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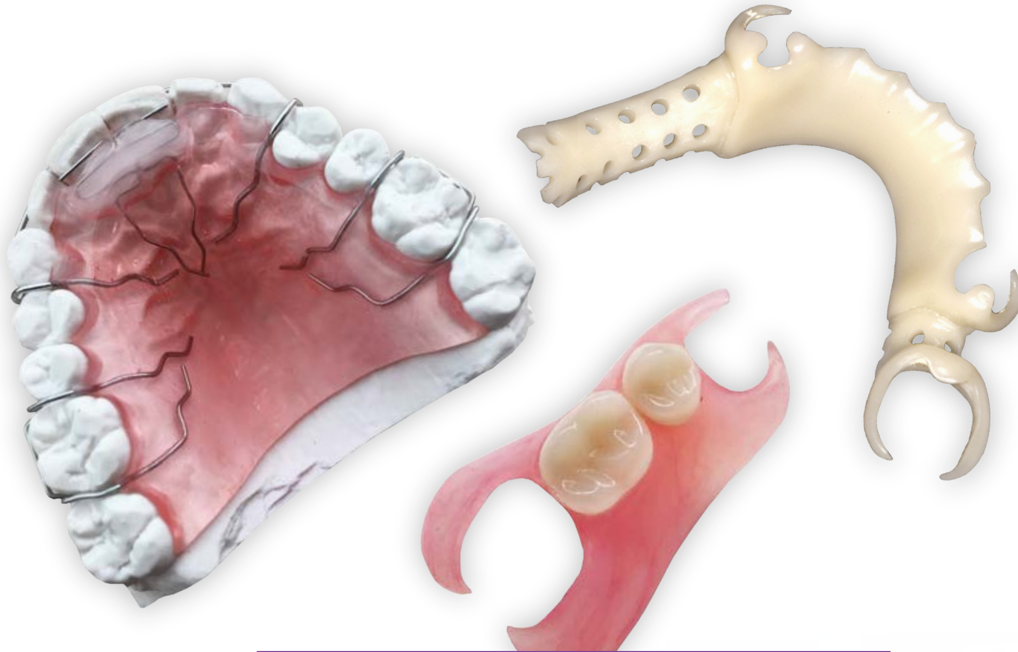

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40 UNDER 40

A new 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. MICHAEL LAZEAR

Our family started practicing dentistry in 1881. I am a fifth generation dentist. I enjoy working alongside my father in our Springfield, VA practice. Our patients enjoy digital dentistry with a quaint, family friendly atmosphere.

Virginia Dental ASSOCIATION

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PRESIDENT'S MESSAGE

Dr. Richard Taliaferro

I hope winter was not too traumatic for you or your practice. I know that I am looking forward to spring as I write this message. Bad winter weather had a major effect on our Day on the Hill and winter committee meetings in January. We were able to hold our Board of Directors meeting on January 21st. The Board of Directors were present at the General Assembly that day when the House Commerce and Labor Committee reviewed our de minimis bill and approved it 21-0. There was some attempted pushback from an insurance company with no success. The VDA and our lobbyists have also been involved with bills regarding remote hygiene supervision, registration of mobile clinics, and a bill to add another citizen member to the Board of Dentistry. Your VDA leadership expressed concerns that with remote supervision, a dentist would remain in charge. We wanted to make sure that mobile clinics are licensed and operated by Virginia dentists, and that all the patient needs were met, not just an exam, x-rays, and a prophylaxis. The leadership was against adding another citizen member to the Board of Dentistry. We are still working to get a Medicaid deferred payment program implemented that was passed two years ago. We also are working to get $100,000 in state funding to support our MOM projects.

Your leadership is studying a program that has been in existence for over 10 years in Ohio and has been highly successful. Ohio was one of the original five states selected by Pew/Kellogg for testing mid-level providers. The Ohio Dental Association proactively developed a plan, on their own, to help solve dental access-to-care issues in their state. They created a scholarship fund that they control to help new dentists pay off their loans while practicing in high need areas. Dentists in Ohio stepped up to the plate and asked the legislature to increase the dental licensing fee by $20, thereby sharing the cost of the program with members and non-members. With over 7000 licensees, they quickly built up a fund to help new dentists move into those areas. The program was so successful that they actually asked for an increase of another $20 a few years later. What is important in Ohio is that their state was similar to ours in that the legislature was not effectively dealing with the issue. In our lobbyist's words, "Virginia legislators will be thrilled this won't cost the state a penny and it serves a great purpose in helping get these recently graduating dentists, with high debt loads, into the remote and rural areas where we struggle getting oral health services to those in need. This is a win/win for all!" With an investment of a modest lunch tab for two, we build positive political capital that will help protect every member's degree, serve our citizens, as well as help out our young dentists. We also feel it is important to show that dentistry is stepping up to the plate to deal with access-to-care through a program such as the Ohio Plan and the Community Dental Health Care Coordinator, which is now in its final stages of development in Virginia. Many thanks to Dr. Mark Crabtree for all of the work that he has done on this important project. Projects such as these show that we, in dentistry, can handle these problems and we don't need new providers such as undereducated mid-Level providers doing our work.

I want to thank the membership in joining us in replying to the Board of Dentistry's intended regulation to require licensees to take a jurisprudence exam every three years. The VDA was strongly against it, with over 190 licensees indicating they were opposed. We still are following how the Board of Dentistry deals with practice ownership. Our concern is with non-dentist ownership controlling dental treatment plans and that the treating dentist should be in charge. We do not feel quotas should control treatment.

By the time this comes to press our Ambassador program should be operating. The Ambassador program is part of our membership focus for this year and the coming years. Several dentists have agreed to be Ambassadors. These folks will visit with nonmembers and educate them on the benefits of being an ADA/VDA tripartite member. They also will help integrate them into local component activities and local study groups etc. As I mentioned in my President's address last fall I am asking everyone to invite a nonmember to join. Personal invitations are one of the best ways to invite a new member. When you go to local meetings be sure to make new members welcome by looking for them and greeting them.

If you have not registered your profile with the ADA, I recommend you do so. People are looking for ADA member dentists to serve them and they are missing you if you have not completed your profile. The PR program that we implemented in 2013 is doing an excellent job of enhancing the reputation of the ADA/VDA. When that happens we all win, as those are the types of dental professionals that potential patients are searching to be their dentist.

My final thoughts for this message are to remind everyone of the importance of being an ADA tripartite member. Compared to most other healthcare professionals, dentists have been somewhat isolated from the outside forces in the past. My son and daughter-in-law have doctorates in physical therapy and their independence and income as health care professionals does not match their level of education. We see that our friends in medicine are retiring early and frustrated at the level of interference from insurers and corporations have affected how they treat their patients. I know these outside forces are not going away anytime soon, if ever. I also feel strongly that the other health care professionals became too fragmented to fight the outside forces, and we see where they are now.

I ask you, how important is the investment of time and money that you put into obtaining your degree? I ask how important is it to you that you have the independence to make clinical decisions that you and your patient, think are best for them, and not what some outside entity think is best? I also ask how important is it to dentists that are working hard every day and are risking themselves financially by setting up, buying or just merely practicing as an associate in a practice that could very well fail from outside interferences? We have to remain united to fight those forces, and not just for us, but also for our patients, who deserve the best that we can offer them. Consider what I am writing thoughtfully, and I hope you will agree to the importance of participating as a member at the national, state and component levels. The more informed and the more active both by active participation and financially each member becomes, the stronger we remain as dental professionals. I hope that you agree with me that along with investing in our families and retirement, this may be one of the most important investments you will ever make. Last but not least, don't just do this short term, be an active member for the long haul; as your profession, your family and your patients are depending on you.

Have a great spring and early summer. I hope you enjoy and have the same passion for dentistry that I enjoy.■

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MESSAGE FROM THE EDITOR

Dr. Richard F. Roadcap

In ancient cultures sins or evils were symbolically removed from the community by placing them on a goat chosen for the purpose and cast into the wilderness, where its fate was a slow death. Modern psychology has refined the concept to those whom we call a "scapegoat", an innocent person or group who takes the blame for others. Many investigations stall or terminate after this moniker is applied.

Much ink has been spilled about the epidemic of opioid abuse and addiction that is sweeping the country. And with good reason: Virginia and other states report that more people die from narcotic overdoses than from auto accidents. News outlets such as CNN and NBC report a wave of pharmacy robberies, often by gunmen who wound or kill non-compliant victims.[1]

A recent article in the *New England Journal of Medicine* states "A key underlying characteristic of the epidemic is the association between the increasing rate of opioid prescribing and increasing opioid-related morbidity and mortality."[2] We've already seen changes here in our practices, such as the reclassification of hydrocodone, a staple of dental prescribing, from Schedule III to Schedule II. No longer are phoned-in refills allowed, often requiring after-hours trips to our office to deliver a handwritten prescription. By now, every dentist in Virginia should have either enrolled with the Virginia Board of Dentistry for the privilege of dispensing controlled drugs or voluntarily opted-out, and also enrolled in the Prescription Monitoring Program (PMP), which can be used to track narcotic prescriptions for patients of record.
(See page 30 for more on this subject.)

I could go on: the Centers for Disease Control reports the number of opioids prescribed between 1999 and 2013 has quadrupled, although the incidence of pain caused by disease remains unchanged.[3] What happens to those pills that aren't taken by the patient? They're often sold on the street for large sums, stolen, or if left unguarded, fall into the hands of a friend or family member where they can be abused. There's an undeniable correlation between the increase in opioid prescriptions, overdose deaths, and the use of heroin.[4] But another type of prescription overuse will haunt dental practices now and in the future: antibiotic prescriptions.

We associate antibiotics with words such as harmless, palliative, curative, preventive, or soothing. Another adjective is needed for our lexicon: dangerous. At the same time that an epidemic of opioid abuse occurs, there's a dramatic rise in the incidence of infections related to antibiotic overuse. *Clostridium difficile*, methicillin-resistant *staphylococcus aureus* (MRSA), and candidiasis are only some the consequences of properly (and improperly) written dental prescriptions. I once sent a patient to the hospital for ten days with pseudomembranous colitis following a (properly-written) prescription designed to prevent subacute bacterial endocarditis (SBE). (At a later date, her heart murmur diagnosis was ruled no longer a condition requiring premedication.) As I have discussed previously in this space, orthopedic surgeons routinely demand antibiotic prophylaxis for dental treatment of patients with prosthetic joint replacements. Many of these patients are age 65 and older, and penicillin-allergic. Clindamycin is the most frequently-prescribed alternative to amoxicillin, yet it carries great risk of *C. diff*. A letter writer to the *ADA News* points out that a clindamycin prescription increases the patient's risk of this disease by twenty times.[5] He goes on to note (with references to the literature) that mortality in *C. Diff* infections is greatest among those over 65.

When it comes to prescribing antibiotics, our habits are far too sanguine. We've all handed out scripts when there's been no evidence of infection, to avoid a late night or weekend phone call, or merely to placate an unsatisfied patient. Often we're not informed of adverse consequences, such as an allergic reaction, or gastrointestinal distress. We frantically rush to Mosby's *Dental Drug Reference*, or other tome, to update our knowledge of antifungal medications when the patient reports thrush or other yeast infections. More than once I've been enlisted to help a patient suffering from thrush secondary to a prescription written by a physician, fearing the onset of a hard-to-diagnose oral condition.

How do we change our behavior? A study published in *JAMA Internal Medicine* found that by posting a signed statement in physicians' examination rooms, agreeing to prescribe antibiotics only when appropriate, prescriptions were reduced 20%.[6] An online study found that 97% of patients understood the dangers of antibiotic resistance, and knew friends or family who had suffered from it.[7] We'll have to educate our patients about the guidelines for antibiotic prophylaxis for prosthetic joints (a difficult task) and also for prevention of subacute bacterial endocarditis (SBE). And, we'll have to remind them not every dental problem requires an antibiotic.

It seems inevitable that our prescription privileges will be curtailed. How should organized dentistry respond? First, we could man the ramparts, and use our PACs to defeat any restrictions. Or, we could change some of our habits, ever-so-gradually, so that when change comes, the adjustment will be easy. It's tempting to say "It's not our fault!" and blame physicians, pill mills, aggressive marketing by pharmaceutical companies, and demanding patients. Unless overdose deaths and antibiotic resistance decline, some of our cherished freedoms as healthcare practitioners will be at risk. If we do nothing, we'll be festooned with the blame and sent to the wilderness. Domestic goats don't survive long in the wild. ■

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1 http://www.nbcnews.com/id/43536286/ns/us_news-crime_and_courts/t/epidemic-pharmacy-robberies-sweeping-us/#.VuWifKT2a1s

2 Compton WM, Jones CM, Baldwin GT. Relationship between Nonmedical Prescription-Opioid Use and Heroin Use. N Engl J Med 2016; 374: 154-163

3 http://www.cdc.gov/drugoverdose/epidemic/providers.html

4 http://www.cdc.gov/vitalsigns/heroin/index.html

5 Samuel Zwetchkenbaum, letter to the editor, *ADA News*, August 15, 2015

6 http://www.medscape.com/viewarticle/828663_4

7 http://www.medscape.com/viewarticle/828663_2

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LETTER TO THE EDITOR:
CHIN UP AND OUT!

Marvin E. Pizer, M.A., D.D.S., M.S. FACOMS*

An attractive 38 year-old white female wonders why she is not gaining weight, but her "double chin" is growing. (Fig. 1) She apparently questions her primary care physician who refers her to a (medical) surgeon who specializes in diseases of the head and neck. The doctor palpates the neck and then with a light and tongue blade depresses the tongue and has the patient say "ah". "This second chin is due to excess fatty tissue and can be removed from a small skin incision." Fortunately the patient makes a routine visit to her family dentist who after inspection and palpation intra-orally, and of the neck, refers this patient to my office.

The patient presented with the same findings as her family dentist. (Fig. 2) She was hospitalized and after a thorough work-up was brought to surgery. Under naso-tracheal anesthesia a throat pack was inserted and the tongue retracted with sutures. Gauze was also placed in the mucobuccal folds bilaterally in the region of the mental foramina. The incision was made in the midline over the raised mass extending from the lingual cortex to the frenum at the floor of the mouth. Combining sharp and blunt dissection, three round masses, each with an apparent capsule but connected to each other, were excised. (Fig. 3) The masses were moderately firm and yes, there was some "fatty tissue" in the sublingual and submental spaces. Once bleeding was controlled the wound was sutured closed. An elastic pressure dressing was placed extra-orally to prevent a hematoma and was removed in 48 hours. The final diagnosis was a multi-lobular inclusion cyst. The patient was followed on a weekly basis and a photo was taken one month postoperatively. (Fig. 4)

It is not enough to put a tongue blade on the dorsum of the tongue and have the patient say "ah". A gloved index finger and a good light make the difference.[1]

*Formerly:

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

Emeritus Staff, Alexandria Hospital, Alexandria, Va.

