its clout rivals that of the gun lobby.”*

Really! We tell kids to eat less candy and approve minty toothpastes but are as powerful as the gun lobby! I find the first half of the sentence to be extremely offensive, and trite, but I am so extremely proud of the final part of the sentence!

Do you think it’s a bad thing, as the paper would have you think? Or do you believe that dentists fight for their patients’ best oral health and our ability to provide that care free of insurance and regulatory intrusion? I am convinced that what we do in politics is for the benefit of our patients and the care they receive- nothing more, nothing less. Do you think the Teachers’ Union, or the AFL-CIO, or the Electrical Workers Union, or any other group that lobbies in Washington, DC would not want this article written about them and their political power? All groups vie for influence in Washington, and in our state capitals. It seems we are being called out for being effective at what we do. I take that as a compliment and am extremely proud of it. You should be to.

But can we maintain that influence? It requires that dentists, all dentists, participate in the process. This can be done by contributing to VADPAC, ADPAC, and being willing to spend some time with your state and federal representatives. They all want to make good decisions and rarely have all the facts. You are not interfering with the process when you contact them on issues, you are educating them as to what could happen if a bill is or is not passed. They want your help- they want to make the best decisions they can concerning their constituents. We are the experts on dental care – take the time to develop the relationship and share the information. It makes a difference. Develop the relationship and share our story. Dentistry has a great story to tell. We are proud of the dental care our citizens receive. The best in the world.

What is a mid-level provider? The short story is that there are organizations (The Pew and Kellogg Foundations) trying to push legislation through various state legislatures that would allow a community college educated “dental therapist” to do simple extractions and routine fillings on our patients! I appears they now may have their sights set on Virginia. I find this alarming.

We have an access-to-care problem. We have an access to “who will pay for the dental care” problem! There are plenty of dentists to provide the needed care- but no one is willing to pay for it. The theory, flawed as it is, is that a cheaper person (cheaper labor) can do our job (the dentists job) as good as we can with less training and for less money. Like I said, we all see the fallacy in this.

We must protect the public from this flawed idea. We are in charge of looking out for the best interests of our patients. We must fight this concept. Who else cares about our patients’ best oral health? The insurance companies? The government? Pew and Kellogg? No, we, the dentists of America are alone in fighting for the best interests of our patients. We have the knowledge and the political clout to do it. We know the solutions- we must speak up.

We must be vigilant. The threat of mid-levels in Virginia is real. We must fight. We must remain politically active. We must support or VADPAC and ADPAC to keep our influence strong. That is a big part of our strength. Let’s keep dentistry in the dental office and not farm it out to the cheapest, half-trained provider. It won’t save money, and patients will be harmed. We don’t want that in our state! We can all see where that would go. Let’s keep dental care in Virginia and the US the very best in the world. Help the VDA win this battle and possibly stop it before it can get rolling. Support VADPAC today!

40 UNDER 40

DR. JOHN H. WHITE

Formerly an investment banker, I later decided that instead of making big business smile, I’d rather make someone’s smile bigger. After the Great Recession, I turned my attention toward another type of recession and began my career as a Periodontist.

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CUSTOM RETIREMENT PLAN DESIGN = BIG TAX SAVINGS

David Kupstas and Jon'e Liuzza, ACG Financial

LEARN

Imagine buying a car. There are so many types to choose from! A family with children might want a minivan or SUV. Someone on a budget may prefer an economy car. Still others might like an exciting sports car.

It is the same with workplace retirement plans. Some dental practices will want to keep things simple with a relatively straightforward plan. Others may want to increase tax-deductible contributions or have more flexibility in how benefits are allocated among employees. These organizations would need a more advanced plan design.

If you went to an auto dealership that had only one type of car to sell, would you buy from that dealership? Not likely. Yet, all too often we come across businesses whose retirement plan design is one-size-fits-all. It's not that they actively chose this type of plan. Rather, it's what their financial professional sold them. Their "retirement plan dealer" had one kind of car on the lot, so that's what the business got, whether it was the right kind of plan for them or not.

In this article, we will take a look at a few retirement plan designs that you may not be familiar with but that could be beneficial in helping a dental practice achieve a particular goal.

SAFE HARBOR 401(K)S LET YOU SAY GOODBYE TO FAILED ADP TESTS

You likely know about 401(k) plans, under which an employee may make contributions from his paycheck called "salary deferrals." Employers usually contribute to these plans as well in the form of profit sharing or matching contributions. If Highly Compensated Employees (HCEs) defer significantly more dollars than Non-Highly Compensated Employees (NHCEs), the plan will fail what is known as the ADP test. If this happens, the law requires deferrals to be returned to HCEs or additional employer contributions to be made to NHCEs.

A failed ADP test can be very frustrating to an HCE. Fortunately, there is a plan design called "safe harbor" that allows an employer to avoid the ADP test. In addition to satisfying certain notice and other requirements, a safe harbor plan must provide employees either of the following contribution types:

- A matching contribution equal to 100% of salary deferrals up to 3% of pay plus 50% of deferrals between 3% and 5% of pay, for a maximum match of 4% of pay.

44 Continue Reading

43 Continued From

- A nonelective contribution of 3% of pay. Nonelective means the employee receives this contribution whether he defers from his own paycheck or not.

If one of these contributions is made, the company's HCEs are free to defer as much as they want up to the $18,000 limit unconcerned about whether NHCEs make significant contributions or not. Safe harbor contributions do carry some restrictions in terms of vesting schedule and eligibility conditions, but many employers are willing to make this tradeoff in order to avoid ADP testing.

Even though the 4% maximum match percentage is higher than the 3% nonelective percentage, the match can sometimes be cheaper if a lot of employees do not defer enough to receive the maximum match. Which safe harbor contribution we recommend depends on the circumstances. While a safe harbor match makes sense in certain situations, we normally recommend a 3% nonelective contribution.

CROSS-TESTING GIVES YOU MORE CHOICE IN WHO GETS CONTRIBUTION DOLLARS

Besides a match or nonelective contribution, an employer may make a profit sharing contribution. The business does not need to have made a profit in order for there to be a profit sharing contribution. If an employer decides to make a profit sharing contribution, a plan document will specify how the contribution is to be shared, or allocated, among the plan members. There are four major ways to allocate:

1. Uniform allocation, whereby each member receives the same percentage of pay or the same dollar amount.
2. Integrated, which resembles uniform allocation, except those whose pay exceeds a certain level receive a slightly greater amount.
3. Age-weighted, under which older employees get larger contributions.
4. Cross-tested, where the employer has discretion in how the contribution is shared.

Reading those four options, you may wonder, "Why would anyone pick anything other than cross-tested?" Well, there is a catch. Unlike the uniform allocation and integrated designs, contributions in a cross-tested plan have to be run through a nondiscrimination test. The HCEs may not benefit to a significantly greater extent than the NHCEs. Also, there may be minimum "gateway" contributions some years – perhaps 4.5% to 5% of pay.

Despite these hurdles, the cross-tested design is almost always more favorable for the plan sponsor. If the employer would like to maximize contributions to the owner and minimize contributions to others, the cross-tested plan is the place to do it. If the employer is fine with giving similar levels of contributions to all employees, this, too, can be done in the cross-tested plan. The rules concerning cross-tested plans have become so flexible over the years that they are the first design we look at for any client. If you have a plan and your service provider did not at least consider cross-testing for you, you should ask why.

Below is a simple example comparing a cross-tested plan to an integrated plan – a design commonly "sold" by those who do not specialize in retirement plans. The dental practice has two owners, both older than 50, earning more than the $270,000 annual compensation cap. There are eight employees of varying ages and wage levels. The owners' goal for themselves is to receive $60,000 in contributions from all sources – deferral, nonelective, and profit sharing. In the integrated plan, the employees would need to be given $41,803 from the employer (not including deferrals) for the owners to achieve this goal, while only $16,481 is needed in the cross-tested plan. That's a savings of over $25,000!

Since $41,803 would be a big amount for this employer to contribute to NHCEs, the more likely scenario in the integrated plan is that it would scale back contributions both to owners and employees. The owners would be unable to enjoy the full contribution limits allowed under the law. We have had several cases where partners have been able to receive an additional $20,000 or more in contributions by changing to a cross-tested plan without having to raise employee contributions one cent!

CASH BALANCE PLANS CAN LEAD TO SUPERSIZED DEDUCTIONS

For owners that have an appetite for bigger deductible contributions than the 401(k) allows, we recommend adding on a cash balance plan. Details of cash balance plans are beyond the scope of this article. Suffice it to say that it is possible for an individual to be allocated an additional $100,000 or even $200,000 per year beyond what the 401(k) offers, depending on age and other factors.

MAKE SURE YOU KNOW YOUR OPTIONS

We have just described some of our favorite retirement plan options. There are numerous other plan designs that can help dental practice owners achieve big tax savings, flexible contribution allocations, and other favorable outcomes. Don't settle for a simplified, mediocre plan design. Know your options and choose a plan type that's right for your business.

			Contributions	
Participant	**Age**	**Compensation**	**Integrated**	**Cross-Tested**
Owner 1	60	$270,000	$60,000	$60,000
Owner 2	52	$270,000	$60,000	$60,000
Employee 1	62	$75,000	$8,474	$3,341
Employee 2	55	$65,000	$7,344	$2,895
Employee 3	50	$55,000	$6,214	$2,450
Employee 4	45	$45,000	$5,084	$2,005
Employee 5	40	$40,000	$4,519	$1,782
Employee 6	35	$35,000	$3,954	$1,559
Employee 7	30	$30,000	$3,389	$1,336
Employee 8	25	$25,000	$2,825	$1,114
Total		**$910,000**	**$161,803**	**$136,481**
		HCEs	**$120,000**	**$120,000**
		NHCEs	**$41,803**	**$16,481**

UNIVERSITY OF RICHMOND HOSTS SPECIAL SMILES

Barbara Rollins, Director of Missions of Mercy

On June 10 the University of Richmond hosted Special Olympics Virginia where the one day dental clinic was also held. Through partnerships with the VCU School of Dentistry and Dental Hygiene, Special Smiles of Virginia Healthy Athletes Program, University of Pittsburgh, School of Dental Medicine, Virginia Dental Association and VDA Foundation over 132 Special Olympics athletes received dental care valued at $31,805 (made possible by 188 dental professionals – dentists, hygienists, dental assistants, dental and dental hygiene students and dental support volunteers).

