IN THIS ISSUE:

ETHICS AND PROFESSIONALISM IN DENTAL EDUCATION AND LICENSURE - PUTTING PATIENTS FIRST pg. 21

ORAL HEALTH IN OLDER ADULTS pg. 33

VIRGINIA DENTAL Journal

VOLUME 93, NUMBER 1 • JANUARY, FEBRUARY & MARCH 2016

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HOW ONE VIRGINIA COMMUNITY CONFRONTS ACCESS-TO-CARE

Page 6

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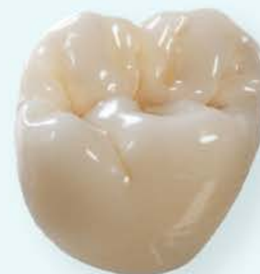

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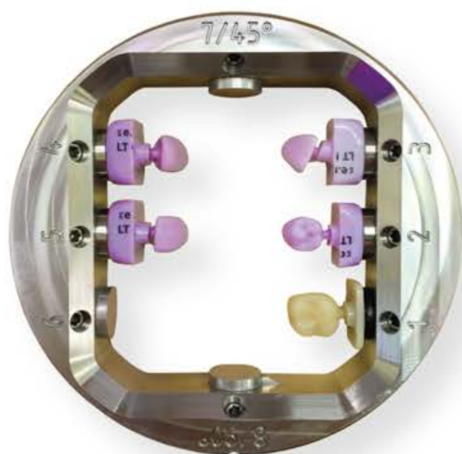

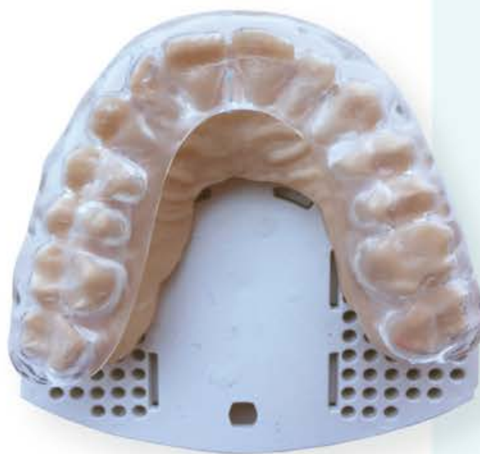

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VIRGINIA DENTAL JOURNAL

JANUARY - MARCH 2016 VOL. 93, NO 1

Contents

COLUMNS

3 PRESIDENT'S MESAGE
Dr. Richard Taliaferro

5 MESSAGE FROM THE EDITOR
Dr. Richard F. Roadcap

12 LETTER TO THE EDITOR:
Some patients do not smile and cannot smile
Dr. Marvin E. Pizer

14 LETTER TO THE EDITOR:
Modern record keeping in the dental patients' charts?
Dr. Robert Allen

17 HOW WHITENING CAN IMPACT YOUR PRACTICE
Dr. John "Cappy" Sinclair

47 THE TRIPLE THREAT DENTAL PRACTICE
Dr. James Schroeder

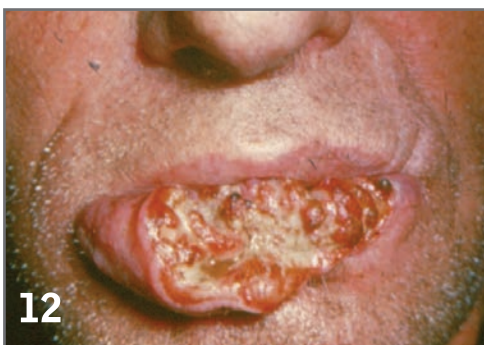
BACK COVER MEMBER SPOTLIGHT:
DR. NEIL SMALL
Dr. Chris Spagna

SCIENTIFIC (19-39)

19 PATHOLOGY PUZZLER
Dr. John Svirsky

21 PROCEEDINGS OF THE 59TH SOUTHERN CONFERENCE OF DENTAL DEANS AND EXAMINERS:
Ethics and professionalism in dental education and licensure - putting patients first
Drs. Sarrett, Lantz, Tankersley, Wentworth, Cranford, Bennett, and Wilson

33 ORAL HEALTH IN OLDER ADULTS:
A survey of long-term care facilities in Virginia
Lyubov Slashcheva; Drs. Coe, Bonwell, Best and Iuorno



FEATURES

6 WORLDS APART - How one Virginia community confronts access-to-care

11 IN THE LOBBY
Dr. Albert E. Converse

15 GUEST EDITORIAL:
Student debt and its impact on the dental profession
Dr. Michael McMunn

45 CREATE OPPORTUNITIES TO INCREASE REFERRALS
Bernie Stoltz

53 THREE KEYS TO INCREASED INTERNET VISIBILITY
Lance McCollough

60 VDA CO-HOSTS 2016 BIG SKY SKI AND LEARN SEMINAR

ADVOCACY (41-44)

41 VDA 2016 LEGISLATIVE INITIATIVES
Laura Givens

42 ARE YOU RELEVANT IN THE ELECTION PROCESS?
Dr. Bruce Hutchison

43 VADPAC FUNDRAISERS

44 VADPAC UPDATE
Laura Givens

OUTREACH (49-52)

49 MAKING A DIFFERENCE FOR THE HOMELESS
Joel Rubin

50 DONATED DENTAL SERVICES AT WORK

51 INTEGRATING ORAL AND OVERALL HEALTH IN GRUNDY
Tara Quinn

UNIVERSITY CONNECTIONS (54)

54 DOING IT YOUR WAY
Mikhail Bondarew

MEMBERSHIP (55-59)

55 WELCOME NEW MEMBERS
Karen Clendenen

56 LEADERSHIP, DIVERSE MEMBERSHIP GROUPS CRAFT STRATEGIC PLAN
Dr. Benita Miller

57 ADA TRUSTEE'S CORNER
Dr. Julian H. Fair, III

58 MEMBER AWARDS AND RECOGNITION

Virginia Dental ASSOCIATION

VIRGINIA DENTAL JOURNAL

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

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Volume 93, Number 1 • January, February & March 2016

VIRGINIA DENTAL JOURNAL (Periodical Permit #660-300, ISSN 0049 6472) is published quarterly (January-March, April-June, July-September, October-December) by the Virginia Dental Association, 3460 Mayland Ct, Unit 110, Henrico, VA 23233, Phone (804)288-5750.

SUBSCRIPTION RATES Members $6.00 included in your annual membership dues.
Members – Additional Copy: $3.00
Non-Members- Single Copy: $6.00
Non-Member outside the US: $12.00
Annual Subscriptions
in the US: $24.00
outside the US: $48.00

Second class postage paid at Richmond, Virginia.
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POSTMASTER Send address changes to: Virginia Dental Journal, 3460 Mayland Ct, Unit 110, Henrico, VA 23233.

MANUSCRIPT, COMMUNICATION & ADVERTISING Managing Editor, Shannon Jacobs, 3460 Mayland Ct, Unit 110, Henrico, VA 23233 or jacobs@vadental.org

PRESIDENT'S MESSAGE

DR. RICHARD TALIAFERRO

I hope that 2015 was a good year for you and your practice and that 2016 will even be better. This year will be a busy one for the Virginia Dental Association.

We are in the midst of a three-year strategic plan that will focus mainly on membership and finance. We had a large group of members meet in late October to lay the ground work for our plan. We have focus groups in five different areas: 1. New Dentist Membership, 2. Diversity Membership, 3. Non Renews Membership, 4. Dental Faculty Engagement, and 5. Finance.

As you can see a heavy emphasis is being placed on membership. Membership in the VDA (our market share) is now at 57.5%. It is important in terms of relevance when promoting our agendas to outside interests that we have a membership percentage of at least 60% of dentists in Virginia. Obviously, 60% is a minimum level and we should have a much higher percentage to do what is necessary to maintain our profession. We started an Ambassador Program in 2014 and had to deal with some obstacles and our success has not been as expected. We are putting forth more effort this year and hope the program will deliver much better results. We are engaging more members as ambassadors and are targeting specific groups of dentists. We know that one-on-one contact gets better results. If our program is as successful as it should be, we hope to grow to 60% in 2016. We then can build on that success and move to a 65% percentage in 2017, and 70% in 2018. This can be done and must be done to insure that our profession and member dentists can function without excessive third party payer, government, and outside interest interference. I hope you will do your part to help the ambassador program work.

You can do your part by inviting a non-member to join the ADA/VDA. Be on the lookout for non-members in your area and invite them to be a part of our organization. Be sure to engage them at component meetings and study club meetings. Also, with younger dentists, be ready to offer help as they work to establish themselves, pay off debt, and raise families. Finally, help steer them into an active role in the Association. They are the future leaders of our profession and more important for them, their profession.

We will be working this winter on a bill in the General Assembly that will revamp a bill on Non-Covered Services that was passed in the 2010 General Assembly as a result of our efforts. The 2010 legislation said that insurers could not dictate fees on non-covered services to their participating dental providers. We learned that some insurance companies were covering services as low as 5% to skirt the intent of the law. A deminimis clause will be added to the original legislation. The language mirrors closely language that optometrists passed last year that indicated covered provider percentages must be reasonable and not trivial. We have already started lobbying our legislators and I hope that you will lend a hand by speaking to your legislators, and by joining us on the Hill in Richmond when our legislators debate the VDA's suggested changes. You will be notified in e-mails about the dates. If you have not submitted your e-mail address, please let Laura Givens, our Legislative Liaison at the VDA, know your contact information. We had great numbers approaching their delegates and attending hearings in 2010, and our bill passed overwhelmingly. We need to do the same this year.

I hope you shared your opinion on the Town Hall that ran from November 16 through December 16, 2015 concerning a change that the Board of Dentistry was making to state statutes, requiring licensed dentists and hygienists to take a dental jurisprudence exam every 3 years. Our leadership felt this was an overreaction on the Board's part to an increase in cases that they are handling. Our feeling is that the overwhelming majority of practitioners who obey the law are being punished for the acts of a few repeat offenders. We do feel that all licensees should complete an exam as part of initial licensure. We believe that the Board could better handle the problem by keeping practitioners better informed by doing quarterly newsletters dealing with various regulations especially new ones as they are passed.

As always, we are constantly keeping an eye on the Board of Dentistry and trying to help them as much as possible, as we know they have a difficult job. However, we are not afraid to voice our members' concerns when we see things differently.

Our PR campaign, which the VDA House of Delegates approved at a lower cost in September, continues to show impressive results. Make sure that you are keeping your personal and practice information up to date with the ADA/VDA. People are responding to our advertising and are actively looking for VDA member dentists. Make sure they don't overlook you!

There is a lot going on with the ADA/VDA – make sure that you are informed. As previously mentioned make sure your contact information is up to date. Read the *Virginia Dental Journal*, check out "The Chatter", but most importantly check your e-mails and stay informed. We need your opinions and at times we need specific actions from you. An active membership makes a strong association, united we stand divided we fall.

In closing, I think we have a strong professional association. We have accomplished a lot. When you compare our profession with other health care professions, they are envious of us. We have more independence from outside groups. We have the opportunity to practice as we see fit. We can only insure that it stays that way through our involvement in organized dentistry. Remember, the outside groups only care about their agenda and not necessarily what is right for our profession and our patients. We need to keep educating them and the public what is really right for dental care.

As always, I consider it an honor to practice dentistry. I consider it an even greater honor to serve as your president. I hope we all continue to share a passion for dentistry.■

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MESSAGE FROM THE EDITOR

Dr. Richard F. Roadcap

Dentists like to think of healing in clinical terms: the extraction site filled in, probing depths were reduced, the recipient site for a free gingival graft appeared nearly indistinguishable from adjacent tissue. It's no different when we look at radiographs: the periapical lesion resolved, the newly-placed implant shows osseointegration at four months, reparative dentin is deposited beneath a deep restoration. Sometimes healing takes on a different dimension that can't be measured with a Williams probe or a radiograph.

Last summer, on day two of a three-day MOM project, triage form in hand, I went to fetch the first operative patient of the day. I noted a restoration had been indicated for the upper right second molar. I also made note that the lower right first molar had been removed on day one. When I approached Vickie*, she didn't look happy. I asked about her procedure the day before. She said "Well, I guess it went OK". (Not a ringing endorsement.) My first thought was my treatment was not off to a good start. She took her seat in the folding operatory chair covered with a dry cleaner's garment bag and I saw that the extraction site was as well-healed as one could hope for in a less than a day. No hemorrhage, no suppuration, only a socket with an adequate clot. I told Vickie we planned to fill an upper tooth. She seemed to know this.

While my assistant, Arion, and I arrayed our instruments and disposables, Vickie asked where we lived. I told her we were both from the Richmond area. She said she had been to Richmond once about twenty years ago, from her home in southwest Virginia. "My next-door neighbor beat me up." What followed was a harrowing tale of domestic violence. Her neighbor assaulted his young wife, and when Vickie and her daughter answered her cries for help, he savagely beat both of them. Vickie suffered multiple injuries, including a broken jaw. She couldn't eat, she couldn't put her teeth together. She sought treatment from a doctor in Bristol, but was told nothing that could be done for her there. A referral to the Medical College of Virginia (now Virginia Commonwealth University) was made. She felt her doctors were uncaring because her injuries stemmed from domestic violence.

Soon after I administered local anesthesia, Vickie volunteered that Dr. (Daniel) Laskin had treated her in Richmond. "He saved my life! He put my teeth back together and I could eat again." I immediately told her, "Well, you know he's here today."

"You mean, he's here? Now?" For a moment I don't think she believed me. Not knowing his whereabouts, I offered to bring him over to our chair. I removed my gloves and headed to the oral surgery tent. Several volunteers were asked if they'd seen Dr. Laskin. "He's in the (Health Department) trailer." The trailer is an air-conditioned oasis on a July day at the fairgrounds.

I bounded up the steps to the trailer door and was surprised to see the driver in his seat at the front. "Is Dr. Laskin in here?" The driver pointed down the hallway to the back of the trailer. I could see staff huddled in an operatory. But there was Dr. Laskin in conversation with his patient. He greeted me and I told him Vickie, his patient from the mid '90s, was in my chair. He recognized her name. I thought he'd say "Let me finish my patient first" but he peeled off mask and gloves and headed for the trailer door. I was in close pursuit.

Down the steps of the trailer and across the wet grass, I guided him beneath the white dome of the surgery tent. We both danced around the tables laden with just-autoclaved instruments, stepping over the PVC pipes, compressed air hoses, and yellow 15 amp extension cords that graced the crumbling asphalt of the treatment areas. We crossed the de facto hallway between hygiene and operative dentistry and squeezed between the folding tables that served as workstations. Just enough time had elapsed for profound anesthesia.

Vickie sprang from the chair when she saw Dr. Laskin. "You're my hero!" she said, expressed with a bear hug. She was crying. He asked "How's my doll baby?" There were more hugs and more tears. The reporter in me said I should take pictures. I don't think either Vickie or Dr. Laskin expected they'd cross paths again. I was grateful to have witnessed another form of healing, delayed twenty years.

We completed the class II restoration in the upper right second molar without complication. Upon leaving, Vickie hugged Arion and said "You remind me of my granddaughter!" I think it was the way my assistant related to adults of another generation. Vickie looked happy.

*not her real name ■

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.

DR. EMILY DASILVA

Dentistry combines Dr. DaSilva's passions for family, education, travel, language and volunteerism. Since completing her DDS and GPR, she has cared for underserved from Alaska to Guatemala and here in Northern VA. An active tripartite member dentist, she practices in Springfield.

WORLDS APART

HOW ONE VIRGINIA COMMUNITY CONFRONTS ACCESS-TO-CARE

AN OVERVIEW

Suppose I told you there is a community in Virginia where:

- Almost all children have access to dental care
- Caries among school children is rapidly declining
- Dentists and physicians enjoy a high level of (electronic) communication
- Medical care includes oral health literacy and dental examinations
- Dental disease is often intercepted in the first year of life
- All healthcare fundraising is directed towards oral health

Most readers of the *Journal* would find this hard to imagine. Access in many areas of the state is problematic for adults and children alike. Oral healthcare and medical care still operate in silos, and dentist-physician communication is fraught with technical and cultural barriers that serve to keep professionals at arms' length when the best interests of the patients are at stake. Finally, it's a rare occurrence when fundraisers place oral health as a first priority.

Virginia's Eastern Shore faces many obstacles other communities don't endure. First, there's poverty: Accomack and Northampton counties are among the ten poorest counties in the state. One fourth of the population has no health insurance, and another one-fourth is enrolled in Medicaid. Then there's isolation: the Shore's only connection to the rest of Virginia is a bridge-tunnel bearing a one-way $13.00 toll (rising to $15.00 during summer months). Add to this a large migrant worker population and difficulty recruiting healthcare providers, and all the elements for medical and dental suffering are present.

Yet the Eastern Shore Rural Health System, in the last 30 years, has achieved nearly all of the accomplishments listed above, and sees within its grasp, community-wide medical and dental care available to all. This has been accomplished not with an influx of grants and government largesse, but instead through the dedication of laypersons and healthcare professionals who have one goal in mind: preventing disease (this includes dental disease) and delivering health care to everyone in the community using shared resources. Their vision is to be "the provider of choice for primary and preventive services offering comprehensive care…for all people" on the Eastern Shore. What started as a single medical center with two physicians has now grown into seven facilities employing 34 MDs and 7 dentists. There are two clinics that feature medical and dental care under one roof, and two elementary schools with dental clinics onsite. As of November 2015, ESRHS employed 225 people.

In the pages that follow, you'll meet the individuals striving to make this a reality and learn more about a unique public-private partnership. Although he did not originate the phrase, President John F. Kennedy was fond of saying "A rising tide lifts all boats". Let's see how one community in Virginia aims to float higher.

All articles pages 6-10 are written by the Editor unless otherwise noted.

AN EASTERN SHORE GLOSSARY

ESRHS – Eastern Shore Rural Health System

CHC – Community Health Center

FQHC – Federally Qualified Health Center

NNOHA – National Network for Oral Health Access

HRSA – Health Resources and Services Administration

VHCF – Virginia Health Care Foundation

CDHC – Community Dental Health Coordinator

CBBT – Chesapeake Bay Bridge Tunnel

VCHA – Virginia Community Healthcare Association

- Eastern Shore Rural Health System Location

"CHILDREN ARE THE BEST CHANCE WE HAVE."

A profile of Nancy Stern, Executive Director, ESRHS

Nancy Stern

Nancy Stern didn't found the Eastern Shore Rural Health System. But she's the face of the healthcare system that serves over half of the population, including over 90% of the children in Virginia's portion of the Delmarva Peninsula. She arrived in 1983, having been a teacher for five years. It was here that she saw an opportunity to lead using her background in health education.

The Eastern Shore has all the attributes that make healthcare delivery difficult: poverty; geographic isolation; a large population without medical or dental insurance; a higher-than-average incidence of chronic illnesses; and difficulty recruiting healthcare providers. Yet ESRHS has not only managed to confront these obstacles, but it in many cases surmounted them, drawing heavily on widespread support from the community and resources provided by a national network of community health clinics, private foundations, and public agencies.

Accomack and Northampton counties lie on a north-south axis and separate the Chesapeake Bay from the Atlantic Ocean. The Shore is bordered by Maryland to the north, and connected to the Virginia mainland by the Chesapeake Bay Bridge Tunnel (CBBT). (See map page 6) Agriculture is the primary industry, followed by tourism. Nearly 45,000 live on the Eastern Shore; ESRHS clinics average 30,000 patients, and 100,000 visits per year. Ms. Stern highlights the breakdown of their patient population:

- 23% are without medical insurance
- 23% are enrolled in Medicaid
- 16% are Medicare beneficiaries
- 39% have some form of private (medical) insurance

She says that for every one person without medical insurance, four do not have dental coverage. And then there's the underinsured, those with insurance who still lack access. She gives an example of a young woman who works at "Pony Tails", a Chincoteague candy store, by day and waitresses at night, but can't afford health insurance. She may qualify for a sliding fee discount. Ms. Stern says the tale of hard-working Shore residents with no or limited healthcare insurance is repeated often, leaving many to rely on ESRHS for care.

How is this healthcare model financed? Ms. Stern says that of a \$21 million annual budget, \$3.7 million is a Health Resources and Services Administration (HRSA) grant to pay for care for the uninsured. The dental program started with a \$100,000 grant. The Virginia Health Care Foundation has been a "phenomenal" source of grant funding, she says, with much of the credit going to their Executive Director, Debbie Oswalt. "She's one of our stars." A visit to the Atlantic Community Health Center in New Church revealed the VHCF's support: a state-of-the art multi-chair clinic that will accommodate multiple dentists and hygienists.

I asked Ms. Stern if it's possible that all children on the Eastern Shore now have access to dental care. She answered with a qualified "Yes". She said all children can visit a dentist, but there are cultural and oral health literacy barriers, as well as circumstances in which parents don't know care is available. She then talked about the benefits of education and prevention. "Children are the best chance we have." If the emphasis could be shifted towards outreach and prevention she said, high cost dental (and medical) care could be avoided in adulthood. She admitted that the present dental care model on the Shore leaves many adults without access to care.