Clinical Professor, Oral and Maxillofacial Surgery, Virginia Commonwealth University, Richmond ■

1 Archer, WH. Oral and Maxillofacial Surgery, Vol. I, 5th edition: Pizer 682-683. W.B. Saunders Co. 1975

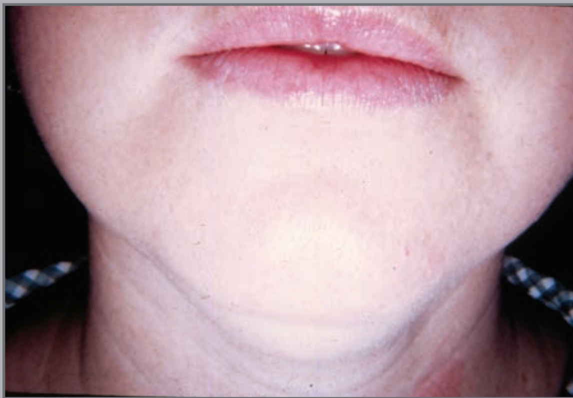

Figure 1

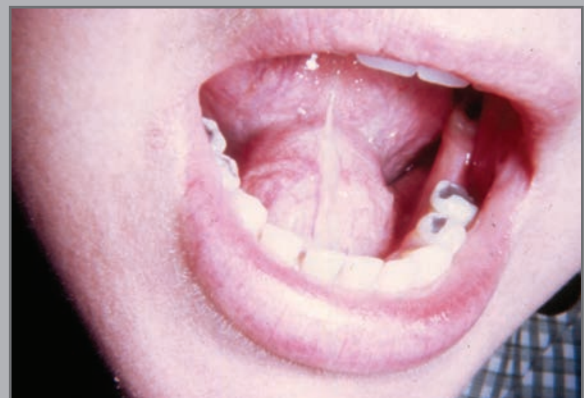

Figure 2

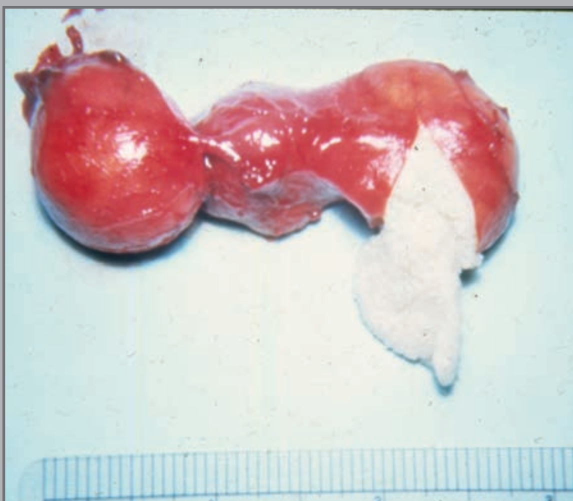

Figure 3

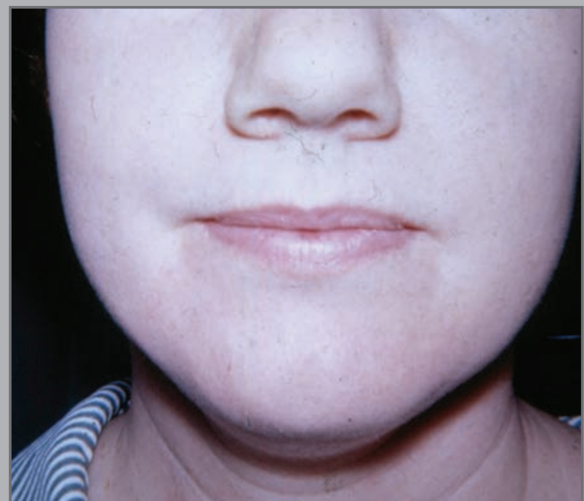

Figure 4

LETTER TO THE EDITOR:

MODERN RECORD KEEPING IN THE DENTAL OFFICE, PART 2

Dr. Robert Allen

I retired from actively managing a dental practice 13 years ago; turning management over to an associate who had been with me for 15 years. However, I did not stop doing dentistry. I began doing it differently. There are many opportunities to continue to serve and do what I have enjoyed for 60 years. There is the opportunity to teach dental students, serve in free dental clinics, to work in the state correction facilities, Indian reservations, and to be available for dentists needing practice coverage while sick or vacationing. My skills have become somewhat rusty as the progress in dentistry has shifted away from treating caries, and periodontal disease to prevention of the diseases of the oral cavity (and to cosmetic dentistry). The skills I have to offer have narrowed dramatically to removable prostheses, extractions, and some uncomplicated operative dentistry.

I always was pretty good at most low-level skills of dentistry: operative, preventive, and surgery. Once retired, my insurance carrier dictated that I no longer do endodontics, orthodontics, implants, cosmetic veneering, and extraction of third molars. However I am allowed to work an average of 20 hours per week in dentistry. In exchange, my malpractice insurance fee is low. Because my skill set has narrowed...I am doing removable prosthetics and extractions--an area of need in a segment of the population with low dental I.Q. and with limited financial resources.

Mainstream dental practice has raced past me. I now provide these minimal dental treatments without regard to insurance dictates and little or no direct involvement with patient payment for services. Money is out of the equation.

As in the practice of medicine, the management of a dental practice has changed rapidly while I have been away. Yesterday I was fortunate to be exposed to an all day continuing education class by the peninsula dental society and presented by Dr. Charles Blair. I think I have never heard Dr. Blair before...his past lectures have centered on practice transitions--that is: selling one's practice. Yesterday, I needed a few more hours to renew my state dental license. I was not really interested in the topic. Boy, did he open my eyes. "Stay out of jail: avoid coding errors, etc…" there was a full house, mostly dental managers. I was not bored.

If you have the opportunity to hear Dr. Blair, who has been around about as long as I, go and take your employees. Frankly, I just could not absorb all that he presented in one session. But those who have been dealing with insurance and billing codes probably already know some of what he covered. I have not, so the information was complete, well presented and he has a smooth delivery. He is a great educator and reminded me of Linda Miles, practice management consultant.

Dr. Blair has been in so many dental situations and offices that he not only is a wealth of insurance, and legal knowledge, he also has many tips on patient management (mainly financial and insurance situations).

Our Virginia board has been discouraged because many of the cases they investigate have to do with dentists who are ignorant of Virginia dental law. The board of dentistry has now proposed that all dentists be required to take the Virginia law exam every 3 years for license renewal.

Yes, laws subtly change from year to year and after a few years, one realizes that much has changed. Likewise insurance coding and the way one must file claims changes slightly every year and so if one does not stay right on top of those changes...the patient and the practice suffers loss of financial benefits.

Insurance coding has become downright confusing and difficult. An insurance driven practice , as many have become, must stay up to date with computer codes which fit "exactly; the procedure you are doing for the patient and the insurance company. Computer codes must fit "exactly" with what you have done and will do for the patient to satisfy the Board of Dentistry investigators.

As I explained in my previous article on how to maintain modern dental records, Dr. Blair takes record keeping to the next level. He pointed out that each step of a procedure must be in the written record and correspond to a specific insurance code. It will get worse for us in the coming years... New brackets of codes are inserted into the process annually. Once there were only 75 dental codes--now there are nearly 750 codes. Maybe more? I got lost in some of the overwhelming numbers.

Nevertheless, this is merely a warning from an "old guy" who used to keep very crude and unacceptable charts and insurance claims that things have changed and to continue to be professional and receive the financial benefits, one must take the time to hear an expert like Dr. Blair and take his advice and knowledge to heart.

Do not allow the record keeping and insurance side of your practice to become obsolete--the insurance company, the attorneys, and the Board of Dentistry will be there watching. ■

40 UNDER 40

DR. FERNANDA LEVINE

I came from the Amazon jungle where my dental chair was a school desk and the locals used donated tooth brushes to clean river crabs. Fast forward seven years, I am in Northern Virginia quickly becoming a pro in veneers.

Employment Law: KNOW THE RULES!

EMPLOYMENT LAW

KNOWING THE LAW IS ESSENTIAL FOR PRACTICE SUCCESS

Douglas R. Burtch*

If you are starting a dental practice or reviewing the operations of your current practice, you are not just a dentist, but also a business owner. As you may know, the key to any successful business is its people. Your staff members must possess the requisite substantive knowledge (or be teachable); they must be professional, personable and flexible; and they must provide excellent customer service.

It's important to hire the right people. It's equally important for you to establish a positive office environment and culture. Keeping your staff motivated can ensure an efficient and profitable practice. The wrong hire, excess negativity, or an employee unwilling to change can all impact work, staff morale, patient service – and your bottom line.

Below are some tips for the initial and continued success of your dental practice:

- **Hire correctly**. Use an employment application. Interview multiple candidates. Know what you can and can't ask on the application and in the interviews. Check references. It's worth the time to make those calls. You will find out unexpected things about a candidate – some good, some bad, all helpful. You will hear what someone doesn't say, and that will make all the difference.
- **Use a background check.** In today's electronic age, background checks can be quick and relatively inexpensive. They are an effective hiring tool, and they are legal if done correctly. You'll need an authorization from the candidate, and you must comply with the laws relating to background checks. Basically, that means following federally-mandated notice procedures to initiate and conduct the check, and to use any information you find influencing your decision not to offer a candidate the open position. By all means, use background checks to properly vet a potential employee for long-term service.
- **Establish clear employment policies.** Every business needs an employee handbook. Dental practices are no exception. A clear, concise, unambiguous statement of employment policies assists all employees in better understanding how the practice operates. It also doubles as a valuable reference in understanding the general terms and conditions of employment. A good handbook sets out the employer's authority and gives much-needed flexibility in handling most all workplace issues – including time and pay practices, leaves of absence, employee dress, and even communication on social media. Some businesses incorrectly think they just don't need an employee handbook. Far too many others use a handbook obtained from a friend or created for some other company (often times in some other jurisdiction). Laws change. Workplace procedures and expectations vary. No two businesses operate the same way. Taking the time to craft a set of policies tailored for your own practice – and for the laws applicable to your employees – will

CONTINUED ON PAGE 11

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CONTINUED FROM PAGE 9

save time, money, and energy in the long run.

- **Use employment contracts (or at least offer letters).** Written employment contracts and offer letters codify pay, benefits, job duties, reporting relationships, schedule and other basic terms and conditions of employment. Legal disputes can easily be avoided by setting such things out in writing. These documents can also give the employer the power and ability to change most all aspects of the employment relationship. They can demand employees use their best efforts at work, comply with all company policies, and not take any action detrimental to the practice. These fundamental employment documents may also contain post-employment restrictions on an employee's competition with the practice. They can spell out policies on solicitation of practice patients or employees and disclosure of confidential and patient information. If narrowly tailored to protect the practice's legitimate business interests, these non-competition, non-solicitation and confidentiality obligations are enforceable in Virginia.
- **Document employee performance issues.** Not everyone rates 5 out of 5 on a performance review. Honestly assess employee strengths and weaknesses. Set out specific goals and expectations. Note the areas in need of improvement. If an employee is disruptive, consistently late, frequently texting on work time, or is just inflexible, document it. Put a copy of the write-up in the employee's personnel file. These contemporaneous records are invaluable in the event your practice finds itself contesting a claim for unemployment benefits, or worse, responding to a lawyer's demand letter or a charge of discrimination from the Equal Employment Opportunity Commission (EEOC).
- **Pay people correctly.** Complying with wage payment laws can actually be difficult, even with the best of intentions. Most every business has some sort of wage and hour issue, whether it has to do with timesheets, break periods, overtime, flex or comp time, deductions from wages, or exempt/non-exempt and employee/independent contractor classifications. Keep scrupulous records. Seek counsel when needed. Understand this is an area with real legal exposure.
- **Terminate when it's time.** You will know when that is, although the human element can make discharging an employee quite difficult, especially in a small office. Yet smaller workplace settings are precisely where underperforming or unmotivated employees can do the most long-term damage. One practice had a long-time, valued employee resign out of the blue, only to discover the real reason was perceived unfairness due to other employees' lack of cooperation and motivation. Plan the discharge. During the discharge meeting, use talking points. Some things you should usually say, others you should never say. Have a witness in attendance. Cut off the separating employee's e-mail and access to the practice's server, cloud and/or electronic systems prior to (or during) the actual discharge meeting. Decide whether the reason for termination warrants a letter or not. Written notice can be useful in some situations, harmful in others. Be sure to collect all property belonging to the practice on the spot.

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**Douglas R. Burtch is Owner and Principal of Burtch Law PLLC. His practice focuses on employment law matters, while also encompassing school law, aspects of administrative and healthcare law, and business disputes. You can reach him at* douglas@burtchlaw.com *or 804.593.4003.* ■

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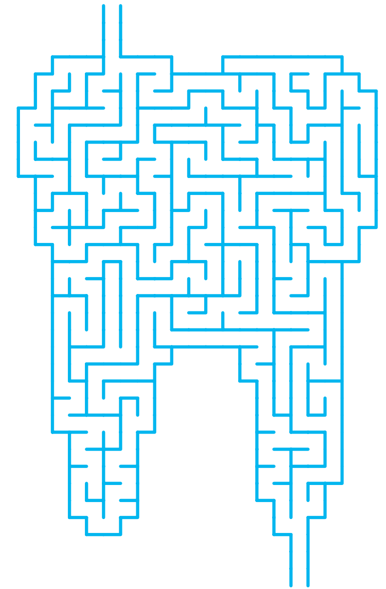

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Thursday, September 15

Mr. Theodore Passineau	*The Things I'm Concerned About in the Practice of Dentistry*
Mr. Corey Perlman	*Dental Digital Marketing: 7 Simple Moves to Become More Searchable, Improve Your Online Reputation, and Stay Connected to Patients and Prospects*
Mr. Joe Piscatella	*Living Healthy in a Doublebuger.com World: Diet, Exercise and Stress Management*
Dr. Casey Leser	*Patients Undergoing Radiation and Chemotherapy; Dental Care and Concerns* (am)
Tidewater Center for Life Support	*Heartsaver CPR* (pm)

Friday, September 16

Dr. Dennis Tarnow	*Immediate vs. Delayed Sockets* (am) *Interdisciplinary Treatment of Esthetic Problem Cases* (pm)
Tidewater Center for Life Support	*Heartsaver CPR* (am)
Dr. Jeff Brucia	*Adhesive Materials Simplified*
Rebecca Wilder	*Top Trends in Periodontology*
Dr. Christopher Ramsey	*Your Sixth Sense: Understanding Body Language and Human Decision-Making for Improved Treatment Acceptance*
Mr. Joe Piscatella	*Living Healthy in a Doubleburger.com World: Diet, Exercise, and Stress Management* (am) *Raising Fit Kids in a Fast World* (pm)
Mr. Josh Contrucci and Mr. Mohamed Abdulla	*Bank of America Practice™ Committed to Keeping Healthcare Professionals since 1996*
Dr. Frank Serio	*Volunteerism*

Mr. Bruce Christopher — *Emotional Intelligence* (am)
Leap! The Net Will Appear! (pm)

Mr. Theodore Passineau — *Ten Things I'm Concerned about in the Practice of Dentistry*

Tidewater Center for Life Support — *Advanced Cardiac Life Support*

Dr. Casey Leser — *Oral and Head/Neck Exam Revisited* (am)

Dr. Patty Wunsch — *Pulp Therapy for Primary Molars*

Dr. Tim Finkler — *Endodontics for 2016*

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PATHOLOGY PUZZLER

Dr. John Svirsky

A 58-year-old white female referred from oral surgery presented to the oral medicine clinic at Virginia Commonwealth University for a sore mouth of several weeks duration, with lesions affecting the buccal mucosa, lip mucosa, tongue, posterior hard palate and soft palate (figures 1-6). The patient was previously diagnosed with lichen planus confirmed by biopsy.

The patient's extensive past medical history was reviewed and included smoking and alcohol consumption, fibromyalgia, rheumatoid arthritis, gastro-esophageal reflex disease (GERD), hypertension anxiety, chronic obstructive pulmonary disease (COPD) and xerostomia. Her medications included Lyrica (fibromyalgia), hydrocodone (pain), Effexor (antidepressant), alprazolam (anxiety), omeprazole (GERD), amlodipine (calcium channel blocker for high blood pressure), Spiriva (COPD), prochlorperazine maleate (anxiety) and hydrocortisone (steroid).

The patient's xerostomia is easily explained by the fact she is on eight medications that cause dryness coupled with a history of anxiety.

Your differential diagnosis of the oral lesions would include which of the following?