Dental treatment provided to patients included:

Exams: 132
Cleanings: 103
Fluoride treatments: 103
Fillings: 57
Extractions: 19
X-rays: 68
Total dental procedures: 496

A special thanks to Dr. Matthew Cooke, lead dentist and site coordinator, for his continued leadership of the Special Olympics MOM project.

If you have not had the opportunity to attend this project, we encourage your participation – you will find it to be a rewarding experience.

Save the Date: Special Olympics MOM 2017 to be held on Saturday, June 9th. We invite volunteers to visit the VDA Foundation website and register at www.vdaf.org.

40 UNDER 40

DR. ZANETA T. HAMLIN

I'm a second generation dentist currently practicing at LWSS Family Dentistry. Knowing that my work is on display 24/7 I'm always striving to learn and do my best. I plan to expand my licensure internationally in the future.

TEN THINGS WE'VE LEARNED OVER TEN YEARS AT WISE

Dr. Robert W. Bigelow

(L-R): Dr. William Bigelow, Dr. Robert Bigelow

1

DON'T EAT CANTALOUPE ON THE THIRD MORNING

it seems to be a little too ripe by then. However, we will have to say that the Lions do a great job providing breakfast and lunch to the volunteers each day.

2

PATIENTS ARE SO VERY APPRECIATIVE

Some of the best "thank-yous" come from the mouths full of gauze. We have never come across a patient that was not grateful for getting the services received at Wise.

3

DON'T LEAN ON TENT POLES DURING THUNDERSTORMS

This is like a M*A*S*H unit and is often exposed to weather. A number of times there are rivers flowing through the tent area but work continues as long as there is no danger to patients and volunteers.

4

BE READY TO SHARE YOUR FAVORITE INSTRUMENT

Those end-cutting rongeurs go fast.

5

SUPPORT STAFF IS AMAZING!

They get there early, set up and take down all the equipment, organize the supplies and they're there to help if there are any problems.

Of all the things a father and son can enjoy together, dentistry has to be one of the best. It goes for any parent and child who are both in the profession. Practicing together, talking shop—business and clinical, sharing cases, and discussing triumphs and struggles are all part of the bonding between family members in dentistry.

Dad and I got started doing the Wise MOM Project in the summer of 2008, when I was about to start my fourth year of dental school. I had been on other MOM projects throughout dental school, but Dad was new to them. This year (2017) was our tenth consecutive Wise MOM Project. Although we practice in different cities, the MOM project allows us to work side by side at Wise and to share time.

Starting in 2009, we'd come that Thursday evening and stake out our chairs in the extraction area and drop off any supplies that we specifically wanted to use. This way, we were ready to hit the ground running early Friday morning. When I got tired of doing extractions, I would go do restorative. When Dad got tired of doing extractions, he would walk around and help those students who needed it.

Over these 10 years, we've had some great experiences with the assistants, dental students, residents, and other dentists who have come to volunteer at Wise. Years ago, we had the "Cuspid Challenge"—where dental students would get a prize for the longest canine extracted. This was to help deter root fractures. We would have students walking up with the bloody canine still in the forceps asking if theirs was the longest that day. The prize was usually a honey bun or candy bar from the snack trailer. Sometimes it came down to a line-up on a tray. During some lulls in patient care, Dad would have suturing practice with the dental students—using the peel of a banana.

Each year had its own highlights and weather. We learned the optimal time frame to get there in the mornings to avoid the long line of cars, and to also try and avoid parking across the road in the tall grass. It was interesting to explore the fairgrounds to see other opportunities that are being offered to the people that come to the project. Besides dental, there were a variety of services that come to support needs, such as drug counseling, mammograms, clothing, chiropractic, educational, optical, prescriptions and more.
When we were not at the fairgrounds, there were the annual traditions of "Blizzards" at Dairy Queen, cribbage games in the hotel in

the evenings, and taking the backroads up and down the mountain road to get to the fairgrounds.

Dad and I have put together a list of "Ten things we have learned over our ten years at Wise".

We have learned a lot about how we can help those in need and have felt the reward of appreciation through these experiences. To be able to work with the volunteers that give their time and talent is a great feeling, and we are glad to be with that group of people. We're both exhausted at the end of each day and at the end of each weekend, but we're also glad we did volunteer and make a difference in the lives of those who need it!

Editor's Note: Dr. William Bigelow practices oral surgery in Staunton; Dr. Robert Bigelow practices general dentistry in Richmond.

6

MASSIVE DONATIONS

The contributions given from different dental and dental-related organizations make the job possible to do. They supply the restorative materials, anesthesia needs, and refreshments.

7

THANKFUL WISE RESIDENTS

The residents in Wise are also thankful; you can hear the appreciation from the employees in the local businesses that are supported by volunteers.

8

DON'T MISS THE FRIDAY DINNER

Hands down, the best spread of food for a picnic. The locals have worked all day to prepare pork, chicken, steak, salmon, ribs, beans, slaw, and rolls. If you're not paying attention, you will also find a fresh-roasted corn on the cob appear on your plate.

9

THE CAMARADERIE IS GREAT

It's awesome to see new and familiar faces each year. They show an eagerness to work and help each other out with difficult cases.

10

DENTAL STUDENTS REPRESENT

It is nice to see that the future of dentistry, exhibited by these students, is in good hands. And we are proud to know that they will make dentistry even better in the future.

DONATED DENTAL SERVICES - A TRUE GIFT

Patrice Harmon, DMD

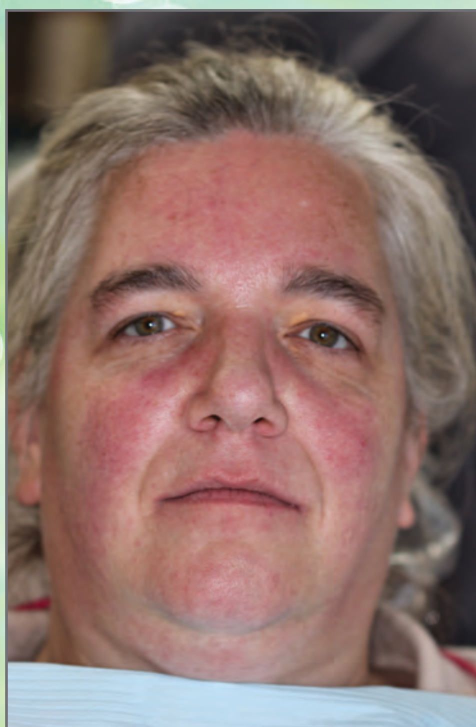
"Access to care" is such a buzz phrase these days that it often passes our ears and lips without much thought. I volunteer regularly with a free clinic, have been on a few Mission of Mercy projects, and have done international mission work—I'm doing my part, right? That mentality was called into question last spring when a patient asked if I knew of anyone who could help a friend of a friend who had fallen on tough times. My patient introduced me to Stacy Lane who, with her family, has the lofty goal of eradicating homelessness in the greater Richmond area. Stacy and I communicated through email, and she told me about Staci. At the time, Staci was a 43-year-old woman who suffered depression, schizophrenia, severe anxiety and was a recently diagnosed diabetic. Stacy and Staci were making tremendous strides to improve Staci's health and quality of life, but one important piece was missing—Staci was without any teeth. She had a hard time eating healthy foods and feeling good about herself, as any of us would, without any teeth.

I sent Stacy information about the Crossover Clinic, Daily Planet, and Donated Dental Services. I had never worked with any of these groups, so I wasn't sure how successful we would be in having her cared for via any of these routes. On the advice of my boss Dr. Rebecca Angus, I went out on a limb, unsure if Staci would qualify due to her young age, and reached out to Barbara Rollins at the Virginia Dental Association Foundation to see what we could do for Staci. Barbara could not have been kinder nor made it any easier for me to treat Staci. She handled all of the applications and communicated with Staci about her responsibilities to make her appointments. She also made arrangements with Eddi von Schlichting at Inter-chrome Dental Lab to donate the lab time and materials.
Stacy, Staci, and I finally met in person in August 2016 when Staci came for her initial consult. Staci was visibly nervous but also excited to get started. My heart sank a bit when I looked in Staci's mouth and realized she would need fairly significant alveoloplasty before a well-fitting set of dentures could be made. I reached out to Barbara to see what could be done about having the oral surgery donated. Barbara came to our rescue again in coordinating with Dr. Ross Wlodawsky, who generously donated his time and talents to recontour Staci's ridges.

From there, the dentistry was easy, and after all the visits associated with dentures, Staci received her new smile on May 4, 2017. There were happy tears, hugs, and more hugs—and from Staci, "now people won't think I'm my son's grandmother!" Dentistry is often rewarding, but having the ability to restore our patients' confidence is truly a gift. Throughout this process, Staci has lost an incredible amount of weight and has really come out of her shell around us. I look forward to seeing her for follow-up and hearing about how she is taking control back over her life, thanks to much personal perseverance, a wonderful friend in Stacy Lane, and in a meaningful part to Donated Dental Services.

Sincere thanks to Barbara Rollins, Eddi von Schlichting, Dr. Ross Wlodawsky, Dr. Rebecca Angus, my assistant Candice Buckland, and to Stacy Lane in such a successful outcome for Staci. What a wonderful resource we have in the VDAF and Donated Dental Services to provide direct care to patients who need it most!