Ms. Stern gave credit to the Missions of Mercy projects held at Nandua High School in Onley. The last project was held in 2009. She called them "the gift that keeps on giving". "It was bittersweet when the last MOM project ended. It gave us a foundation for where we are today." She recounted how the projects exposed countless (mainland) doctors to the need for adult dental care on the ES. One story came to mind: a patient came to the project two years in a row, first for full mouth extractions, then for complete dentures. Ms. Stern notes that the patient's new teeth led to first, a job interview, and then a job. She'd like to have this type of success replicated on a large scale.Two elementary schools, Pungoteague, and Metompkin (in Parksley) have on-site dental clinics for treatment of any children enrolled in the school system, not just students attending those schools. ESRHS operates the school dental clinics in Accomack County. She says "By having the school program it gives them (the schools) a stake in our success. Both our stats and the anecdotal evidence show that absenteeism due to toothaches is down, and behavior and learning are up. So we're a part of the educational system as well."

Metompkin Elementary School

I asked Ms. Stern for her wish list – what she'd like to have happen in the future. She listed the following:

- An adult dental care delivery system
- The start of a planned AEGD residency program (operated by Lutheran Medical Services)
- Financial sustainability for all dental care programs
- Grant funding for a Community Dental Health Coordinator (CDHC)
- Delivery of dental services not available now, such as advanced prosthetics

Ms. Stern recalled how the ESRHS held its first capital campaign in 2007. She proudly noted that in additions to gifts from the Hearst and Kresge foundations, local retirees, school teachers, and business people all donated in the hope for better healthcare and a better community. That's the mission statement of ESRHS: "…enhancing the quality of life for the people of the Eastern Shore." This unique healthcare delivery system celebrates its 40th anniversary in July 2016.

THE ROAD LESS TRAVELED

TWO EASTERN SHORE DENTISTS REFLECT ON THEIR CAREER MOVE

Dr. Noel Root

Dr. Ed Griggs

A dental career can follow many different paths. Two former Richmond-area dentists headed east for a different type of practice at a time when many of their peers were contemplating retirement. Drs. Ed Griggs and Noel Root are employed full-time by the Eastern Shore Rural Health System in a practice setting far removed from their former suburban practices.

For Dr. Root, his continued involvement with outreach projects in rural areas, then his regular attendance at Missions of Mercy, set the stage for a meeting with ESRHS Executive Director Nancy Stern. He says "After two years I got so involved I asked myself did I want to continue in practice where I was?" He noted "This was a new frontier in oral healthcare. This was the first organization that had it together and could make it work." He's been in practice on the Eastern Shore now for 11 years.

Dr. Griggs credits Dr. Root with encouraging him to consider a practice on the Shore. "I would see him at the dental school on Friday afternoons. I thought I would check it out." MOM projects were held annually on the Eastern Shore at that time, and while attending the 2008 project he met with the ESRHS staff. "I was very impressed by the organization, its leadership, facilities and people." He says "It was a great beginning and it so happened they were looking to hire a dentist." I asked both, what gave them the greatest profession satisfaction, and what were their greatest challenges? Dr. Root finds great satisfaction in saving teeth with endodontics, thereby preventing edentulism. Celebrating the completion of treatment with a patient provides great rewards to Dr. Griggs. They both cited surgical extractions as a great challenge, especially with no oral surgeons in the area. "Managing oral surgery treatment is tough" says Dr. Root. "We address the whole spectrum, from serial extractions on patients with complex health issues to young, healthy patients with complex oral infections." They both indicated specialty referrals were problematic, with patients reluctant to travel to the mainland if they don't perceive a problem. "We refer to specialists here just like I did in Richmond." says Dr. Griggs. "The difference here is that often our folks don't go. The financial piece is a big part of the problem, too, as most of our patients can't afford to go to the specialist they need to see. If they feel better, they don't make the call."

Dr. Griggs and Staff

Dr. Root and Staff

Both cited the joys of seeing schoolchildren embracing good oral health, and at the same time, witnessing the discouraging number of adults with rampant dental disease. Dr. Root says "We see far fewer decimated mouths (in kids)." He adds, "I see the kids' program as an antidote to the frustration we feel when treating the adult population with acute care needs. Our school dental program has changed the entire school age population…that's where our system shines. With the adults we haven't made a dent in the problems of those who have not received comprehensive care." Dr. Griggs commented on the state of adult dental health: "Often, it's like being at a MOM project every day. There are often three or more emergency patients on my schedule every day. In my suburban practice, there usually weren't three a week."

Dr. Root gave me a tour of the Franktown CHC, one of two facilities with medical and dental care under one roof. There I met pediatric dentist Dr. Alex Kordis, who started a program with ESRHS pediatricians to provide oral health care beginning with infants. Often a dental visit is combined with the mandatory preschool physical to make parents aware of the need. I visited the Metompkin Elementary School dental clinic in Parksley, where Dr. Griggs was working that day. The trailer allows two operatories and a tiny waiting room, but it's only a few steps away from the patients next door. Atlantic CHC in New Church also has medical and dental care at one site. The facility there can only be described as "gleaming" and "state-of-the-art", due to the generosity of the Virginia Health Care Foundation (VHCF).

Both Dr. Root and Dr. Griggs are optimistic about the future for children's dental access on the Eastern Shore, yet frustrated by the overwhelming need for adult dental care. "The kids are immersed in prevention and home care" says Dr. Root. "That's where I feel I've really made a difference." They both believe a Community Dental Health Coordinator (CDHC) would be a great asset to Eastern Shore dental care delivery. Dr. Root states "One of the ways they can help us is with no-shows. The CDHCs can engage communities – or a remote site. A no-show policy doesn't get them in. It has to have a face – a person who knows clinical dentistry and understands the community." He adds, "They're part outreach worker – someone who engages with families."

The US Census Bureau says Virginia ranks fifth in per capita income among the 50 states.[1] Yet poverty and isolation are part of the landscape on the Eastern Shore. A different model of dental care delivery exists there in an attempt to meet the needs of the community. It's a model unknown to most Virginia dentists, and it depends on support of the community and the efforts of dentists like Dr. Noel Root and Dr. Ed Griggs to be successful. Their career choice has made a difference to the people of the Eastern Shore.

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1 https://en.wikipedia.org/wiki/List_of_U.S._states_by_income

AN INTERVIEW WITH DR. SCOTT WOLPIN

Dr. Scott Wolpin

Virginia Dental Journal: Tell us about your career path. What (or who) brought you to Virginia's Eastern Shore?

Dr. Scott Wolpin: I have worked in community health centers for much of my professional career with 24 years of experience as a dental program director on the Eastern Shore of Maryland and now 2 years in Virginia. What brought me to the Eastern Shore were a visionary CEO, Nancy Stern, strong leadership team and a Board of Directors committed to oral health as their number one strategic priority. All of them truly understand how oral health is integrally connected to overall health, all of them wishing for the dental program to continue to grow.

VDJ: In your organization, how do dentists interface with physicians and other healthcare personnel?

Dr. Wolpin: This is a very important interface for our health center especially if we hope to improve the overall health status of the Shore. We have a few quality improvement projects underway now where are piloting integration efforts. For example, children often see the medical team multiple times during the first year of life for well check visits and immunizations. This is a great opportunity to intercept dental disease, develop a dental home and improve oral health awareness. What we are doing at ESRHS is having our pediatric dentist visit the toddler in the medical treatment room after the medical team has completed care for a first dental visit. At this visit we provide caries risk assessment, toothbrush cleaning and fluoride varnish, and share important oral health information with the child's caregiver(s). There are also efforts underway to train our medical staff to provide these same services to their patients realizing that our health center is the primary pediatric provider of the Shore and that our health center's dental program is much smaller than its medical program. We simply do not have the manpower to meet the needs of the Shore.

Additionally, we are protecting time on our dentists schedule for more vulnerable individuals in our community like pregnant women, poorly controlled diabetics and other patients with complex medical conditions where providing dental care will result in improved health outcomes and/or better medical management of their chronic disease.

VDJ: How would you describe your relationship with the private practice dentists here? In what ways have you interacted with them?

Dr. Wolpin: Well some of the private practice dentists are actually spouses for a few of us. We refer often to the local private practices because we are currently unable to provide a full scope of services (i.e. dentures, crowns and bridges.) The specialists in the region (i.e. oral surgeons, pediatric dentists) have been very supportive in helping us with patients with complex care needs. Additionally, we have even partnered with non-dental private practitioners like Dr. Henderson who helps adolescent patients with behavioral health issues. Dr. Henderson is utilizing our new group medical visit/health education room at our Franktown dental office to counsel his patients. Many of these children are already ESRHS dental users, we are finding others who do not have a dental home. Finally, Dr. Alex Kordis, our pediatric dentist, is working on pulling together a local study club for dentists here since much of our professional organization's activities occur on the other side of the bay.

VDJ: As your facilities are spread up and down the Eastern Shore, how do you make decisions about assigning personnel and resources?

Dr. Scott Wolpin: Well we sort of employ a "three legged stool" strategy in meeting the Shore's needs; we have two large dental offices in our largest medical offices (one in Accomack county and the other in Northampton county) that serve primarily high risk adult patients, two fixed dental clinics on the campus of two elementary schools (one at Metompkin and the other at Pungoteague) and an Outreach program that brings preventive dental services wherever they are needed (other public elementary schools in Accomack County, other ESRHS medical offices that do not have dental services, and migrant agricultural workers' camps.)

Franktown CHC

The school board in Accomack County has been a tremendous champion of our oral health program and that is where we may see the most growth of our dental program looking forward.

The hope is to position our dental providers with the competencies needed to meet the treatment needs of our patients. For example, we just employed a wonderful pediatric dentist to provide patient care at Metompkin Elementary School. And we are recruiting another dentist with excellent competencies in caring for patients with complex medical problems for our dental office in Franktown.

VDJ: What are your goals for the dental program in five years? In ten years?

In five years, I am hoping for continued and strengthened partnerships with the local hospital system, academic institutions to broaden our scope of services bring more health professionals to the region and develop a teaching health center at ESRHS. In ten years, a truly integrated health home for all of our patients and capacity to meet the community's needs/demand for care.

Editor's Note: *Dr. Wolpin is Chief Dental Officer, Eastern Shore Rural Health System. He is a member of organized dentistry and lives in Maryland. He was interviewed in Onancock on August 6, 2015.*

CDHC PILOT PROGRAM CONDUCTED

In the summer of 2015, Jenna Linden, a Dental Hygienist and Community Dental Health Coordinator (CDHC), conducted a short term demonstration project at Eastern Shore Rural Health System (ESRHS) on Virginia's Eastern Shore. ESRHS consists of five community health centers, two with attached dental clinics and additionally has two school-based dental clinics. As a CDHC, Ms. Linden sought to increase access to dental care through community education and outreach. The geographical isolation of the Eastern Shore poses unique barriers to accessing dental care due to the limited options for the local residents. To combat these limitations, Ms. Linden collaborated with medical providers and community organizations to achieve goals such as:

- increasing the number of first dental exams by the age one
- expanding awareness of Medicaid dental care coverage during pregnancy
- implementing and expanding dental educational outreach efforts targeting high risk population groups.

Ms. Linden worked alongside local pediatricians, OB-GYN office staff, WIC offices, the local health department home visiting nurses, and ESRHS medical outreach staff to implement access-to-care initiatives and increase knowledge of the link between oral health and overall health. This demonstration project highlighted several areas in which a CDHC could bridge patient barriers such as language, transportation, education, poverty, geography, and culture to help connect patients to much- needed care and ultimately improve the quality of life for the community.

Dr. Noel Root, one of seven dentists employed by ESRHS, comments, "I see the CDHC coming into play as part health educator, part outreach worker, a mediator between the medical and dental community – all those things rolled into one. Also he says "I see a CDHC operating as an 'in-reach' worker to coordinate treatment for patients with complex systemic issues so we can develop programs for those patients." Dr. Terry Dickinson, Executive Director of the Virginia Dental Association, remarked "Jenna impressed me, not only with her dental knowledge, but with her grasp of the complexity of the subject of access to oral health and the role of social determinants as factors in that issue. She demonstrated an ease with all that she interacted with, from three year-olds to those baby boomers. Watching and listening to her on the phone to a parent who missed their child's appointment was a real education in patience and listening skills. I suspect the no show rates will be decreasing as a result of her input to the scheduling staff."

In an interview August 6, 2015, ESRHS Executive Director Nancy Stern stated that she hoped that grant funding would be available to hire a CDHC to work on the Eastern Shore. She says, "The biggest challenge is to get adults to accept the importance of good oral health." A CDHC would address this and other barriers to improving dental health in the Eastern Shore community.

Editor's Note: *Jenna Linden, RDH, CDHC, Dr. Terry Dickinson, and Dr. Noel Root contributed to this report.* ■

L-R, Jenna Linden, CDHC; Dr. Terry Dickinson

40 UNDER 40

DR. BARCLAY WEISBERG

Dr. Weisberg is a graduate of Brown University, VCU School of Dentistry, and University of Florida-AEGD. He is currently working towards his Mastership in AGD and works with his father and the amazing team at Eastern Virginia Family & Cosmetic Dentistry in Hampton Roads.

IN THE LOBBY

Albert E. Converse, DDS, Springfield, IL

REPRINTED WITH PERMISSION FROM THE ILLINOIS STATE DENTAL SOCIETY, BULLETIN OF THE ILLINOIS STATE DENTAL SOCIETY, VOL. XIX, NO. 6, **NOVEMBER 1923**.

They were sitting in the lobby of their hotel after one of the evening sessions of the State Society--the Old Timer, the Grouch, and the Youngest Member--enjoying one last cigar before they retired to the hay, "even as you and I" have done on like occasions. The Youngest Member was favoring them with an elaborately detailed account of his own original method of of treating putrescent pulps.

The Grouch was about to give vocal expression to the sneer, which was on his face when the Old Timer silenced him with a surreptitious poke in the ribs.

"That's fine, my boy," said the Old Timer, thoughtfully refraining from mentioning the fact that he had himself given a clinic before the State Society five years before on this identical method.

"Are you enjoying the meeting?" he inquired.

"Oh, fairly well," replied the Youngest Member, patronizingly "You ought to have more young blood in the Society, though, if you know what I mean. There's too much –"

"He's dead right!" interrupted the Grouch, savagely throwing away his half-consumed cigar. There's too much 'old fogyism' in this Society: I'm getting sick and tired of it. Year after year you see the same birds on for clinics, reading the papers and discussing them, and crowding everybody else off the map. It's the same way in the local societies. Something ought to be done about it."

"Yes, something really should be done about it," agreed the Youngest Member: "the fellows are losing interest. A chap will get fed up on almost anything if you just shove it at him often enough. The Venus de Milo is a very handsome dame, but who wants to put in the rest of his life looking at her?"

"Not bad," chuckled the Grouch, disagreeably; "and believe me, these birds that are trying to run the Dental Societies are not as easy to look at as the Venus de Milo, either; I'll tell the world they're not!"

"Another thing that ought to be changed," said the Youngest Member, glancing complacently over his new checked suit, and flicking imaginary specks from it, "the programs are not practical enough. There are too many papers on scientific subjects. The fellows don't like these highbrow essays – they want to get something that they can cash in."
"You've said a mouthful, my boy." The Grouch chimed in heartily. "We're fed up on this high-falutin' stuff that nobody understands, not even the fellows that write it. Why can't they hand us something that will help us bring home the bacon – that's what we want. I'm not practicing dentistry for pastime, nor to improve my health. I'm trying to corral the good old hard iron dollars so that I can buy beef steak and shoe leather. When I go to dental society meetings I want to learn something that will help me get the coin – and that's what all the rest of them want, if they'd tell the truth. There's nothing to these long, dry lectures on chemistry, and histology, and physiology, and metallurgy, and all that."

"Well," said the Old Timer; after waiting a few moments to see if there was anything more to follow, "I'm glad you boys got that all out of your systems. If you'd gone to bed with all that poison bottled up inside of you it might have been disastrous."

"Quite right, my boy, quite right," the Old Timer hastened to assure him. "I'm glad you're so interested. By the way, I believe you're on for a clinic tomorrow, aren't you? I suggested your name to the chairman of the Clinic Committee. I presume he wrote to you?"

"Why—er—yes, he did," replied the Youngest Member, fidgeting slightly in his chair. "But—well—to tell the truth—I was busy, I just didn't have time to get up a clinic."

"Oh, that was too bad," the Old Timer sympathized. "But perhaps it's just as well, for you can't afford to get in the 'old fogy' class, you know."

The Youngest Member vouchsafed a sickly grin.

"And I just happened to remember," continued the Old Timer, "the Chairman of the Program Committee told me that he asked you to present a paper on 'Amalgam Fillings,' Grouch."

"Yes, he did, confound him," growled the Grouch. "But I—I—well—"

"Don't get excited," said the Old Timer, soothingly, "I understand perfectly. You were too busy also, and no doubt you thought, too, that an essay on 'Amalgam Fillings' would necessarily be so scientific and theoretical that it would only bore the boys."

"Oh, go to the devil," snarled the Grouch.

"Don't misunderstand me, boys," continued the Old Timer, "there has been just as much theorizing and scientific research work done on 'Amalgam Fillings' as on any other subject in which the dental profession is interested. Whole reams of scientific papers have been written on it, and literally years of careful, painstaking laboratory work devoted to it. As a result, we now know more about amalgam, and can perform better amalgam operations than ever before in the history of our profession. It's the same way with the Gold Inlays, Root-Canal Operations, Extractions, and every other scientific investigation and experimentation in order to arrive at practical results. That's why we have essays on scientific subjects, which you boys complain about. They many be a little over the heads of some of us, but we have to have them if we want to progress, and in the end they bring solid returns to every one of us."

"I hadn't thought of that," said the Youngest Member, while the Grouch registered interest.

"Now boys, you're dead wrong if you think we old fogies—as you call us—you're dead wrong if you think we're trying to run the Society, and that we want to crowd everyone else off the map. Many a time I have sat around with some of the older men—men who have been most active in the State Society, and in the local societies—and we have tried to work up schemes to get the younger men to take a more active part.

"We realize the need of new blood, and we'll be tickled to death to get out from under. Nothing would suit us better than to stand on the sidelines and cheer while the boys get in the game. And some of the young fellows are getting in the game the only way anyone can get in it—by working—not by grunting. When they're asked to do a job, they're—pardon me for saying it—they're not too busy; but they come through, and they do the job to a finish. And then they're rewarded by being handed a harder job. If that doesn't sound attractive to you, I'm sorry, but that's the only way to get recognition in a dental society, or in any other organization. There is plenty of work to be done in the Illinois State Dental Society, and it's got to be done by men—be they young or old men—men of energy and enthusiasm, men who have learned the joy of service.

"Quit your kicking, boys. Get busy. When you're asked to give a clinic, or write a paper, or discuss a paper, do it, and put your whole heart and soul in it. When you're asked to serve on a committee serve, and given the best service of which you are capable. It will do your Society good, and it will do your profession good, but it will do you the most good of all."

"I'm sorry," said the Youngest Member, extending his hand.

"Here too," said the Grouch.

"Let's go to bed," said the Old Timer. ■

LETTER TO THE EDITOR:

SOME PATIENTS DO NOT SMILE AND CANNOT SMILE

Marvin E. Pizer, M.A., D.D.S., M.S., F.I.C.D., F.A.C.O.M.S. (hon)

The colorful cover on the June 2015 issue of the *Virginia Dental Journal* was lined with photographs revealing healthy lips, delightful maxillary anterior teeth, and the lower borders of the nose. What I noticed was these patients appear to be smiling. This made me look at other slides, especially the lips, and nothing resembling a smile! That was for a good reason – these patients were seen at the cancer clinic or in my office for treatment of lip malignancies. No smiles!

Almost every patient had been to a health professional asking "What is that thing on my lip?" I will not upset you with some of the answers – but not a one answered "a possible cancer". These patients came to the cancer clinic or to my office because of lip pain, bad taste, possible halitosis, trouble eating, sexual difficulties, speaking problems and yes, where a male patient would put his pipe or cigar.

Is it reasonable for the health professional to have this concerned patient, with obvious pathology, return again in two weeks for a second examination? Those of you who do not urge these patients to return for follow-up exam are just plain negligent. If the health provider has any doubt – do, or have someone do, a biopsy. A diagnosis is desperately needed.

Perhaps we can put back those smiles for the many patients we can cure.

You will find the lower lip the most frequent site for lip malignancies. Approximately 25% of oral malignancies involve the lip, and 95% are in the lower lip in men over 40 years of age.

The lips are one of the most vulnerable sites for malignant disease. The skin on the outside and the mucous membrane inside produce two environments, with many factors capable of producing malignant disease. Some of these are:

1. Chronic ionizing radiation or actinic radiation
2. Tobacco alone, or combined with alcohol
3. Human papilloma virus
4. Syphilis
5. Chronic mechanical trauma
6. Oral Sex
7. Plummer-Vinson Syndrome
8. Inadequate diet

The clinical appearance varies:

1. Chronic ulceration
2. Wart-like, or fissured
3. Firm mass with rolled edges and an ulcer in the center
4. Raised crusty lesions, which when rubbed will bleed
5. A white plaque, or red lesion, which is soft and spongy, or in some lesions both red and white appear

The most frequent site of the cancer is half-way between the midline and corner of the lip. About 15% of lip malignancies occur in the middle of the lip.