A. Benign mucous membrane pemphigoid
B. Candidiasis
C. Erythema multiform
D. Lichen planus
E. Pemphigus
F. Proliferative verrucous leukoplakia
G. Squamous cell carcinoma

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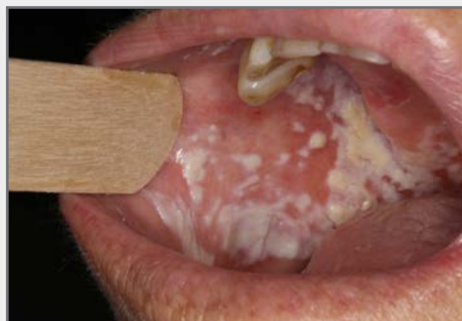
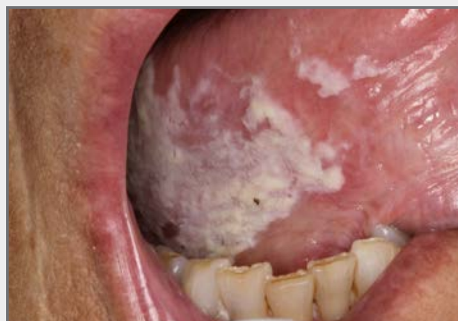
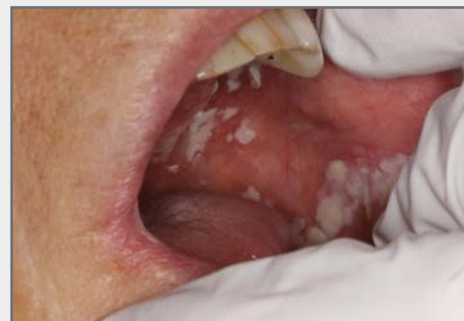
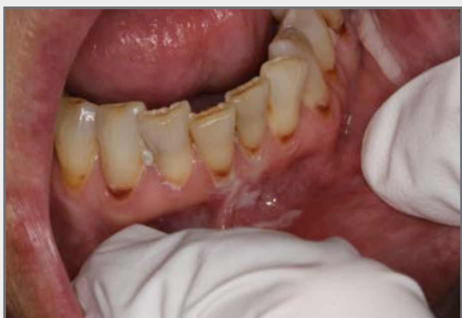
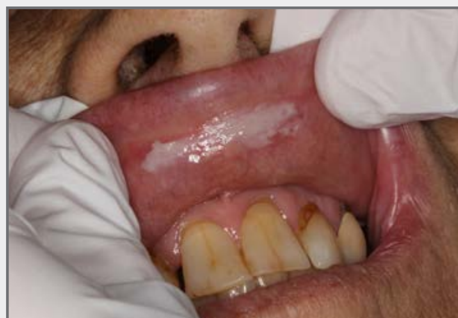
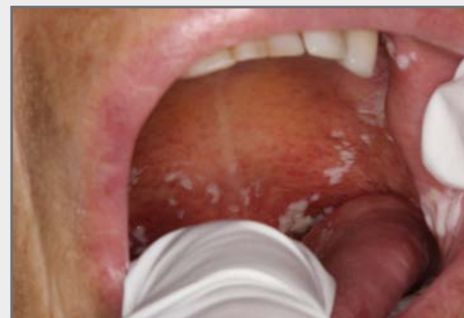







Figures 1-6 on presentation

40 UNDER 40

DR. CAMPBELL S. DELK

Eight years ago I began my professional career as an associate in my uncle's dental office. Patience, learning, mentorship from my uncle, and dedication allowed me to purchase the practice and realize my dream of running my own dental office.

CONTINUED FROM PAGE 19

PATHOLOGY PUZZLER

Dr. John Svirsky

From the clinical appearance I would eliminate all except candidiasis. Squamous cell carcinoma would not be multifocal, nor show patchy white lesions. It would have a granular appearance with induration. Pemphigus would be more painful with eroded lesions that appeared as ulcerations and not white. Typically pemphigus would have skin lesions and a positive Nikolsky (rub unaffected tissue and cause a separation) sign. Benign mucous membrane pemphigoid would also have a positive Nikolsky sign and would typically show bleeding gums and bullae. Erythema multiform (EM) would be extremely painful with an explosive onset and erosive lesions. EM typically shows up in younger individuals and skin lesions are common. Lichen planus is typically white with a lacy appearance in areas and only painful when erosive. It typically does not have a patchy appearance and would show its characteristic features with disease this extensive. The fact that the patient had biopsied diagnosed lichen planus would lead people to think that this was the correct diagnosis. Proliferative verrucous leukoplakia has a papillary surface and is not usually painful.

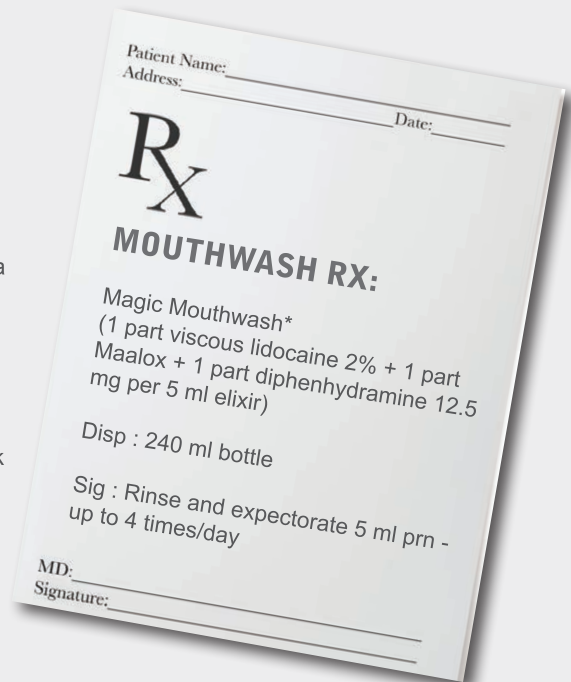
Of the patients that I see with candidiasis in my practice, the majority are related to the steroid therapy for lichen planus. This patient additionally has xerostomia from multiple medications which will additionally increase her likelihood of a yeast infection.

My preliminary diagnosis was candidiasis and I treated her with two weeks of Clotrimazole troches. If the patient did not respond to the therapy she would be biopsied at the two week recall.

I also gave her Magic mouthwash for comfort.

The patient returned in two weeks completely free of disease (figures 7-10).

This case was submitted by Alexa Gruber, Michael Marotta and Charles Smith, senior dental students at Virginia Commonwealth University School of Dentistry. ■



Patient Name:
Address:
Date:

Rx

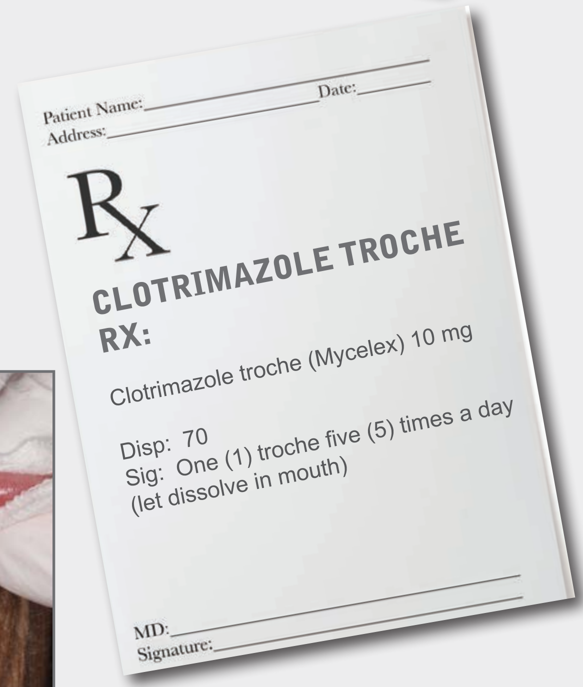
MOUTHWASH RX:

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:



Patient Name:
Date:
Address:

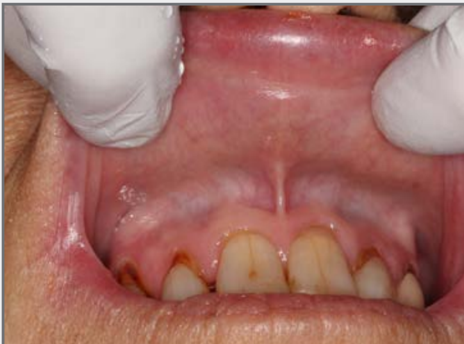
Rx

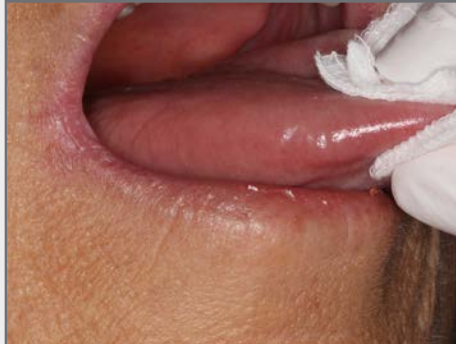
CLOTRIMAZOLE TROCHE RX:

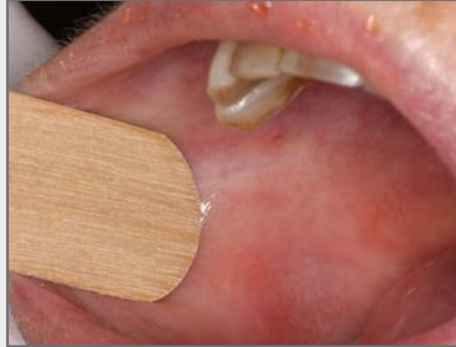
Clotrimazole troche (Mycelex) 10 mg

Disp: 70
Sig: One (1) troche five (5) times a day
(let dissolve in mouth)

MD:
Signature:







Figures 7-10: after two weeks of treatment, completely free of disease

AEGD ABSTRACT:

CARVALHO AO, BRUZI G, ANDERSON RE, ET AL. INFLUENCE OF ADHESIVE CORE BUILDUP DESIGNS ON THE RESISTANCE OF ENDODONTICALLY TREATED MOLARS RESTORED WITH LITHIUM DISILICATE CAD/CAM CROWNS. J OPER DENT 2016; 41(1):76-82

Problem: There is a wide general agreement that the ferrule effect is a critical element in the performance of crowned endodontically-treated molars. However, in cases when the ferrule is absent, there is no consensus about the optimal buildup design required to rehabilitate endodontically treated molars with extensive loss of coronal structure. With advances in mechanical properties of dental materials, it is logical to question whether these materials can be used to develop and internal adhesive ferrule effect without a post.

Purpose: To assess the influence of adhesive core buildup designs (4 mm buildup, 2 mm buildup, and no buildup/endocrown) on the fatigue resistance and failure load of endodontically- treated molar teeth restored with lithium disilicate CAD/CAM complete crowns placed with self-adhesive cement.

Methods and Materials: Forty-five (45) freshly extracted, sound human molars were decoronated at the level of the cementoenamel junction and endodontically treated. Standardized tooth preparations were applied to all specimens. A 1 mm horizontal reduction was obtained to create a flat preparation following the CEJ, with no ferrule. Teeth were randomly divided into three groups according to restorative technique (n=15). Group 1: 4mm buildup; Group 2: 2 mm buildup; Group 3: endo-crown restoration. Buildups were made using Optibond FL adhesive system and Filtek Z100 composite resin and placed in 1.5 mm increments with a 20 second light cure. All molars were restored using the Cerec 3 CAD/CAM system and milled in lithium disilicate ceramic IPS e.max CAD blocks. Standardized occlusal anatomy was applied. All crowns were cemented with RelyX Unicem 2 Automix cement according to manufacturer instruction.

Fatigue testing: Each specimen was stored in distilled water at ambient temperature for at least 24 hours after restoration. Masticatory forces were simulated with an artificial mouth using closed-loop servo hydraulics. Cyclic load was applied at a frequency of 10 Hz, starting with a load of 100 N for 5000cycles, followed by stages of 400, 600, 600, 1000, 1200, and 1400 N at a maximum of 30,000 cycles each. Samples were loaded until fracture or to a maximum of 185,000 cycles. Optical microscopy was used to distinguish catastrophic failure (crown/root fracture requiring tooth extraction) or repairable failure (cohesive/adhesive failure).

Load-to-failure Testing of Surviving Specimens: Specimens that survived the fatigue test were then axially loaded until failure or to a maximum load of 4500N. This test contained the same occlusal contacts as the fatigue test.

Results: Survival rates after the fatigue test were—100% for 4mm buildups (15), 93% for 2mm buildups (14), and 100% for endocrowns (15). No statistical differences were found among them. Only one repairable failure occurred during the fatigue test on a 2 mm buildup specimen that fractured cohesively at 1400 N. Post fatigue-testing load to failure averaged 3181 N (4 mm buildups), 3759 N (2 mm buildup), and 3265 N (2 mm buildups). One-way ANOVA revealed the higher load-to-failure resistance of 2 mm buildups compared with 4 mm buildup and endo-crown designs, but no difference between the 4 mm buildup and endocrown. Only one endo-crown and one 2 mm buildup survived the load-to-failure test at 4500 N.

Conclusion: It can be concluded that buildup design influences the performance of lithium disilicate CAD/CAM complete crowns. All three buildup designs exceeded expectations, but the use of 2 mm buildup was the most successful approach. This design provided good fatigue resistance and yielded higher loads to failure than the other two specimen groups.

DR. MICHAEL A. WEBB;
Resident, Advanced Education in General Dentistry, Virginia Commonwealth University ■

40 UNDER 40

DR. ALICIA HUTCHISON

Alicia Hutchison was born and raised in Virginia. She graduated from her orthodontic residency in June 2014, and welcomed her first child in November that year. She opened Potomac Orthodontics with two locations, Woodbridge and Manassas.

AEGD ABSTRACT:

MONACO C, CALDARI M. CLINICAL EVALUATION OF ZIRCONIA-BASED RESTORATIONS ON IMPLANTS: A RETROSPECTIVE COHORT STUDY FROM THE AIOP CLINICAL RESEARCH GROUP. INT J PROSTHODONT 2015; 28 (3): 239-242

Problem: Zirconia based restorations in combination with CAD/CAM are potentially favorable for implant-supported prosthesis due to their mechanical, physical, chemical and biologic properties. However, clinical failures of zirconia restorations due to technical complications such as chipping have generated controversy. Hence, there is a need for more information on the behavior of the implant-zirconia interface, the rigidity of complex implant-abutment restoration, and on the zirconia restoration in absence of proprioception in combination with high chewing forces.

Purpose: The authors conducted a retrospective cohort study to evaluate 1 to 5 year clinical results of zirconia-based implant supported single crowns and fixed dental prostheses (FDPs) in an effort to establish major risk factors that may contribute to restoration failure.

Materials and Methods: For this study, the authors enrolled 131 patients who were treated with 210 zirconia-based restorations on dental implants. Of the 210 restorations 61 were FDPs; 17 anterior and 44 posterior restorations. Of the 61 FDPs, 26 were screw-retained and 35 were cement-retained. Of the 149 single implant crowns, 46 were anterior and 103 posterior restorations. Of the single implant crowns 49 were screw-retained and 100 cement-retained.

The authors also divided patients based on their parafunctional habits by performing patient interviews and clinical examinations of tooth wear facets. Of those examined, 89 patients were determined to have no parafunctional habits, 28 had light habits, 8 had moderate habits and 6 had severe parafunction habits.

Researchers used United States Public Health Service parameters modified by FDI design for evaluating esthetic, functional and biologic properties of restorations. Single implant crowns and FDP's were ranked in four levels of parameter for each esthetic/functional property; parameter 1= clinically excellent, 2= clinically good, 3= clinically satisfactory, and 4= clinically unsatisfactory. The esthetic property evaluated was surface luster. The functional properties evaluated were framework fracture, ceramic veneering fracture, and patient perspective of esthetics.

The Estimated Cumulative Survival (ECS) was defined as a restoration remaining in place as long as no parameter recieved a score of 4. For Estimated Cumulative Success (ECSs) analysis, chipping scores of 3 or 4 in addition to 4 on any other parameter were considered a terminal event. The authors generated Life tables using Kaplan-Meier analysis and SPSS version 21 statistical software. They also calculated Odds Ratio for subgroup of patients with parafunctional habits.

Results and Conclusion: From 1-5 years, cumulative ECS of all zirconia-based restorations was 91.95% and ECSs was 88.37%. The ECS of single crowns was 91.25% and FDPs was 95.23%. ECSs of single crowns was 88.84% and FDPs was 87.96%. Odds Ratio for all zirconia- based restorations was 3.39 with moderate association between failure and parafunction.

Of the 210 zirconium restorations, the following failures were noted: 4 core fractures, 5 delaminations, and 4 chipped restorations (most in combination with parafunctional habits). There was no correlation between mechanical failures and whether the restorations were screw or cement-retained.