BEFORE — **AFTER**



36TH ANNUAL NFED CONFERENCE HELD IN NORTHERN VIRGINIA

Karen S. McAndrew, DMD, MS

This year, the National Foundation for Ectodermal Dysplasia (https://www.nfed.org/) conference was held July 20-22 in Falls Church. Ectodermal Dysplasia is a condition effecting structures derived from the ectoderm during embryonic development ranging from mild to severe in presentation. Hair, teeth, sweat glands/skin and nails are most commonly effected. Ectodermal Dysplasia is a syndromic condition of considerable importance to the dental profession as many of those effected show symptoms effecting the formation and presence of teeth influencing function, speech and mastication/nutrition. Patients of all ages arrived to the 36th annual conference from all areas of the country with many having traveled very long distances. Some were attending the conference for the first time while others attend on a yearly basis. Patients, families and clinicians gathered at the most widely attended meeting, shattering previous attendance records, and shared information and support for those with ectodermal dysplasia and their families.

All were here to meet and learn more about the 180 different types of ectodermal dysplasia and connect with other people with the same or similar conditions. Each combination of abnormalities identifies the distinctly different types of ectodermal dysplasia. For some, this was the first time that they had ever connected with another individual with ectodermal dysplasia. Mary Fete, executive director of the NFED noted, “The 2017 National Foundation for Ectodermal Dysplasias Family Conference was the largest gathering in history of people affected by this condition. It was a life-changing event for the 468 individuals, 45 new families and 180 children at this conference who attended. They connected with other families, learned from our experts and left empowered to handle the issues of ectodermal dysplasia.”

Families and friends joined to learn more about this condition and provide support and encouragement. Learning about all aspects of the symptoms and how to manage them served as a valuable resource to this group as they participated in discussions ranging from dentistry, dermatology, genetics, and research to advocacy and psychological impact. Most importantly, they were able to “connect with someone walking a similar path”.

Dr. Karen McAndrew and Dr Frank Farrington from Richmond were joined by Dr. Clark Stanford (IL) and Dr. Timothy Wright (NC) to conduct dental screening exams on patients at the ectodermal dysplasia conference. They met with patients and their families to conduct head and neck exams and answer questions pertaining to tooth development and treatment options. Pediatric residents from VCU Dental School provided assistance on the screenings. Patients presented with a variety of dental conditions, many having missing teeth with some being completely edentulous. Malformed and misshapen teeth are othercardinal symptoms of the condition and treatment options range from removable prostheses to dental implant therapy. It is important to note that, in the state of Virginia, individuals effected with cleft lip/palate and ectodermal dysplasia are often covered for treatment through their medical insurance via Virginia statute.

Dr. Frank Farrington provides dental screening and information on dental restorative options to a young patient with ectodermal dysplasia.

Linda Shait, Pediatric Specialty Care Coordinator for Bon Secours St. Mary’s Hospital, helped with registration at the dental screenings and provided insight into the impact the meeting has for patients and their families. “As coordinator for our cleft and craniofacial team at Bon Secours St. Mary’s Hospital, as well as our team geneticist, I occasionally help coordinate appointments for patients and their families who are affected by Ectodermal Dysplasia. I have to confess that I knew very little about the disorder. The conference was very enlightening and educational for me. I certainly have a much better appreciation for what these families deal with on a daily basis. I enjoyed meeting and talking with both the families and the sponsors of the conference. Experiencing the NFED conference first hand will help me be a better advocate for families that I may encounter in the future.”

Dr Karen McAndrew and Mrs. Linda Shait attend the 36th National Ectodermal Dysplasia conference.

There is much that is still unknown about the condition and early diagnosis and intervention helps individuals with improved comfort and better outcomes. The NFED is a wonderful resource for patients, their families, and clinicians in dealing with the syndrome and providing advocacy for legislation to guarantee appropriate treatment for all congenital anomalies. Contact the national chapter for more information and patient/clinician support.

WELCOME NEW MEMBERS

Karen Clendenen, VDA Membership and Meeting Coordinator

TIDEWATER DENTAL ASSOCIATION

Dr. Courtney Baker – Virginia Beach – University of New England 2017

Dr. Sara Elsiddig – Virginia Beach – University of Missouri-Kansas City School of Dentistry 2016

Dr. Patrick Grube – Virginia Beach – University of Mayland Dental School 2016

Dr. Christine Howell – Suffolk – Virginia Commonwealth University School of Dentistry 2017

Dr. Mina Hwang – Virginia Beach – University of Illinois at Chicago College of Dentistry 2016

Dr. Khanh Nguyen – Norfolk – University of California at San Francisco School of Dentistry 2017

Dr. Ashley Sara – Virginia Beach – University of Connecticut School of Dental Medicine 2013

Dr. Geoffrey Schreiber – Virginia Beach – Virginia Commonwealth University School of Dentistry 2013

Dr. Zuzanna Wojtkowska – Virginia Beach – MidWestern University College of Dental Medicine 2016

PENINSULA DENTAL ASSOCIATION

Dr. Aarthi Balasubramaniam – Yorktown – Tufts University School of Dental Medicine 2017

Dr. Erno Fulop – Williamsburg – University of Pennsylvania School of Dental Medicine 2016

Dr. Aaron Hayes – Smithfield – University of Southern California 2008

Dr. Steven Hornsby – Williamsburg – Virginia Commonwealth University School of Dentistry 2017

Dr. Ellen Nordgren – Hampton – University of Minnesota School of Dentistry 2009

SOUTHSIDE DENTAL SOCIETY

Dr. Peter Hanley – Chester – Roseman University of Health Sciences 2017

Dr. Crystal Joyce – Midlothian – East Carolina University School of Dental Medicine 2017

Dr. Lucia Perez Troisi – Carrollton – Nova Southeastern University College of Dental Medicine2017

RICHMOND DENTAL SOCIETY

Dr. Mahammed Alrahbi – Henrico – Virginia Commonwealth University School of Dentistry 2017

Dr. Danijela Bratic – Richmond – University of Louisville School of Dentistry 2017

Dr. Kenneth Eliason – Richmond – Virginia Commonwealth University School of Dentistry 2016

Dr. Rania Fetouh – Glen Allen – University of Michigan School of Dentistry 2007

Dr. Brittany Field – Chesterfield – Virginia Commonwealth University School of Dentistry 2017

Dr. Petar Georgiev – Glen Allen – Virginia Commonwealth University School of Dentistry 2017

Dr. Mitchell Grimmer – Henrico – Virginia Commonwealth University School of Dentistry 2017

Dr. Shilpi Gupta – Glen Allen – Virginia Commonwealth University School of Dentistry 2017

Dr. Thomas Han – Richmond – Virginia Commonwealth University School of Dentistry 2017

Dr. Nora Hermes – Richmond – Virginia Commonwealth University School of Dentistry 2017

Dr. Akshay Kaushal – Richmond – Virginia Commonwealth University School of Dentistry 2017

Dr. Jonathan Leist – Richmond – Virginia Commonwealth University School of Dentistry 2017

Dr. James Oliver – Henrico – University of Minnesota School of Dentistry 2017

Dr. Erin Sharkey – North Chesterfield – Virginia Commonwealth University School of Dentistry 2015

Dr. Minkyeong Son – Richmond – Virginia Commonwealth University School of Dentistry 2017

Dr. Robert Tart – Richmond – University of Louisville School of Dentistry 2017

Dr. Allison Tran – Richmond – University of North Carolina School of Dentistry 2017

Dr. Jennifer C. Tran – Richmond – Virginia Commonwealth University School of Dentistry 2017

Dr. Alexander Vaughan – Midlothian – University of Southern California 2013

Dr. Mahsa Varshovi – Henrico – New York State University at Buffalo School of Dental Medicine 2008

Dr. Cathy Vo – Henrico – Arizona School of Dentistry & Oral Health 2017

Dr. Eugena Waggoner – Mechanicsville – Virginia Commonwealth University School of Dentistry 2017

Dr. Christopher Wolberg – North Chesterfield – Virginia Commonwealth University School of Dentistry 2016

Dr. Timothy Yang – Richmond – Virginia Commonwealth University School of Dentistry 2017

Dr. Harvey Youssef – Henrico – Arizona School of Dentistry & Oral Health 2017

Dr. Hui Zhou – Montpelier – Virginia Commonwealth University School of Dentistry 2016

PIEDMONT DENTAL SOCIETY

Dr. Jeffry Burke – Daleville – Medical University of South Carolina 2012

Dr. Yuanbing Gong – Rustburg – New York University College of Dentistry 2016

Dr. Jessica McAuliffe – Lynchburg – University of Kentucky College of Dentistry 2013

Dr. Brett Rhodes – Roanoke – Virginia Commonwealth University School of Dentistry 2016

Dr. Tremayne Richard – Danville – Meharry Medical College School of Dentistry 2017

Dr. Laurie Sargent – Hot Springs - Georgetown University 1987

Dr. Benjamin Shapiro – Roanoke – Virginia Commonwealth University School of Dentistry 2017

Dr. Jennifer Tummarello – Roanoke – Virginia Commonwealth University School of Dentistry 2016

SOUTHWEST VA DENTAL SOCIETY

Dr. Andrew Denardo – Blacksburg – West Virginia University School of Dentistry 2016

Dr. Duong Hoang – Monterey – Virginia Commonwealth University School of Dentistry 2016

Dr. Erich Lutz – Tazewell – Virginia Commonwealth University School of Dentistry 2016

Dr. Kayla Mullins – Radford – West Virginia University School of Dentistry 2017

Dr. Shadae Person – Christiansburg – Virginia Commonwealth University School of Dentistry 2017

Dr. Steven Robertson – Blacksburg – Medical University of South Carolina James B. Edwards College of Dntl Med. 2016