The clinical or macroscopic variations of these malignancies are:

1. Verrucous – rare, have papillary appearance with ulceration in deep crevice
2. Exophytic – most common, warty, with nodular surfaces and ulceration in the center
3. Ulcerative – most aggressive – on the surface only a small ulcer – highly invasive and more likely to metastasize than #1 or #2.

There are four histologic varieties:

1. Epidermoid or squamous cell carcinoma. Approximately 99% of lip malignancies are of this variety.
2. Melanoma – rare
3. Salivary gland tumor – rare
4. Basal cell carcinoma – rare

You will note lip malignances take on different appearances. This is probably because the etiology of the cancers comes from various sources. As a matter of curiosity, I generally ask my patients questions relating to the high risk factors, as well as the duration of the suspected lip lesion. I also get a medical history and do a physical examination of the head and neck. The patients that I present in this paper had no evidence of local (neck) or distant metastases.

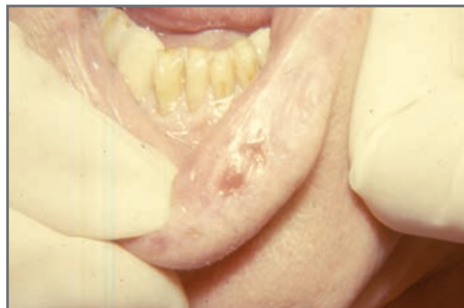
CONCLUSIONS

From reading this letter you may think I biopsy everything. Part of your equation is correct, I do biopsy when I visualize or palpate a "lump or bump" etc. that does not belong to the patient and does not disappear within a reasonable period of time. If the lump or bump is getting less obvious then I am willing to wait and see.

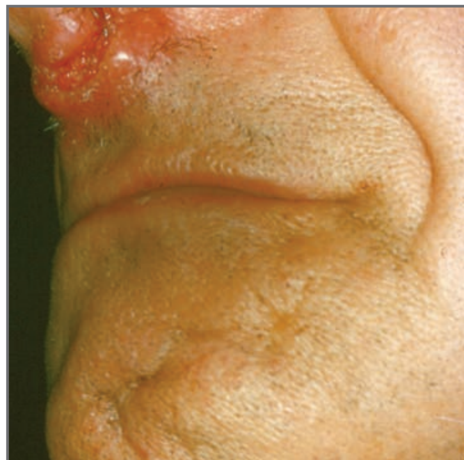
I must confess that I have biopsied my share of benign lesions and am truly glad to see the good report and share it with my patient. How much discomfort and pain would be experienced by us if we neglected to diagnose a malignant lesion and hear of the patient's demise from that neglect.

All I propose is that healthcare providers give their patients the necessary follow-up care and have suspected and unknown lesions biopsied. With a competent pathologist a diagnosis can be made and treatment instituted when necessary.

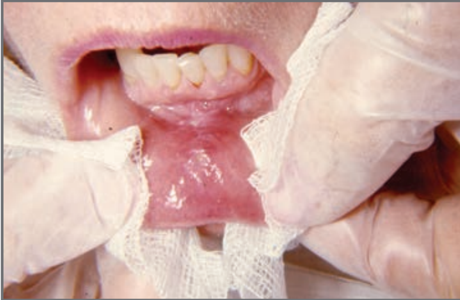
Neglect can haunt you! Treat your patients with competence and kindness and then you can smile with your patient. ■



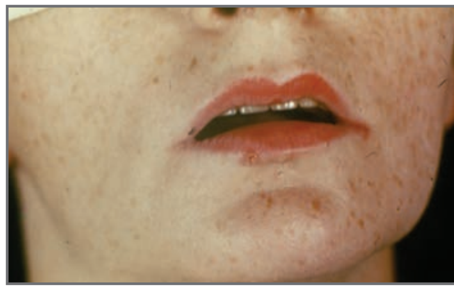
Slide A – a 72 year old male, a heavy pipe smoker, with an exophytic squamous cell carcinoma. Patient felt discomfort with pipe on one side of the lower lip and therefore put pipe on the other side of the lower lip. Only the site demonstrated was malignant and the other side was on its way. The entire lip was treated.



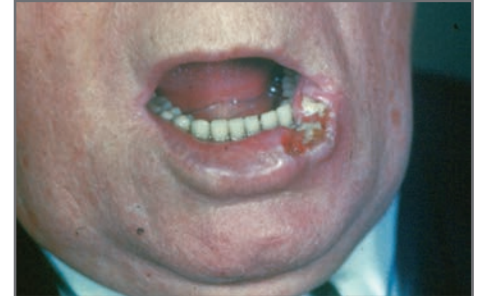
Slide B – This is a rare finding, an epidermoid carcinoma from the upper lip extending into the floor of the nose. Note the scars on the chin from past skin cancer. The upper lip carcinomas have a poorer prognosis compared to the usual lower lip cancer.



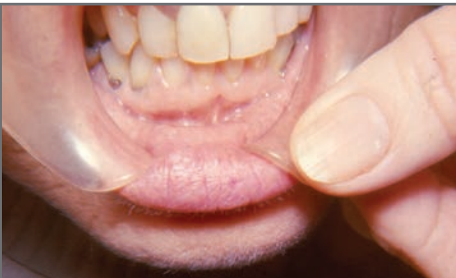
Slide C – This is a recurrent squamous cell carcinoma. The location and appearance of this lesion could possibly have been of salivary gland origin. I was unable to find the diagnosis on the patient's first surgery, so I will assume it was a squamous cell carcinoma. Malignant salivary gland tumors of the lip are rare.



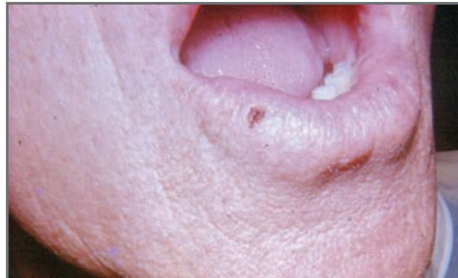
Slide F – Just below the muco-cutaneous border of the lower lip, in the midline, is the malignancy diagnosed as an epidermoid carcinoma. Note the freckles on his face and the lips coated with sun protection cream, as well as the skin above the chin. Actinic radiation is most likely the culprit.



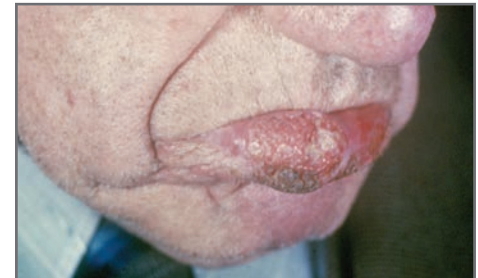
Slide I – The patient complains of lip pain, periodic bleeding and a bad taste. He is concerned because it is "growing". Squamous cell carcinoma, as it is observed here, is approaching the corner of the lips. Cancers appearing at the corners of the lips have a higher degree of malignancy for reasons not known. Note the leukoplakia at the corner of the lip.



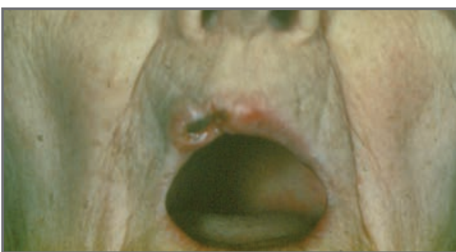
Slide D – This was an early finding. The lesion felt crusty, and on pathologic examination was diagnosed as an early squamous cell carcinoma. This cancer is not at the usual site of lower lip malignancies. As to etiology, my guess is chronic irritation from maxillary anterior teeth.



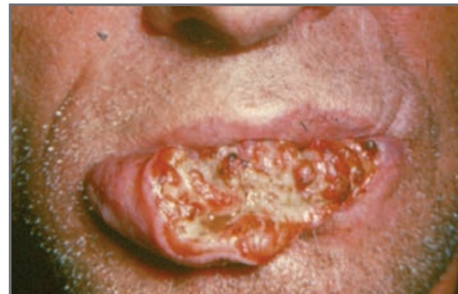
Slide G – A senior male friend, with multiple health problems, was hospitalized and under local anesthesia brought to surgery. After biopsy and frozen section, the pathologist reported this lesion a "melanoma". Not more than 3-5 minutes later, a second call from the pathologist said "not a melanoma – an epidermoid carcinoma". P.S.: the patient was cured.



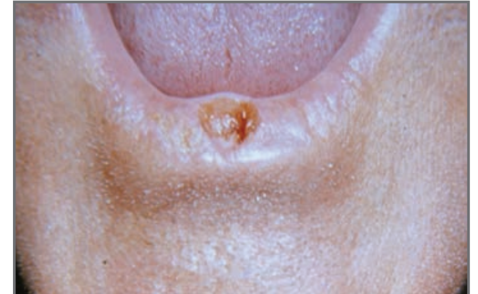
Slide J – This middle aged male has a raised squamous cell carcinoma of the lower lip. This cancer has a raspberry-like feel on palpation, is not indurated and leukoplakia felt and visualized near the midline of the lower lip. Patient states mass is an obstruction when eating and kissing.



Slide E – My first impression was that this lesion was a chancre. The biopsy proved me wrong; it was a squamous cell carcinoma. This is an elderly male who was nearly edentulous. On visualization and palpation this lesion is indurated and appears to be a part of another similar shaped adjacent cancer. The smaller lesion was firm and on pathologic examination was a part of this malignancy.



Slide H – A middle aged male who after much consideration and consultation with his family made a visit to a physician. Without hesitation, a lip biopsy was performed and sent to a competent pathologist for diagnosis. The patient returned to physician to find the doctor somewhat elated. The patient was informed of the good news "This is only a basal cell carcinoma" which generally does not metastasize and can be cured. The patient decided to wait a few months longer, then had a significant surgical experience.



Slide K – This is the typical appearance of the ulcerative squamous cell carcinoma. It appears as though the ulcer is hiding under the mucosa. This is the most aggressive malignancy of all the other squamous cell carcinomas of the lip. This is the most likely of the epidermoid and squamous cell carcinomas to metastasize. It is deeply invasive. The patient in this slide has this aggressive lesion in the most serious location because it is in the middle of the lower lip. If this cancer metastasizes to the cervical nodes, it can easily be a bilateral metastasis. The surgery for this lesion requires wide 2 cm (if possible) healthy margins. He is a coal miner and is exposed to many risk factors; a kind and mature man who did well surgically, and can smile again. He was 50 years of age.

LETTER TO THE EDITOR:

MODERN RECORD KEEPING IN THE DENTAL PATIENTS' CHARTS?

Dr. Robert Allen, Hampton

The Virginia Board of Dentistry is coming down hard on dental offices that do not keep records that the Board considers satisfactory.

There are many things that the Board considers should be in the patients records:

There may be an initial emergency exam but which includes a written record:

What is the patient's initial complaint?
A review of patient's health history. A description of the doctor's first impression of the patient's complaint. Are x rays taken? How many?

What are the findings after the initial exam and evaluation of the x rays? (Diagnosis)

How does the doctor plan to treat the problem?

Final treatment completed for this day.

If the patient has no initial complaint--

A thorough examination will be necessary, including complete x rays, blood pressure recording, an oral cancer exam, and a periodontal charting of the entire mouth. All recorded in the patients chart.

Any treatment, any observations, any conclusions must be in the record. A written diagnosis and treatment plan must be in the record. Similar to that done on the initial emergency visit.

For treatment one must consider permission forms, post operative instructions, signed by patient and doctor..

A patent could be given forms describing potential side effects and unfavorable consequences of the proposed treatment.

Into the chart must be recorded any prescriptions , dosage and why they are prescribed--instructions given with the prescription? Premedications--why?

A patient cannot be given a prescription who is not a patient of record.

At time of dental treatment:
Record blood pressure
Review the patients health history and have a current (each year) new
Long form filled out and signed by the patient.
At each visit quickly review the health history form and note that you have done that.

Signed consent forms for endodontics, or extraction. Signed parental permission for underage children.

Record in the chart topical anesthetic used (lidocaine, cetacaine, etc) how long the topical was in place

What local anesthetic was used: for example--infiltration over tooth #3 using 1.7 Cc 2% lidocaine 1 to 50,000 epinephrine. Then waited ten minutes before beginning treatment.

Or; mandibular block injection on lower left with 1.7 Cc (times two) 1.7 Cc 2% lidocaine 1 to 100,000 epinephrine

Waited 10 minutes before treatment was begun.

Was sedation, or nitrous oxide administered? What ratios and the circumstances?

Any events during the treatment should be addressed in writing:

Pulp exposure? Bases placed? What was the base material? Surgical extraction or non surgical...Sutures place? How many were taken, were they gut or black silk? Was a tooth filled--what materials were used. Is patient to return for suture removal?

If endo is done, what chemicals were used during treatment, what was the filling material...

Was the treatment uneventful? Write it down. "Treatment today was uneventful"

If treating a dry socket--write a description of how it was resolved--including any dressings

Any post operative visits must be thoroughly documented.

Doctors name and assistant's name must be entered on each visit.

There are probably other things that can be written...More is better than less.

The board of dentistry wants to know that an effort is being made to meet their demands for better recordkeeping.

Dental laboratory prescriptions must be kept on file for 3 years.

Dentists who are not careful about records are putting their license to practice in jeopardy. Some local dentists have already felt the pain , humiliation and expense of not improving their record keeping practices before the board of dentistry came calling . ■

40 UNDER 40

DR. NEIL AGNIHOTRI

I am part of a high-quality, highly trained, personable and caring practice that puts patient comfort first. My passions include maxillofacial surgery with focus on orthognathic surgery and cosmetic surgery, my beautiful wife and three kids, adventure races and triathlons.

GUEST EDITORIAL:

STUDENT DEBT AND ITS IMPACT ON THE DENTAL PROFESSION

Michael O. McMunn, DDS; Diplomate, ABDSM, MAGD

Recently, I was speaking with a young man who just graduated from dental school this past May. We were talking about the general practice residency he was entering in July. He was sharing his excitement about all that he was going to learn in his upcoming program. Since I am serving on the Virginia Dental Association's Student Debt Committee, I was curious about the amount of student debt he had accrued in his four years of undergraduate education as well as his four years of dental education. His response was $318,000!!

He went on to tell me the interest rate of student loans is 7% and the bank expects him to pay it off completely in 10 years. His monthly payment is approximately $3,500, and by 2025 he will be "student debt free". The total interest he will have paid on the loan will be $136,000, meaning the total cost of the loan will be over $450,000!

Imagine for the moment, that you now have a letter from the bank or the IRS telling you that you now have a debt that equals $450,000. You are told that you will need to pay it off over the same 10 year period at $3,500 per month. Ask yourself how that might impact your dental practice decisions and how it might impact your personal life. In your practice it might impact your ability to give raises to your employees for 2016. Or you may not be able to purchase the new dental equipment you were hoping to buy in 2016. Or, could it cause a serious cash flow problem and have an impact on your take-home pay, as well as how much you will be able to put into your retirement program?

In regard to your personal life, this monthly payment could have funded a 529 educational plan for your children or grandchildren, or this money could have paid for family vacations over that ten year period or the home remodeling you were hoping to do. My point is that most of us would be significantly affected with a $450,000 bill even though we have an established dental practice with hundreds if not thousands of paying patients. Our new dentists, who actually have this debt, do not have a thriving dental practice. In fact, many of these graduating dentists do not have a job and are very stressed as they search for one. Or the new graduate may want to buy a practice, but can't get loans; or they receive a $500,000 loan to buy a dental practice, and now the new practitioner is a million dollars in debt! It is difficult for me to imagine the pressure our new dentists are facing as they stress getting out from under this educational debt. And, at the same time they have car payments, rent or mortgage payments, child care, and all of the other day-to-day living expenses.

These young men and women are our future dental care providers for the patients we have loved and served for so many years. We want them to love this profession with a sense of thriving, and not a stressful career of surviving. So the question is:

"How can we help reduce student debt, and help educate our prospective dental students long before they even apply to dental school?"

1. I believe that all of our high school students need to have built into their senior year some lectures on finance and in particular, their responsibility as they take on debt, be it student loans or credit card debt. It was recently reported that student loan debt is greater than all credit card debt. The Federal Reserve Bank of New York states that outstanding student loan balances in 2015 now stand at $1.16 trillion. This significantly surpasses the national auto loan debt, at $955 billion, and the national credit card debt at $700 billion. Sadly, student loan delinquency rates have increased. Not surprising for our new dentists who owe an average of $247,000 in student loans, according to 2015 stats from The American Dental Association. So we need to start early with our high school students as they prepare for college, when the borrowing begins.
2. Our students entering their first year of dental school should be given access to school-sponsored financial advisors who can give good financial advice and consultation. Dental school financial advisors can help our dental students set goals and give loan procurement, with private and federal type loans.
3. Our dental school administrators need to be sure that the dental education and clinical skills their students receive prepares them to enter private practice and enables them to perform a multitude of procedures in the areas of restorative, endodontics, periodontics, oral surgery, and crown and bridge. Without being equipped to be a "general dentist", the new dentist will essentially be a triage dentist. The production he or she will produce will not be enough to begin to pay off their heavy student loan debt.
4. The VCU Dental Alumni are already part of the solution. At this point most of the classes have set up scholarship funds at their reunion year and then fund the scholarship through donations from the class membership. Then each class will set up guidelines that determine how the scholarship funds will be distributed. As an example, the Class of 1977 set up a scholarship fund in 2002 and today there is

Continued on page 16

40 UNDER 40

DR. LARRY SCARBOROUGH

If ever one word could describe Dr. Larry Scarborough, it would be "passionate." Only second to that would be "grateful". He and his vibrant team find the height of personal fulfillment treating and serving the community they love - RVA.

Continued from page 15

$113,665 in the fund. This year we gave out approximately $4,700 in scholarships. The intent is for the student recipient to use the money to reduce the amount they would normally borrow. Although we call it a "Scholarship Fund" it is not based on scholarship but on the recipient pledge to practice in the state of Virginia and on their participation in class leadership and in volunteerism in community projects.

5. The Virginia Dental Association also has a desire to help students pay back their loans. We want our dental students to know we are concerned and we want to be part of the solution. One strategy would be to emulate an Ohio plan that assesses their membership a "loan repayment fee" at the time of their annual dues statement. This assessment is used to reduce a new dentist's loan and certain amount for each year they practice in an area of the state this is underserved to the dentist. In the case of the VDA, if our 3,200 members were assessed a $25 fee we could raise $80,000 a year for loan repayment.
6. The Commonwealth of Virginia participates in the Health Resources and Services Administration Bureau of Clinical Recruitment and Service (BCRS) Grants to states for loan repayment. This is a program that identifies federally designated Health Professional Shortage Areas. A total of $140,000 can be awarded for a four year commitment to serve in an area of the state designated to be a health professional shortage area. Call (804) 864-7431 for details.
7. There is a National Health Service Cooperation (NHSC) Loan Replacement Program. This is similar to the above but you must apply through the NHSC. Call (800) 221-9393.
8. Since most of the student loans are federal loans, in an effort to reduce delinquency rates, perhaps the Feds can reduce the federal student loans to a more reasonable rate of 3%-4%.

In closure, our dental profession is impacted at every level from the dental student to the dental practice owner, and most importantly, the dental patient. Student loan debt in the hundreds of thousands for the dental student is daunting and possibly a debt they will not be able to pay. The new dentist burdened with such debt could tend to over diagnose and treat, or the joy of doing dentistry could turn to a dislike of dentistry and the dental school from which they graduated. As we graduate more dentists with great financial stress we will see more bankruptcy, more marital problems, and divorce due to financial problems. Financial problems are the number one reason marriages break-up. As for the retiring dentist, he or she may have a difficult time finding a buyer who can procure a loan to purchase the practice. Huge student debt is a cancer on our profession and we, as professionals, must seek solutions to address this significant challenge.

Please share your thoughts on the student debt challenge by contacting the VDA Student Debt Committee, chaired by Dr. Ted Sherwin. Dr. Thomas Padgett and I also serve on this committee. Please send your comments to rupinski@vadental.org, or call Elise Rupinski at the VDA central office (804) 523-2148. We look forward to working with the students, the VCU School of Dentistry administrators and the dental school alumni, and the VDA membership in addressing this student debt challenge. ■

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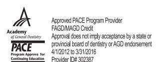

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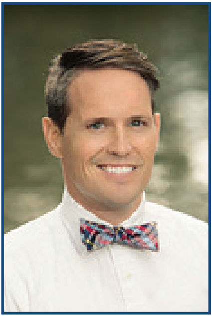

HOW WHITENING CAN IMPACT YOUR PRACTICE

Dr. John "Cappy" Sinclair

As a student in dental school, I used to hear tales about how patients would come into practices during the cosmetic dentistry boom in the early 2000s just seeking elective dental care. I envisioned a future of patients on waiting lists and being booked out weeks with just veneer patient after patient. However, then the great recession hit, and many of those patients seeking elective care disappeared. After the recession, many dentists felt that dentistry would never return to that era with patients seeking elective and cosmetic enhancements to their smile for various reasons. Many of the reason that I hear from talking with other practitioners range from the issues of affordability to the idea that patients today don't want those services. However, today I am going to go over one of few items that we do here in our office that opens that door to elective services back up, and it's one that you can start right away, even immediately right after dental school. What is this one service? It's tooth whitening!