In this 5-year follow-up study, results indicated that implant supported zirconia restorations may be a viable treatment option as an implant supported prosthesis. The limited number of failures that occurred, primarily happened in patients with parafunctional habits. However, randomized controlled, long term studies are still needed to assess the suitability of using zirconia based implant restorations instead of metal.

DR. FARHEEN AMINA;
Resident, Advanced Education in General Dentistry, Virginia Commonwealth University ■

40 UNDER 40

DR. PADMALATHA NAVUBOTHU

Dr. Navubothu is originally from India. She graduated with a D.D.S. degree from University of Michigan School of Dentistry in 2012 and has been practicing general dentistry in the Richmond since then.

AEGD ABSTRACT:

MAROULAKOS G, NAGY W, KONTOGIORGOS E. FRACTURE RESISTANCE OF COMPROMISED ENDODONTICALLY TREATED TEETH RESTORED WITH BONDED POST AND CORES: AN IN VITRO STUDY. J PROSTH DENT. 2015; 114(3): 390-397.

Problem: The most important prognostic factor regarding the long term success of endodontically treated teeth is the amount of remaining tooth structure. Endodontically treated teeth that do not have an adequate ferrule are the most challenging from a restorative standpoint. It is currently unclear which type of post and core system has the best prognosis when bonded to severely compromised endodontically treated teeth.

Purpose: The purpose of this in vitro study was to compare the fracture resistance, as well as the mode of failure, of severely compromised endodontically treated teeth restored using three different post and core systems.

Materials and Methods: Thirty extracted anterior maxillary teeth were obtained and examined microscopically and radiographically for evidence of fracture(s) and/or internal resorption. All teeth were sectioned, leaving 15mm of sound tooth structure from the root apex. The teeth were endodontically treated using rotary NiTi instrumentation and the crown down technique. Canals were prepared to a 0.04 taper, and obturated leaving 4mm of an apical gutta percha seal and an 11mm post space. Teeth were mounted in resin blocks; 12mm embedded from the root tip, with 3mm of exposed tooth coronally. Of the 30 included teeth, 10 teeth were randomly assigned into three groups; CPC (ParaPost XP-Lab, for custom cast post and core), TPC (ParaPost XH, prefabricated titanium post), FPC (D.T. Light-Post, prefabricated quartz fiber post). All core buildups resembled a central incisor preparation, and were restored using cast gold crowns with a complete lack of ferrule. All post and cores were cemented using adhesive cements. The specimens were aged with thermo-cycling and cyclic loading. Two specimens per group were randomly selected for micro-computed tomographic imaging before and after aging. A universal testing machine was used to induce failure. The mode of failure was characterized by the interface separation: failure of the crown (crown fracture, Type 1), the crown-core interface (crown debonding, Type 2), the post (post fracture, Type 3), the post-dentin interface (post debonding Type, 4), or the dentin (root fracture, Type 5). Statistical analyses were completed using a 1-way ANOVA (α=.05) followed by post hoc tests (Bonferroni).

Results: The mean (SD) failure value of CPC was 174.0 N (51.0), of TPC 123.5 N (23.4), and of FPC 117.6 N (19.3). A one-way ANOVA test showed statistically significant differences among the groups. The fracture resistance of CPC was higher than either TPC or FPC, while the fracture resistance of TPC was not significantly different than FPC. Evaluation of the µCT images of the 6 selected teeth taken before and after aging revealed no remarkable differences. The primary mode of failure for CPC was root fracture (Type 5), with 2 cases of post debonding (Type 4) and 1 case of post fracture (Type 3). For TPC, 9 of 10 specimens failed by means of root fracture (Type 5), with 1 case of post debonding (Type 4). While in FPC, the primary mode of failure was post debonding (Type 4), with 3 cases of root fracture (Type 5). In all cases of root fracture (Type 5), the fracture line was located on the mesial or distal aspect of the root surface. In the cases of post debonding, residual cement was noted on the post surface of teeth treated using CPC and TPC, in comparison to FPC which demonstrated no residual cement on the post surface following debonding. Failure at the core/crown interface (Type 2) was not observed in any of the experimental groups.

Conclusions: This study demonstrated that the selection of a post and core system bears a significant impact on the fracture resistance, and thus the prognosis, of severely compromised endodontically treated teeth. The teeth treated with bonded CPC showed significantly higher fracture resistance compared with FPC, and at thresholds closer to the reported maximum occlusal forces of anterior teeth. The teeth treated with TPC exhibited the highest rate of root fracture, and at significantly lower forces. The teeth treated with FPC showed a more favorable mode of failure, i.e. post debonding, although also at very low fracture resistance values. This study concluded that CPC performs better than TPC or FPC in severely compromised endodontically treated teeth exhibiting no ferrule effect.

DR. JASON M. LANDINO;
Resident, Advanced Education in General Dentistry, Virginia Commonwealth University

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40 UNDER 40

DR. IZZAT SBEIH

Dr. Sbeih is a 2008 VCU/MCV graduate. Since graduating he has earned his FAGD and is expecting to receive his MAGD next year. In 2012 he co-founded Novel Smiles - A multidisciplinary practice based in McLean.

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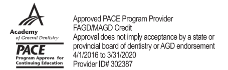

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AEGD ABSTRACT:

POUSETTELUNDGREN G, MORLING VESTLUND GI, TRULSSON M, DAHLLÖF G. A RANDOMIZED CONTROLLED TRIAL OF CROWN THERAPY IN YOUNG INDIVIDUALS WITH AMELOGENESIS IMPERFECTA. J DENT RES. 2015; 94(8):1041-1047.

Problem: Patients with Amelogenesis imperfecta (AI) report social implications associated with the negative effects of un-aesthetic tooth color and morphology. Current treatment recommendations center on the use of direct and indirect composite restorations to ameliorate the effects of AI. However, such composite restorations often lack predictable long-term success and require multiple replacements. The development of zirconia dioxide with porcelain layering and lithium disilicate crowns has introduced options for full coverage long-term restorative options, but the performance of each material has raised questions regarding which is most desirable in AI patients.

Purpose: This study compared clinical outcomes of Procera crowns (zirconia dioxide coping with Vita porcelain) cemented with Rely X ARC, alongside IPS e.max Press crowns (lithium disilicate glass-ceramic) cemented with Rely X ARC in patients with AI. The authors also aimed to document complications associated with each of the two therapies.

Materials/Methods: The authors developed a single-center double-blind randomized controlled trial with split mouth design. Inclusion criteria required clinical and family history or histologically verified diagnosis of AI. Patients with fluorosis, hypomineralization localized to incisors and molars only, oral developmental disparities other than AI, systemic disorders, or unable to give informed consent, were excluded. Also excluded were patients with AI, but whose age or clinical presentation contraindicated prosthodontic treatment. Recruitment occurred from May 2009 through March 2012 among patients referred to the Department of Pediatric Dentistry in Dalarna County, Sweden and produced 82 possible enrollees. The final patient pool included 27 patients from age 11-22 (12 boys and 15 girls). Patients received split-mouth treatment determined via random number generator. Treatment occurred on a per-tooth basis upon full eruption. Analysis was conducted on individual tooth by tooth basis with 119 teeth receiving Procera crowns and 108 teeth receiving 108 IPS emax crowns. Pre-treatment evaluation included assessment of caries, gingival bleeding, tooth sensitivity, history of trauma and endodontic problems. Follow up examinations were conducted by a non-treating dentist 1 month, 1 year and 2 years after treatment and data were collected on the quality of the restorations, longevity of the restorations, gingivitis, and sensitivity. Gingivitis was measured by bleeding per probing site, and sensitivity determined by visual analog scale (VAS). Statistical analysis included chi-square and Fisher exact tests, Kaplan-Meier survival tests, t-test and Wilcoxon signed-rank test, and a final survival comparison determined using a Cox Multinomial Regression model.

Results:

- Quality of restorations at 2 year follow up: Among the 119 Procera crowns placed, 3 needed adjustment two years after placement but none threatened the prognosis of the tooth. Among the 108 IPS e.max Press crowns placed, 2 needed adjustment two years after placement and 1 threatened the immediate prognosis of the tooth.
- Longevity of crowns: Survival analysis found that after 2 years, only 3% of crowns in both groups required adjustment or replacement. No statistical difference was observed between the two groups.
- Gingivitis: Prior to treatment 1.3±0.9 surfaces per tooth were found to have bleeding on probing. A statistically significant difference ($p<0.001$), was observed following crown therapy with 0.9±0.9 surfaces per tooth found to have gingivitis after treatment. No significant difference was found between the two crown types.
- Sensitivity: No difference was observed between the two crown types in sensitivity. However, a significant decrease in mean VAS scores from 5.2 before treatment to 0.6 after two years ($p<0.001$).
- Adverse events: The authors observed 12 teeth with adverse events, and noted dental trauma as the etiology in all but one of these teeth. Complications included difficulty obtaining impressions or cementation (usually due to patient maturity), development of apical periodontitis after two years (3% of crowns), and one tooth resulted in pulpitis.

Conclusions: The data show no significance between Procera crowns versus IPS e.max Press crowns in quality or longevity at two years of follow up. A statistically significant decrease in sensitivity was also observed. Given the difficulty in establishing long-term predictable success with composite restorations in AI patients, the findings of this study suggest that it may be possible to perform early crown therapy.

DR. MATTHEW WINHEIM;
Resident, Advanced Education in General Dentistry, Virginia Commonwealth University■

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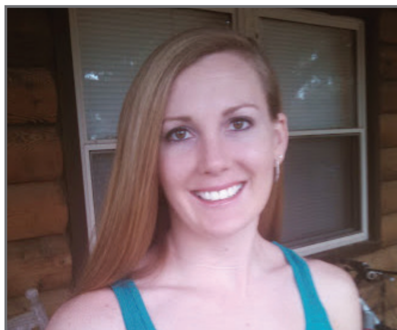


DR. JULIE B. HAWLEY

I’m from a rural community in Southside with great dental need, so I decided to come “home” to Emporia to practice. I joined a private practice and love treating patients from all walks of life.

GIVE KIDS A SMILE!® 2016

Julie Ericksen, Donated Dental Services Program Manager

I was excited to attend my first Give Kids a Smile!® events on February 5, 2016. Indeed, I can attest there were a lot of young people smiling that day! 350 grade school children made their way through the ACCA Shriner maze in a program carried out by the Richmond Dental Society, to be screened and receive prophy, varnish, and oral hygiene instructions. Additionally, steps were taken to make sure that children who need it have a dental home after that day for ongoing care from area dentists who participate in the program.

I also attended the VCU Dental School's Give Kids a Smile!® program which was a hubbub of activity taking over significant portions of the dental school. VCU expands on their program each year. Last year they had record numbers of young patients and provided services including preventive and restorative as well as specialized care from pediatric dentists, endodontists, and oral surgeons. Their project also finds dental homes for children that need additional care after the event.

With over 30 projects across the state, each one is unique in what and how they offer services but united in their goal to impact children while they are young and hopefully set a foundation for a lifetime of dental health. I feel deep gratitude for the legions of volunteers who showed up to make a difference in children's dental health this month. ■

Richmond Dental Society Give Kids A Smile!® event

NORTHERN VIRGINIA M.O.M. PROJECT

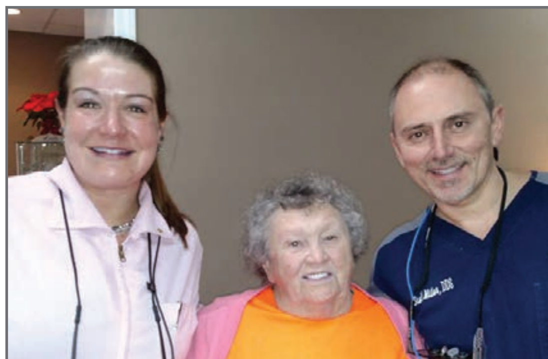
James Willis, DDS

The entire Northern Virginia is a close-knit community whose residents truly care for one another and go out of their way to show support and appreciation toward each other. The dental community of Northern Virginia is no different. The Northern Virginia Dental Society (NVDS) hosted on the 11th and 12th of March 2016 its 13th Mission of Mercy (MOM). In addition to the dental professionals who volunteered, we were also joined by a couple hundred community volunteers who were excited to contribute in whatever way they could. With such wonderful volunteerism, and with such a strong team of leaders, chairing the committee is a breeze. We were able to provide much-needed dental care to a wonderful portion of our community. Senator Tim Kaine supported our efforts by visiting during the event and learning about our MOM project. We also received media coverage from NBC, the *Fairfax Times*, and other local reporters. We are very grateful to have been able to take advantage of the exceptional facilities of the Medical Education Campus of the Northern Virginia Community College. It is genuinely heart-warming to participate and witness such a large community coming together to provide services to those in need. We are particularly thankful that we were able to use MOM to provide our community members information regarding our two Northern Virginia Dental Clinics that are available for their use in Fairfax and Sterling. ■

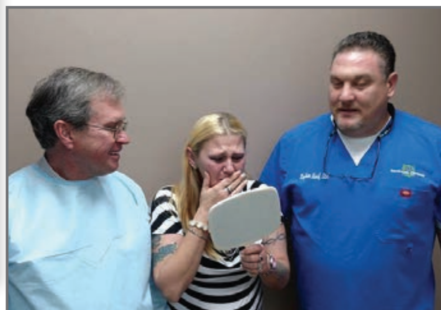
Northern Virginia M.O.M. Project

A DENTURE DAY IN DOWNTOWN PULASKI

Julie Ericksen, Donated Dental Services Program Manager



L-R: Dr. Cynthia Southern, Aletta, Dr. Scott Miller



L-R: Dr. Henry Higginbotham, Dana, Dr. Steve Alouf

L-R: Dr. Henry Higginbotham, Dr. Steve Alouf, Harry (H.B.), Dr. Scott Miller

Dr. Cynthia Southern (cynthiamsouthern.com) opened her dental office on Main Street in Pulaski on a Friday in January for a denture extravaganza. With the support of Dr. Scott Miller (Bristol), Dr. Steve Alouf (Salem) and Greg Gray (Southern Gray Dental Lab, Fredericksburg), all representing Benchmark Dentures (benchmarkdenture.com), eight grateful patients went home with a new set of dentures by early afternoon.

The Virginia Dental Association Foundation provided the qualified patients through its Donated Dental Services (DDS) Program and the Dental Aid Partners of the New River Valley (nrvsmiles.org) provided support and inspiration for the project. The event created some buzz in Pulaski with the appearance of local newspaper, TV, and posts flying around social media. Each patient left with a new lease on life: the opportunity to experience better overall functioning, digestive health and improved appearance. An important byproduct of the day was three dentists learning to use this innovative denture technology.

This denture technology is valuable because it can be done in one day, even in an hour or two unlike the usual 4 or 5 appointments and the involvement of lab services. This particular product is made from the same materials that traditional dentures are made and it provides additional opportunities for fit that a traditional denture may not allow. Greg Gray showed me one such case that he said would have been more challenging or impossible with a traditional denture. The short time frame is ideal for Donated Dental Services patients who often struggle with transportation issues and disabilities that make it difficult for them to tolerate multiple appointments.

Dana was a 36 year old patient who had been edentulous for 7 years. When she was fitted with her denture, she lit up like a birthday cake and her appearance was remarkably changed. Charles sings gospel music to audiences. His old denture fit so poorly that he would use a piece of candy to hold it in place while he sang. This will not be necessary anymore! Harry is excited to eat peanuts again. Elizabeth and Dustin had very significant health issues including cancer, renal disease and diabetes. The opportunity to chew food properly will have a significant impact on their ability to metabolize food. I have no doubt that the ripple effect of these dentures will be quite significant in the lives these patients will touch.

I am very moved and inspired at the generosity and passion of these practitioners to care for our population of applicants – the most needy in our society. They have each provided tens of thousands of dollars' worth of care through Donated Dental Services and I know that they have also contributed care through the Mission of Mercy projects and Give Kids a Smile! projects. What a difference a day makes! ■

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DR. LAUREN GIBBERMAN

Voted "Best Smile" in high school, Dr. Lauren Gibberman wanted to spread the wealth by becoming a dentist! Dr. Gibberman graduated from the VCU School of Dentistry and is excited to be practicing with her father in Alexandria, Virginia.