Dr. Grant Throckmorton – Blacksburg – Virginia Commonwealth University School of Dentistry 2017

SHENANDOAH VALLEY DENTAL ASSOCIATION

Dr. Reham Alnajjar – Charlottesville – Virginia Commonwealth University School of Dentistry 2016

Dr. Ian Bernard – Harrisonburg – MidWestern University College of Dental Medicine-Illinois 2016

Dr. Arsany Botros – Winchester – Indiana University School of Dentistry 2016

Dr. Stuart Fargiano – Lexington – University of Connecticut School of Dental Medicine 1989

Dr. Evan Garrison – Harrisonburg – Virginia Commonwealth University School of Dentistry 2017

Dr. Mitzy Golden – Staunton – University of Colorado Denver School of Dental Medicine 2014

Dr. Tuan Levo – Fishersville – West Virginia University School of Dentistry 2016

Dr. NoorUs Sabah – Charlottesville – Stony Brook University School of Dental Medicine 2010

Dr. Mark Shaw – Charlottesville – University of Pittsburgh School of Dental Medicine 2014

Dr. Raymond Simpson – Charlottesville – Virginia Commonwealth University School of Dentistry 2017

Dr. Jose Urresti Soberon – Charlottesville – University of Connecticut School of Dental Medicine 2007

Dr. Steven Woodard – Lexington – University of Louisville School of Dentistry 2017

NORTHERN VA DENTAL SOCIETY

Dr. Farah Ahmad – Falls Church – New York University College of Dentistry 1993

Dr. Ali Al-Doori – Bristow – University of Colorado Denver School of Dental Medicine 2016

Dr. Miriam Al-Keliddar – McLean – University of Maryland Dtl School 2016

Dr. Zaynab Al-Quraishi – Spotsylvania – University of Colorado Denver School of Dental Medicine 2016

Dr. Wajiha Amer – Purcellville – Boston University Goldman School of Dental Medicine 2016

Dr. Dany Barakat – McLean – University of Maryland Dental School1996

Dr. Sarah Carlisle – Alexandria – Medical University of South Carolina James B. Edwards College of Dental Medicine 2016

Dr. Smaiyra Chaudhary – Fairfax Station – New York University College of Dentistry 2017

Dr. Jada Daniel – Manassas – University of North Carolina School of Dentistry 2012

Dr. Rodrigo Guevara – Falls Church – University of MD Dental School, Baltimore College of Dntl Surgery 2016

Dr. Mehdi Hasan – Chantilly - University of Maryland Dental School 2017

Dr. Megan Hurd – Centreville – University of Washington – Health Sciences School of Dentistry 2017

Dr. Elnaz Javadkhani – Fairfax – Howard University College of Dentistry 2017

Dr. Amber Johnson – Stafford – Nova Southeastern University College of Dental Medicine2013

Dr. Sanju Jose – Vienna – University of Maryland Dental School, Baltimore College of Dental Surgery 2013

Dr. Dina Khalf-Allah – Alexandria – Temple University The Maurice H. Kornberg School of Dentistry 2015

Dr. Matthew Lam – Woodbridge – University of Iowa College of Dentistry 2016

Dr. Caroline Lee – Alexandria – LECOM College of Dental Medicine 2017

Dr. Tiffany Maldonado – Haymarket – University of Oklahoma College of Dentistry 2017

Dr. Jason Marrazzo – McLean - University of Maryland Dental School 2013

Dr. Gauri Pande – Chantilly – Howard University College of Dentistry 2016

Dr. Shridhar Patankar – Springfield – Nova Southeastern University College of Dental Medicine2016

Dr. Sneha Patel – Arlington – Baylor College of Dentistry 2016

Dr. Felix Ramos – Gainesville - University of Maryland Dental School 2015

Dr. Peajmun Razmjou – Arlington – University of Maryland Dental School 2014

Dr. Kayvan Shahrzad – Warrenton – Western University of Health Sciences College of Dental Medicine 2016

Dr. Yeliz Swayne – Springfield – Virginia Commonwealth University School of Dentistry 2016

Dr. Reza Tahernia – Leesburg – Canada/ University of British Columbia 2006

Dr. Tony Truvan – Fairfax – Virginia Commonwealth University School of Dentistry 2004

Dr. Annie Ware – Manassas – Western University of Health Sciences College of Dental Medicine 2016

VDA - MINUTES OF THE 148TH ANNUAL BUSINESS MEETING

THE OMNI HOMESTEAD RESORT - SEPTEMBER 17, 2017

1. President William V. Dougherty III, D.D.S. called the meeting to order and the flag pledge was recited.

2. The following deceased members were remembered:
Component 1: Marshall Mahanes , Paul E. Prillaman , E. James Reitano. Component 3: John P. McCasland, Shannon G. Sink.
Component 4: Madison R. Price, Norman W. Littleton, William B. Massey, Michael O. McMunn. Component V: George J. Orr.
Component 6: H. Neal Davis, David A. Kovach. Component 8: Jerome I. Rock, Henry L. Zak.

3. Recognition was given to:
2017 VDA Fellows: Component 1: Joseph A. Bernier-Rodriguez. Component 4: John A. Alexander, Avi B. Gibberman.
Component 8: Robert D. Argentieri, VaCora L. Oliver-Rainey.

2017 Recipients of Life Member Certificates:
Component 1: Richard A. Arnaudin, Paul N. Berger, Dearl C. Duncan, Randall I. Furman, Frank B. Gigliotti, David S. Hirschler, II, Dean E. Kent, David Konikoff, Edward S. O'Keefe, Robert A. Simmons. Component 2: Paul K. Hartmann, N. R. Lee, James F. Pape, Donald L. Taylor, Jr., Lionel W. West. Component 3: James K. Johnson, Harlan Schufeldt, Kent Yandle, Reginald S. Young.
Component 4: David A. Beck, Bruce C. Cook, John C. Doswell, II, Steven E. Evens, Dean M. DeLuke, Barry L. Kurzer, Frank D. Straus, John A. Svirsky, David S. Wozniak. Component 5: Michael A. Abbott, Robert M. Bielawski, Robert S. Carlish, David K. Fitzgerald, Raymond A. Green, Paul D. Harvey, David L. Morris, William E. Morris, Jr., Thomas M. Richardson, Amy D. Rockhill, Michael W. Tyler, Kyle W. Wheeler. Component 6: Roger N. Bays, Claude V. Camden, Jr., Dean Evans, Charles E. Harris, Ronald W. Householder, Steven L. Wheeler. Component 7: William C. Berbes, Kenneth R. Eye, Frank D. Jones. Component 8: M. A. Bagden, Fred A. Bubernak, Stephen Cicinato, Gary F. Ellenbogen, Harold L. Frank, Michael L. Gannon, Jeremiah J. Kelliher, Jr., James R. Lazour, Lawrence R. Muller, Mona F. Nashid, Aurelio A. Roca, Richard Rubino, Wayne Schecht, Phillip C. Scheider, Peter W. Smith, Jr., Susan A. Yung.

2017 Recipients of 50 Year Membership Certificates:
Component 1: Bruce L. Bosworth, David K. Foster, Ralph W. Haywood. Component 2: Harry S. Conn, Charles R. Harris, Jr., William Pearlman. Component 3: Joseph C. Hillier. Component 4 Donald S. Bolick, James Cumbey, Jr., William B. Kemp, Harvey F. Selden, John J. Sweeney, Leslie S. Webb, Jr. Component 5: Bobby D. Burnette, Daniel E. Grabeel, Jim A. Keesee, Joseph H. Penn.
Component 7: Kenneth D. Bowman. Component 8: Robert M. Averne, John E. Bilodeau, Richard C. Brigleb, Charles E. Ehle, Irwin S. Feldman, Richard D. Fiorucci, Richard M. Goldman, Frank P. Grosso, Earl E. Klioze, John W. Willhide.

2017 Receipts of 60 Year Membership Certificates:
Component 1: Calvin L. Belkov, Jerry J. Garnick, Howard S. Tugwell. Component 2: Paul Burbank, Jr.
Component 4: James J. Andre, Robert V. Perkins, Jr., William C. Williams Component 5: Fred G. Alouf, Jr., Lewis G. Coffey.
Component 6: Walter H. Hankins, Jr. Component 7: Robert S. Markley, Charles L. Shank. Component 8: Dick S. Ajalat, Henry M. Botuck, Thomas G. Gilbert, Jr., Charles H. Miller, Jr., Alvan M. Morris, Wedo Nutaitis, Nathan S. Spitler.

2017 Recipients of 70 Year Membership Certificates:
Component 3: Herbert R. Boyd, Jr., Component 4: Watson O. Powell, Morris Robinson. Component 5: Thomas T. Upshur.
Component 8: Joseph G. Bosco, John Y. Embrey, David D. Peete.

4. Dr. Elizabeth Reynolds gave information on donations that can be made through the ADA Foundation and encouraged members to donate money to benefit members who have experienced recent hurricane damage.

5. The following VDA awards were presented:
Honorary Membership: Thomas Wilson, Executive Director of the Northern VA Dental Clinic
Emanuel W. Michaels Distinguished Dentist Award: Kirk Norbo, D.M.D
Dental Team Member: Joyce Morgan
New Dentist: Jeena Devasia, D.D.S.
Leadership: David C. Anderson D.D.S., Alonzo M. Bell D.D.S. , David E. Black. D.D.S., Peter K. Cocolis, D.D.S., Jared C. Kleine, D.D.S, Kirk M. Norbo, D.M.D., Richard L. Taliaferro, D.D.S., Gus C. Vlahos, D.D.S., Roger E. Wood, D.D.S.
Presidential Citations: Samuel W. Galstan, D.D.S., Karen S. McAndrew, D.M.D., Tyler Perkinson, D.D.S., Elizabeth C. Reynolds, D.D.S., Richard F. Roadcap, D.D.S., Cynthia Southern, D.D.S.