Now I know what many of you are saying and thinking, "I already offer tooth whitening to my patients, and it doesn't really open too many doors." However, many ideas regarding tooth whitening haven't changed since the days of the golden era of dentistry before the recession, and I'd like to offer a few new ways for marketing and options for whitening in the post-recession practice? In doing so, I am going to discuss the 3 different types of whitening procedures (pre-fabricated trays, custom trays, and in-office) that we use in our office, and how each one can be customized to fit the needs of today's patients.

- **Prefabricated trays:** There are several companies that make these products such as the Ultradent Opalescence Go trays and the Venus White Ultra trays. New to the market just a few years ago, these are the go-to trays in our office. They come in varying percentages from 6-15% hydrogen perioxide(HP) and are therefore great for many different patients. We use the 15% HP for patients that are just looking for a quick way to maintain their whitening while traveling, 6% HP for teens in braces looking to freshen things up before school photos, or the 10% HP as a primer a few days before in-office whitening to pre-condition the teeth. These are the most versatile trays as well as the most cost effective. There is very little time that is needed to show patients how to use the trays, and in many cases it can be done in 5 minutes at the end of a hygiene or new patient exam appointment. It also helps to keep many of our patients motivated towards moving on with the next phase of treatment. The fees for these trays are commonly $50-100 for a set of 10 trays depending on your location.
- **Custom trays:** This is the workhorse of whitening and one of the reasons is that there are many different whitening options with this in both carbamide and hydrogen peroxides ranging from 10-35%. I am sure there are many patients in your practice that have a set of whitening trays somewhere at home in a bathroom cabinet that they hadn't used in years. This could be due to a number of reasons such as they have had dentistry done that caused the trays to no longer fit, or in some instances they may have had issues with sensitivity from some of the earlier whitening products. So the good news is that many of your active patients are familiar with this procedure, so it is easy to talk about! The even better news is that they are great new whitening products out there that can help even the most sensitive patients. All of the Ultradent Opalescence products now come with potassium nitrate and fluoride in the whitening solutions that cut down on sensitivity. Also one of the newer uses for custom trays is to help with our periodontal patients. SDI has a great whitening product that is 3% hydrogen peroxide that we use prior to and after scaling and root planning procedures with our patients that helps break down calculus and prevent biofilm from reoccurring. Not only can it get the patient involved from day 1, but it also can make the appointments with the hygienist go a little easier. Note: We occasionally use this protocol with the 6% HP Go trays. The time commitment for custom trays takes a little longer than the prefab trays since it involves impressions and pouring up models, and fees range from $99-149 again depending on location.
- **In-Office:** This is the last whitening option that we offer at our office, but still a great one for specific patients such as those needing a whitening boost before a big event such as a wedding or class reunion. This whitening process utilizes several application of a 40% HP gel on teeth under isolation such as Ultradent Boost 40% HP. Before the recession, it seemed that in-office whitening such as ZOOM or Boost was all the rage, and patients were willing paying a premium for it. Many offices were charging $600-$1000 for this procedure and many currently still do. In my limited experience, I have found that this fee is a large obstacle for many of our patients with competition in the market being so fierce. In some states, including Virginia, whitening can be performed by a non-dentist, and so it devalued the services. However, at many of these non-dentist locations, there is no way to open up that dialogue about other procedures that can be performed to enhance your smile. Fortunately the laws don't allow the ability for mall kiosks to offer the services of veneers or Invisalign yet! So how do you adjust your fee while still making in-office whitening profitable? One of the easiest ways to adjust the cost is by limiting doctor time, and in our office the whole in-office procedure is handled by a team member. By enabling the resources of a team member to handle these tasks, the doctor time is left untouched allowing you to still go on using your time more productively doing restorative and prosthodontic dentistry. If your team is a little rusty as to how to do this procedure, many of the reps will come in and go over and perform the processes step by step with your team. As mentioned above many offices still offer this procedure at $600-1000; however, I propose the fees being somewhere in the range of $150-250 depending on your location and with total team involvement.

Once a patient has started whitening, as mentioned above it can create a whole new awareness with their smile and lead to questions about other procedures. Many of our patients that have started the whitening process have asked about other enhancements from replacing old stained composites, to tooth alignment, and even veneers. With this in mind, I know that I wasn't able to practice dentistry during the so called golden era, but I'd like to think that for this generation of new dentists, the best is yet to come.

Editor's Note: *Dr. Cappy Sinclair, a VDA member dentist, practices in Virginia Beach and writes on subjects of interest to new dentists. He may be contacted at* cappysinclair@gmail.com. ■

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PATHOLOGY PUZZLER

Dr. John Svirsky

A 67 year old white male presented to the oral medicine clinic with mouth pain of two weeks duration which has been increasing in intensity. The patient's past medical history was reviewed and included management of elevated blood pressure with 10 mg of Lisinopril, elevated cholesterol with 20 mg of Crestor and rheumatoid arthritis with 15 mg of methotrexate per week. The patient stated that the pain affected his eating and sleeping. His lesions were located throughout the oral cavity (figures 1-5).

Which of the following would you include in your differential diagnosis?

1. Pemphigus
2. Benign mucous membrane pemphigoid
3. Erythema multiforme
4. Lichen planus
5. Drug toxicity reaction
6. Squamous cell carcinoma

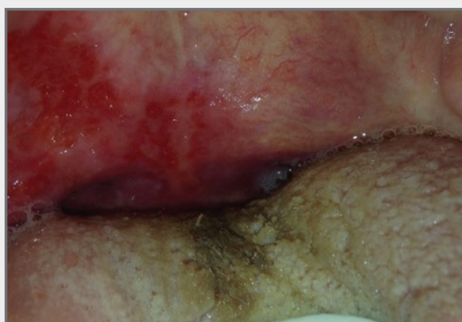
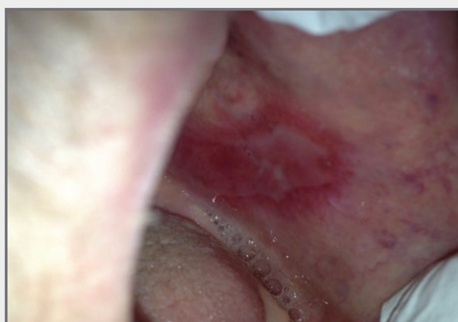


Figure 1



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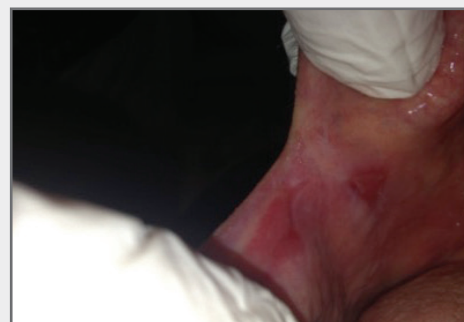

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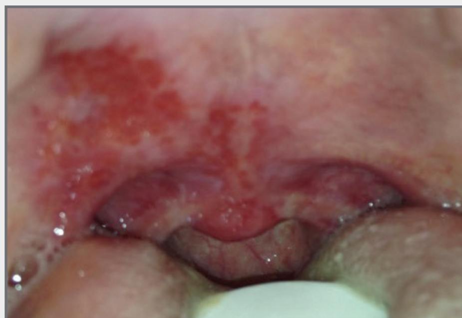

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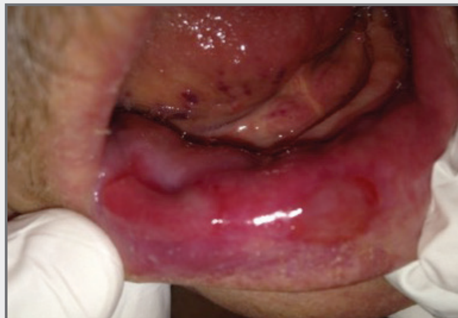

Figure 4

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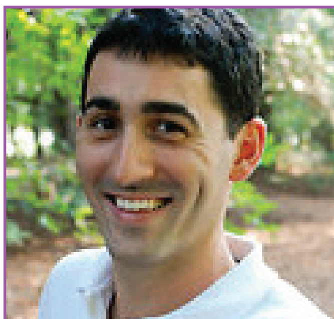


DR. MICHAEL GIGLIOTTI

I was very fortunate to have a wonderful opportunity after dental school to enter straight into private practice. I am currently practicing in Virginia Beach with my father and two other excellent dentists who continue to teach and mentor me.

CONTINUED FROM PAGE 19

PATHOLOGY PUZZLER

Dr. John Svirsky

I would include erythema multiforme and drug toxicity reaction as the most likely choices. I would exclude lichen planus since there are no areas of white striations. Squamous cell carcinoma would not be painful, have this appearance or be multifocal. Benign mucous membrane pemphigoid typically has bleeding gums with lesions that have bullae. Pemphigus could be this ragged, multifocal and involve the mouth. The patient would typically have skin lesions.

The age of this patient fits all the lesions listed except erythema multiforme, which typically occurs in a younger age group. The more severe the outbreak, the more likely a drug is the cause. Outbreaks of erythema multiforme related to drugs are not dose related. We now divide erythema multiforme into erythema multiforme major (EMM) which was formally known as Stevens- Johnson Syndrome and erythema multiforme minor (EMMi) which has oral lesions and a few skin lesions. EMM is always related to a drug and EMMi can be a drug but in most instances the cause is not found. If the cause is not found in EMMi , the patient has a 30% chance of getting a recurrence.

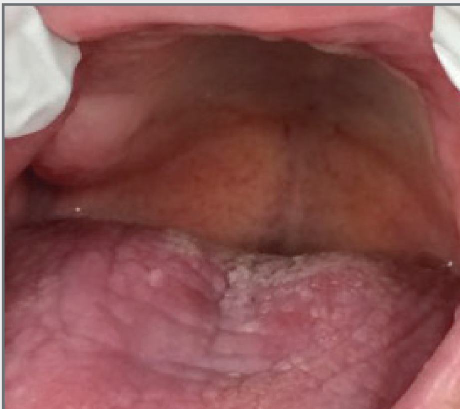
Since the patient is on methotrexate for rheumatoid arthritis, a methotrexate toxicity reaction must be considered. Methotrexate is one of the most effective and widely used medications for rheumatoid arthritis and is a relatively safe drug compared to most of the immunosuppressant drugs used by rheumatologists. Methotrexate can cause a folic acid deficiency which can lead to oral ulcerations/erosions with pain as was seen in this case. Treatment consists of palliation and folic acid supplementation. I had the patient increase his folic acid to 3 mg per day and use magic mouthwash for pain. The patient was to return in two weeks if the lesions had not improved for biopsy. He returned in one month completely free of the oral lesions and without pain (figures 6-9). In figure 9 there is a small focus of lichen planus in the left posterior buccal mucosa. This was not related to his oral pain, but an incidental finding when he presented after a month. In reality this case is a folic acid deficiency caused by methotrexate therapy for rheumatoid arthritis. ■

NAUSEA OF METHOTREXATE

- The nausea may be related to the folic acid deficiency rather then the methotrexate
- Methotrexate nausea is not due to stomach irritation, but rather to a receptor in the brain that causes nausea
- Some cases of nausea are treat-ed with a histamine H2 blocker or ondansetron (Zofran), a drug that blocks the signal in the brain that causes nausea and vomiting

TREATMENT OF TOXICITY

- Folic acid supplementation (increase from 1mg to 3mg/day (max. 5 mg)
- If paitent does not respond to folic acid, use folinic acid, the reduced form of folate



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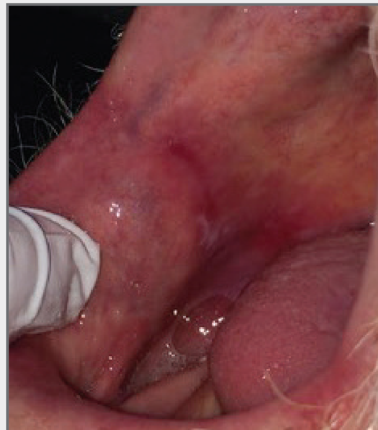

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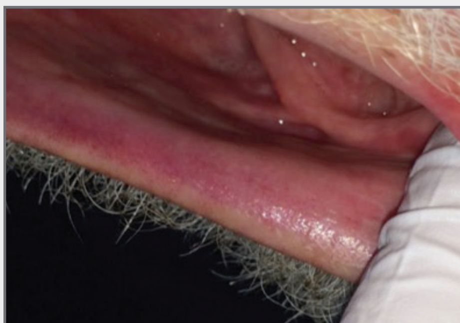

Figure 7

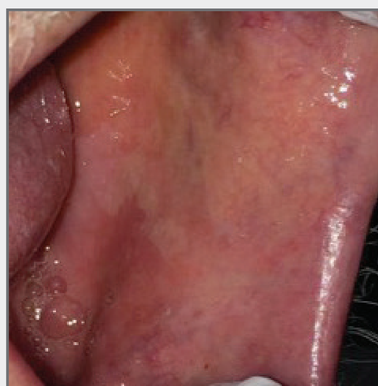

Figure 9

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:

PROCEEDINGS OF THE 59TH SOUTHERN CONFERENCE OF DENTAL DEANS AND EXAMINERS: ETHICS AND PROFESSIONALISM IN DENTAL EDUCATION AND LICENSURE – PUTTING PATIENTS FIRST

Drs. David C. Sarrett, Marilyn S. Lantz, Ronald L. Tankersley, Rodney B. Wentworth, William D. Cranford, William J. Bennett, Sarah K. Wilson

INTRODUCTION

The 59th Southern Conference of Dental Deans and Examiners (SCDDE) was held on January 24-26, 2014 in Richmond, Virginia. Virginia Commonwealth University (VCU) School of Dentistry served as the host dental school for this annual meeting, along with leaders in the Virginia Dental Association and the Virginia Board of Dentistry. The SCDDE meeting rotates around the member states and the hosting school is responsible for organizing the meeting. The goal of the SCDDE is to enhance the communications and collaboration among schools, boards of dentistry, and board examiners. This year's conference title was *Ethics and Professionalism in Dental Education and Licensure – Putting Patients First.*

The topic of ethics and professionalism is front and center in our profession and it is challenging to understand what it means, how it evolves, how it is evaluated, and the correct actions that will move dentistry forward. VCU School of Dentistry selected this conference topic because its leadership, the faculty, and students have recently taken actions to increase the educational focus on ethics and professionalism. The goal for this SCDDE conference was to bring together scholars, educators, clinicians, students, and administrators to engage in a deep dive discussion about ethics and professional behavior in dentistry. The conference title tag line, Putting Patients First, served to focus development of the program and as a guiding light during the two days of the conference. During Dean David Sarrett's welcoming comments he said, "I expect we will have differences of opinion and perspective about what we will learn and discuss. Passion often runs high when ethics is the agenda topic. Often one constituency says "If only those people…" and you can fill in the blank. I believe we all want the same outcome in raising the bar for professionalism in dentistry. I also have realized that we all, educators, practitioners, board members, examiners, and directors, have to work within the framework of each of our organizations and environment. I hope we come away from this meeting with some shared perspectives and understandings as well as shared goals and action items as we move ahead in Putting Patients First."

The format of the program was selected to engage participants in discussion and inspire collaborative thinking with the goal of developing recommendations for stakeholder organizations to enhance professionalism in dentistry. The first session featured speakers who presented under the theme of "Ethical Development Across the Professional Lifetime." The charge to these speakers was to address this topic from the viewpoints of organized dentistry, dental education, and boards of dentistry. Dr. Tankersley's presentation considers the threat to the future of the profession of ethical misconduct by its members as well as current cultural challenges to our ability to maintain traditional ethical standards in our profession. Dr. Lantz's presentation examines the evidence supporting the importance of professional identity formation for dentists and the role played by dental education in supporting professional identity formation. Dr. Wentworth's presentation describes some of the challenges faced by new graduates as they enter dental practice as well as the challenges of keeping ethics at the forefront of dental practice. Finally, Dr. Cranford 's presentation reviews the roles and responsibilities of state dental boards as well as the steps in the adjudication process when a complaint is made against a licensee.

The second session was a panel discussion with the charge to the panelists to discuss "Challenges Facing Dentists and Organizations" and to engage the conference participants in discussion of prepared questions as well as questions submitted in writing from the floor by conference attendees. Prepared questions related to dental board procedures, processes, sanctions, and challenges, roles and responsibilities of professional societies in promoting professionalism in dentistry, unique professionalism challenges facing dentist-employees and new dentists, and potential best practices for stakeholder collaborative efforts to improve professionalism in dentistry.

The final session presented three questions to break-out groups of less than ten conference participants per group. The groups were asked to record their responses to the questions. When the groups came back together, a spokesperson from each group summarized the group's discussion and presented the group's written responses to each of the three questions.

SESSION 1: SPEAKERS' PRESENTATIONS

DR. RONALD TANKERSLEY

PERSPECTIVES ON ETHICS

Today's dental profession faces many challenges: a struggling economy, increased federal control over healthcare, a hyper-litigious society, decreased public funding for dental education, and challenges to the autonomy of dental boards. In my (Dr. Tankersley's) opinion, the greatest threat to our status as a self-regulating profession is ethical misconduct by our colleagues. Human instinct is to protect self-interests as a method to survive the evolutionary process, but successful societies learn when it is appropriate to subordinate short-term self-interests for the long-term benefit of society. This learning process is called socialization. Successful societies influence the behaviors of their members to improve the society's future. These shared actions represent moral behaviors and require shared values. Cultures and groups without shared moral values lose cohesiveness and fail to survive (Haidt, 2012). As dentists, it is in our long term interests to learn when to subordinate our short term interests to those of others. Our professional status requires proper socialization of our members and continued credibility with the public. Our continued credibility as a science-based profession requires: 1. quality education; 2. practice based on sound science and; 3. impeccable ethics.

Dentistry has a proud history and legacy. Just imagine being those dentists who sat in the American Dental Association's (ADA's) House of Delegates in the 1950s with the majority of their practice time devoted to extractions, restorations, and dentures. Those dental leaders were confronted with scientific evidence that fluoridating drinking water would dramatically reduce caries and that periodontal disease was preventable. Instead of protecting their jobs like trade unions, they stepped up to

Continued on page 22

Continued from page 21

Table 1. Top three responses from breakout groups to questions posed to the groups

What are the three most important things you learned from the presentations and discussion that should be publicized?	**Environmental Factors (The Perfect Storm)** • Increased student debt, corporate dentistry pressures, and industry marketing ("The Perfect Storm") and the subsequent influence on professional behavior • New graduates are facing increased debt and diminishing returns on educational investment • Increased number of graduates from increased class sizes and new dental schools has reduced employment opportunities for new dentists **Ethical Behavior Can Be Learned** • Ethical development occurs over time well beyond dental school • Ethical identity is a continually evolving trait/behavior • Creating an ethical profession is a multifactorial responsibility requiring purposeful effort from schools' admissions committees, the educational experience, dental association programs and activities, and board regulation and enforcement **The Hidden Curriculum & Licensure Process** • The "hidden" curriculum in dental schools and some licensure procedures place students in compromising ethical situations • Live patient exams present ethical, legal and liability issues • Dental schools need to be aware of the impact of their policies, procedures, and environment on the ethical development of their students
What were the most important issues discussed relative to each of these organizations: educational institutions; testing agencies; boards of dentistry; and professional associations?	**Educational Institutions** • Make the climate/culture of ethics a foundation within the school • Monitor the economics of education and oversaturation of market with new graduates and respond accordingly • Understand the hidden curriculum and the pressures on completing the educational process **Testing Agencies** • Work toward elimination of live patient exams and replacement with an appropriate alternative • Ensure that examinations are fair and reliable. The validity of current licensure examination processes continues to be debated • Schools and boards should collaborate to develop a national licensure examination **Boards of Dentistry** • Define the "Caring Dentist" model for ethical improvement as an alternative to dental boards being seen as the "policemen" of the profession • Maintain strong collaborative relationships with schools and state dental organizations and communicate regularly with licensees and other regulatory boards • Institute continuing education requirements in ethics and seek ways to evaluate ethical development of dentists after the initial licensure process **Professional Associations** • Encourage a culture of accountability within professional organizations (e.g., adoption of an honor system with an obligation to police members) • Take more active role in professional development/mentorship in ethics • Increase awareness of ethical standards among members and disseminate information on available ethic courses
What are the three action items for institutions and organizations to consider?	**Improve collaboration between schools, dental boards, and dental associations & societies that support development of ethical dentists** • Require mandatory ethics continuing education for license renewal • Boards, schools, and dental societies should work together to develop improved licensure examinations • Provide personal financial management at the entry level in dental school **Develop programs to mentor dentists** • Schools, dental organizations, and boards should collaborate to determine how best to ensure that high ethical standards are present and maintained across the professional lifetime • Promote and reinforce ethical culture throughout the profession with mentoring programs for all dentists • Develop a national consensus about best practices in ethics education for dentists **Increase ethics instruction in the dental school curricula and involve state boards in design and delivery of instruction** • Ramp up ethics discussions to increase ethics awareness within schools – engage faculty as well as students • Encourage formal presentations by state boards to the students on cases and regulations • State boards could assist schools with coursework development

the plate and behaved like true healthcare professionals. The ADA's decision to advocate for fluoridated drinking water and change the focus of dental practice from disease management to prevention speaks volumes about our profession. Today, the ADA and its sister organizations, such as the American College of Dentists, make ethics and professionalism a first priority. For example, the ADA science division adheres to the highest evidence-based standards, in spite of substantial pressure to do otherwise from those who are motivated by self-interest. Also, the ADA continues to advocate for fluoridated drinking water and dental amalgam use even though doing so reduces dental expenditures and it continues to advocate for comprehensive safety-net programs while trying to fill the void with charitable outreach programs such as Missions of Mercy.