PIEDMONT REGIONAL DENTAL CLINIC GIVES LOW-INCOME VETERANS A REASON TO SMILE

Mary Hintermann

The Piedmont Regional Dental Clinic (PRDC) in Orange held its second "Our Turn To Serve" program to provide free dental care to low income, uninsured Virginia veterans on Veterans Day, November 11, 2015. Participating veterans received oral cancer and blood pressure screenings, a flu shot (optional) as well as preventative and restorative care.

This is the second year PRDC has held the "Our Turn To Serve" clinic. The first year was successful and a staff favorite. In 2014 PRDC treated veterans aged 25-91; a significant number hadn't seen a dentist in more than twenty years. Participating veterans served their country as far back as World War II and the Korean War, as well as more recently in Iraq and Afghanistan; the majority were Vietnam War veterans. The same pattern held true in 2015.

This year the Veterans Day event was made possible by the generous sponsorship of David and Linda Gibson, The Hintermann Family Foundation, Wells Fargo, Virginia National Bank, Dominion Resources, Mclean Faulconer Realtors, S.L. Williamson and Mason Insurance. In-kind donations have been provided by Delta Dental Veterans Affairs Insurance, Orange Pharmacy, Virginia Commonwealth University School of Dentistry and UVA Culpeper Health System.

Local dentists have been pivotal to the success of the project. They donate their time to ensure as many veterans as possible can be treated. These generous providers included Dr. Jack Thompson, (USAF Ret.), Dr. Jay Thompson (USA Reserve), Dr. Emma Jeffrey and Dr. Alex Schaap. They were joined by Dr. David Sarrett, Dean of the VCU School of Dentistry.

Dr. David Sarrett, Dean VCU SOD, treats a veteran who sought care.

Veterans typically do not have dental coverage as part of the healthcare benefits they receive through the Veterans Administration (VA). "Eligibility for dental care is extremely limited for veterans, and differs significantly from eligibility requirements for medical care," according to Phil Sterbling, Colonel, US Army (Retired) and Piedmont Regional Dental Clinic (PRDC) Board member. "Unless a veteran is 100% disabled, has been a prisoner of war, is homeless, is enrolled in a VA vocational rehabilitation program or has a dental condition directly service-related, they receive no dental care from the Veterans Administration." There are currently more than 12,000 uninsured, low income veterans in Virginia.

To qualify for free care on Veterans Day a veteran must:

- Be a veteran of the US uniformed services,
- Have a household income at or below 200% of the federal poverty level,
- Lack dental insurance, and
- Provide a photo ID and proof of military discharge.

The Piedmont Regional Dental Clinic is a nonprofit dental safety net clinic providing access to affordable oral health care for underserved residents of the Piedmont area. PRDC offers an Affordable Care Program providing discounts for income-qualified households. The Clinic accepts Medicaid insurance and is always accepting new patients. For more information visit www.vaprdc.org.

CONTINED ON PAGE 27

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DR. STEPHANIE VOTH

As a Board Certified Periodontist who focuses on continued personal and professional growth, I look forward to helping build a premiere periodontal practice within Virginia Family Dentistry.

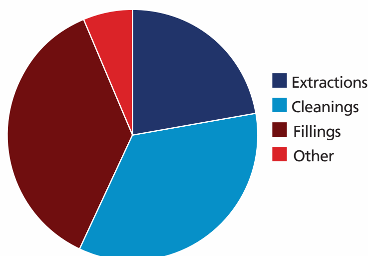
CONTINUED FROM PAGE 26

Our Turn To Serve 2015

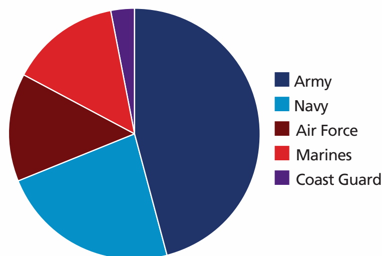
Thanks to the generosity of local donors David and Linda Gibson, the Hintermann Family Foundation, Wells Fargo, Virginia National Bank, Dominion Resources, S.L. Williamson, McLean Faulconer Realtors, and Mason Insurance, PRDC was able to provide over three dozen US veterans with free oral health care on Veterans Day.

Only 7% of participants have a regular dentist. Of the veterans who had seen a dentist in the past year, 72% had attended PRDC's Veterans Day clinic in 2014. 29% of the veterans had not received oral health care in over 5 years.

SERVICES PROVIDED



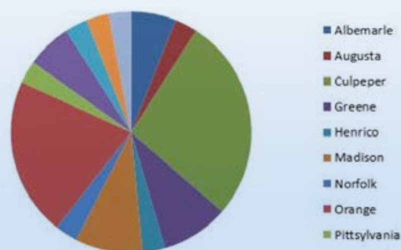
WHO ARE THESE VETERANS?



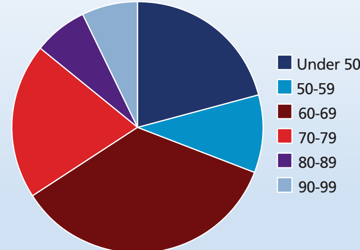
WHERE DID THEY SERVE?

Germany, France, Spain, New Zealand, Antarctica, Morocco, Okinawa, Korea, Phillipines, Vietnam, Afghanistan, and Italy as well as the United States, including Pearl Harbor.

WHERE DO THEY LIVE NOW?



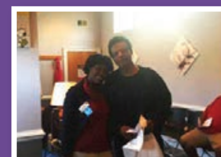
AGE OF VETERANS



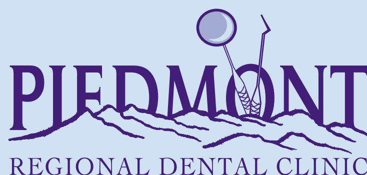
WHEN DID THEY SERVE?

WWII, Korea, Vietnam, Persian Gulf, Afghanistan, Iraq, Desert Storm, Bosnia, and Somalia.

Among these veterans were winners of the:



- Bronze Star
- Purple Heart
- Meritorious Service Medal
- Air Medal
- Army Commendation Medal
- Good Conduct Medal
- Humanitarian Service Medal



PRDC is a nonprofit dental safety net clinic located in Orange, Virginia. Our mission is to increase access to oral health care for underserved residents of the Piedmont. We except Medicaid and Delta Dental insurance and welcome new patients.

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2016 GENERAL ASSEMBLY SESSION REVIEW

VDA Lobbyists Tripp Perrin & Chuck Duvall

The 2016 General Assembly has come and gone and, after 59 long days and nights (they adjourned a day early), this session will no doubt go down as one of the more productive in recent memory for the VDA membership. The General Assembly adjourned after considering over 3,000 bills and resolutions and passing a two-year budget that totaled more than $100 billion. Economic development, workforce training, and health care topics of various shapes and sizes took top billing in terms of time and attention from Virginia's 140 member legislature.

The VDA membership battled the insurance companies, worked tirelessly with the Virginia Dental Hygienists Association on judiciously expanding the remote supervision statute, secured $200,000 for the MOM project in the state budget and beat back a couple of attempts by the Department of Health Professions (DHP) to significantly alter the governance of the Board of Dentistry (BoD) without any input from VDA members.

The bills that our membership requested as outlined below (HB310, SB712 & HB16) passed without a single 'NO' vote in either the House or Senate. This speaks to the hard work the VDA members were able to do prior to session in terms of educating legislators as these were not simple bills. The unanimous votes speak, also, to the diligence relative to how and what to ask for in terms of policy changes.

Below are the specific items and details that impacted our membership. This is by no means an exhaustive list but some of the key items on which we worked. Thank you for all your assistance and the overwhelming support of Laura Givens and Dr. Dickinson to make this a successful session for the Virginia Dental Association – Congratulations!

HB 16 (Ware) – Non-Covered Services Legislation – Protection Against the Insurance Companies

You may recall the 2010 General Assembly passed non-covered services (NCS) legislation that was intended to ensure health plans could not mandate fees for procedures for which they are not paying. At that time, several dental insurance companies were amending their contracts or putting new contracts in front of dentists that set the fees dentists could charge not only for covered procedures but also for procedures that are not covered by the policy. The overwhelming support by the General Assembly demonstrated that legislators believed the practicing dentist should maintain some level of financial control over their practice through billing for those services that are not insured (meanwhile, the fees agreed to by dentists for covered services remained in place). Since then there has been some scattered evidence of dental plans covering only a small percentage of specific procedures – to effectively skirt the law and disingenuously claim it is covered. The VDA membership felt it appropriate to close the loophole immediately by working to pass legislation with what is often called a "deminimis clause". This law will say that a dental plan cannot call a service covered – thereby dictating the fee – by reimbursing a nominal amount – ie, 5 or 10%. This bill, once signed by the Governor, will become law on January 1, 2017.

VDA AT WORK FOR YOU!

HB 310 (Orrock) – Mobile Dental Labs & Nursing Home Privileges – Taking Care of Our Most Vulnerable Citizens

In 2010 Delegate John O'Bannon introduced legislation (HB308) at the VDA's request. This legislation forced operators of mobile dental clinics to find locally-based dentists to treat the kids in need of treatment and had them held to the same standard as a fixed base dental office. Unfortunately, the law as written unintentionally ensnared those Virginia dental clinics that want to do the right thing and see these kids and make sure they get the necessary care. HB 310 fixes this issue by adding an exception to the registration requirement for: 1) federally qualified health centers with a dental component that provides dental services via a mobile model to children within 30 miles of the center and 2) free health clinics or health safety net clinics that have been granted tax exempt status.

Furthermore, after consulting with DHP we were able to amend the original draft of the bill to expand the mobile exemption for all dentists servicing nursing homes and assisted living facilities – a practice that is already happening with regularity and is much needed for the elderly population in particular.

SB 712 (McDougle) – Remote Supervision of Hygienists – Protecting the Profession & Expanding the Safety Net

The 2012 General Assembly passed a bill that expanded a successful remote supervision dental hygiene regional program into a statewide program which has provided more access for underserved populations in need of dental care. The protocol allows public dental hygienists employed by the Virginia Department of Health (VDH) the ability to provide educational and preventative services, especially to patients in rural and underserved areas. SB 712 expands the 2012 program even further and launches the formation of a protocol for remote supervision of dental hygienists employed by private practice dentists. Under this strict definition of remote supervision, dental hygienists would be allowed to see patients in locations including community health centers, free clinics, long term care facilities, schools, head start programs and women: infants and children (WIC) programs.

$200,000 for Capital Investment for the M.O.M. Project – Expanding the Safety Net

In the past the MOM program has been supported by tremendous in-kind contributions of professional services, grants, and other contributions. In most years the majority of the operating funds come from corporate and foundation grants, many of which are initial, one-year awards. While the VDA Foundation continues to work to broaden the base of support, the cyclical nature of such grants leaves much speculation about whether they will continue in future years. For this reason we asked for $100,000 in both years of the biennium to help us make necessary investments for equipment and other operating expenses. Given the program's successful metrics, education of key legislators over the last many years and hosting the Governor and his team at Wise MOM the last couple of

CONTINUED ON PAGE 30

THREE DENTISTS IN CONGRESS - IS THAT ENOUGH?

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

There are 128 lawyers in Congress and only three dentists. Is that good? Can we change it? Who do you want in Congress, more lawyers, or more dentists? What are each of them trained to do? Lawyers are trained to use the law to defend their clients, right or wrong, innocent or guilty. They are trained to persuade and to fight for whatever side is paying the bill. A dentist, on the other hand, is trained to initially diagnose their patient's problem through evaluation of the symptoms and the application of appropriate diagnostic tests with input from the patient. Treatment options are then presented to the patient who makes the final educated decision. It is often based upon their financial situation.

We are taught to seek the truth, and then proceed to solve the problem. Isn't that the type of person who you want in Congress? How would Congress look if they sought out the diagnosis (what's the real problem) developed a treatment plan with the patient (talked to America about how to fix our many problems) and then went about in a logical and methodical way to treat the patient (solve America's problems on America's budget)? You can make this a reality. Do you want more Congressmen who are adversaries, or problem solvers?

Currently, we have three dentists serving as members of Congress: Rep. Mike Simpson, D.M.D., ID-2; Rep. Paul Gosar, D.D.S., AZ-04; Rep. Brian Babin, D.D.S., TX-36. They represent their constituents, dentistry, and our patients every day. They do what they can to solve problems. What if we had more dentists in Congress? Well….. we can!

Presently there are several other dentists running for Congress and the American Dental Political Action Committee (ADPAC) has identified two to fully support. Dr. Fred Costello of Florida and Dr. Drew Ferguson of Georgia are each running for "open" seats (meaning there is no incumbent running). We believe that they each have an excellent chance of being elected and sitting in Congress next January. But they each need your help! Will dentists step up and support our own? Running for Congress is not inexpensive. If you would like to see more dentists in Congress- then you must do something about it- you must contribute to their campaigns. Here's how, it's easy:

Go to www.ADA.org/ADPACDIRECT

Our three sitting members of Congress will appear on the webpage alongside Drs. Costello and Ferguson. Contribute directly on this site whatever you can. Even $20 makes a difference. More is always appreciated.

Doctor, we need your help, dentistry needs your help, Drs. Costello and Ferguson need your help. We need more representation!

Let's all jump in and contribute. Let's send more dentists to Congress. Let's send problem solvers to Congress. I did! So can you!

Again it is: www.ADA.org/ADPACDIRECT

Thank you for all you do for dentistry and the patients we serve. Please feel free to call me with any questions. I'd be happy to talk about our dentists running for Congress. ■

CONTINUED FROM PAGE 29

years, we were successful in securing these funds ($200,000 total).

Stopping Efforts to Change the Governance of the Board of Dentistry

The VDA opposed a couple of different attempts at changing the governance of BoD. The first was a bill that was introduced by Senator Dunnavant (SB 212) that made changes to numerous boards including the BoD whereby one additional citizen board member would have been added to the membership. The VDA objected to that move for numerous reasons including the fact that VDA had NOT been consulted in advance Senator Dunnavant acceded to our request to strip that provision out of the legislation (over the strong objections of DHP).

The second piece of legislation was a result of the FTC's engagement with and subsequent SCOTUS ruling regarding the North Carolina Board of Dentistry. The bill (HB1388 patroned by Jennifer McClellan) would have given broad powers to the staff of DHP to disregard/veto any ruling that it believed was in any way "anti-competitive". This gave too much power to the bureaucracy. We pointed out to legislators that the way things are done in NC are not the same in Virginia (in NC the Association appoints BoD members, whereas in Virginia the Governor does the appointing—arguably making for a much more sovereign appointment process). After consulting with the patron she agreed to carry the measure over for further review to the 2017 General Assembly Session.

Prescription Monitoring Program (PMP) Legislation

With more and more of a spotlight being put on the public safety issues regarding opiate and prescription drug addiction, there were several bills introduce that impacted the PMP. The legislation should have little to no impact on dentists specifically but will require prescribers check the prescription monitoring program before initiating any course of treatment of opioids or benzodiazepines, except in cases of non-refillable prescriptions after surgery, hospice or palliative care, or if the PMP is not operational. Prescribers will be required to check the PMP when initiating a new course of treatment of opioids (benzodiazepines have been removed from the law entirely) that is expected to last longer than 14 days. Furthermore, a DHP advisory panel will set forth criteria of unusual patterns of prescribing or dispensing of covered substances by prescribers or dispensers AND misuse of covered substances by recipients.