6. Bruce Hutchison, VADPAC chair, gave a committee update and announced the following VADPAC awards:

Category A – Percentage of members who contributed to VADPAC:
Large Component – Tidewater Dental Association (36%)
Small Component – Southwest Dental Virginia Dental Society (54%)

Category B – Percentage of Commonwealth Club Members or higher:
Large Component – Tidewater Dental Association (25%)
Small Component – Southwest Virginia Dental Society (42%)

The Governor's and Apollonia Club members were recognized.

Winner of the drawing for a $500.00 gift certificate for contributing to VADPAC during The Virginia Meeting – Tim Collins.

7. The Golf Tournament winners were announced.

8. The following election results were announced (this being an uncontested election, the candidates were declared elected by acclamation at the opening Business Meeting session on September 13, 2017):
<u>President Elect</u> – Samuel W. Galstan
<u>Secretary/Treasurer</u> – J. Ted Sherwin
<u>ADA Delegates</u> (3 year terms ending in 2020) – Bruce R. Hutchison, Frank P. Iuorno, Rodney J. Klima, Richard L. Taliaferro.
<u>ADA Alternate Delegates</u> (2 year terms ending in 2019) – Paul T. Olenyn, Danielle H. Ryan, Cynthia Southern, Brian C. Thompson, Stephanie N. Vlahos. (David C. Sarrett was appointed by the Board of Directors to serve another term also ending in 2019.)

9. The out-going component presidents were recognized:
David T. Marshall (1)
Robert J. Feild (2)
Eric Shell (3)
Claire C. Kaugars. (4)
James K. Cornick (5)
Marlon Goad (6)
Caitlin S. Batchelor (7)
Hugo Bonilla (8)

10. The president installed the newly elected VDA officers, ADA delegation members and the following component presidents:
Joseph A. Bernier-Rodriguez (1)
Sayward Duggan (2)
Julie Hawley (3)
Trisha A. Krause (4)
Kevin Snow (5)
Marlon Goad (6) (second term)
Brooke D. Goodwin (7)
James W. Willis (8)

11. The president thanked the Council on Sessions for their hard work resulting in a successful meeting.

12. Vince Dougherty presented in-coming president Benita Miller, with the president's pin.

13. Benita Miller presented Vince Dougherty with the past president's pin, the VDA Torch Bearer Award and the ADA Constituent Past President's Pin. He was also given a gift in appreciation of his service during the past year.

14. The meeting was adjourned.

VDA - BOARD OF DIRECTORS

ACTIONS IN BRIEF - SEPTEMBER 13-17, 2017

1. Approved: The following amendments to the Board of Directors Investment Policy Statement:

a) **Short Term Account**. This account, along with the Operations Account is designed to maintain a liquid reserve in an easily accessible form in case of emergencies. The target amount in this Account is roughly ~~40% of the total investment Fund~~ $400,000

b) **Long Term Account:** This fund will be constructed to accomplish the VDA's long term financial goals (3-5 years). The amount in this Account represents ~~roughly 60% of the total Investment Fund~~ all funds not required for the Operations Fund or Short Term Account. Money transferred into this account must be approved by the elected officers (President, President-elect, Secretary/Treasurer and Past President) in consultation with the Executive Director.

Background: With growing reserves, we need to transition away from past needs of the Association, and more on the needs of today. Currently there is nearly $450,000 in the VDA's Short Term Account. This change would allow us to move the additional amount into the Long Term Account. I feel that $400,000 is more than adequate to meet a short term crisis. Also, remember that we have set up the ability to borrow against our building if a temporary need arouse. These kind of circumstances are highly unlikely, but we are prepared none the less. This changes Board Policy and does not require a House vote.

2. Approved: The VDA supports the allocation of appropriate funds in the Virginia Department of Health to support long-term compensation for dentists and support staff, including CDHC's, in Lenowisco and Cumberland Plateau Health Districts. If the Department of Health does not re-allocate funds then the VDA will be prepared to make a legislative initiative to obtain the necessary funding through the budgetary process.

3. Approved: The Board of Directors urges the VDA president to appoint a task force to determine the VDA's next steps to eliminate the crisis in oral health care in Southwest Virginia. The task force to report back to the Board in January 2018.

4. Approved: The VDA Board of Directors will allow the VDSC to use the VDA email list quarterly to promote use of the VDSC venders. (Interim Policy to be re-affirmed by the 2018 House of Delegates.)

Background: The VDSC royalties are decreasing. The VDSC Board is worried their vender information is not communicated well with the VDA membership.

VDA - 46TH HOUSE OF DELEGATES

ACTIONS IN BRIEF - SEPTEMBER 15-17, 2017

1. **Approved:** VDA Policy change - Committees and Councils #5.3 (Page 7)
   Removal of:
   ~~3. The secretary of each committee will be elected by the committee members or appointed by the chair. The secretary will assume the duties of the vice-chair in case of the absence or incapacity of the vice-chair.~~
   Replaced with:
   3. If the committee chair is absent, the vice-chair will assume his/her duties. If the committee has no vice-chair; the committee members will elect a chair pro tempore.

2. **Approved:** An amendment to Bylaws Article I, Section 1
   E. Fellows: Designation to this class of membership is limited to Active, Life or Retired Members of the Virginia Dental Association who have been members of the Association for at least ~~ten~~ seven years. Military and or federal service personnel having served a minimum of ~~5~~ 2 years active duty and maintaining active membership in the ADA may be considered for VDA Fellowship after 5 years of VDA Service.

3. **Approved:** The chair of the New Dentist Committee will serve as a voting member of the Board of Directors.

4. **Approved:** The 2018 Budget as presented.

5. **Approved:** The VDA supports the allocation of appropriate funds in the Virginia Department of Health to support long-term compensation for dentists and support staff, including CDHC's, in Lenowisco and Cumberland Plateau Health Districts. If the Department of Health does not re-allocate funds then the VDA will be prepared to make a legislative initiative to obtain the necessary funding through the budgetary process.

6. **Approved:** Honorary Membership for Thomas Wilson, Executive Director of the Northern Virginia Dental Clinic.

7. **Approved:** The 2017 Life Members:
   Component 1: Richard A. Arnaudin, Paul N. Berger, Dearl C. Duncan, Randall I. Furman, Frank B. Gigliotti, David S. Hirschler, II, Dean E. Kent, David Konikoff, Edward S. O'Keefe, Robert A. Simmons. Component 2: Paul K. Hartmann, N. R. Lee, James F. Pape, Donald L. Taylor, Jr., Lionel W. West. Component 3: James K. Johnson, Harlan Schufeldt, Kent Yandle, Reginald S. Young. Component 4: David A. Beck, Bruce C. Cook, John C. Doswell, II, Steven E. Evens, Dean M. DeLuke, Barry L. Kurzer, Frank D. Straus, John A. Svirsky, David S. Wozniak. Component 5: Michael A. Abbott, Robert M. Bielawski, Robert S. Carlish, David K. Fitzgerald, Raymond A. Green, Paul D. Harvey, David L. Morris, William E. Morris, Jr., Thomas M. Richardson, Amy D. Rockhill, Michael W. Tyler, Kyle W. Wheeler. Component 6: Roger N. Bays, Claude V. Camden, Jr., Dean Evans, Charles E. Harris, Ronald W. Householder, Steven L. Wheeler. Component 7: William C. Berbes, Kenneth R. Eye, Frank D. Jones. Component 8: M. A. Bagden, Fred A. Bubernak, Stephen Cicinato, Gary F. Ellenbogen, Harold L. Frank, Michael L. Gannon, Jeremiah J. Kelliher, Jr., James R. Lazour, Lawrence R. Muller, Mona F. Nashid, Aurelio A. Roca, Richard Rubino, Wayne Schecht, Phillip C. Scheider, Peter W. Smith, Jr., Susan A. Yung.

8. **Elected:** The following component directors to serve on the VDA Board of Directors:
   C. Sharone Ward – Component 3 (3-year term ending in 2020)
   Dustin S. Reynolds – Component 5 (3-year term ending in 2020)
   Caitlin S. Batchelor – Component 7 (Will serve last 2 years of an unexpired term ending in 2019.)
   James W. Willis – Component 8 (3-year term ending in 2020)

9. **Re-elected:** Scott Berman as Speaker of the House for 2018.

IN MEMORY OF:

Name	City	Date of Death	Age
Dr. Carol N. Brooks	Richmond	October 1, 2017	65
Dr. H. Neal Davis	Big Stone Gap	August 28, 2017	74
Dr. John P. McCasland	Warrenton	August 17, 2017	86
Dr. Paul E. Prillaman	Chesapeake	July 10, 2017	55
Dr. David A. Kovach	Bluefield	June 28, 2017	73
Dr. Jerome I. Rock	Ponte Vedra Beach, FL	November 23, 2016	89
Dr. Richard E. Ruble	Forest	September 28, 2015	75
Dr. Thomas J. Fitzgerald	Goochland	October 30, 2014	95

THE FOUNDATION OF MEMBERSHIP

Dr. Elizabeth C. Reynolds; Chair, Council on Membership

We are so excited to update everyone on the VDA Ambassador program! This has been an incredibly busy year for this program, and we feel we have survived through the growing pains and have emerged on the other side with an incredible program that will be the flagship of our new member engagement activities.

Membership has been a primary focus of our organization these past few years. The leadership has taken this responsibility of maintaining and increasing our membership seriously. There have been a number of programs put into place to support this goal, and the Ambassador Program is one of the strongest and most important.

In order for an organization to be successful in this day and age, it must not just meet, but exceed, the expectations of its members. This relationship is initiated by ensuring that new members are immediately welcomed and comfortable upon joining the organization in order to help them understand how to become engaged members of our community. Once they feel a part of something larger than themselves, they are then committed. Once we have a committed membership we have built a community of like-minded people who care about the organization and want it to succeed into the future. Our hope is that the Ambassador Program will be the foundation that will assist us in achieving this lofty goal.