Most dentists today are good, hard-working people who strive to protect the best interests of their patients and their profession as they provide the most sophisticated dental care in the history of the world; however, ethical and professional misconduct by a small number of dentists can destroy the public's perception of the entire profession. In dental schools, there have been reports of appalling instances of ethical misconduct regarding cheating on exams, falsifying patient records or faculty signatures (Beemsterboer, Odom, Pate, & Haden, 2000). One study of dental faculty and students reported that cheating and plagiarism is a problem in dental schools and perceptions on cheating differ between students and faculty members (Andrews, Smith, Henzi, & Demps, 2007). Unfortunately, there is evidence that if students engage in ethical misconduct while in school, particularly certain kinds of misconduct, their risk of being disciplined by a state medical board later on in their career increases (Papadakis et al., 2005).

Some dentists recommend only the most lucrative, or the most remedial procedures, without informing patients of other options. Others make claims that far exceed the evidence-based implications of current knowledge or recommend diagnostic studies and treatments that have no known clinical efficacy. Explanations for this misuse of science include:

1. Some dentists don't keep up with advances in the profession and just don't know any better; that's why life-long learning is an essential part of the ethical pillar– "non-maleficence" - do no harm.
2. In addition to helping students learn the facts of science upon which practice is based, one of the purposes of science in our dental curriculum is to cultivate the critical thinking skills required to function in a science-based profession.

Nevertheless, some dentists make errors such as equating "correlations" with "causality". They confuse procedural success with good healthcare. They make erroneous assumptions based on information that is incomplete or out of context. They believe junk science claims either because of a deficit in science knowledge or a deficit in the ability to critically appraise relevant scientific literature. Misplaced beliefs can be more dangerous in the healthcare setting than ignorance.

3. Some dentists "intentionally" misuse science for personal gains. They knowingly violate the ethical pillar -"veracity" - and are a primary focus of our ethics discussion.

The consequences of inappropriate behaviors aren't dependent upon the intent of those behaviors. So, regardless of the reason, the profession's credibility is tarnished when our colleagues abandon sound science.

Informed consent is an essential ingredient for the most important pillar of ethical behavior - patient autonomy. If doctors believe that they know what's best for their patients, why do they need to offer options that they believe are less desirable? The operative word is "believe". Regardless of our education and experience – regardless of what we would do ourselves or recommend for our families – regardless of how strongly we "believe" that we know what's best for our patient, we can never know with certainty what's best for any specific patient.

Deceptive advertising such as announcing as pseudo-specialists or using patient testimonials that are carefully crafted or edited by the dentists themselves have become commonplace. This behavior confuses patients and denigrates the entire profession. It sends the message that we're just like all the other hucksters in the marketplace.

Why do some intelligent, well educated professionals who chose healthcare for a career and have tremendous opportunities for legitimate success behave like hucksters? Six significant cultural challenges to our ability to maintain traditional ethical standards may answer this question.

1. MORAL DIVERSITY

According to social psychologists (Haidt, Rosenberg, & Hom, 2003), the most successful cultures have "demographic diversity" and "shared" moral values. Demographic diversity enriches the culture with a broad spectrum of perspectives, customs, art and science. Shared moral values maintain social cohesiveness. Conversely, moral diversity undermines the fabric that holds us together. Until recently, our culture benefited from the shared moral values of the sanctity of human life, a strong work ethic, self-reliance, accountability, and personal integrity. Evidence of this moral diversity is ubiquitous. Deception, denial of accountability, and dissemination of information that's un-vetted, or out of context, are part of our everyday lives. Ethical breaches in athletics, education, research, government, banking, and journalism are commonplace, often with little consequence or remorse. This is a sad commentary on our general culture, but it's especially unacceptable for dentists since they have a "de-facto monopoly" on the knowledge of oral conditions, the acceptable diagnostic and therapeutic options available for those conditions, and their risks and benefits. Dentists also perform irreversible procedures on our fellow human beings on a regular basis. Few in society are given that level of trust and to preserve that trust, our behavioral standards must be higher than those with lesser responsibilities.

2. DEFICIT SPENDING

The declining savings rate in the United States coupled with increasing debt of households created deficit spending contributing to the economic decline that began in 2008 (Glick & Lansing, 2011). This behavior by individuals seems to be validated by the federal government's uncontrolled debt and unfunded liabilities. Spending more than we make has become culturally acceptable. Self-imposed financial pressures are a catalyst for ethical misconduct throughout our society. The implications of these findings are significant for both dentists and students with large debts.

3. CULTURAL EMPHASIS ON EXTRINSIC GOALS

American culture increasingly equates success with attaining extrinsic goals, rather than fulfilling a mission. Unfortunately, this focus on extrinsic goals is pervasive in our profession. Many popular continuing education courses focus on selling financially lucrative services, not optimizing patient care. Some even suggest financially incentivizing allied personnel for their marketing efforts. Healthcare recommendations should not be based on production quotas or a bonus system.

4. CULTURE OF ENTITLEMENT

We have become a culture of entitlement. This entitlement mentality is not limited to any particular socioeconomic sector. Some dentists believe that their educations entitle them to a high income. That belief is propagated by those who infer that education is the primary determinant of income. Many well-educated people never achieve financial success for a variety of reasons. Others, with little education are financially successful at almost everything that they attempt. Dentists have the technical skills and knowledge necessary for financial success, however, success depends upon many other factors: the quality of their services; the demand for their services; their ability to work with others; their work ethics; and their business models.

5. EGOCENTRIC PERSPECTIVE ON INTRINSIC VALUE

Some dentists believe that they deserve to be well compensated, because of their "intrinsic" value to society – an egocentric assessment. Our economic value is based on supply and demand, not intrinsic value. Gifted athletes are paid more than school teachers because there are fewer gifted athletes than teachers, not because they are more intrinsically valuable to society. Our value to society is dependent on our behaviors, not our job description. In fact, when dentists abdicate their ethical responsibilities, they have a negative intrinsic value – they become a "menace" to society.

6. INCREASED CODIFICATION OF PROFESSIONAL BEHAVIOR

In the past, laws governing the professions were limited to issues that were clearly defined, requiring little judgment. Ethical standards were much higher than legal requirements and society recognized that ethics are not absolute; they're provisional. Ethical issues were adjudicated by members of the professions, who better understood both the nuances and the ramifications of the aberrant behavior. Their obligation to use their knowledge wisely and honestly was taken seriously. During the 1960s, policy makers decided that the professions were too autonomous, and began to codify professional behaviors through regulations. As regulation of their professional behaviors increased, many professionals felt that ethics was no longer their responsibility (Ariely, 2008). To make things worse, the professions' ability to regulate itself also decreased making it more difficult to regulate behaviors that are unethical, but legal. The Federal Trade Commission and American Civil Liberties Union will vigorously defend those who violate ethical standards, but satisfy legal requirements. Thus, state boards and professional associations have become pusillanimous about enforcing their own ethical standards.

Obviously, these finding are pretty discouraging. How can we, realistically, even hope that dentistry can maintain its professional standards? It may be unrealistic to expect society-at-large to uphold a proscribed set of ethical standards. But, it's not unrealistic, or unusual, for members of smaller groups who share the same mission to subordinate their self-interests to that mission. Where should we concentrate our efforts?

Continued on page 24

Continued from page 23

PROMISE FOR NEW UNDERSTANDINGS ABOUT MORAL DEVELOPMENT/MORAL REASONING FROM THE FIELDS OF NEUROSCIENCE/NEUROBIOLOGY

Results from both functional and neuroimaging studies (fMRI) suggest that morality is supported not by a single brain structure but by several circuits overlapping with other complex processes (Pascual et al 2013). The field of neuroscience currently lacks identification of the core features of morality and moral-related processes. Also unclear at this time is how cognitive and emotional processes interact across many brain domains to create a moral judgment. As further research is conducted and the knowledge base in these areas expands we can look forward to more information that will support and expand the field of moral psychology, from which current theories of moral development and reasoning derive. Furthermore, as these new understandings become more scientifically accepted, they might suggest new and potentially more effective approaches to ethics education.

PEER PRESSURE

Peer pressure is a double-edged sword – it can produce either positive or negative outcomes. Peer pressure to engage in behaviors that are unethical (negative peer pressure) is generally thought to have the most impact on individuals who have the least developed professional identities. Having a clear understanding of our professional duties and obligations, those to our patients, our colleagues, society, and our profession can help mitigate the impact of negative peer pressure. On the other hand, peer pressure to maintain high standards (positive peer pressure) protects the integrity and the future of the profession. In fact, the ADA Code, the collective voice of generations of our peers in the dental profession, describes what our profession expects of us and is an example of positive peer pressure. Knowing this and using the ADA Code as a guide is a key to improved ethical decision-making.

TAKE ACTION

First, we need to do more than just talk about it. That's what we do at white coat ceremonies and that's what the American College of Dentists does at its annual meetings and courses. Moral behavior requires us to do the right thing, at the right time, for the right reason. It requires actually "taking action" to bring about a better profession. As David Chambers says, "It matters more what we do than what we say about it". So, what actions should we take?

DENTAL EDUCATION

We can start with dental education. Today's dental students are the brightest, most diverse, and most sophisticated in our history, however, for many, critical thinking was not stressed in their pre-dental educations. Some of them cheated to gain admission to dental school so dental education needs to place critical thinking and ethics among its highest priorities. Entering dental students may not fully understand the tremendous responsibilities that we assume as dentists. Some leniency is justified for them but if senior dental students do not understand those responsibilities, there's either a deficiency in the students' characters, or a deficiency in their educations.

A survey of six Pennsylvania medical schools revealed that there may actually be ethical erosion of students as they progress through their clinical training. (Fendtner, Christakis, and Christakis, 1994) This is probably due to gradual desensitization to clinical situations and a blind acceptance of the behaviors of those above them in the medical hierarchy. These unintended environmental influences on behaviors are referred to as the "hidden curriculum" and shouldn't be ignored. To compound the situation, educators are more reluctant to expel or sanction senior students compared with freshmen. Of course, empathy for students nearing graduation is understandable, however, from an ethics perspective, it's the wrong approach. If behavioral expectations are made clear from the beginning, if students are properly taught their ethical responsibilities, and if the ethical misconduct is "well documented", then applying sanctions is fair. It is the "moral" thing to do. It is likely that if students have not internalized high standards of ethical conduct by the time they graduate, it's unlikely that they will be ethical in their careers.

DENTAL PRACTICE

We also need to take action and address the ethical misconduct of practicing dentists. As discussed earlier, dentists can learn rational, ethical behavior at any age; therefore, regardless of how high they have climbed on their ladders to success, we need to teach them how to position their ladders in the right place. We need to be sure that critical thinking is embedded in continuing education courses that are part of their life-long learning. We need to develop initiatives that assure that dentists clearly understand what ethical misconduct is and that it is unacceptable to their peers. Finally, we need to find ways to appropriately sanction those who threaten our profession's future with unethical behavior.

DR. MARILYN LANTZ

Formal Instruction, Role Models, and Institutional Culture: What we know about supporting dental students' professional ethical development

This presentation will focus on what we know about the role of dental education in helping students develop an ethical professional identity. Simply put, developing a professional identity requires individuals to integrate into their personal value system the values of their chosen profession, society's expectations of the profession and to give priority to these values and expectations. To be clear, formation of a professional identity requires much more than superficial behavior such as "acting like a professional." Rather it requires deep understandings of professional values, professional responsibility and professional expectations and integration of these values and expectations into one's sense of self (Hafferty, 2006).

Bebeau and Monson (2008) have reviewed evidence from research conducted in a number of professions and in the military which suggests that professional identity formation begins prior to entry into professional school and that it can continue across the professional lifetime, although for some it does not. These findings have at least three important implications: 1) Professional ethical development is not complete at the time of graduation from dental school; 2) Support for continued learning and ethical development should be readily available to dentists as they mature as professionals; and 3) Continued ethical development is neither automatic nor guaranteed to occur with time in practice.

EVIDENCE FOR THE IMPORTANCE OF PROFESSIONAL IDENTITY FORMATION

One line of evidence that supports the importance of professional identity formation in the development of professionals comes from studies of disciplined practitioners. Papadakis et al. (2005) demonstrated that disciplinary action by a medical board was strongly associated with prior unprofessional behavior in medical school. The types of unprofessional behavior in medical school most strongly associated with subsequent discipline by a medical board were severe irresponsibility and a diminished capacity for self- improvement. While these behaviors could result from deficiencies in other capacities or abilities, they could clearly be accounted for by deficiencies in professional identity formation.

Working with a state dental board, Bebeau developed a remediation program for dental professionals disciplined by the board following adjudication of complaints about their (the dental professional's) competence or conduct. The program consists of an intake interview, a pre-instruction assessment phase to detect potential deficiencies in ethical capacities, an educational program, final assessment, report to the board and reinstatement of the dental professional to practice (Bebeau, 2009a). In comparing pre-instruction assessment scores of 41 dental professionals referred by the board between 1990 and 2005, Bebeau reported that while the disciplined professionals varied greatly in their ethical sensitivity, reasoning, and ethical implementation abilities, one shortcoming was noted for 39 of the 41

referrals – an inability to clearly articulate societal expectations of dental professionals. This inability reflects a deficiency in professional identity formation, and this finding led Bebeau to recommend an explicit focus on professional identity formation in the remediation process (Bebeau, 2009a). In a follow up report, Bebeau (2009b) provided evidence, in the form of improved performance on final assessments and importantly by the very low recidivism rate (< 5% among program completers), that an educational intervention could remediate deficiencies in ethical capacities and abilities.

Another line of evidence that supports the importance of professional identity formation in the development of professionals comes from a study by the Carnegie Foundation for the Advancement of Teaching. It's Preparation for the Professions Program (PPP), was a series of comparative studies of preparation (education) for five professions: law, engineering, the clergy, nursing, and medicine. It was completed over a ten-year period in the US and concluded in 2010. In the foreword of the fifth and final volume published from these studies, Educating Physicians, Lee M. Schulman, President Emeritus of the Carnegie Foundation for the Advancement of Teaching, stated the following: "In every field we studied, we concluded that the most overlooked aspect of professional preparation was the formation of a professional identity with a moral and ethical core of service and responsibility, around which the habits of mind and of practice are organized." (Shulman, 2010)

In a review article examining findings of the PPP, Colby and Sullivan (2008) noted that in all five professions studied, teaching for professional purpose and commitment was subordinate to teaching for professional knowledge and skill. In apparent support of this assessment, a recent study of ethics teaching and learning in US dental schools (Lantz, Bebeau, & Zarkowski, 2011) noted that compared to the areas of science and practice, little curriculum time is devoted to ethics instruction in US dental schools. While 80% of the dental schools reported that they offered a "stand alone" ethics course for dental students, the mean clock hours for the course were 26.5, roughly the equivalent of a one semester, 2 credit-hour course. In contrast, based on the latest ADA Curriculum Clock Hours Report for dental education programs (2010-2011), mean clock hours for instruction in the biomedical sciences reported by dental schools were about 800 and mean clock hours reported for dental/clinical sciences instruction were about 3800.

LEARNING ABOUT "WHAT IT MEANS TO BE A DENTIST"

Research suggests that dental students learn essential information to support professional identity formation - what it means "to be a dentist," from three main sources in dental school: through the formal curriculum; through observing and interacting with individuals who become "role models," and though the lessons taught informally by the dental school environment (Lantz, Bebeau and Zarkowski 2011).

The formal curriculum. All accredited US dental schools offer a curriculum in ethics and professionalism and all assess the competence of graduates in these domains, although there is variation across schools in how this curriculum is organized and how competency is assessed (for a recent review see Lantz, Bebeau and Zarkowski 2011). In general, schools offer a solid grounding in the values of the dental profession, the nature of professional responsibility, the "social contract" that defines the relationship between the profession and society and societal expectations of the profession as part of the formal curriculum in ethics and professionalism. These values and expectations are the core elements that must over time be internalized by the developing dentist/professional in the process of professional identity formation. Specific learning strategies such as studying the actions and thought processes of moral exemplars (Rule & Bebeau, 2005), or assessment strategies such as writing and critiquing professional identity essays are often used to support students' professional identity formation and have been shown to be effective for this purpose (Bebeau & Monson, 2011).

Dental schools generally offer curriculum that assists students in developing other capacities and abilities known to be important in helping professionals consistently choose the best moral actions in the many situations they face as practicing professionals. These include ethical sensitivity, ethical reasoning and judgment, and practice in the behavioral and social skills needed to implement moral actions. Some schools use validated measures to assess students' development in these areas.

Role models. While dental school faculty develop, deliver and manage the formal dental education curriculum, students also learn a great deal about what it means to be a dentist by observing the professional behaviors of faculty, not only as they teach in the classroom and the clinics but also as they carry out other faculty roles, as researchers, scholars, members of organized dentistry and as school administrators. Thus whether or not faculty members have the intention of serving as role models for students, they do serve in this capacity. In fact, a recent systematic review on teaching professionalism in medical education concluded that students learn professionalism most effectively through the influence of clinicians they encounter in the course of their education and less so through classroom instruction (Birden et al., 2013). Therefore, both formal and informal student-faculty interactions have the capacity to strongly influence students' professional identity formation as students select faculty behaviors they want to emulate and those that they want to avoid.

Another recent systematic review (Passi et al., 2013) identified attributes of positive and negative role models in medical education. Evidence suggests that positive role models affect both professional development of medical students and also their career choice. Characteristics of positive faculty role models include demonstration of high standards of clinical competence, excellence in clinical teaching skills, and humanistic personal qualities. They also modeled good communication skills and demonstrated respectful interactions with and attitudes toward other health care providers. In contrast, negative role model behaviors such as use of derogatory humor, disrespectful comments about other health care providers, specialties, departments and/or institutions, and the existence of gender issues were identified as highly problematic. A conclusion of this review was that more research was needed to develop best practices for minimizing negative role model behaviors and/or developing strategies that ameliorate its effects on students.

THE INFORMAL OR "HIDDEN CURRICULUM"

No consideration of students' professional identity formation would be complete without examining the impact of the dental school's climate and culture, the so-called "hidden curriculum" (Hafferty, 1998) on the process. Dental schools, through their policies, priorities, evaluation activities, resource allocation decisions, culture and learning environment send powerful messages to students and faculty alike about what is valued, and what "really counts" at the school. These intended and unintended messages about "how things really work and get done around here" can either facilitate or inhibit students' professional identity formation.

Masella (2006) makes the case that done well, the informal/"extra-curricular" learning offered by a school can add great value to the dental education process. He suggests that engaging in research experiences, extracurricular seminars, externships, and participation in dental fraternities and the like can all accelerate professional identity formation. On the other hand, if dental students observe that students who "cut corners" are rewarded or that unprofessional behavior by peers is not addressed, or for example if student assessments of performance weight clinical production more heavily than the quality or outcomes of the care provided, students could conclude that professional values such as honesty, integrity and the priority of the needs of the patient ("putting patients first") don't apply, thereby undermining professional identity formation.

Continued on page 26

Continued from page 25

It is notable that the most recent revision of the Commission on Dental Accreditation's Standards for Dental Education Programs recognizes the importance of the learning environment in the dental education process. Standard 1-3 states that "The dental education program must have a stated commitment to a humanistic culture and learning environment that is regularly evaluated." The intent of this standard is described as follows:

The dental education program should ensure collaboration, mutual respect, cooperation, and harmonious relationships between and among administrators, faculty, students, staff, and alumni. The program should also support and cultivate the development of professionalism and ethical behavior by fostering diversity of faculty, students, and staff, open communication, leadership, and scholarship.

In conclusion, dental schools have the responsibility to help students develop an ethical professional identity. It is the beginning of a journey that should continue across the professional lifetime. Professional identity formation is required in order for a dentist to consistently "put patients first." What can schools, the dental practice community, organized dentistry, and state dental boards do collaboratively to foster professional identity formation across the professional lifetime of dentists?

DR. RODNEY B. WENTWORTH ETHICAL DEVELOPMENT ACROSS THE LIFETIME

Before, and during a student's dental education, they tend to have altruistic goals to improve people's oral health and, in general, make their communities healthier. The dental school experience facilitates these goals, often times providing opportunities to care for the underserved populations, hopefully instilling these values as part of becoming a professional. Upon graduation young dentists are confronted with challenges that require them to set new goals based on survival in the real world. There is a priority to find employment, to service their debt, and earn a living.

Out of the shelter of the academic environment, the new dentist is introduced to new stressors that may impact ethical practice. The American Dental Association (ADA) published studies in 2013 from their Health Policy Resource Center (Vujicic et al., 2014) that show a decline in dental visits from 2007 to 2011 and predict relatively flat revenue for dentistry in the upcoming two to three decades. The authors also predict that fewer dentists will be needed in the future. New dental schools are opening, contributing to an increasing number of dentists entering the workforce. Declining dental visits and additional new dentists competing for employment have created a practice stressor that may affect ethical behavior of some practitioners.