Once again thank you for all of your efforts and congratulations on a productive session – one that will help our members and patients across the Commonwealth. If anyone has any interest is pulling up more specifics on these or any other bills you can go to this link and enter the bill number: http://leg1.state.va.us/cgi-bin/legp504.exe?161+men+BIL. Reconvene Session (where the House and Senate will consider all vetoes and amendments the Governor proposes) is scheduled for Wednesday, April 20th and we will update everyone after that point on anything that might impact the association.■

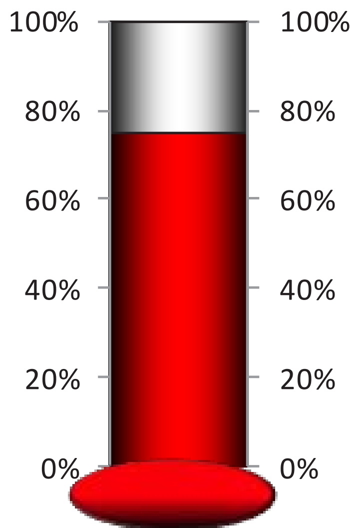
VADPAC UPDATE

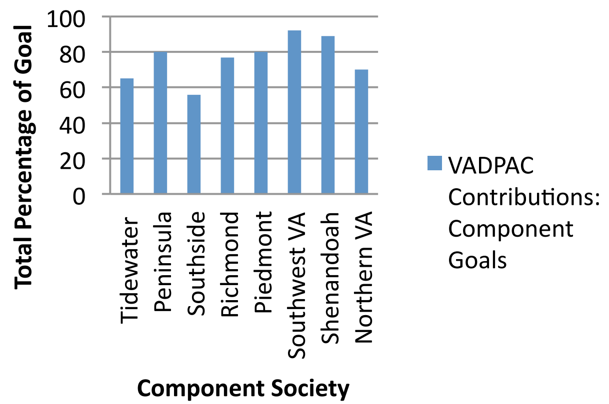
WHEN WE GIVE TOGETHER, WE HAVE A STRONGER VOICE!

Laura Givens, VDA Director of Legislative & Public Policy

The Virginia Dental Political Action Committee (VADPAC) is one of the largest and most influential political action committees in Virginia. Legislators and legislative Candidates routinely seek out the VADPAC for assistance with political campaigns. This provides a tremendous opportunity for the VDA to educate candidates and legislators on dental health positions they may address in the future.

Your generosity has played a large part in VADPAC's success through the years and we must remain more vigilant than ever in protecting patients and our profession. This means that we need your generous support today! As stated in the 2016 General Assembly Report, we had a very productive Session on the policy front and we hope to continue with this success. If you have not already contributed to VADPAC for 2016 or, if you would like to increase your contribution, please contact Laura Givens at givens@vadental.org or 804-523-2185. ■





Component	% of 2016 Members Contributing to Date	2016 VADPAC Goal	Amount Contributed to Date	Per Capita Contribution	% of Goal Achieved
1 (Tidewater)	32%	$45,500	$29,746	$254	65%
2 (Peninsula)	39%	$27,500	$22,089	$269	80%
3 (Southside)	31%	$14,000	$7,771	$251	56%
4 (Richmond)	29%	$67,750	$52,089	$299	77%
5 (Piedmont)	31%	$30,000	$24,027	$273	80%
6 (Southwest VA)	45%	$25,250	$23,236	$332	92%
7 (Shenandoah Valley)	39%	$30,000	$26,593	$274	89%
8 (Northern VA)	29%	$135,000	$94,295	$286	70%
TOTAL	34%	$375,000	$279,846	$280	75%

Must Raise $95,154 to Reach the Goal

2016 Goal: $375,000

THE ART AND SKILL OF FEEDBACK

Dr. James R. Schroeder

The workplace, family and marriage are often greatly impacted by our ability to provide consistent feedback to people we interact with on a daily basis. It can impact the work performance of our employees and the quality of our relationships at home. As a consultant, I interview many employees across the state where I consistently hear a desire for meaningful feedback from their employer and a desire for stronger relationships. Considering the average dental office spends 25% to 35% of their revenue on employees we would do well to become students in the art and skill of effective feedback. It affects every area of our lives. As father of six children I can vividly remember times where I missed the target in an effort to provide meaningful "feedback" to one of my children, or even worse, my wife of 44 years. Feedback can come in many different forms which can be either subjective/objective or destructive/constructive and be heard quite differently than we intended! At the School of Dentistry we all remember reviews that brought either exhilaration or disappointment. The learning process must be woven with encouragement and constructive correction. A great resource for assessment of employee engagement is Gallup's Q12 Survey, "Twelve important questions to engage employees." These principles apply as we develop employees or teach students. This will help you understand where your employees line up with engagement in your office. It will also give you a hint of your return on investment in staff salaries. A fully engaged and energized staff member will make a great contribution to office growth.

Will you improve the art and skill of how you provide feedback to your team? Major studies indicate the lack of employee engagement exists across the workforce.[1] Investment in this area could provide immense financial and job

satisfaction for all involved. Let's start with a simple self-assessment of ourselves! Have you developed a process for conversational feedback when engaging your team members or is it shot from the hip? Would you start a complex treatment plan without a plan? As doctors we often overlook our role of developing others on our team. This requires reflective time to make a plan of communication coupled with metrics the employee understands are their responsibility. Think back over the past few months and evaluate your ability to provide feedback in the development of your team. Has it been effective in bringing about the desired change or rewarding exceptional performance? I am including two references for your development. Warning! Feedback and employee development are often avoided, or procrastinated because they are uncomfortable, or the skills were never developed because you are just too busy at the dental chair and your office manager has not acquired the effective feedback skills."[2]

Following are some tips to strengthen your feedback system to enhance a thriving culture and growing employees. As employees grow, your organization grows; take the time to invest in these critical skills, no less important than our endodontic or restorative skills. "I believe that everyone is a leader at some point in time, we have a choice how well we lead."[2]

Building a relationship the first step

1. Telling someone something is not the first step in feedback. The Gallup survey reveals employees want to know the boss or management cares about them and takes time to listen to them. When this takes place it opens the door to receive feedback.

Making regular deposits in the brain bank is critical

2. I like the model of depositing "positive feedback-appreciation and affirmation" regarding an employee performance, like a bank account. When critical feedback is needed, which I call a withdrawal, you have built up deposits in the account for the withdrawal to take place. If you find it impossible to make positive deposits it may be time for the employee to be on probation or dismissed.

A multi-lingual mind set is required

3. Become multi-lingual; by this I mean understand that we all have different communication styles. We often have to speak the language of the employee we are engaging. I often have a dominant boss come to me saying, "Jim, I don't understand. I provide feedback and my employee starts to cry or get angry - I just tell it like it is." The employer often does not realize they are perceived as being rude, cold and ineffective in empowering their team member. Two great tools to improve our multi-lingual skills are the DiSC instrument and the Strength Finders. I use one or both of these with all of my clients. Understanding our own language and that of the people we are evaluating or developing can be a major factor in our effectiveness. Acquiring and applying these skills can take your practice to the next level!

Develop a feedback toolbox for diversified situations

4. Feedback can begin with a simple affirmation such as "Great Schedule", or "You were really organized for the complex procedure". Affirmation of individuals is tremendously underutilized, yet it is a powerful transformer of attitudes. A recent comment from a doctor, "Why should I have to affirm them, that's what I pay them to do?" The absence of affirmation impacts an organization and the quality of service and employee retention. The most effective feedback is conversational, directed with the individual not at the person. Having the skill to create an interactive conversation is most valuable. Often we fail to define clear metrics that indicate the objective quality of the employee performance. These should be written, clearly defined and objective. Feedback can be simply verbal or include a written report and scheduled meeting. One size does not fit all. The leader must have the knowledge and discernment to differentiate poor performance from your failure to train and equip the individual to do the job or acquire the skill.

What gets measured and reviewed gets attention

5. Feedback with metrics requires further planning, conversation and understanding. The School of Dentistry has many metrics in place and is in continuous pursuit of calibration of multiple faculties providing consistent feedback to students. Calibration without a mentoring relationship will short circuit the learning process at schools and offices. The most effective learning and growth takes place when clear metrics, healthy communication and dialogue are in place. Both parts of your brain (ANALYTIC +RELATIONSHIPS) need to be engaged for maximum learning to take place.

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1 http://www.gallup.com/poll/165269/worldwide-employees-engaged-work.aspx

2 Moran, Doug. *If You Will Lead – Enduring Wisdom for 21st Century Leaders*. Chicago: Agate Publishing, 2011.

Establish a time and place for important feedback

6. Selection of time and place are important components of creating an atmosphere to provide meaningful feedback. A common statement I hear from many employees, "It's been three years since I have had feedback or a review, I really feel devalued. It's always going to be in a few weeks." It makes a statement to the employee or family member: "I am important because time is being given to me and someone is listening to me in a conversation." Time and listening are two great tools for meaningful dialogue.

Dentistry in the 21st century requires more than dental skills

7. We are often expecting change when giving feedback for growth and improvement, but without planning and developing our own skills we fall short of our expected outcome. A skilled leader and communicator will develop a personal feedback style that recognizes both excellence in performance and addresses standards that do not meet the core values and expectations of your organization. We cannot relinquish the important development of this "Art and Skill of Feedback" in our home or office. It requires multiple factors to be in alignment: time, planning, dialogue, understanding of the multi lingual nature of relationships and clarity of the topic being addressed. This will lead to mastery of a powerful feedback system. It shuts down the commonly-used system of accuse and defend that leads to frustration and confusion between doctor and employee.

Where Do I start?

I have provided several references for your reading in addition to a complimentary telephone conversation on this topic. Acquiring a coach, taking courses and reading on the development of people are all ways to grow. Take the time to develop this skill set to enhance your leadership and growth in your practice and life. It will lead to growth of everyone around you. "Leaders become great not because of their power, but because of their ability to empower others"[3]

IS YOUR FEEDBACK EFFECTIVE?

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

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3 Maxwell, John. *The Five Levels of Leadership – Proven Steps to Maximize Your Potential*. New York: Hachette Book Group, 2011. p. 9

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Richmond General Practice Location!

General practice located in a great area of Richmond. This office is equipped with 8 treatment rooms and is grossing over $1M! This could also be a great partnership opportunity as well.
Opportunity ID: VA-4050

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Opportunity ID: VA-3785

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MEET THE CANDIDATES
2017-2018 PRESIDENT ELECT

Cast your vote beginning July 5, 2016 at vadental.org

DR. DAVID BLACK

I recently retired from full-time clinical dental practice, but still teach and precept students in local programs, work as a volunteer at The Bradley Free Clinic, and help coordinate our local Mini MOM through Project Access. I am also actively involved in my new Consulting business. Even with all of this, I have the energy and drive to want to lead the VDA in the coming years.

I have been active in the Piedmont Dental Society and the VDA for many years, including two terms on the Board of Directors of the VDA. I have been chairman of committees and task forces to deal with Non-Renewal of Membership, Annual Meetings, Insurance issues, Public Relations Task Force, relations with the VDAF, and Awards.

I have actively participated in the Day on the Hill for many years and am liaison to several local legislators. I understand that we need to be politically active through VADPAC to protect the profession we love against those who would like to take us over. I have donated at the Apollonia Level for six years, which I feel should be a requirement for anyone seeking the higher offices in the VDA. I feel this is an indication of commitment to our society, putting my money where my mouth is.

Although many issues cannot be anticipated far in the future, I feel I have experienced many changes we have gone through in recent years. I don't always agree with all decisions our board makes, but I help carry out our vision and commit to our mission once it is set. I have the sense to seek the advice of those who came before me, and would make full use of the experience of past-presidents and our executive director. The VDA president does not run our Association, but rather helps implement the shared vision of the board and leaders.
I would consider it an honor if you would support me in my quest to be elected President-Elect of the VDA. ■

DR. BENITA MILLER

When I first joined the ADA/VDA/RDS as a new practitioner, it was because that's just "what you did". The VDA was "the place to be". What I have found over my years of involvement is a community of close friends and colleagues like no other I could ever have imagined. We are so easily isolated in our daily practices whether they are small or large.
I would have completely missed out on these relationships if I had not joined our tripartite organization and remained an active member all these years. These relationships have added a richness and depth to my life that I could not have found elsewhere and have helped me achieve my professional goals as well. The VDA gives us the opportunity to develop relationships with other groups who impact our profession, e.g., our legislators, oral health coalitions, schools, and helps broaden our horizons in our communities. They in turn have come to realize how much we care about our patients' oral and overall health.

"To whom much is given, much is expected in return". I have long felt a responsibility to give back to the profession that has given me so much. There are many days when it would be so easy just to go home and stay home - there's lots to do there. As dentists we have the rare opportunity to provide a valuable service to our patients and our communities and to provide for our families. We all have a responsibility to strengthen the profession and move it forward for our next generation.

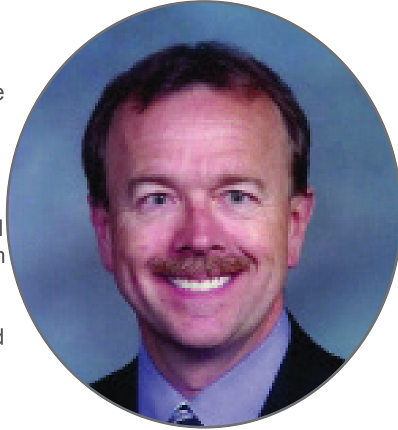
Over the years, serving as President of the Richmond Dental Society, member and Chair of various VDA Committees, recent VDA Board member, and present member of the Virginia State Board of Health, I have had the opportunity to work with VDA members in helping to address the ever evolving challenges our profession faces. Some of our most serious issues include declining membership, government interference, insurance squeeze, and student debt. With these challenges also come great opportunities to strengthen our core and our values and to make our profession stronger. Highly successful organizations that have remained relevant through rapidly changing environments are those that have strengthened their core vision and have adapted their community to anticipate and respond to the changes. We have a wealth of talented members who bring their considerable skill to work together and in conjunction with our incredibly dedicated VDA Executive Director and staff.

Our demographics have changed over the years, but the uniqueness of our profession has not. We need to "embrace our diversity and strengthen our unity". Yes, we have challenges facing us, but if we strengthen our community, we strengthen ourselves and our profession. We can be successful personally and professionally if we see our challenges as opportunities to pull together, to be inclusive, to lean in and get involved, and to affirm that the VDA is truly "the place to be." ■

MEET THE CANDIDATES
2017-2018 ADA DELEGATE

Cast your vote beginning July 5, 2016 at vadental.org

DR. RALPH L. HOWELL, JR.



As our profession continues to struggle with stresses from inside and outside the practice of dentistry, it is imperative that the Association sends delegates who have a broad base of knowledge to represent their wishes on a national level. Internally, we have seen membership numbers decline and externally we have seen increased pressures from third party payers and government regulations. In order to combat these issues we need to maintain a strong association and to regain our market share of membership as well as keep our voice strong on the national level. Having served the Association in various leadership positions in the past, and currently serving on the ADA Council on Communications, I feel that I can effectively continue to represent the VDA as a Delegate to the ADA. I humbly ask for your support for the office of ADA Delegate.■

DR. TED SHERWIN

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

While serving as an ADA Delegate and Alternate delegate, I have had the privilege to serve five times as District Chair of our Observation Team on Budget and Finance. In addition, I have had the honor to serve the ADA House on the Board of Trustee Committees for Strategic Planning and Budget and Finance. Last year I began my service on ADA's Council of Membership. These have been terrific opportunities to work with members of our District Delegation as well as other state delegations to build consensus on key issues facing our profession. I ask for your support for a second term as Delegate in order to build on this experience. ■

DR. MICHAEL LINK

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

Dentistry today faces many new trials and tribulations. Some of today's major issues have not changed over the past few years; however, the ADA has been active in turning the tide to help our member dentists. In order to have meaningful solutions to our problems, we need to "think outside the box". As we have seen over the past few years, Foundations, Representatives from Congress and some state Legislators are trying to come up with their own solutions to our problems. They have spent in the neighborhood of $70 million dollars over the last 5 years to promote their agenda! I believe the ADA has slowed this progress of these outside agencies to some extent. Plus, I believe the ADA has come up with their own innovative ideas to solve our problems. The CDHC program is a great example of a solution to best address the economic issue of "the access to care". Through all of the upcoming debates, we must adhere to one simple principle: The Dentist is in charge of the Dental team.