Our focus for the past year has been to standardize the new member experience across our components so that every new member has the same opportunity to feel welcomed into the VDA. This will give us the chance to show these members who we are and what we can do for them and their dental careers. We will be able to highlight all we do for the dental profession and assist them in understanding how important the VDA is to all Virginia dentists, be they specialists or generalists, single practitioners or group practitioners, faculty or corporate, and that what we all have in common is our profession and the importance of maintaining it for the future generations.

If you are excited about the VDA and would like an opportunity to become involved, please contact Sarah Mattes, our Membership Advocate at the VDA, and she would be delighted to assist you in becoming an ambassador.

What an amazing opportunity to foster and disseminate VDA mission and vision! Come make a difference!

Protecting your patient information is our #1 priority.

Excel Micro is ready to partner with **Virginia dental professionals** by providing you with HIPAA compliant email security solutions.

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LEARN

COMMUNITY DENTAL HEALTH COORDINATORS:

A POSITIVE CONTRIBUTION WITHIN PUBLIC PROGRAMS/PRIVATE PRACTICES

Dr. Scott Cashion, ADA 16th District Council on Advocacy for Access and Prevention

There has been much information lately about a program for dental team members designed by the ADA called the Community Dental Health Coordinator (CDHC).

A CDHC emphasizes case management, patient navigation and community/individual oral health prevention. With the expansion of Medicaid in so many states and statistics showing that only about half the people covered by commercial dental insurance actually use it, the time is right to discuss the true value of a CDHC.

The ADA began contemplating the benefits of a CDHC in 2007 as a five year pilot program in three sites. When the pilot concluded in 2012, the data from over 80 case studies was analyzed to get a real sense of the "impact" that a CDHC can have.

In addition to the thirty four CDHC graduates of the pilot program, most of whom were hygienists or dental assistants, there are an additional 75 CDHCs now working in over 20 states across the country. They are new members of the dental team who work within a state dental Practice Act; they are not "mid-level providers."

The goal of the CDHC program is to integrate community health worker skills with oral health experience and training. During the pilot phase, students came from various backgrounds: assisting, hygiene and social work. The curriculum is taught in an online format combined with several in-person meetings over the length of training, typically 6-12 months. A certificate of completion is granted after the program is completed, usually within a dental assisting or hygiene program.

The current online curriculum breaks apart into "stackable" credits, which a community college can conveniently integrate into their own existing dental hygiene curriculum. The course can also be offered as a separate continuing education series.

CDHCs may provide preventive services as the State Dental Practice Act allows, but their true value lies in their community work, including oral health promotion and prevention, patient navigation, health literacy, community mapping, and case management. These skills are explicit parts of the CDHC curriculum.

Why do patients need navigation and case management?

Case management has been defined as the coordination of care that a patient may need to maximize access to care and their overall health outcomes. This includes explaining the procedure in plain language, ensuring transportation to the appointment, arranging translation services as needed, and following up with support services. As much as most dentists like to think that patients understand what treatment they need, studies indicate that may not to be true in many cases!

Patients with commercial or public insurance may not know how to access a dental office. Just picking up the phone and making an appointment can be confusing and overwhelming for many people. They may be unsure of which dental office accepts their insurance and how to begin when seeking care.

The current CDHCs help patients find dental offices that accept their insurance, (they can also enroll patients into insurance programs), offer office hours that fit their work or school schedules, and answer questions regarding what dental treatment consists of and how long it may take. With the information gleaned from community mapping, CDHCs can guide patients not only into public health clinics, but into private practices as well, depending upon the patient's eligibility for various insurance options.

These personalized navigational skills have been shown to greatly reduce patient no show rates. As community health centers and public health clinics well know, patients experience many barriers to keeping appointments. CDHCs are trained to effectively reduce those rates and track patients to completion.

Medical-Dental Collaboration is a prime area where a CDHC can assist patients in improving their overall health. As the ADA and the American Academy of Pediatric Dentistry have stated, the first dental visit should happen by 12 months of age. Many pediatricians appreciate this policy, but guiding parents and young patients to dental homes typically involves only the pediatrician making the suggestion. With a CDHC personally connecting the office of a pediatrician to the dental office, families may be directly appointed into the dentist's schedule.

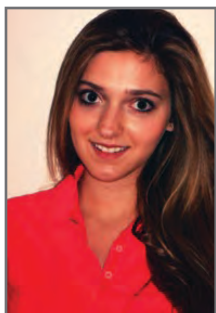
CDHCs often spend time in nursing homes or assisted living facilities performing oral health screening services and making referrals to a dental office. Of added value is the CDHC's ability to provide in-service training to nursing home personnel on oral health care and denture maintenance.

The ADA and the American College of Obstetrics and Gynecology collaborated on a Joint Consensus Statement several years ago that reinforced the safety factors and importance of having women receive dental care throughout their pregnancy. This largely unknown information, coupled with the uncertainty of locating dental services, can be enhanced by a CDHC who could provide oral health education and navigation to these pregnant women.

There are now thirteen states that offer or will soon offer the CDHC program: California, Arizona, New Mexico, Mississippi, Illinois (4 Hygiene schools), Virginia, Florida, Michigan, North Carolina, Hawaii, Massachusetts, Maryland and Kentucky. Rio Salado Community College in Arizona has a distance learning program that allows students from any state to participate. They currently have over 35 students from 13 states participating in the 2017-2018 program.

As your 16th District representative to the Council on Advocacy for Access and Prevention, I am happy to answer any questions about CDHC or any of the Action for Dental Health initiatives. My contact information is: Scott Cashion, scashion@me.com, 16th district Council on Advocacy for Access and Prevention (CAAP) representative.

For more information on the CDHC program, please visit ADA.org.



BEHIND THE SCENES AT VCU:

THE STAFF THAT MAKE OUR DAY POSSIBLE

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

As a third-year dental student beginning full-time patient care, I have gained a new perspective on the complexities of our clinics. The School of Dentistry sees hundreds of patients a day in its dental student clinics, resident clinics, and faculty practice. The success of these clinics would not be possible without our excellent and experienced faculty members, but there are also many people at our school who sometimes go unnoticed. Unlike private practice, a dental school requires a large staff of qualified technicians who oversee the sterilization and dispensing of all of instruments and materials to the entire school. Some are also involved in running our pre-clinical labs and supporting our digital technology. I interviewed some of our technicians to gain insights on their day-to-day work life and everything that they do to keep our school running smoothly.

I talked with Robert Armstead, a digital technologist who works with CAD/CAM and 3D printing. Speaking excitedly about our new technology, he said, “It’s adding digital innovation to the school; we are getting our students ready for the future and we want them to be good with the traditional and the digital. There’s always more than one way to skin a cat.” Robert introduced my class to CAD/CAM last year in our fixed prosthodontics lab, and I remember being greatly impressed by the technology once I finally got the hang of using the scanner. “I love the students – they’re ambitious, they want to learn, and they want to be great dentists,” said Robert. “We have a new CAD/CAM lab coming, hopefully in 2018 – it’s state of the art!” Robert’s passion for our school and new technology is obvious, and shows how invested our staff members are in the success of students.

“In IMS [Instrument Management System] we have our ups and downs, but if you work as a team everything comes together,” said Shante Harvey, a sterilizing technician who has worked at VCU for the last two years. Her days are long and hectic – she helps man the autoclaves on the first floor of our building, which sterilize instruments for the entire school. “We have four carts and three autoclaves and on any given day we always have a cart waiting to go into an autoclave. I know we sterilize over 400 units a day.” With an IMS staff of under 20 people, many of whom are faced with other daily tasks, the sterilization and packaging of all of our supplies is a huge undertaking.

Two brothers, Marcos and Joseph Watson, also shared their thoughts with me. They work in dispensing in our student clinics. “I love providing customer service skills and using my knowledge of dentistry to help you guys receive what you need in dispensing. Without IMS there would be no sterilized items; there would be no clean cassettes to go about each and every day,” said Marcos. “I like working with people… we’re the first people to do all the dirty work,” said Joseph. They and their co-workers speak with happiness and pride about working with students and patients. They hope that faculty, students, and the patients as well, recognize their contribution to the safe and efficient operation of a university dental school clinic.

As I continued talking with IMS staff members, I heard similar sentiments. “I feel like as far as pay and respect, it takes a lot to maintain the labs or have sterile instruments every day… I feel like the students value me more than others,” said a worker in in our pre-clinic lab.

Dental school is a huge investment. We invest time, money, and energy into our studies and our patients, all so that we can accomplish our personal goals. Undoubtedly, we could not function in our clinics without the help of our technicians, just as private practice dentists rely on their assistants and office managers. Shouldn’t we invest in our staff members as well? I want our technicians to know that their work is valued, and I hope that their exemplary service is well rewarded. Dental students will learn that, throughout their career, hard-working staff members are essential to their success.

AWARDS AND RECOGNITION

Dr. Daniel Laskin
International Award for Research and Educational Contributions to the Specialty
Spanish Society of Oral Surgeons (SECIB)

Dr. Roger Wood
Special Recognition - VDSC President 2013-2017
Virginia Dental Service Corporation (VDSC)

VDA CLASSIFIEDS

JOBS - DENTIST

5535 – Mobile Practice Dentist
Premier Mobile Dentistry of Va, LLC is seeking a Virginia-licensed DDS or DMD to travel with a Premier mobile dental clinic and provide routine dental care to non-ambulatory residents of long-term care facilities. The mobile clinic will be based out of Christiansburg, but the successful candidate must be willing to travel throughout the Southwest part of Virginia as required. Premier is looking to staff a mobile clinic 5-days per week and will consider full- or part-time applicants. The successful candidate will have a current Virginia license, valid malpractice insurance, and a dedication to ensuring the highest quality of care to patients. EOE. To apply, contact Amie Rabel at amiefalcon@gmail.com or 225-324-5945.