Another stressor is the increased debt new graduates are accumulating. Dental education is expensive and reduced public support for dental schools has resulted in student loan payments being a major expense in the budget of a new dentist (American Dental Education Association Policy Center, 2013). Compounding this fact are continued declines in dental benefits reimbursement rates while business overhead continues to increase. A study of the influence of educational debt on career choices indicates increasing debt has minimal impact on seeking a career choice toward private practice, however, debt has a larger negative impact on graduates seeking government, academic, and research employment (Wanchek, Nicholson, Vujicic, Menezes, & Ziebert, 2014). This also adds to the competition in private practice. Unknown future changes that may impact the practice stress of new dentists include government interventions in health care and trends toward large group and corporate owned dental entities.

Expressing these factors in mathematical terms results in the following formula:

[(Fewer patients) + (More dentists) + (Lower reimbursement) + (Increasing overhead)] x (Degree of debt) = Treatment Decision

Where do dentists go to seek help in managing these influences? There are scores of practice management consultants that offer services from continuing education courses to individual coaching and who are eager to teach their sure fire strategies to a successful practice. Dental product and supply companies and manufacturers are always offering classes, webinars, and lunch-and-learns to sell their latest and greatest materials and equipment to make your care more efficient or attract more patients to your practice. Just checking the daily mail will reveal throw-away journals and advertisements touting new techniques, products, and systems with testimonials from dental gurus endorsing what they can do for you. There are also pseudo-academic institutes available to attend for a day, week or for series of classes to learn "their method".

The concerning issues with these practice resources are: 1. there is no ethical oversight; 2. they commonly are not presenting evidence-based information, and; 3. training providers are also in it to make a profit. Fortunately, there are many consultants that go out of their way to make sure their clients are taught in an ethical manner. There are also those that teach sales tactics that circumvent informed consent, recommend care based on insurance coverage instead of patient need, or prescribe unethical referral incentives. The new dentist may feel sources are credible just because the speaker is popular or has been on the circuit for a long time. They may be swayed when a speaker uses a study to support their recommendations when in fact the evidence says something else. These same concerns also apply to manufacturers recommendations. Often a clip from a dental newsletter is included as proof it is a better product. Testimonials are commonly used as evidence. An example that encompasses these issues happened when digital dental radiographs became available. There was a common theme in advertising that they reduced radiation exposure by 90%. Some consultants and dentists assumed this was factual and used it in advertising this service to the public. This statement was not supported by evidence, was motivated by profit to sell a product and perpetuated by a lack of ethical oversight.

With all these ethical stressors, we need to discuss the "ethical elephant in the room". Dentistry has worked hard, and continues to be diligent, in addressing the underserved. The question posed is, are we neglecting another population – the overserved? Who feels this is a concern? I suspect that anyone having served at least a year on a dental board will tell you this is a problem. Those involved in dental ethics at dental schools and in their dental associations will agree. The 1997 article in Reader's Digest that chronicled widely varying treatment plans and costs recommended to the author was not one of dentistry's finer moments (Ecenbarger, 1997). You might criticize the methods of the author's research but there are also peer-reviewed studies that indicated there is an overtreatment problem in dentistry. One study using insurance claims data showed a significant difference in replacement rates of amalgam and composite restorations if the patient changed dentists (Bogacki, Hunt, del Aguila, & Smith, 2002).

The most important stakeholders, our patients, are keen to make sure they are treated ethically and appropriately. The other concerned group is our dental staff. Since 2010, the Pacific Northwest Dental Conference has held an Ethics and Rules Class where a panel consisting of an ethics expert, prosecuting attorney from the Department of Health, malpractice attorney, Washington State Dental Association staff attorney, and past Dental Quality Assurance Committee (state dental board) member fielded questions about ethics and jurisprudence issues. For each year, the vast majority of those attending are staff, not dentists, and there were multiple inquiries questioning the office policies their dentist imposes.

So how do we currently address dental ethics? The ADA has a formal disciplinary process for ethical violations. A few state dental associations have formal committees that act as watchdogs for ethical transgressions of its members. There is

some continuing education available with a sparse offering of classes and seminars. There are also online studies offered. The American College of Dentists (ACD), for example, offers free online courses in dental ethics. The Journal of the American Dental Association has a column, Ethical Moment, which appears regularly in the publication. The ACD, ADA and its component and constituent societies have publications that feature ethical topics available to their members both in print and online.

Although there is some information available to dentists, there are barriers to improving ethics. We have already discussed the fact that there is no ethical oversight for continuing education speakers. Without an incentive, ethics classes are typically not well attended. Most dentists don't feel there are any problems with ethics in the profession and are not motivated to learn more about the topic. Even when there are state and local issues that arise, it is difficult for dental associations to get the word out. Another barrier is that there may not be significant consequences for unethical behavior. When a member of the ADA is subject to discipline for ethics violations, the most severe sanction is loss of membership. From the dental board perspective, some complaints that are specifically ethics related may be considered di minimis. With case backlogs and limited time available, dental boards may give higher priority to violations that have an immediate impact on the public (like standard of care or impaired practitioners) and decline to pursue violations such as non-recognized specialty announcement or fee splitting. Finally when a dentist is aware of unethical practice by another practitioner in their community, they are reluctant to make a complaint about one of their peers for fear of themselves being accused of some violation as retaliation.

What actions can we take to bring ethics to the forefront? Do we mandate periodic ethics education as a condition of license renewal? Do we promote the complaint process? Do we involve the public and our staff in our efforts? Are there enough "we" to accomplish this task? These are questions for us to consider during this and other conferences and discussion on promoting the ethical practice of dentistry.

DR. WILLIAM D. CRANFORD, JR. DENTAL ETHICS AND BOARD COMPLAINTS: A REPORT FROM THE FIELD

Dental licensing boards are charged with protecting the public by overseeing the legal and ethical standards of dentists and allied dental personnel. When complaints are filed against dental practitioners, the dental board has the serious responsibility of adjudicating reported ethical and professional violations. Dental board members must be aware of pressures that dentists face today that could lead to compromises in the practice of dentistry. Dr. Wentworth has reviewed these factors and provided a formulaic representation of these pressures as they relate to treatment decisions. Dentists under these pressures can be enticed to perform complex dental procedures for which they lack the training and experience and/or treat patients quickly to generate greater revenue. Boards of dentistry are faced with the demands of adjudicating numerous and severe complaints filed against licensees. It is likely that the demands on dental boards to evaluate cases will continue to increase as dentists react to these pressures. Boards of dentistry must continue to insure they are capable of making decisions that benefit the public.

Dentists should know the standards of ethical behavior in their profession and develop an ethical base of practice. The Principles of Ethics and the Code of Professional Conduct, published by the American Dental Association, offers a good summary of ethical expectations of dental providers. As they communicate with patients, dentists need to be frank and clear concerning the course of treatment and proceed only with informed consent. Communication should be seasoned with compassion and understanding. The patient's health remains paramount and no harm should be rendered. An extremely simplified summary of dental ethics is doing the right thing at the right time for the right reason. Knowing and doing the "right thing" is predicated by the practitioner's base of knowledge and experience in all aspects of dentistry and its associated sciences. The "right time" is based on knowing the doctrine of patient autonomy, understanding the goals and needs of the patient, and reaching an agreement with the patient concerning the best course of treatment. The "right reason" concerns the underlying motivation of both the dentist and the patient, insuring that the treatment is correct for the overall health of the patient.

As with any transaction between humans, errors will be made and misunderstandings will arise in the course of dental treatment. Often issues can be resolved through caring communication. Occasionally the patient may feel they have been injured or their rights violated. This patient may choose to file a complaint against their dental care provider. With the complaint, the adjudication process of the state dental board begins. Complaints most often involve failure to meet standard of care, however, there are other allegations that can trigger a complaint and investigation. Examples include abuse by over treatment or aggressive behavior, abandonment, false or inappropriate advertising and promotion, inefficient equipment and sterility of facility, incomplete or false record keeping, complex cases undertaken by undertrained practitioners, substance abuse by dentists and dental auxiliaries, sedation errors leading to hospitalization or death, sexual allegations, fraud (particularly with government funded programs), wage complaints, and disputes between dentists and corporate owners.

Each state has its own specific laws and regulations that dictate the complaint adjudication process. What follows is a description of the process in South Carolina as an example.

COMPLAINT ADJUDICATION PROCESS

Figure 1 is a flow chart example outlining the investigative and adjudication process used by boards of dentistry. This figure was adapted from the South Carolina Board of Dentistry. All adjudication cases begin with a complaint. The Board responds with an investigation, review by professional committee, decision to dismiss or proceed, and preparation for sanctions if warranted.

COMPLAINT

A complaint against a dentist may be filed by another licensee, a patient, or any citizen. Complaints can be made for any purported violation of a state's practice act, standard of care, or infringement of a patient's rights. Complaint forms, available from the state dental board, must be fully completed, notarized, and submitted to the board's administrator. The administrator reviews the form for completeness and authenticity and authorizes an investigation.

INVESTIGATION

A professional investigator from the state's investigative and enforcement division is assigned to thoroughly analyze and process the complaint. The duty of the investigator is to interview the complainant, the respondent, and all witnesses to gather evidence and records concerning the complaint. The investigator proceeds in a timely manner to prepare a report for the investigative review committee.

REVIEW

The full complaint and investigative report is read and reviewed by the investigative review committee. The committee is comprised of two dentists, the board of dentistry administrator, investigators, and the board's prosecuting attorney. The complaint is discussed and a decision reached for management of the case. Possible recommendations include dismissal, issuance of a letter of caution, or advancement to a formal complaint against the respondent.

FORMAL CHARGES

Formal charges against the respondent are prepared by an attorney retained by the board of dentistry. A consent order is prepared, spelling out parameters and conditions for the offence. The consent order is delivered to the respondent, who may sign and agree with the parameters, or may request a hearing. The hearing may be before the full board or before a panel designated by the board.

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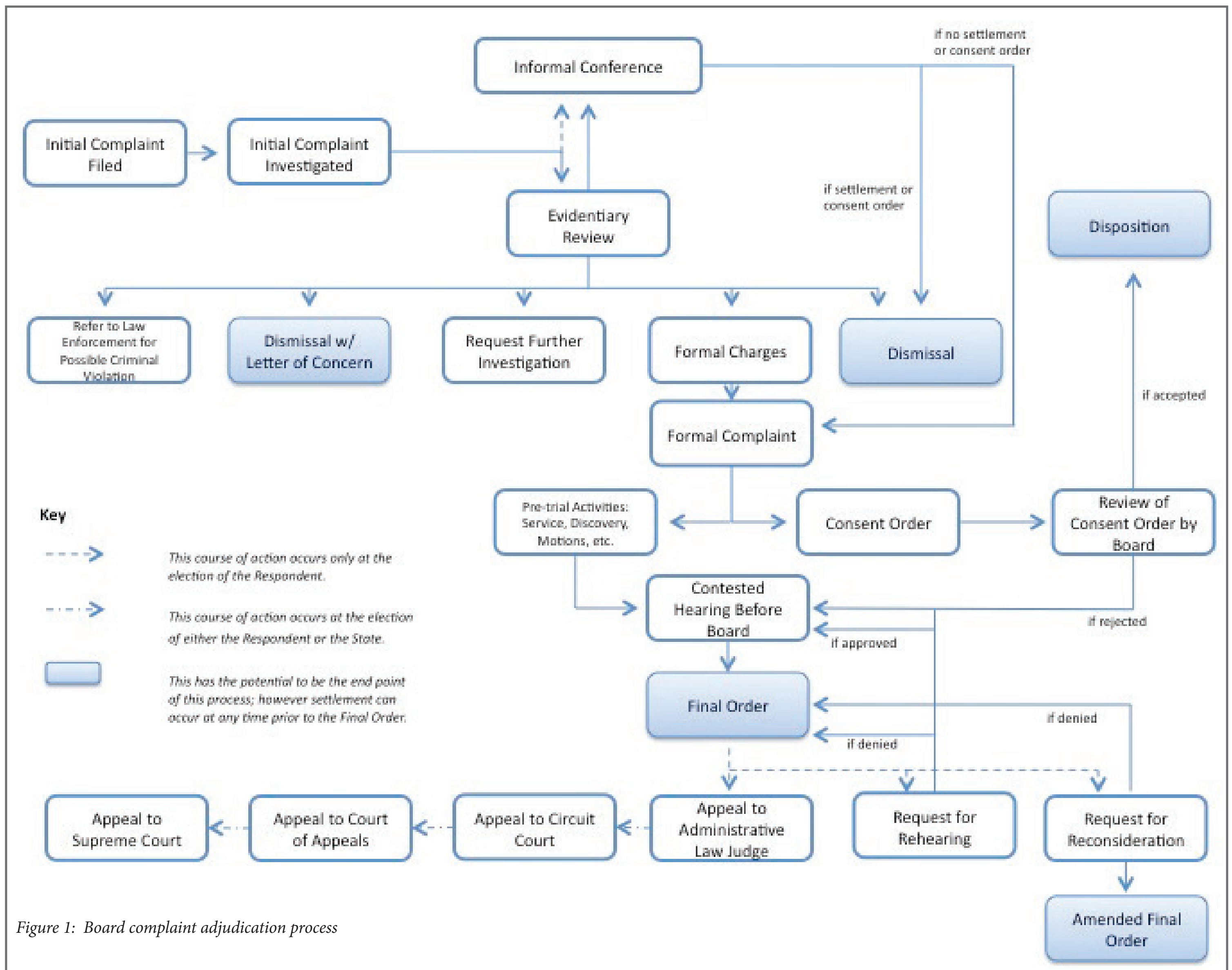

Figure 1: Board complaint adjudication process

Continued from page 27

HEARING

A complaint hearing is similar to a civil trial. The hearing is formal and serious, following a prescribed pattern. Board and panel members need to avoid interrupting the attorneys or chairman, thinking out loud, or pondering "what ifs", and showing favoritism or emotions.

SANCTIONS AND CONDITIONS

The board of dentistry may render varying degrees of sanctions against licensees:

1. Suspension of license – The suspension may be indefinite or for a prescribed period of time, followed by a probationary period. The board may grant a suspension that is stayed immediately followed by probation.
2. Reprimands – The board may issue a written reprimand to a licensee. The reprimand may be public or private and with or without a probationary period.
3. Guidance – The board may order additional training or remand the licensee for physical examination or psychiatric evaluations.
4. Restrictions – The board may restrict a licensee's controlled substance prescribing privileges or limit procedures that the licensee may perform.

Additional conditions that are part of the sanction may be fines of up to $10,000, ordered appearances before the board, random unannounced inspections, repetition of jurisprudence examination, and community service. The board must determine if the goal of its sanctions are reformation, punishment, or some combination of these. For boards of dentistry to remain effective, members should see it as their duty to know the dental code within their jurisdictions, to learn the complaint process, and to review these at least annually. Board members must be well versed in all areas of the dental profession and understand fully the gravity of their position as gatekeepers of the profession. The trust of the public in the ethical behavior of dentists often depends on how well boards examine and oversee the members of our profession. Boards must remain vigilant to their prescribed duties.

MEASURING ADJUDICATION

Dental boards should develop parameters to measure the effectiveness of the adjudication process. This will be a difficult task; however the public and the profession desire to know how well boards of dentistry are doing in the investigative, adjudicating, and enforcement of professional violations. Boards of dentistry should be able to document they are effective in protecting the public. Patients may expect restitution from the board adjudication process, only to realize that restitution can only come through filing suit in civil court. It is important to determine if justice is being achieved by the process.

SESSION 2: PANEL DISCUSSION – SUMMARY COMMENTS PREPARED BY DRS. WILLIAM J. BENNETT AND SARAH K. WILSON

CHALLENGES FACING DENTISTS AND ORGANIZATIONS

The dental profession faces many challenges today. Establishing and maintaining ethical and professional behavior is ever more complex now with legal, governmental, technological, educational, and promotional issues. The reputation of the dental profession and public welfare is at stake. A strong commitment to work together as a team is essential. The team comprises dental educators, ethical professional organizations, and state regulatory dental boards. This team is like a three legged chair. If one of the legs falls short the chair's function is altered in a negative manner.

The role of dental educators is teaching professional principles. Dental educators must attempt to instill the ideals of ethical conduct and professionalism in dental healthcare students. It begins in dental school and must continue in all the levels of dental continuing education. Educators should perform their roles in a professional manner as an example for students to emulate.

Recent graduates face unique challenges as they embark on their professional careers. Student debt tops the list. It adds to the financial pressures associated with finding a job and settling down. Educational costs, and resulting student debt, may serve to drive our profession toward the corporate dentistry model - which has both positive and negative aspects to it. It is changing and will continue to change the market, and this fact raises several questions. Is the corporate dentistry model creating an increase in ethical conflicts? Does increased debt load affect decision making regarding practice models selected and patient care delivered? Another issue is the patient-based portion of the licensure examination. Many question whether a high-stakes patient-based licensure examination offers enough certainty about the competence of the examinee to justify the ethical issues that such examinations raise - from both the student's and the patient's perspective.

The role of professional dental organizations is to maintain and promote professionalism and ethics within their membership. Members agree to abide by the standards set by the organization. The organization must uphold those standards. If these ethical standards are not practiced there should be willingness to call out the behavior.

The role of a dental board is to set the legal parameters of care and professional behavior within a state. Board members administer these laws. Having clear guidelines for regulation is essential for legal compliance. Rulings and statute interpretations should be consistent. Adequate regulations should be in place to ensure protection of the public.

The American Dental Association's Code of Professional Conduct and Principals of Ethics is the United States standard if not the world's standard for professionalism and ethics. Ethical and legal standards may not always be the same. However, the goal should be to provide the best possible care to the individuals we as dental professionals treat. Lessening of that goal is not in the best interest of the public or the dental profession.

In recent years, the Virginia Dental Association [VDA] and Virginia Commonwealth University School of Dentistry have made significant progress in improving ethical and professional awareness. The VDA has set up ethics committees in all state component societies, established a hearing procedure for ethical complaints, published ethics related articles in the VDA Journal, established an ethics section for the public and members on the VDA website, and participated in ethics presentations at the dental school. At the dental school an ethics program for 1st year students was established at the very beginning of their education. The White Coat Ceremony and ethics presentation occur prior to students' engagement in patient care. These efforts between the VDA and the dental school are cooperative and have been rewarding and productive.

In Virginia, collaborating with the Board of Dentistry has presented challenges related to public notification of board meetings. If more than two board members gather, it is considered an official meeting which requires public notice. This presents a barrier to meet to discuss and share ideas and plan collaborative activities. Open communication regarding the different issues facing each of the three team groups – the dental school, the VDA and the state board - is paramount. Differences between the groups may exist but a high level of dental care should be the obvious mutual goal. Some states have a planned conference to openly discuss, evaluate and improve issues relating to dental care. Professionalism and ethics is best served with cooperation of the three essential groups of the three legged chair.

SESSION 3: BREAK OUT GROUPS' REPORTS OF IMPORTANT LEARNING, RECOMMENDATIONS AND ACTION ITEMS FOR STAKEHOLDER ORGANIZATIONS

The responses of the break out groups to three questions are summarized in Table 1. In distilling all the submitted responses, we decided to include in the figure the top three themes that emerged from the written responses submitted.

The groups reported that important learning occurred in three key areas. First, attendees learned about the plight of new dental graduates, particularly regarding their level of debt and the impact of this debt on their choice of practice model. They also learned about the difficult employment opportunity landscape with more dentists and fewer patients. Second, attendees learned that professional behavior can be learned, that professional ethical development can and should occur across the professional lifetime and that supporting this development is envisioned by many as a shared responsibility among all stakeholders. Third, they learned about the "hidden curriculum" of values in dental education and in the licensure examination process, particularly the use of live patient examinations. This "hidden curriculum" teaches important, though often unintended, lessons about professional values. The same is true for ethical conflicts that arise for students in the live patient examination process.

The groups identified important issues for each of the key stakeholder organizations to consider. They suggested that dental schools make the climate for ethics foundational with the school, understand the hidden curriculum, and monitor the economics of dental education and entry into practice. Testing agencies were encouraged to replace live patient examinations with a good alternative, ensure that licensure examinations are fair, reliable and valid, and to collaborate with dental schools to develop a national licensure examination. Boards of dentistry were encouraged to emphasize their value to the profession in ways that emphasize "non-policing" roles of the boards, to communicate frequently and effectively with other stakeholder organizations and develop strong collaborative relationships with them, to institute ethics continuing education requirements for license renewal, and to develop methods to assess the ethical development of dentists after initial licensure. Finally, professional associations were encouraged to improve the climate for ethics, disseminate information about ethics courses to members, support professional self-regulation, increase awareness of ethical standards among members and assume a more active role in mentoring members in ethics and professionalism.

The groups also identified action items for stakeholder groups to consider. Most were suggested as collaborative efforts for stakeholder groups to take on in the interest of developing and supporting ethical dentists. They include: developing programs to mentor dentists and support their professional ethical development across the practice lifetime, requiring ethics continuing education for licensure renewal, improving licensure examinations, developing a national consensus about best practices in ethics education for dentists, raising ethical awareness in dental schools, and engaging state boards in a variety of ways as partners in developing and delivering ethics education in dental schools.