My work ethic, consensus building and past experience on the Virginia Delegation, the Virginia Board of Dentistry and as your VDA President have provided a strong foundation for my continued service on the National level.■

MEET THE CANDIDATES
2017-2018 ADA ALTERNATE DELEGATE

DR. DAVID BLACK

I would count it an honor to be elected Alternate Delegate to the ADA. I have served for two terms on the VDA Board of Directors, I am a candidate for President-Elect, I have been a member and chairman on several Task Forces over the years.

I have experience with the workings of our board, and have an attitude of getting our work done instead of debating issues over and over. Board work is hard enough without repeating discussions that should be once and done. I have the ability to work well with our present delegates and alternate delegates, and feel I could bring my years of experience to the delegation. In this age of government regulation and insurance company intrusion in our practice lives, we need experienced people representing us who have the ability to tell our story. I believe I have those qualities and that ability.

Thank you for your consideration.■

DR. ROD KLIMA

It is a privilege to serve the members of the Virginia Dental Association on the delegation to the ADA. These are turbulent times for dentistry. We saw evidence of this with a recent cover of the VDA Journal. "The storm is here, survival is optional." We continue to deal with the outside forces, non-dentists, so called experts who purport to know what is best for our patients and how best to deliver dental care.

As practicing dentists, we need to remain the captains of the ship of dentistry. We need to be proactive at all levels, including legislative first and foremost, regulatory, public health, and evidence based scientific affairs. My interest has always been focused on the public affairs part of dentistry and the delivery of quality dental care. I appreciate the members allowing me to serve and represent you.

Thank you for your support.■

DR. FRANK IUORNO

At this point in my career, I feel I have enough experience from both private practice and organized dentistry, yet I am not too far away from school to appreciate the needs of our young practitioners. The strength of our membership is directly correlated to the strength of our profession. We need to continually grow in number to ensure a strong voice when issues that may change our livelihood come to the forefront. The ADA is working hard to ensure our membership remains vital, but much needed leadership from younger members is needed. I would be honored to accept the role as the VDA's alternate delegate to the ADA and strive to represent our delegation positively with special emphasis on the needs of our younger members.■

DR. JUSTIN NORBO

First, I'd like to say that I am proud to be an ADA and VDA member. Being a member of organized dentistry has afforded me opportunities to develop friendships and learn a tremendous amount from my respected colleagues. As many of us would agree, being a member has also instilled in me the obligation to give back to the profession. For this reason I am committed and passionate about continuing to protect the profession as we know it.

I am seeking the position of ADA alternate delegate because I understand the needs of new dentists and young members and will advocate for those needs at the ADA House of Delegates. It is very evident that the profession is rapidly changing and we are constantly facing new challenges. New dentists especially see these challenges from growing student loan debt to changes in employment opportunities and a host of others. While the profession as a whole must have a united voice it is also important that young practitioners have a seat at the table.

I have had the opportunity to serve on the new dentist committees with the VDA and ADA and feel that I have an awareness and knowledge on the issues at both levels. I believe that my dedication, commitment and willingness to serve will allow me to represent our sixteenth district well at the ADA level. ■

MEET THE CANDIDATES

2017-2018 ADA ALTERNATE DELEGATE

Cast your vote beginning July 5, 2016 at vadental.org

DR. RICHARD L. (RICK) TALIAFERRO

I am running for the office of ADA Alternate Delegate and I seek your support. I have served the past two years as an Alternate Delegate and will serve again this year in Denver. I am running for a two year term to serve during 2017 and 2018.

I have served in several leadership areas in organized dentistry including serving as President of the VDA. Those who know me well, know of my passion for dentistry. With my involvement as a leader, I know that we face many important issues; including third party interference from insurance companies and special interest groups. Our future as independent practitioners and independent diagnosticians is and will be threatened.

I have been and remain ready and willing to fight the forces to keep our great profession as it has been. Having served as an alternate delegate the last two years, I feel I am well prepared to represent our association in the ADA House of Delegates.

I hope you will support me and I will do my best to serve as your alternate delegate. ■

DR. BRENDA YOUNG

It has been a great honor to serve as your ADA Alternate Delegate this past year. I would like to continue to represent the VDA in this capacity. For over 25 years, I have been a member of the VDA and I want to continue to be an active part of organized dentistry. We are only strong in numbers and the ADA is working hard to preserve our ability to practice dentistry and continue our livelihood. I want to be involved in this process. I feel the need to protect our profession and our patients. As a member of the ADA Delegation, I can support actions that best represent our interests in Virginia. We face many difficult decisions and changes in our professional future. I would like to continue working toward solutions.

I am grateful for your support and would be honored to continue serving as your ADA Alternate Delegate. ■

CENTRAL OFFICE WELCOMES NEW STAFF

MEGAN WYMAN

DIRECTOR OF CONTINUING EDUCATION AND MEETING PLANNER

Megan is a Richmond native and graduated from VCU with a Bachelors in Psychology. She has been in the hospitality industry for 15 years and thoroughly enjoys all aspects of the meeting planning process. Mrs. Wyman has previously worked for an association planning meetings of all sizes. As a mother of a toddler, Mrs. Wyman is constantly on the go. In this new position things will be no different, which is what drives her. Megan is looking forward to all the new connections and friendships she will make at the Virginia Dental Association. ■

WELCOME NEW MEMBERS

Karen Clendenen, VDA Membership and Meeting Coordinator

TIDEWATER DENTAL ASSOCIATION

Anne Green - Hampton - University of Florida 2009

Zaneta Hamlin - Virginia Beach - Howard University 2012

Tuo Sheng Joel Khoo - Chesapeake - National University of Singapore 2005

Angela Melton - Suffolk - Howard University 2011

Jayme Oliveira Filho - Virginia Beach - Brazil- Universidade Federal Do Ceara 1999

Louis Park - Virginia Beach - Temple University 2010

PENINSULA DENTAL ASSOCIATION

Maria Fashing - Williamsburg - Virginia Commonwealth University 2015

Sungmin Jeoun - Newport News - New York University 2015

Richard McCoy - Williamsburg - Virginia Commonwealth University 2015

Pam McDonald - Providence Forge - West Virginia University 2013

RICHMOND DENTAL SOCIETY

John Andre - Richmond - Howard University 1986

Sandy Chang - Richmond - University of Pennsylvania 2005

Benjamin Crowley - Richmond - Virginia Commonwealth University 2007
William Dahlke - Richmond - University of Nevada Las Vegas 2006

Nasser Damirchi - Glen Allen - Virginia Commonwealth University 1996

Genevieve DeVera - Midlothian - Virginia Commonwealth University 1998

Pragya Goel - Midlothian - University of California San Francisco 2015

Wanda Hall - Glen Allen - Virginia Commonwealth University 1991

Martha Holland - Richmond - University of Mississippi 2015

Nazafarin Javdan - Richmond - University of California-Los Angeles 2012/NY-Montefiore Med.Ctr. 2012

Ojas Parikh - Richmond - University of Maryland 2015

PIEDMONT DENTAL SOCIETY

Evan Chalk - Lynchburg - Temple University 2008

Michelle Kim - Roanoke - Loma Linda University 2012

Sean Lawson - Roanoke - West Virginia University 2007

SHENANDOAH VALLEY DENTAL ASSOCIATION

Robert Amos - Winchester - Virginia Commonwealth University 2013

Andrea Galina - Charlottesville - Stony Brook University 1991

Lindsey North - Charlottesville - Virginia Commonwealth University 2013

Latasha Sauls - Madison - Virginia Commonwealth University 2010

Oscar Vega - Madison - Virginia Commonwealth University 2011

NORTHERN VA DENTAL SOCIETY

Amy Adair - Burke - University of Connecticut 2007

Ali Al-Janabi - Alexandria - Columbia University 2015

Elaine Barlar - Alexandria - Marquette University School of Dentistry 2003

Joyce Boesel-Freeman - Herndon - University of North Carolina School of Dentistry 1983

Stephenie Browning - Reston - Baylor College of Dentistry 2012

Ruth Duchatellier-Cange - Ashburn - Howard University 2008

Neda Emad-Azmoudeh - Leesburg - Howard University 1993

Rima Kanbaragha - McLean - Jordan- University of Amman 2010

Rania Khoury - Fairfax - University of Maryland School of Dentistry 2013

Jonathon Konz - Brambleton - State University of New York at Buffalo 2015

Ali Nosrat - Fairfax - Tehran University (Iran) 2002

Amrita Singh - Fairfax - Virginia Commonwealth University 2014

Anthony Palumbo - Vienna - Tufts University 2008

Sara Shambayati - McLean - Case Western Reserve University 1999

Steven Tidwell - Fairfax - University of Southern California 1980

Roopa Vanaharam - Arlington - Tufts University 2012 ■

ADA TRUSTEE'S CORNER

Dr. Julian H. "Hal" Fair, III; ADA Trustee, 16th District

We had a productive first meeting of 2016. Listed below are the topics and discussions that we covered:

Persona Research. We started off with a presentation and discussion on our persona research. This work is essential to guide our messaging to members and potential members. The VP of the Membership Division, Mr. Bill Robinson, reminded us that this research is for internal use, and use by the state societies. It must not be shared outside the ADA; for that reason this is a brief overview of our discussion. The research will shape our messaging, but it is not the message itself.

The persona research goes well beyond demographics and explores behavior, perceptions and feelings. It involves a review of the extensive research we have already undertaken as well as in-depth personal interviews of members and a major survey. All this information was then synthesized by our outside firm, as well as our staff in order to define the personas and identify our key insights which will guide our messaging. This much better understanding of our members and potential members, and how to speak with them, will affect almost everything we do. We look forward to full implementation of this important work.

Ms. Stephanie Moritz, VP of the Communications Division, explained to us that this same approach will be followed to help us better understand our patients, and the public in general, so that we can better and more effectively communicate with them.

Communications Division. Ms. Moritz also briefed us on the reorganization of the Communications Division. This work will allow us to be more responsive and effective in our communications, across all communications platforms. It will also encourage our Communications Division to work across all divisions and to coordinate and focus our outgoing communications. All of this will be shared with our state and local societies.

Strategic Discussion. We are all very familiar with the on-going battles over dental therapists, especially in certain states. Mr. Jon Holtzee reviewed for us the status of the therapist issue throughout the country. It is an active political problem throughout New England. The issue is now appearing in the southeast, Texas, the upper Midwest, and in a number of places in the west. In short, the therapist issue is cropping up throughout the nation, although we have been very successful in fighting this in the states. As an overlay, therapists also remain a very hot topic on Native American lands. Because the issue is so common and will be for the foreseeable future, our discussions were very timely. It is our obligation as leaders to stay current on this important topic. As part of our strategic discussion, we reviewed existing data on the effectiveness and economic viability of the therapist model. Bottom line is that the existing data is not of high quality and the experience in the U.S.is too recent and too little to draw many conclusions. We also reviewed our ADA policy relating to therapists. The science and our policy are, of course, our starting points.

We looked at the therapist issue in light of each our core values:

- Commitment to Members
- Integrity
- Excellence
- Commitment to the Improvement of Oral Health
- Science/Evidence-Based

In reviewing this issue, we examined the costs and benefits of any approach we may take or are taking. In some parts of the country, the battle has been waged for so long that it is taking a toll on both leadership and rank and file. In those areas, should dentistry change its approach? Will other approaches work in those parts of the country? These are difficult questions to answer and generated some interesting discussion around the Board Room.

The purpose of the discussion was not to change our policy, but to bring forth in discussion the most current information available to us. I am certain our discussions will continue throughout this year. Our exercise demonstrated the complexities of the issue and our need to be sensitive to all perspectives, including how our members perceive the issue.

New Dentist Committee. One of our key standing committee is the New Dentist Committee. Its chair, Dr.Chris Hasty, presented to the Board at this meeting committee plans for the coming year. For the last year or so, we have all been working to improve the flow of ideas and perspectives between the Board and the New Dentist Committee. We are now seeing those efforts pay dividends and we look forward to the committee's work over the coming year.

ADA Foundation. We also continued our discussions regarding support for the ADA Foundation. The resolution we passed will help us understand exactly how the ADA's grants to the Foundation will be applied among science, philanthropy and administrative support. We also asked the Foundation to report to us on its development plans for the coming years and its plans for the Volpe Research Center.

Student Loan Consolidation Program. A recent member benefit is the loan consolidation program we launched with Darien Rowayton Bank (DRB). Mr. Robinson provided us with an update on this important and well-received initiative. As of November, DRB has received over a hundred million dollars in loan applications. It is too early to make any judgments, but approval rates so far have been quite good. And, so far, the average savings to an ADA member is approximately $30,000. We have provided DRB details on the very limited feedback we have received from our members and DRB has been very responsive to any issue we have raised. This level of responsiveness is very encouraging for the future of this member benefit.

Government and Public Affairs. Mr. Jon Holtzee and Dr. Jane Grover provided us with a government and public affairs update. Mr. Holtzee provided an overview of the appropriation measures enacted in December, 2015 with the passage of the federal omnibus appropriations bill. A number of dental programs received a significant increase in funding for FY 2016 versus FY 2015. Highlights include:

- CDC Division of Oral Health - $15.8 million in 2015, $18 million in 2016;
- HRSA Title VII General and Pediatric Dental Residencies - $9 million for GPR in 2015, not less than $10 million in 2016. $10 million for pediatric dental residencies in 2015, not less than $10 million in 2016;
- HRSA Maternal and Child Health Block Grants - an increase from $3.8 million in 2015 for pre and post-natal oral health education to $5million in 2016;
- IHS Division of Oral Health increased from $174 million in 2015 to $178.28 million in 2016
- CDC Opioid Prescription Drug Overdose Prevention Activity - an increase from $20 million to $70 million in 2016.

On non-appropriation items, the ADA was also very successful. The prohibition on federal funding for midlevel providers was maintained. Additionally, the ADA led a coalition to prohibit sheltering new tobacco products (e-cigarettes) from the FDA rule-making process. Further the Section 179 extension was approved providing dentists with the ability to deduct capital investments up to $500,000 and then at a decreasing rate through $2 million. Finally, the implementation of the ACA Medical Device and Cadillac taxes was delayed for another two years.

Dr. Grover described the Action for Dental Health initiatives, the collaborative efforts ADA has been making with some tribal nations and the growing success of the CDHC programs across the nation.

Part of this update addressed the complicated topic of Medicare opt out. A CPS resource is available to our members (https://success.ada.org/en/practice/medicare/medicare). In addition, please feel free to refer members with questions to Frank Kyle in our Washington DC office (kylef@ada.org) or Dave Preble (prebled@ada.org).

ED Goals. A key responsibility of the Board is to approve the executive director's annual goals annually, which we did at this meeting. Dr. O'Loughlin presented her goals to us and we discussed the linkage between her goals and Members First 2020. We all look forward to a successful 2016.

Budget Process. Our Budget and Finance Committee had a productive meeting. As part of that committee's report, the Treasurer presented to us on the budget process improvements. The key change is to assure that the strategic plan drives the budget, rather than the other way around. Other changes include standardizing the program descriptions and the use of program categories instead of treating all programs alike. This will allow us to use different criteria depending on the end user of the program and the nature of the program itself. The process will also be more open, to assure input from councils and other stakeholders. Based on the committee's recommendation, we approved this revised budget process and decided to eliminate the Administrative Review Committee as part of this process. The Budget and Finance Committee has the exact same membership as Admin Review and this change streamlines the process without diminishing Board oversight in any way.

Strategic Planning. Members First 2020, our strategic plan, guides our decisions. At this meeting, based on the work of the strategic planning committee, we amended three of the strategies under that plan. This is a key responsibility of the Board. Guided by the committee, we will regularly review and, as necessary, revise the strategies under the plan. In addition, we identified three strategies--focus the message, targeting students and new dentists for membership, and simplifying and standardizing our interactions with members as priorities for the coming year. These priorities mirror the goals of the executive director which we also approved and align our efforts.

State of the Dental Market. Dr. Marko Vujicic presented to us on the State of the Dental Market. He identified trends in the dental market. Dental spending continues to be flat, as does the division of the sources for the spending. Dental care utilization--visits to dental offices--is more varied. Utilization by children continues to grow, now at the highest level we have seen. This is driven primarily by lower income segments and public funding. Utilization by seniors is flat. Also, for the first time in a long time, there was no decrease in utilization by adults aged 19-64. We hope this is the beginning of a turn around, but we will need to closely monitor this to see if it becomes a trend.