5649 - Dental Director
Dental Director Southwest Virginia Community Health Center, a Federally Qualified Health Center (FQHC) and Joint Commission accredited Primary Care Medical Home (PCMH) located in Saltville, Virginia, is seeking an experienced Dentist to join this established practice as the Dental Director. The ideal candidate will maintain a Virginia license and have previous experience managing a dental clinic/practice. Benefits include 403b retirement plan, medical and dental insurance, HSA account, paid time off, CE allowance, malpractice insurance. Please forward resume to: Gail Mullins at gmullins@svchs.com or PO Box 729 Saltville, VA 24370 Website: www.svchs.com

5670 – Oral Surgeon Associate Wanted
Busy solo doctor seeking a part-time associate. Ideal candidate will be board certified or eligible. Practice has a focus on implants and 3rd molar extractions. We are located in suburban DC. Flexible terms, please inquire at oralsurgery@gmail.com

5673 - Associate Dentist (Charlottesville)
Excellent Associate opportunity in Charlottesville, VA with John H. Knight, Jr, DDS & Associates and Spring Creek Family Dentistry & Orthodontics. Full time opportunity with a multi doctor 2 location team of dedicated health care professionals. If you are looking for a great work environment, compensation with a possible ownership opportunity then please contact us ASAP. Please forward resume to JayKnightDDS@comcast.net

5676 – Associate Dentist
Dental Health Associates We are looking for talented dentists to join our team full time or part time. We are a dentist owned multi office group practice in need of a seasoned dentist or a recent GPR/AEGD graduate. We offer comprehensive modern dentistry for the entire family. The candidate must have integrity and possess good interpersonal skills. You'll work with state-of-the-art technology and have valuable opportunities for continued education, training and mentorship. We are in the beautiful Shenandoah Valley of VA. www.MyDentalHealthAssociates.com Send cover letter and CV to: drlagrua@MyDHA.net

5677 – PT Associate – General Dentist
Seeking a general dentist for a part-time associate position 2-4 days a week. We are a busy, family oriented dental office located in Western Prince William County. 1-2 years experience is a plus. Compensation negotiable. Please email resumes to honestdentist@yahoo.com.

5678 – Associate Dentist Needed
Our family dentist office is looking for an associate dentist with the potential earning of over $200,000.00 per year. Must be able to perform molar root canals, extractions, crowns, bridges, fillings, removable prosthetics, work with children.... Must have one year experience working as a dentist, Virginia dental license, current malpractice insurance and DEA license. We are also looking for applicants who are bi-lingual (English/Spanish).
Contact: James Graham 540-720-8630 normagdds@gmail.com

5700 – Dentist – Williamsburg, VA
Morrison Dental Group is hiring for our expanding practice! Opportunity in Williamsburg, Va - Live in the "Colonial Capitol" near beautiful beaches, just a short drive to Richmond, Virginia Beach and Washington DC. Our practice enjoys providing a wide variety of services to our patients including adult orthodontics, CEREC crowns, surgical endo, and placing implants. 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. Mentorship program available to new graduates. Experienced doctors and new grads alike are encouraged to apply. If this sounds like a great fit for you, please contact us by phone or email. We look forward to meeting you! Contact: Allison Morrison, 757-719-2237, amorrison@morrisondentalgroup.com

5701 – General Dentist – Hampton, VA
Morrison Dental Group is hiring for our expanding practice! Opportunity in our newest location in Hampton, Va! Beautiful family oriented practice with great earning potential. 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! Contact: Allison Morrison, 757-719-2237, amorrison@morrisondentalgroup.com

5706 – Part Time Dentist
Seeking Dentist to join PT our general family practice located in Shenandoah County, Woodstock, VA. Position may transition into a full time position associate in the future if desired and/or partnership. Dentist must be comfortable with all aspects of dentistry and be able to provide comprehensive diagnosis and treatment plans. Clinic is fully staffed, with digital x-rays and paperless software. Must have current valid Virginia license, DEA, and malpractice insurance.
Contact: Dr. Dauer, 540-459-2173,
hernandez-dauer@wstockdental.com

5708 – Associate Dentist
Are you ready to join a well established patient focused dental practice located in the Western Branch location of Chesapeake, VA? If so then you have located a new dental family! Midgette Family Dentistry is growing and is a state of the art facility providing quality patient care. Dr. Midgette and his associates have provided comprehensive dental care for 30+ years. We are looking for a general dentist to join our team who can provide all facets of dentistry to the entire family. The position is flexible for part-time or full-time. Candidate should possess great communications skills and integrity. Highly Competitive Salary and Benefits Package to include medical, 401k, CE and more.
Contact: Brian Midgette, DDS, 757-483-4700, bpmmcv87@aol.com

5710 – Dentist Wanted
Dentist Wanted! Southwest Virginia Community Health Center near Abingdon, Virginia is seeking a Dentist to join their established practice. The ideal candidate will maintain a Virginia Dental and DEA license. This is a salaried, full time position including benefits such as: medical, dental, vision, paid time off, 403b retirement, malpractice insurance, CE allowance and much more. Opportunities for student loan repayment available. Please send inquires and resumes to: Amber Hubble at ahubble@svchs.com or PO Box 729 Saltville, VA 24370. Phone: 276-496-4492 opt. 1015.

5711 – Dentist Needed – Chester
Seeking Full-time or Part-time general Dentist. We have two state of the art practices one in Chester and the other one is in Colonial Heights. We have a few general dentist and an Orthodontist in our team. We have a large patient pool with plenty of new patients. Looking for a dentist with experience in all aspects of general dentistry. Great salary and compensation for the appropriate candidate. Immediate opening please send your resume richmonddentist@gmail.com

5712 – Williamsburg – Endodontist
State of the art, high tech, high touch large multi-specialty general practice seeks endodontist to treat our patients in our office one day per week. Microscope and trained staff available to you Visit www.newtowndentalarts.net, then reply with your CV and Cover Letter opportunities@newtowndentalarts.net

5713 – Dentist Opportunity
We are seeking a caring general dentist to join our practice. Large, well-established client-centered office looking for the right person who wants to be part of a team of true professionals. Our practice has a modern, progressive atmosphere with an outgoing multi-talented staff. State-of-the-art freestanding building/facility in a growing, upscale new town center. Want to spend time raising your family and work at your convenience? Semi-Retired and looking for a chance to keep up with practice and technology? We can be flexible. Experience with endo and surgery preferred. Visit us at
www.newtowndentalarts.net Contact us with your CV and Cover Letter at opportunities@newtowndentalarts.net.

5715 – Part Time Associate Dentist
Part time opportunity available in the beautiful mountains of Virginia. This is a private practice open Monday – Thursday in Hot Springs, VA. The schedule is packed and the doctor would like to have an associate to help out two days per week. Compensation will be a guaranteed daily rate or a percentage of collections, whichever is higher. Travel costs and malpractice will also be covered.
Contact: Zac Rhinesmith, 770-710-3042, zrhinesmith@benevis.com

5716 – Dental Director
Seeking experienced Dental Director for growing community health center integrated practice. Wonderful opportunity to join a supportive health center management team and offer leadership and vision to a dynamic, dedicated staff. Oversee 2 dental clinic sites/teams in the City of Roanoke, and also deliver patient care. 25-30% administrative, 70-75% clinical split. Digital x-ray, electronic records. Diverse patient base. Serve all ages with mix of preventive and restorative services, oral surgery, limited endodontics and prosthodontics. Requires graduate from an accredited dental school, and must have Virginia dental license at the time of employment. Willingness to work occasional evenings and/or Saturday mornings, on rotating schedule. Salary DOQ, competitive benefits package, including health, dental, life insurance, retirement, malpractice, generous leave, holidays, CPE, licensure, professional membership, relocation allowance. Site is qualified as eligible for educational loan repayment & scholarship opportunities through NHSC and VSLRP. Located in scenic Roanoke, Virginia in the Blue Ridge Mountains. Great outdoor recreation, cultural and social opportunities. Family friendly, excellent public/private schools. Conveniently located off Interstate 81, regional airport. Please submit resumes by email to ahill@newhorizonshealthcare.org or mail to Andree McTyson, Human Resources Specialist, 3716 Melrose Avenue NW, Roanoke, VA 24017. Resumes will be accepted until position filled. Equal Opportunity Employer.