Continued on page 30

Continued from page 29

CONCLUDING REMARKS

The 59th Southern Conference of Dental Deans & Examiners was structured to engage participants from dental education, dental boards and dental associations in collaborative interactions aimed at making recommendations to enhance ethics and professionalism in dentistry. In some ways, it is not surprising that the major recurring theme that emerged from this meeting is a call for increased and improved collaboration among dental schools, dental boards, and dental associations to accomplish the task. The outcomes of this meeting suggest that difficult issues related to ethics and professionalism in dentistry can be discussed collaboratively, positively, and respectfully among stakeholders with diverse views and opinions on these issues and importantly that strategies for moving forward can emerge from these discussions. We offer them for consideration by the larger communities of interest.

In the conclusion of a review article examining findings of the Carnegie Foundation for the Advancement of Teaching's Preparation for the Professions Program, Colby and Sullivan (2008) suggested the following:

"When the work of institutions such as professional schools, accrediting and licensing bodies, national academies, professional associations, and other practitioner groups is grounded in the ideals and standards of the profession, these organizations can act as trustees for the integrity of the field, buffering it from the effects of market forces, that, if left unchecked, can be destructive to its standards, mission, and ultimately its standing as a profession at all."

If ever there was a time in the history of the dental profession when collaboration among all stakeholders was needed to protect the future of the profession, its ideals and its standards, the time is now.

*EDITOR'S NOTE:

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Dr. Sarah K. Wilson practices in Roanoke.

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ORAL HEALTH IN OLDER ADULTS:

A SURVEY OF LONG-TERM CARE FACILITIES IN VIRGINIA

Lyubov D Slashcheva, Dr. Julie M Coe, Dr. Patricia B Bonwell, Dr. Al M Best, Dr. Frank P Iuorno*

ABSTRACT:

Introduction: Meeting the oral health needs of older adults in Long-Term Care (LTC) settings means addressing unique challenges and disparities for this population. The Virginia Dental Association LTC Access to Care Work Group has begun defining and responding to these realities in Virginia. This study aimed to provide a baseline understanding of the status of oral health in LTC Facilities across the commonwealth.

Methods: We surveyed 239 LTC facilities on factors related to oral health findings within the Minimal Data Set (MDS), an existing tracking system in all LTC Facilities, practices regarding oral health evaluation and financing, and emergency room visit prevalence.

Results: (N=61 LTC Facilities) Reports of oral health measures in the MDS tend to be low and emergency room visit tracking is variable across facilities. LPN and RN staff are most likely to evaluate the oral health-related section of MDS. Many facilities do not frequently utilize alternative payment methods to finance routine dental services for their clients.

Conclusion: LTC Facilities have an existing infrastructure for detecting and responding to oral disease, but its effectiveness is low. Collaboration between oral healthcare and long-term care professionals will strengthen and improve LTC infrastructure for oral health evaluation and appropriate response to need.

BACKGROUND:

In Virginia, edentulism rates in adults age 65 and over have dropped from 29.4% in 1999 to 16.1% in 2012, with 58% of adults in 2012 reporting never having had a tooth extracted[1]; yet, roughly a third of the population still reports not utilizing dental services.[2] When older adults enter LTC facilities, they often present with existing oral health needs, perhaps as a result of decreased ability to access professional dental care in post-retirement years as well as decreased dexterity for adequate oral cleansing.[3] Especially for dentate individuals that have maintained oral health throughout their lifetime, daily oral hygiene and regular professional care is often most important in preventing disease; however, cognitive and medical decline in older adults complicates delivery of these services on a regular basis.[4]

To encourage these and other healthy support structures for older adults, the Centers for Medicare and Medicaid Services supplies a LTCF State Operations Manual that outlines regulations for licensure and recertification by surveyors. Mandates regarding oral health include free provision of oral hygiene supplies, assistance with regular oral hygiene, minimally annual oral health screening as part of the Minimal Data Set, and arrangement of routine, emergency, and referral dental services.[5] Despite an average list of 13.2 dental treatments indicated by a dentist upon admission[6], a major reported barrier to dental care utilization is lack of recognition of such a need and transportation to a lesser extent.[7] Another challenge to receiving regular dental care for Medicaid-covered Virginia LTCF residents is that only emergency extractions (and the associated diagnostic procedures) are covered services.[8] Under the Virginia Commonwealth Coordinated Care (CCC) Program, dual-eligible individuals—that is, those who are eligible for both Medicare and Medicaid—are offered dental benefits through Anthem Health Keepers, which include exams, cleanings, and radiographs, or through Humana, which includes an annual dental evaluation and cleaning.[9]

The Virginia Dental Association (VDA) has created a LTC Access to Care Work Group to improve the oral health of older adults residing in facilities across the state by launching a pilot intervention that employs oral healthcare professionals within the LTC setting to ensure regular routine oral care and make referrals to community dental

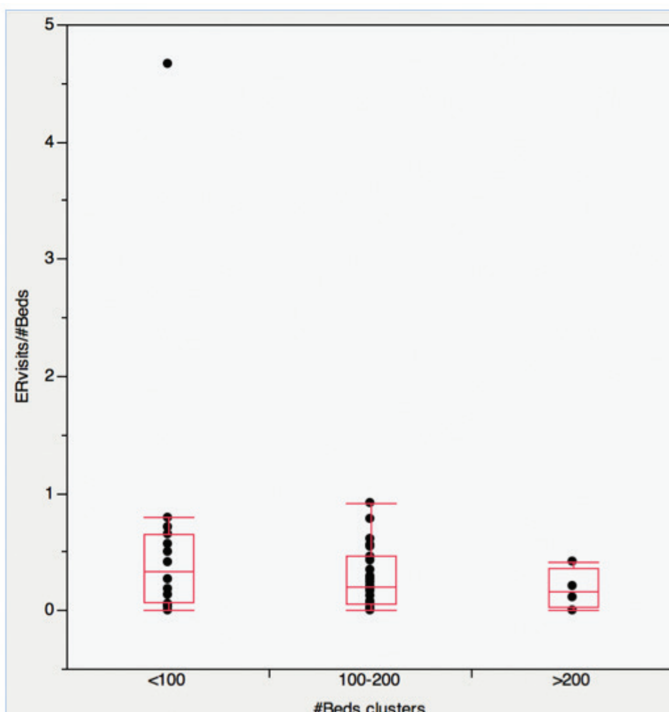

Figure 1: Emergency Room visits per facility size

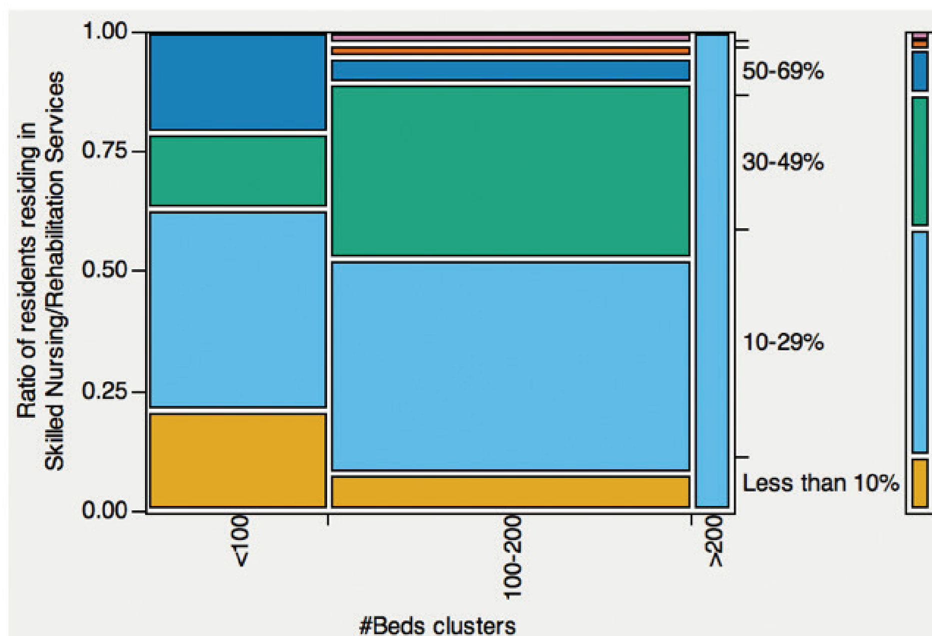

Figure 2: Proportion of residents in Skilled Nursing/Rehabilitation Services per facility size

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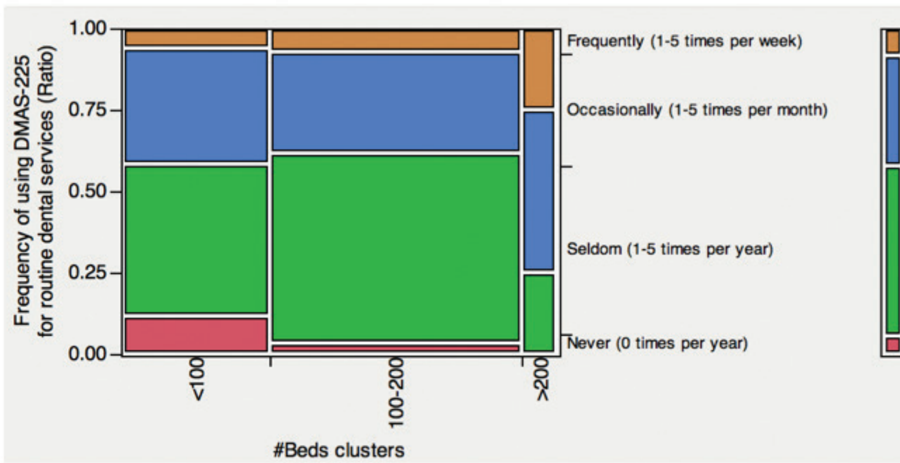

Figure 3: Frequency of using DMAS-225 alternative payment method for routine dental services per facility size

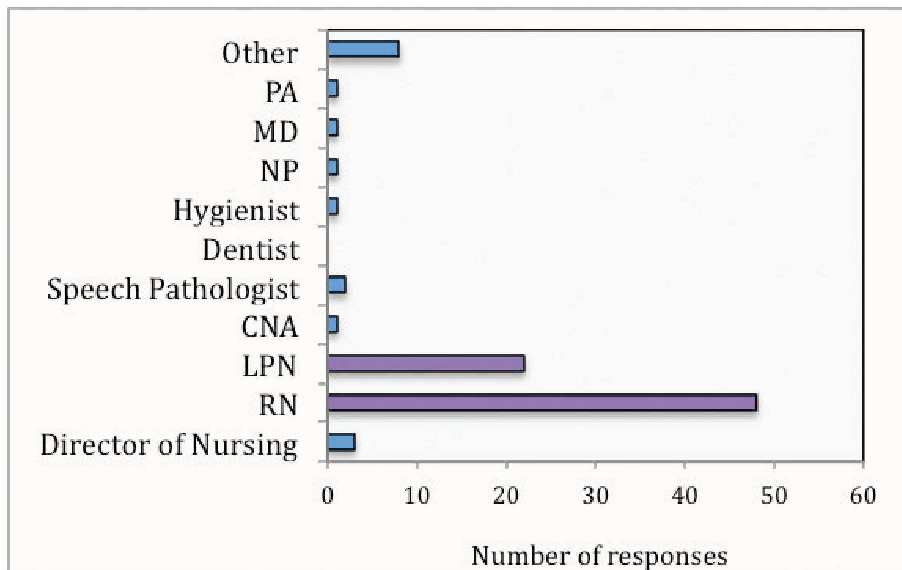

Figure 4: Staff members who administered the Oral Health Section (L) of MDS evaluations (multiple selections were permitted)

offices, drawing from proposed intervention models.[10,11,12] The pilot will be hosted by two facilities in Virginia to track results, especially savings achieved through preventive services and reduction of ER visits for untreated oral conditions; examples of these include aspiration pneumonia due to heavy plaque accumulation and dysphagia, oral abscesses due to tooth decay or gum disease, or fall-related tooth/gum injuries.

As this new model of dental care for institutionalized older adults is tested by the VDA LTC Access to Care Work Group, a baseline evaluation of the current oral health status and needs of LTCF residents in Virginia is indicated. We know of no statewide oral health needs assessment for LTC residents available to the public or the dental profession. This need is consistent with the purpose of the project described below.

DEFINITIONS OF TERMS USED:

- Though citations may use "nursing home" as a generic term for a variety of facility types, this study refers to **Long-Term Care (LTC)** *as inclusive of the full spectrum of residential services offered to older adults ranging from independent living, to skilled nursing/rehabilitation services.*
- Because Virginia Medicaid does not cover dental services, this study refers to an *alternative pay program* **termed Incurred Medical Expense (IME)**, or as referred to more commonly in Virginia, Patient Pay Adjustment using the **DMAS-225** form, which *allows for temporary re-routing of funds entering a LTC Facility to fund a service not routinely covered by that funding source (including optometry and dental care) if it is deemed "medically necessary" by a physician.*
- Each facility has the capacity to analyze Minimal Data Set information to identify how many individuals "**trigger**," or *are positive for a given field on the form.*

PROJECT GOALS:

The purpose of this study was to describe oral health needs in long-term care facilities in Virginia.

Specific Aims:

1. *Survey long-term care facilities across the state regarding the oral health needs of their residents.* These outcome variables serve as a statewide baseline that may guide future longitudinal studies.
2. *Analyze oral health needs as a function of facility characteristics.* These predictor variables allow elucidation of helpful recommendations and may guide effective allocation of resources/services.
3. *Create and present a report to the Virginia Dental Association Long-Term Care Access to Care Work Group*. This Work Group will use the data in determining how to best move forward with increasing access to oral healthcare for long-term care facility residents.

METHODS:

A retrospective cross-sectional study of long-term care facilities across Virginia in 2014 was conducted to evaluate oral health needs. Electronic questionnaires using REDCap, distributed to the members of the Virginia Health Care Association (VHCA) (n=239), a network of LTCFs to which over 90% of the state facilities belong, collected data at the facility level. The survey obtained LTCF characteristics, such as job title of respondent, size, region, payer type, average age of resident, who administers MDS oral health screenings, and prevalence of emergency hospital visits. The survey also asked LTCFs to utilize existing software within facilities to analyze current oral health status of their residents at the facility level: how many residents exhibited diagnosable conditions in the MDS. The questionnaire underwent review by a sample of VHCA members and in-kind contributors on the VDA LTC Access to Care Work Group to ensure clear language. The study was reviewed and approved by the VCU IRB and data was collected in February to March 2015, with reminder emails sent to non-responders. Data (n=61 survey responses) was collected and cleaned-up for use in descriptive statistics using JMP Pro 10, presenting distribution and trends of data.

RESULTS:

N= 61 LTC Facilities

Facility Characteristics:

The majority (66%) of responders were administrators of facilities (Table 1a). The majority of facilities (67%) represented identified for-profit status, a trend that is independent of facility size (Table 1c, distribution data not shown), and have an average of 120 beds, with some reporting fewer than 100 or greater than 200 beds (Table 1b). Facility size by the number of licensed beds was used as a cluster measure to evaluate relationships with other variables. We collapsed facility bed sizes by small

Continued on page 36

Continued from page 35

(fewer than 100 beds), medium (100-200 beds), and large (more than 200 beds). Most of the facilities in our sample size were in the medium size designation, and our sample size contained the least number of facilities in the large facility designation. The majority of residents were 80-84 (49%) followed by 75-79 (22%) (Table 1f), while one facility provided services to residents who were nearly all under 30 (90%) (Table 1e).

Emergency visit reporting
ER visits were reported per cause (oral health-related, fall-related, pneumonia, other) but were collated into one Total ER Visits measure due to variability in reporting. This outcome was measured as a ratio of facility bed capacity to enable reporting of a value that is comparable across facility sizes. A trend is seen that the average ER visit/Beds value is slightly lower (0.18 +/- 0.18) in larger facilities than medium facilities (0.28 +/- 0.28), while one small facility reported a much higher ER visit/Beds value than any other facility, causing the small facility average ER visit/Beds value to be higher (0.61 +/-1.11). The box and whisker plot demonstrates the median value and spread of the data (Figure 1).

Distribution of residents in Skilled Nursing/Rehabilitation Services
Figures 2 and 3 are mosaic plots, representing the distribution of our sample into three facility size categories by width and the outcome variable by height; the legend to the right represents an average of the outcome variable independent of facility size. Small facilities serve a greater proportion of residents in Skilled Nursing/Rehabilitation Services than medium or large facilities, while large facilities serve less than 30% of their residents in these settings (Figure 2).

Medicaid usage
The approximate resident Medicaid utilization rate was reported at 61.2% with a trend for larger facilities reporting slightly higher utilization rates (Table 1d, trend data not shown).

Alternative payment practices
A majority (~75%) of large facilities utilize DMAS-225 alternative payment methods to finance routine dental services frequently (1-5 times a week) or occasionally (1-5 times a month) as opposed to less than half of medium and small facilities utilizing the same service with those frequencies; more than half medium and small facilities seldom utilize the method, while only 25% of large facilities report seldom using the resource (Figure 3).

MDS Data collection process and outcome
Though Dentist, Dental Hygienist, and Speech Pathologist were options on the survey, reported data indicates that RN (48) and LPN (20) staff administer the oral health-related fields of the MDS more than staff in any other position (purple bars in Figure 4). Reported values for the number of residents triggering for components of Section L (Oral Health) of the MDS tend to be low as seen in figures 5.B-G (suggesting low incidence of these conditions), whereas conditions that are commonly diagnosed and recorded in patient health records exhibit more distributed reported values (Figure 5).

DISCUSSION:

Study limitations
Data analysis with responses from a modest sample size describes the source facilities and their infrastructure for collecting and capability for reporting oral health data and related ER visits. Though inability to demonstrate trends with significant p-values due to the small sample size is a limitation of this study, it also reinforces the purpose of the study as a pilot statewide survey seeking a baseline of oral health needs in LTC residents. Actual survey measures that might serve as a statewide baseline exhibit substantial variability in the way that facilities collect and report measures, so descriptive findings about oral health evaluation and response capacity provide more compelling insight. Facility characteristics such as geographic distribution were not collected, so it is unknown if our sample is representative statewide or if non-responders have increased oral health needs. Data collected and reported in this study was on the facility level, though investigation of oral health needs in Virginian older adults is currently in process.

Facility characteristics
Facility administrators were the primary responders to our survey, perhaps representing interest and ownership of improving oral health in the facilities they manage; however individuals in such a high-level position may be less familiar with retrieving survey points such as MDS and ER visit data. The majority of residents were reported to be aged over 80 years of age, falling into the "elder old" category, which often experiences more chronic disease morbidity and risk for falls and infections (like aspiration pneumonia) and a decreased ability for independence and recovery; acknowledging the reality of such a high-risk, high-maintenance demographic, the described study and overall VDA initiative and overall engagement of dentists and dental hygienists in this topic is timely and appropriate.

Emergency visit reporting
Dental-related ER visits are known to be very costly to public programs and usually do not resolve the underlying etiology of the chief complaint.[13] As reported in Figure 1, there is no significant difference in ER visits per bed between facilities accommodating fewer or more beds, though a trend is seen that the average ER visit/Beds value is slightly less in large facilities, perhaps reflecting that larger facilities may have more rigorous ER visit prevention strategies and/or a more diverse (and proportionally healthier) population of residents as opposed to smaller facilities that may provide services to residents with more ailments.

Distribution of residents in Skilled Nursing/Rehabilitation Services
Figure 2 indicates that large facilities tend to service residents in skilled nursing/rehabilitation service to a lesser extent than facilities accommodating fewer beds. This could reflect a wider diversity of health/independence represented in large facilities, perhaps adding a higher proportion of individuals that are more ambulatory, independent, and generally more healthy, rather than a greater proportion of less independent and more medically complex individuals residing in medium and smaller facilities.

Alternative payment methods
Patient Pay Adjustment using the DMAS-225 alternative payment provision that temporarily reroutes a resident's income from general facility income to finance services deemed "medically-necessary" by physician order that are not normally covered by insurance or income of the resident was reported as being utilized for routine dental services. A number of factors may allow larger facilities to utilize the DMAS-225 form more frequently, including additional administrative staff that facilities accommodating more beds have for accessing and utilizing this alternative payment method, being more informed of such options, and functioning in more administratively efficient ways than smaller facilities. A previous VDA LTC Access to Care Work Group survey found that while some facility administrators were aware of this alternative method of payment, the majority would be interested in instruction on how to utilize it for financing dental care. A major challenge with utilizing this system remains accuracy; of 987 replies in a DMAS project evaluating which enrollments were correct, 69% were not correct.[14] Though the Department of Medical Assistance Services offers training resources for utilizing submitting the DMAS-225 form,[14] jointly training both community dentists receiving patients under this provision and facility staff processing the payment would be helpful. The American Dental Association has also offered a "how-to guide" on utilizing Patient Pay Adjustment programs for oral healthcare provision to LTC residents.[15]

MDS Data collection process and outcome
Perhaps the most compelling finding of the survey is that a majority of facilities indicate that RN and LPN staff administer the oral health section of the Minimal Data Set, whereas licensed primary care providers (MD, NP, or PA) or oral healthcare professionals (DDS or RDH) are barely represented as being involved in the task

(Figure 4). None of the facilities surveyed reported having a dentist (who would be most competent) complete this evaluation, suggesting difficulty recruiting dentists from the community and recognizing the value of trained oral health professionals. This finding is not a call for bringing more dentists into LTC settings for administration of oral health-related MDS findings; however, it is a call for equipping RN and LPN staff who are rendering the evaluation with adequate training in recognizing oral health and oral disease. Various training programs [16] have already been offered in collaboration with organized dentistry and LTC organizations and some facilities have incorporated oral health topics into new staff orientation materials. In collaboration with the American Dental Association and the American Health Care Association the University of Pacific has developed an MDS Oral Health Assessment Tool for Nurses with an interactive video of less than 15 minutes training on administering the MDS Section L pertaining to oral health; they also offer an expanded training program titled "Overcoming Obstacles to Oral Health: A Training Program for Caregivers of People with Disabilities and Frail Elders".[17] In its 5th edition, this is an excellent resource for equipping Direct Support Staff and caregivers to become competent advocates for oral health in LTC settings.