In recent years, we have identified the high numbers of individuals citing a perceived cost barrier to receiving dental care. Dr. Vujicic pointed out that we now have five years of data showing that this trend in receding. This is a broad trend. In particular, children and seniors are far less likely to cite cost as a barrier to receiving care. All of this gives us hope that utilization will continue to improve, although we need more data.

Dental earnings declined from 2013-14, albeit only slightly. This may reflect similar data relating to average U.S. Household income. The percentage of dentists who say they are "not busy enough" may be stabilizing. As with other issues, we need a few more years of data points to draw definitive conclusions, but we are hopeful. Finally, Dr. Vujicic showed us data relating to inflation-adjusted private dental plan charges. It is no surprise to us or our members that, in general, there are no significant increases.

Health Literacy. Dr. Lindsey Robinson, ADA 13th District Trustee, briefed the Board on work surrounding health literacy and, specifically, on transforming the ADA into a health literate organization. This will involve a review of ADA publications, for example. Our involvement, through Dr. Robinson, in the Institute of Medicine (IOM) health literacy round table was also described. Dr. Robinson is the only dentist in this group and her involvement assures that the voice of dentistry is heard. Part of her work involves a "dental collaborative", a first for IOM. The impact of this work has the potential to be far reaching and we look forward to future developments.

Membership Update. We were updated on very recent membership numbers and trends. Total membership is up for the year, although the number of full dues-paying members continues to decline. This has caused our dues revenue to decrease. Mr. Bill Robinson discussed some trends as well. We see some improvements among students and new dentists, areas of emphasis for us, though a significant portion of that improvement can be attributed to provisional membership. At the same time the number of retired members is also increasing. Our 2015 market share is now 63.6%, a decrease of about one percent. This is due primarily to the increasing size of the market because our number of active licensed members has been relatively steady. We gained members among women, full-time faculty, specialists, new dentists and foreign-trained dentists. We continue to experience losses in net members among general practitioners. We have also experienced a slight increase in our non-renew rate. Eleven states this last year increased market share, a positive sign. We also reduced the number of states which are below the ADA market share from 15 to 12. We all recognize our work must continue. Mr. Robinson pointed out that we will need to continue to work and innovate if we are to make progress.

Credentialing Service. Our meeting ended with an update on an important new initiative, the development of a credentialing service for dentists. The Board agreed to support this initiative by funding the early stages of the work. We look forward to learning more in the coming months. ■

40 UNDER 40

DR. PATRICE HARMON

A 2011 Ole Miss graduate (Hotty Toddy!!) and Mississippi Gulf Coast native, Patrice Harmon moved to Virginia and joined Hawkins Family Dentistry in Midlothian in 2013. She, her husband Mark, and their two rescue dogs live in the Richmond Fan.

BOARD OF DIRECTORS - ACTIONS IN BRIEF

January 21, 2016

1. Approved: A resolution to approve the concept of a student loan repayment plan as proposed (similar to the Ohio Plan) with a suggested license renewal fee of $30.00. (Resolution to go to the Council on Government Affairs.)

2. Approved: The revised Investment Policy Statement as submitted.

3. Approved: A resolution to approve ACG, an investment management group, as the VDA Investment Fund manager.

4. Approved: A resolution to fulfill the Investment Policy Statement by moving up to 60% of funds inthe Reserve Fund into the Long Term Reserve Fund. This will allow the VDA to earn a modest income.

5. Approved: A resolution approving the election of the 2016 VDAF Board of Directors:Patrick W. Finnerty, President; Robbie Schureman, Vice President; Edward J. Weisberg, DDS, Treasurer; Graham Gardner, DDS, Secretary; Robert H. Walker, Jr.; Anne C. Adams, DDS; Ralph L. Howell, Jr., DDS; Norma Roadcap; David L. Jones, DDS; William R. Harland; Barry Isringhausen; Audra Y. Jones, DDS; David C. Jones, DDS; Juan A. Rojas, DDS; D. Omar Watson, MD, DMD; David Lionberger, Esq. **Background**: The Virginia Dental Association is the controlling entity of the Virginia Dental Association Foundation. Therefore, the VDA elects at least a majority of the members of the VDAF Board (per April 13, 2012 action).

6. Approved: A resolution to create a task force to research the creation of a membership mutual malpractice policy.

7. Approved: The appointment of Justin Norbo to serve the remaining year of Sam Galstan's ADA Alternate Delegate term.

8. Approved: A resolution to oppose the legislative bill to add a citizen member to the Board of Dentistry. ■

IN MEMORY OF:

NAME	COMPONENT	DATE OF DEATH	AGE
DR. THOMAS F. LINDSEY	NORTHERN VA	JANUARY 9, 2016	78
DR. JOHN W. ATKINS	TIDEWATER	DECEMBER 28, 2015	92
DR. AVALON L. FANSLER	TIDEWATER	DECEMBER 4, 2015	85
DR. GEORGE MC GUIRE	TIDEWATER	SEPTEMBER 15, 2015	82
DR. ROBERT S. SIEGEL	NORTHERN VA	JUNE 16, 2015	80

MEMBER AWARDS & RECOGNITION

DR. DANIEL LASKIN

The International Association of Oral & Maxillofacial Surgeons has established the Daniel Laskin Legacy Society.

DR. CHARLES CUTTINO

2016 Distinguished Service Award

Virginia Society of Oral and Maxillofacial Surgeons

MEMBER SPOTLIGHT - DR. STEVEN FORTE

Dr. Frank Iuorno; Associate Editor, Component 4

Dr. Steven Forte

Our spotlight shines brightly on Dr. Steve Forte this month. Dr. Forte has been the past Secretary-Treasurer of the Virginia Dental Association, a Delegate to the VDA, past President of the Virginia Academy of Endodontics, past President of Component 4, and has served on numerous committees for both local and state societies. His involvement in organized dentistry is nothing short of epic, and anyone that knows Dr. Forte can appreciate the passion he has for dentistry. It was my good fortune to talk to Dr. Forte about his involvement in the VDA for the past 18 years and his thoughts for the years to come.

Ironically, it was his lack of knowledge that fueled his passion for organized dentistry early on. After going to local meetings and study clubs and feeling uneasy about not knowing the issues facing the profession, Dr. Forte was introduced to organized dentistry by Dr. Gary Hartwell, a mentor at the VCU School of Dentistry Endodontics Department. "I heard through his words and saw through his actions how crucial it was to be part of our profession" said Forte. That was the start. In the years to come, Dr. Forte discovered that his involvement at the VDA felt like giving back, or repaying a debt for all the opportunities afforded him by dentistry. When asked, "How do you feel you've impacted dentistry in Virginia and locally", Dr. Forte responded.

> *"We begin with a preconceived notion that the only way you will make an impact is if you do something great. The reality is, the impact you make is done on a daily basis. Every day you show up at the office and assist a patient in their oral health, impact. When you offer your service to a dental school or a clinic, impact. Donate to VADPAC, contribute to a campaign, stand with fellow dentists at "The Day on the Hill", have a budding dental student visit your office, listen to a colleague about the frustration of the day, all impacts. I am glad to be part of the overall process."*

It is through these individual "impacts" that organized dentistry finds strength. That strength is important when considering how organized dentistry will play a role in the lives of dentists over the next five to ten years. "Outside influences such as insurance companies, the Board of Dentistry, legislators, OSHA, HIPAA, non-dentists providing care (for example, tooth-whitening services) and the actual cost of dental school can be affected by a concerted effort of our members," says Dr. Forte. Organized dentistry is the only way our profession will be able to manage these outside influences. Our membership needs to be maintained to have a strong voice. Dr. Forte feels that the question we need to ask ourselves is: Why does our profession continue to be over-regulated by these groups? Why do insurance companies, OSHA, HIPAA, and the Virginia Board of Dentistry have so much of an influence on our profession, when the dentists have more knowledge about the best care for patients? The answers lie with our membership, specifically the new members to the VDA and ADA.

The VDA needs the input and commitment of younger dentists moving forward to insure a strong voice in negotiations. Dr. Forte encourages our younger members to find a way to participate in organized dentistry at any level. "A new dentist needs to find organized dentistry and grab hold with all they can." For him, learning about the issues that affected his career was enough to keep his involvement active. Interestingly, he considers his financial obligation to membership and contribution to VADPAC as a kind of insurance policy, like malpractice insurance-- an investment in his future as a practicing dentist.

"The landscape of organized dentistry is different today, than what it was when I graduated" says Dr. Forte. He feels that change in the way organized dentistry functions is not only inevitable, but required to remain viable. The desires and needs of new dentists differ from those of dentists 20 years ago. For our organizations to meet those needs, we need to encourage and allow leadership from our younger members. This should start in dental school and be followed up in the community.

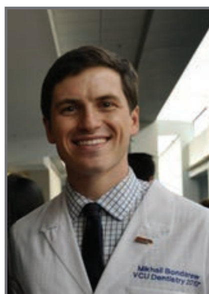
> *"What hasn't changed is the love for dentistry that every student has when they receive their diploma. I believe the next generation will still have the opportunity of a great career, but it will not come without great effort on their part to sustain the viability of organized dentistry."*

Dr. Steve Forte's commitment to organized dentistry has been and will hopefully continue to be admirable. The consistent daily impact of his efforts has made our organization stronger, and for that we extend much gratitude. Thanks, Steve, for all you have done and will continue to do for the VDA. ■

40 UNDER 40

DR. P. SHEAMUS HART

I am proud to be back in Woodbridge practicing orthodontics alongside my father, Patrick Hart, and giving back to the community in which I grew up. It has given me a wonderful opportunity to learn and grow as a clinician.



MY REASONS FOR BECOMING A MEMBER

Mikhail Bondarew, Associate Editor; Class of 2017, VCU School of Dentistry

Many people have told me to participate in organized dentistry because historically it is "just what you did". Upon receiving eligibility, you simply broke out the old checkbook and signed right up - no questions asked.

Some suggested that the tangible discounts for travel, insurance and retirement plans, JADA subscriptions, and online resources are sufficient compensation for dues and expected participation. This may have once been enticing, but in a time where price shopping occurs for goods ranging from laundry detergent to dental services, these simple benefits seem far too superficial.

Others cite the plethora of CE. My passion for lifelong learning makes this intriguing, but I find with any quick Google search that CE is readily accessible through a multitude of respected organizations. Plus, numerous equitable courses are can also be delivered conveniently to your office, kitchen or even airplane seat at a fraction of one year's dues.

The opportunity to engage in advocacy is a benefit that starts to hit close to home. It's a great way for our profession to speak loudly on behalf of our patients, while protecting and expanding our profession. Lastly, it's hard to overcome the thought that my one voice will make a difference. I have to remind myself that it's not my one voice, but the collective 158,000 voices that make change possible (Join!).

In short, connectedness is the reason to join. In our private lives, we connect with others through activities like scouting, kickball leagues, and countless social media platforms. I'm using these platforms to live vicariously, learn, and communicate with others. What I failed to realize is that my tripartite membership offers many of these same benefits.

For starters, it offers connections to like-minded professionals. People willing to unite behind a cause. People willing to go the extra mile for patients, protect our professional image, and preserve the future for the next generation. It offers access to an amazing community with members throughout the country. Members are uniting regularly to help treatment plan, discuss business concepts, acclimate freshly transplanted professionals, and even socialize. These great people are the best benefit for joining and participating, yet we don't emphasize this enough. We millennials especially understand the importance of high connectivity. We're connecting on AIM or Myspace, and have continued in dental school. We've learned our beloved practice in an extremely social setting, yet quickly forget that in a few short years, we could be interacting with far fewer dental professionals each day.

I am not quite sure how to better promote membership. I certainly know many smarter people have been working diligently to retain members and to recruit new ones. The only thing I surely know, is that I'm happy to help - and that I'll be among a great group of professionals.

For more information:

http://www.ada.org/en/member-center/member-benefits

https://www.ada.org/en/member-center/join-or-renew-ada-membership ■

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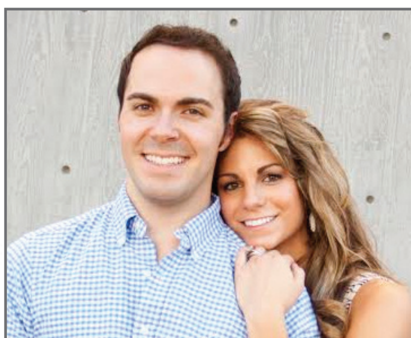

DR. JEREMIAH STURGILL

Jeremiah and his wife Riley, also a dentist, reside in Richmond. He graduated as chief orthodontic resident from Arizona School of Dentistry, and is recently board certified. Practicing at Gardner Orthodontics, he is known for his infectious laugh and crazy socks.

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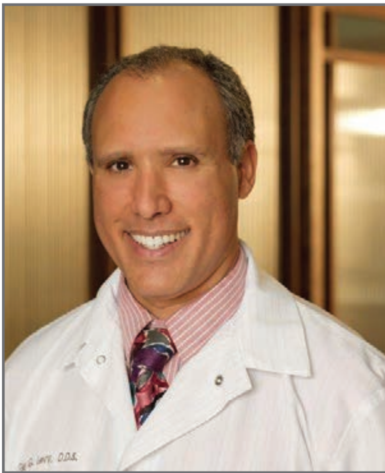
MEMBER PROFILE – DR. GUY LEVY

Dr. Zane Berry; Secretary, Peninsula Dental Society



Dr. Guy Levy

Dr. Guy Levy graduated from Georgetown University's School of Dentistry after completing his undergraduate study at Virginia Tech. He joined his father and mentor, Dr. Mayer Levy, in dental practice in 1987 and began his amazing journey as a dentist in the Yorktown area of Hampton Roads' Peninsula. Always exploring ways to improve the quality of his dental care, Dr. Levy has attended the Pankey Institute for Advanced Dental Study and countless other continuing education programs during the course of his highly-accomplished career.

With two children in college and celebrating his 30th wedding anniversary this summer, Dr. Levy cites family as the greatest of his many achievements. But while you may find Guy out for a jog or immersed in an engaging book in his free time, be sure that his commitment to excellence in patient care and communication is job number one at the office. "Our patients place a tremendous amount of trust in us to help them when they are in a vulnerable position. I am gratified to exceed our patients' expectations with the care and comfort we are able to provide." Recognizing the ever-changing challenges of operating a dental practice efficiently in our current healthcare climate, Dr. Levy decided to bolster his knowledge base with a degree in Health Care Administration at Virginia Commonwealth University after dental school- a pursuit that he declares "has helped me immensely!" While helping Dr. Levy streamline his practice, the additional training has proved particularly useful in his startup of a biomedical device company as well.

While a role model for many, Dr. Guy Levy attributes his own personal growth and professional success to a long network of mentoring dentists and Association colleagues. As a leader in organized dentistry and past president of the Peninsula Dental Association, Dr. Levy was inspired by our dental predecessors who helped evolve our profession into what it is today – a culture of health maintenance focusing on the prevention of disease. He recognizes the tremendous importance that organized dentistry holds and encourages both new and more experienced dentists alike to become actively involved in the ADA and other dental organizations. While noting the high caliber of dentists coming out of dental schools currently, Dr. Levy does see an unsettling trend towards a more loosely affiliated dental community than in the past. "Professional life is much more fulfilling when experienced as an integral part of a local collegiate network," he states, and we should all "look for ways to develop mutual support among our colleagues." Furthermore, Dr. Levy adds that we as dentists must embrace our ability to self-regulate by getting involved and encouraging our colleagues to do so as well. "Organized dentistry is not a spectator sport…If we do not step up and lead the way in educating the public and our elected leaders regarding issues that are important to us and our patients, then we will look a lot more like medicine than we do today." ■

40 UNDER 40

DR. SAYWARD DUGGAN

Dr. Duggan graduated from VCU in 2006. She completed a two year GPR at UVA followed by a periodontal residency at VCU in 2011. Sayward co-owns a periodontal practice in Yorktown, where she resides with her husband, Andy and sons, Jack and Charlie.