5717 – Dentist – Charlottesville
Opportunity to work with children, adolescents, and special needs patients at an established practice located in Charlottesville, Virginia. Additional information is available upon request.
Contact: Jessica Moore, drmoore@cvillechildren.dental

5719 - Dentist (Glen Allen/Richmond)
Associate Dentist needed to join our growing practice. We have a State-of-the-art facility and we offer a wide range of dental services.
Contact: Mr. Jad Jean Babik, 804-755-8050, jbabik@drbabik.com

5722 – General Dentist
Seeking full time General Dentist for our state of the art private practice. you would be the sole dentist. We have a wonderful staff and patient base. New beautiful office located in Manassas Virginia. We are currently seeing 80-90 new patients a month. Must have confidence and excellent skillls in all aspects of dentistry, to include RCT, EXT, CR & Bridge Implants. If you are looking to make your professional mark on a community, this is your chance. Build valuable relationships with patients while providing top-notch dental care. 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.
Contact: Lisa, 571-379-2434, lisa.smdc@gmail.com

5723 - Associate Dentist Wanted for Family Practice - P/T
Bowman Family Dentistry is eagerly seeking an associate dentist to join our growing and busy family practice. We have served our patients for 50 years in the beautiful Shenandoah Valley, Waynesboro, Virginia. Must be a positive, highly motivated, compassionate, team-oriented candidate with excellent chair-side manners who provides high quality dental care with high ethical and moral standards. As a team we perform a wide range of services, for families with members of all ages, which include Preventive, Restorative, Prosthodontics (Fixed & Removable), Extractions, & Endodontics. Initial hiring terms will be part-time (3 days per week, Wednesdays through Fridays) with potential to build into a full time position. Excellent earning and growth potential. Current Virginia Dental License, DEA, & CPR required. Please email your Resume/CV and Cover Letter to
info@bowmanfamilydentistry.com or fax to 540-221-4297

5728 - PEDIATRIC DENTIST - VIRGINIA BEACH
WEIS PEDIATRIC DENTISTRY is located in Virginia Beach, Chesapeake and Portsmouth, VA. Are you a pediatric dentist who is looking for a practice that practices with a high standard or care, takes great care of its' patients and has a practical approach to how we offer dentistry? Are you looking to work in a fun culture with a supportive team? Do you want to work with people with strong values that are passionate about what they do? Are you looking to not only work with purpose but also have a system in place that allows for you to make good money doing it? This may be the job you are looking for… About Weis Pediatric Dentistry: For years, Weis Pediatric Dentistry has aimed to set a standard for how pediatric dentistry is done in our Virginia markets. We have locations in Chesapeake, Portsmouth and Virginia Beach. Our practice cutting edge, all the latest technology as well as a paperless office. Hospital Dentistry Available. Send your resume as well as a cover letter that explains what you love about pediatric dentistry to Amy Fitzgerald at amy@weisteeth.com A qualified candidate will have: •DMD or DDS Licensed in the state of Virginia or the ability to do so. •Pediatric Dentist Certification
www.weisteeth.com

5736 - Experienced General Dentist
Fusion Dental, a large multi-specialty dental group has an opportunity for an experienced restorative dentist to assume the practice of a departing senior partner in the northern Virginia area of Reston. A high level of experience with challenging and routine restorative treatment including rehabilitation of failing dentitions, implant supported restorations and integration of restorative care with specialty services is critical. Applicants for consideration should have 7-10 years of clinical experience and training in advanced, restorative dentistry. This is a full time position in a very productive clinical setting which allows you to work collaboratively with highly qualified general dentists and multiple specialists. Excellent compensation and benefits package including malpractice, medical, life insurance and 401K with matching is available. A route to ownership, as a doctor group partner, is possible. Contact: Kate Anderson,
781-213-3312 kateanderson@amdpi.com

JOBS - DENTAL STAFF

VDA CLASSIFIEDS

5661 - Williamsburg Dental Administrative
Seeking caring, experienced dental administrative assistant to join our practice. 4 day work week. Large, well-established client-centered office looking for the right person who wants to be part of a team of true professionals. Our practice has a modern, progressive atmosphere with an outgoing multi-talented staff. Paperless, digital, etc. Flexible schedule, excellent compensation package for the right individual. If you are ready to start your next challenging position and have at least 3 years' experience, are motivated to reach goals and ready to excel, then send us your resume with salary requirements, contact us at opportunities@newtowndentalarts.net with cover letter and resume.

5695 - Part-Time Bilingual Dental Assistant
Part-Time Bilingual Dental Assistant (Richmond) license info: Please submit resume A Richmond based clinic, is seeking a dental assistant for both locations. This position assists in the performance of quality, caring, clinical dentistry. The Dental Assistant performs clinical and technical procedures under the supervision of licensed dentists. Some responsibilities include preparing for dental treatment, taking x-rays and translating for the patient and dental team. Requirements: Candidates must be a team-attitude, have Compassion, Integrity and Leadership skills. Bilingual in Spanish High school diploma or equivalent Minimum of 1 year relevant experience in the dental profession Valid X-ray certificate CPR & first aid certificate Job Type: Part-time(24 hours) Required education: • High school or equivalent Required experience: • Dental Assistant: 1 year Required language: • Spanish Required licenses or certifications: • CPR/First Aid • X-ray certificate. Contact: Daily Planet Dental Health, 804-934-1837, sarterj@dailyplanetva.org

PRACTICE TRANSITIONS

VDA CLASSIFIEDS

5698 - BLACKSBURG, VA - DENTAL PRACTICE FOR SALE!
BLACKSBURG, VA- 38 year old general practice plus real estate for sale in the Blue Ridge Mountains, home to VA Tech. Sales price is $299,000 which includes the real estate last assessed at $217,000. Has 3 treatment rooms in about 1500 sq ft located in nice professional condo office complex just off South Main St. Employs Dentrix and Dexis. Since the area has many high quality specialists, refers out all specialties. Approaching retirement, dentist has cut back to 2-3 days per week and practice revenue was $150,000 in 2016. With plenty of potential patients to expand the hours, revenues would more than double. Montgomery County is known for its school system and is a safe place to work and play. Nearby colleges, lakes, rivers, mountains, and proximity to Roanoke, VA, offer many cultural and recreational opportunities. Great opportunity for any dentist wanting a small town atmosphere with some of the big city amenities. Dentist bought this practice in 1979 when it was 2 years old and now it's time for someone else to make it their own. Email with questions.
Contact – Dr. Harris bburgvaharrisdds@gmail.com

5563 - Office Space Available for LEASE
Description: Newly expanded building needs PEDODONTIST OFFICE to augment existing large general dentist practice in same building. Only one other Pedo in town. Great potential for market share. Warrenton. Please contact by email OR phone.
Contact: Vincent Murray (540) 937-4330
murrayhill2010@wildblue.net

PRODUCTS AND SERVICES

VDA CLASSIFIEDS

5681 – E4D Scanner, Mill and Glazing oven
This E4D was only used a handful of times, and then it sat in a corner for a few years. Still under warranty until Nov 2017. Get the whole set-up for about the cost of just the camera. $43,000. Very New Condition!! (Original cost when new: $125,000) Email for photos.
Contact: Tim Johnston, 757-564-0804, tkjohnstondds@gmail.com

5687 - Dental Chairs + Digital Panoramic Ceph Unit for Sale
3 Extremely nice dental chairs + Digital Panorex Modern Blue covering, Clean white Metal base. Designed for modern Infection Control & Ergonomics. Fully Functional tip back & height motion + foot controller + buttons on unit. Condition Excellent A++ ; No tears, No marks, Excellent. Lightly Used in an Orthodontic Office. Delivery Available. Priced for quick sale: 580 each, two for 1000, all three for 1400 Digital Panorex / Cephalometric Combo Xray also available - Please Inquire. 703-771-1220

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DENTAL THERAPY DOGS:

MAN'S (AND PATIENT'S) BEST FRIEND

Dr. Chris Spagna; Associate Editor, Component 8

Let's face it, for many people, seeing the dentist is not something they really look forward to. In fact, they often dread it. Dentophobia, otherwise known as the fear of dentists, isn't a new concept at all – it's actually one of the most common phobias and affects people of all ages. Different tactics to combat patient anxiety have surfaced over the years, but today the latest trend is the use of therapy animals. These trained and certified animals (usually dogs) are being featured in an increasing number of dental practices across the country, helping to provide a sense of ease and comfort to the anxious dental patient.

Fredericksburg Smile Center, in Fredericksburg, is one such practice that currently offers the services of two Havanese dental therapy dogs - 8 year old Diego and 4 year old Debra Jean (DJ). The mother and son team of Dr. Cathie Hidalgo-Seaman and Dr. Joel Butterworth have always been dog lovers. And when Dr. Cathie recognized a need for therapy dogs to help patients with anxiety a few years ago, she enrolled Diego and DJ in a special training program to become therapy certified.

Dr. Joel says, "Diego, our older dog, is very adept at recognizing anxiety. When a child or adult is extremely anxious, he will lay on their lap or the floor of operatory, and stay with them throughout the duration of procedure." He feels that the practice has gained a large number of patients due to the fact they have therapy dogs. And they have used this as a big marketing tool, along with sedation, to capture the anxious patient population. "The therapy dogs have completely changed our practice," he says, "and I believe it is what we are 'known' for."

The dogs come to work five days a week and have free roam of the entire office, but they are so small many people don't even know they are there. Diego and DJ have a bed in Dr. Cathie's office, so when they're not 'working with a patient', you can usually find them sleeping there or curled up in a corner somewhere.

Patients who have allergies to pet dander are made aware the dogs are hypoallergenic, and have a non-shedding coat. Due to their smaller size, they have never had a situation where someone has been fearful of them. The practice paperwork has a section about dental anxiety where patients are able to note if it is an issue and their level of discomfort at the dental office. Patients are asked if they would like to have one of the dogs with them during cleanings or procedures. The front desk staff is also very good at recognizing when patients are nervous and uncomfortable and will sit with them to ask if they would like Diego to come hang out.

Not only do the patients love the dogs, these two 'employees' get along great with their fellow team members. They say, "It has been a blessing for our staff because when the patients are calm and comfortable, they are much easier to work on and it keeps the schedule running smoothly."

There is strong evidence in research that animal companionship helps to reduce blood pressure, lower stress and anxiety levels, and stimulate the release of endorphins which make people feel good. The doctors and staff at Fredericksburg Smile Center feel that Diego and DJ are able to do all of this for their anxious patients. They remark that the dogs are especially great with children. Since kids may often develop fears about the dentist at a very early age, this helps to create a lifelong change in their outlook on dentistry.

Diego and DJ are favorites among older patients as well. Many adults develop deep-seated issues or dental phobias over decades, and the dogs have brought a new found willingness and openness in adult patients. All too often, despite knowing that they are in need of care, many patients are unfortunately so phobic that they don't see

the dentist for an extended period of time - compounding the problem.

Dental anxiety and phobia are extremely common. It has been estimated that 9% to 15% of Americans avoid seeing the dentist because of anxiety and fear. That's about 30 million - 40 million people. With the success of therapy animals in healthcare and their growing popularity in dentistry, its possible more and more dentists won't just be working on upper canines … they'll have 'upper canines' working for them!