MDS reported findings (Figure 5) per category indicate that oral health findings score low in incidence with substantial variability in some categories (B, H) when compared to MDS data representing a diagnosis in dementia (I) or diabetes (J). Incidence of dementia in residential care communities has been reported as 42%[18] and diabetes rates are about 25% in nursing home residents[19]. In comparison, the percentage of LTC residents with untreated oral needs ranges from 80% to 96%.[20,21] The MDS dataset obtained in this study would not confirm these observations from the literature. This could be because diagnosed conditions such as diabetes and dementia are easy for staff administering MDS evaluations to retrieve from the medical chart but this capability does not seem to be present for oral health conditions and may suggest gaps in oral health care that LTC residents are receiving, and limited participation of oral healthcare professionals in LTC settings.

CONCLUSIONS:

The Virginia Dental Association acknowledges the challenges that LTC settings experience with providing oral health services to residents. In response, a LTC Access to Care Work Group is facilitating a pilot inclusion of a dental hygienist and assistant in two Virginia facilities to increase access to preventive services, daily oral care, and coordination of referrals. Though the study described in this report aimed to offer statewide baseline measures of oral health in LTC Facilities, findings reinforce the need for such investigation and the VDA's initiative to continue.

Emergency room visits, especially those resulting in hospital stays, are very expensive, a health risk, and a quality of life detriment for LTC residents; current tracking of the causes of ER visits is not consistent across facilities and may be improved to identify preventive strategies, notably those relating to oral health disease prevention.

Continued on page 38

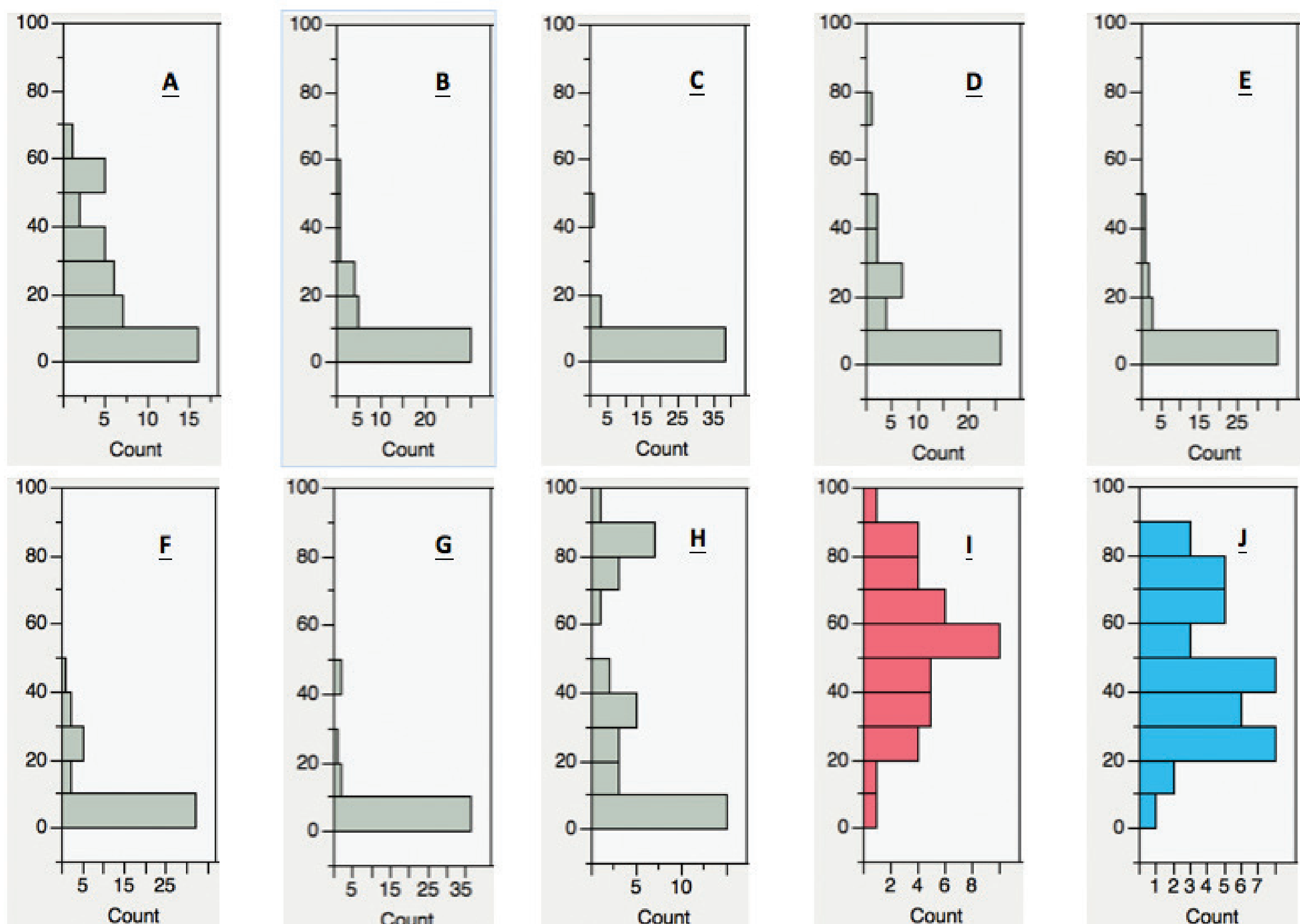

Figure 5 A-J: The y-axis represents the percentage of residents that triggered for a given Minimal Data Set measure in Section L (Oral Health) and two common diagnosable conditions. The x-axis represents the number of facilities responding within that range of trigger prevalence.
A: Broken or loosely fitting full denture (chipped, cracked, uncleanable, or loose)
B: No Natural teeth or tooth fragments
C: Abnormal mouth tissue (ulcers, masses, oral lesions, including under denture or partials if worn)
D: Obvious or likely cavity or broken natural teeth
E: Inflamed or bleeding gums or loose natural teeth
F: Mouth or facial pain, discomfort or difficulty chewing?
G: Unable to examine
H: None of the above were present
I Diagnosed with Dementia
J: Diagnosed with Diabetes

Continued from page 37

Appendix: Tables and Figures

Table 1: Characteristics of Participating Facilities

Characteristics of Participating Facilities (n=61)	
a. Survey responder	Percentage
Administrator	66%
MDS Coordinator	3%
Director of Nursing	10%
Social Worker	13%
Director of Social Services	7%
Other	2%
b. Number of nursing facility/skilled nursing facility beds in facility	Mean (STD)
	120.62 (58.18)
c. Business model of facility	Count (Percent)
For-Profit	41 (67%)
Not-For-Profit	18 (30%)
Other	2 (3%)
d. Approximate Medicaid utilization of residents	Percent (STD)
	61.2% (20.49)
e. Approximate percent of residents under age 30	Percent of facilities—percent <30yo
	2%--90%
	98%--100%
f. Excluding residents under 30, average age of residents	Percent
55-59	0%
60-64	0%
65-69	7%
70-74	5%
75-79	22%
80-84	49%
85-89	12%
Over 90	5%

Distribution of residents served in Skilled Nursing/Rehabilitation Services suggests that some facilities carry more disease burden in their resident population than others, requiring programs to manage and prevent oral disease. Financing is integral to such programs; training on DMAS-225 alternative payment methods is a necessary component of equipping facilities to be fiscally able to refer residents for indicated oral health services. This study demonstrates that training and support of staff supervising MDS evaluations is necessary for identifying and responding to oral disease in its early stages.

Presented to the VDA LTC Access to Care Work Group and the Virginia Health Care Association, a summary report of this investigation may be used in both organizations' initiatives. This study has illuminated several weaknesses in the way oral health is evaluated and the ability of LTC Facilities to respond to any identified needs. Strengthening the infrastructure in LTC Settings for accurate oral health surveillance and appropriate response capacity will occur best as a partnership between oral healthcare professionals and long-term care professionals. Such collaboration, as demonstrated by the VDA and VHCA, will further oral health of older adults in LTC settings across the state.

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OTHER RESOURCES FOR FURTHER READING/EQUIPPING:

http://www.dentistrytoday.com/practice-management-articles/long-term-care/1378

RN Association in Ontario resources for evaluation and training: http://ltctoolkit.rnao.ca/resources/oralcare

http://www.nbc29.com/category/175568/video-landing-page?clipId=11451524&topVideoCatNo=82958&autoStart=true

http://www.newsplex.com/news/local/headlines/Effort-to-Improve-Dental-Care-for-Senior-Citizens-302232061.html

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The pilot project has been generously funded by the American Dental Association, Altria Companies Employee Community Fund and the Dental Trade Alliance Foundation. ■

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VDA 2016 LEGISLATIVE INITIATIVES

Laura Givens, VDA Director of Legislative & Public Policy

NON-COVERED SERVICES LAW DE MINIMIS CLAUSE AMENDMENT:

Solution to Dental Plans Covering Small Percentages on Specific Procedures

The 2010 General Assembly passed non-covered services (NCS) legislation that was intended to ensure that dental plans could not mandate fees for procedures for which they are not paying. Legislators supported the legislation as they believed the practicing dentist should maintain some level of financial control over the practice through billing those not insured appropriately (meanwhile, the fees agreed to by dentists for covered services remained in place).

Since the passing of the legislation in 2010, there have been examples of dental plans covering only a small percentage of specific procedures – to effectively skirt the law and disingenuously claim it is covered. This practice is not being implemented yet in any sort of widespread fashion, but the VDA felt it appropriate to proactively close the loophole now rather than wait until there is a real problem.

The solution is typically referred to as a "de minimis clause" – similar provisions have already been enacted in several states and, when passed, should serve to deter plans from playing games with the intent of the 2010 law. The legislation as drafted will be patroned by Delegate Lee Ware, who carried the House version of the original bill, and it simply adds the underlined and bolded language: **Reimbursement payable or paid by a dental plan for covered services shall be reasonable and not provide nominal reimbursement in order to claim that services are covered services under the applicable dental plan. For purposes of this subsection, "reasonable" means the negotiated fee, rate or reimbursement methodology that is set forth in the participating provider agreement and is acceptable to the provider.**

This is a very important piece of legislation and is proof positive that our membership is both thoughtful and proactive when making sure insurance companies are held accountable for following both the letter and intent of the laws in the Commonwealth.

LEGISLATION TO AMEND THE MOBILE DENTAL CLINIC REGULATIONS

In 2010 Delegate John O'Bannon introduced legislation at the VDA's request directing the VA Board of Dentistry to make permanent regulations already in place governing the operation of mobile dental clinics. The bill passed both houses unanimously.

You may recall that the original bill was passed to corral the for-profit out of state groups from coming in and 'cherry picking' at schools doing just basic things (exam, x-rays, cleaning and fluoride treatments) and then turning the child over to a local dentist with little, if any, direction for follow-up treatment. The 2010 legislation forced operators of mobile dental clinics to find dentists to treat the kids in need of treatment and had them held to the same standard as a fixed base dental office. Prior to the legislation becoming law, the for-profit groups were doing the initial screening, etc. but the kids (many of whom were on Medicaid) needed additional care and showed up at a dental office without the x-rays (or other examination paperwork) – at which point their 'new' dentist ended up having to retake x-rays sometimes and do a new exam (required under law) which means Medicaid was paying twice for the same services- not fair to the child, their new dentist or the public.

The law has worked well except in one important situation -- 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 receive the necessary care. These dental clinics already are part of a fixed-base clinic that have mobile units to initiate treatment for kids in their unit and then get them to regularly receive treatment at their clinic -- clinics that have actual buildings with addresses (unlike the out of state crowd that was mobile only). We do not feel there is any need to have to register as mobile dental clinics – it's simply not necessarily when the core of their operation is a fixed address and the mobile units simply facilitate service – especially in rural areas.

This legislation fixes this issue by adding an exception to the registration requirement for: 1) Federally Qualified Health Centers (FQHCs) 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. Delegate Bobby Orrock from Caroline and Spotsylvania will be introducing this legislation.

REQUESTS FOR BUDGET CONSIDERATION

- **Fully Fund Medicaid Income Deferral for Virginia's Dentists**
  The 2014 General Assembly unanimously passed legislation which enabled the Virginia Retirement System (VRS) to establish a pilot program whereby dentists that take Medicaid patients – through the Smiles for Children program – could deposit a small portion of reimbursed Medicaid payments into tax-deferred VRS 457 Deferred Compensation Plan. Most states limit participants under 50 years of age to $17K annually and above 50 to $22K annually.

  The legislation (specifically HB 147-O'Bannon & SB 412-Hanger) is designed to ensure ongoing access to oral health care by giving dentists an additional incentive to maintain current service levels in the Medicaid Smiles for Children program. As has been done in several other states, this objective would be achieved by allowing them to defer paying taxes on limited amounts of Medicaid income through a VRS account. The legislature felt it was an "out-of-the box" solution during tight budget times – designed to ensure the continuity of the program and ongoing access to oral health care, especially in the areas of the Commonwealth that need it most.

Continued on page 41

Continued from page 40

VRS worked with the Virginia Dental Association (VDA) and other stakeholders on the legislation and in those discussions VRS requested a delayed effective date of January 1, 2015 which is in the bill along with a five year sunset provision. Unfortunately, DMAS, which originally levied a $50,000 fiscal note on the legislation prior to passage (it passed nonetheless despite the budget woes at the time) has subsequently concluded that the impact is $500,000+. We are unclear as to the specifics of that estimate and understand that in other states the costs has not been anywhere close to that number. No matter as a result of that note the program has stalled until it is funded – and that opportunity exists as your team puts together the next biennial budget.

The VDA has asked the McAuliffe Administration to fully fund the program.

- **Missions of Mercy (MOM) Project -- $100K in Both Years ($200K total)**
  Despite the program's success and accolades, funding uncertainty remains a serious challenge that inhibits our ability to invest for the long-term and ultimately serve more patients. In addition to the vital grant funds that Virginia Department of Health has provided (the funding has been cut in recent years), the MOM program has been supported by tremendous in-kind contributions of professional services, grants, and other contributions. In most years the majority of our operating funds come from corporate and foundation grants, many of which are initial, one-year awards. While we continue to work to broaden the foundation of support, the cyclical nature of such grants leaves much speculation about whether they will continue in future years and have the team scrambling for funds instead of investing in patient care and program operations.

  Further exacerbating the funding problem, many of the long-time sponsors are becoming less dependable for various reasons. While the communities in which MOM serves dearly need to be able to rely on the presence of MOM's annual services, our team needs to be in position to plan for the future by having a level of funding that is certain. For these reasons we are requesting an additional $100,000 in each year of the biennium ($200,000 total) for the project.

Note: The VDA has asked the McAuliffe Administration to consider both of these proposals and add them to his introduced biennial budget, which was unveiled in December.

TAKING ACTION

VDA members and VCU dental students will be visiting the General Assembly on January 22nd for the annual VDA Legislative Day on the Hill, where they will address these issues and advocate for support of our legislation.

YOUR VOICE CAN AND WILL MAKE AN IMPACT. As always, we encourage your participation in expressing concern about these very important issues to your legislators- make a phone call, visit their offices, and send them information on the issue. Please contact Laura Givens at 804-523-2185 or givens@vadental.org with questions, concerns and updates on the progress of these bills. Thank you for your interest and efforts! ■

ARE YOU RELEVANT IN THE ELECTION PROCESS?

Bruce Hutchison, D.D.S.; Chair, ADPAC; Chair, VADPAC

Do you matter- do you make a difference? The pyramid below clearly shows how simple it is to make a difference. Did you realize that of everyone qualified to vote (citizens 18 and older) only 65% of those eligible even bother to register to vote? Dentists, even as well-educated as we are, do only slightly better at 69%. Statistics show that for the past five Presidential election years, an average of 53% of registered voters actually voted. Substantially fewer people are "engaged," or bother to meet with or write their legislators and even fewer contribute to candidates, either through a PAC or personally. Isn't it interesting that by registering to vote, voting, becoming involved with or contacting your legislators and contributing to VADPAC- you become one of the most influential people in the United States! It isn't difficult- and your voice can be heard. You can make a difference! Remember to contribute to VADPAC when you pay your VDA dues.

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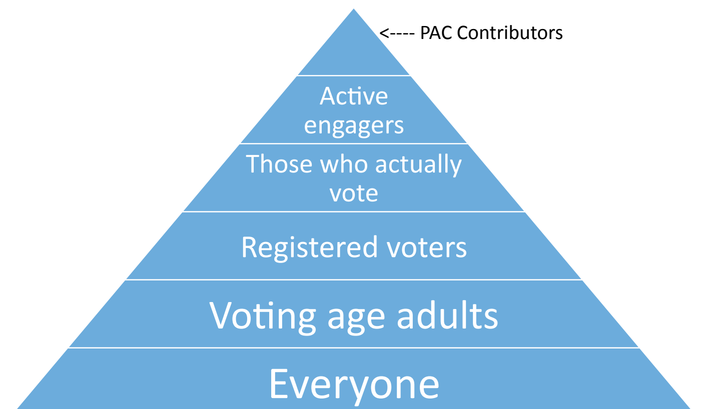

VADPAC FUNDRAISERS

DELEGATE LEE WARE IN MIDLOTHIAN

Dr. Jim and Mrs. Gloria Keeton hosted a VADPAC fundraiser for Delegate Lee Ware at their home in Midlothian on September 22nd. For nearly 20 years, Delegate Lee Ware has represented the 65th district in the Virginia General Assembly, which includes parts of Chesterfield, Goochland, Powhatan and Fluvanna counties. He has been a determined public servant and leader that we can count on to advocate for common sense solutions facing our Commonwealth generally and our healthcare delivery system specifically. This event was a great opportunity for VDA members to thank him for his hard work.

DELEGATE TIM HUGO IN CENTREVILLE

On September 23rd, Dr. Bruce and Mrs. Nancy Hutchison hosted a VDA fundraiser for Delegate Tim Hugo at their home in Centreville. Delegate Hugo represents the 40th district in the Virginia General Assembly and has shown steadfast leadership on many important issues facing our Commonwealth, not the least of which is his unwavering support of small business owners and commitment to maintaining a business-friendly climate in all corners of Virginia. Dentists, friends and family from his district and surrounding areas were happy to attend to support Delegate Hugo in September and to have the opportunity to thank him for his hard work in the General Assembly.

SENATOR DICK SASLAW IN CENTREVILLE

Dr. Bruce and Mrs. Nancy Hutchison hosted another successful VADPAC event for Senator Dick Saslaw at their home in Centreville on October 20th. Senator Saslaw represents district 35 in the General Assembly and he has worked tirelessly in his position for nearly 40 years on behalf of the citizens in his district. VDA members, family and friends gathered at this event to express their appreciation and help ensure that he remains firmly in the middle of key negotiations in Richmond.

DELEGATE CHRIS JONES IN SUFFOLK

VDA members and guests gathered on October 21st to thank Delegate Jones for his hard work through the years. Dr. Jim and Mrs. Barbara Baker hosted the event at their home in Suffolk and Dr. Ralph Howell chaired the fundraiser. Delegate Chris Jones represents the 76th district in the Virginia General Assembly, which covers part of the South Hampton Roads area. As a small business owner (pharmacist) and committed healthcare professional himself, Chris truly understands the structural and fiscal challenges our profession faces on so many fronts. This special event at the Bakers' home was a great opportunity for VDA members, family and friends to join and express their appreciation to Delegate Jones for the work he has done as a thoughtful and tireless leader since he took office nearly 18 years ago.

VADPAC APPRECIATES VDA MEMBER INVOLVEMENT IN STEERING COMMITTEES TO MAKE THESE FUNDRAISING EVENTS SUCCESSFUL.

40 UNDER 40

DR. ELIZABETH C. MILLER

I give my patients "sleepy juice," not shots. I use "tooth pillows," not mouth props. My saliva suction tool is affectionately called "Thirsty Thelma." Yes, creativity is important when your patient is four years old.

VADPAC UPDATE

Laura Givens, VDA Director of Legislative & Public Policy

Total Contributions: $353,774

2015 Goal: $375,000

Congratulations to Components 2, 3, 4 and 6 for meeting your goals!

Component	% of 2015 Members Contributing	2015 VADPAC Goal	Amount Contributed to Date	Per Capita Contribution	% of Goal Achieved
1 (Tidewater)	28%	$45,500	$36,587	$240	80%
2 (Peninsula)	**34%**	**$27,500**	**$31,220**	**$326**	**114%**
3 (Southside)	**32%**	**$14,000**	**$20,415**	**$245**	**146%**
4 (Richmond)	**35%**	**$67,750**	**$71,035**	**$291**	**105%**
5 (Piedmont)	31%	$30,000	$24,315	$261	81%
6 (Southwest VA)	**41%**	**$25,250**	**$26,895**	**$390**	**107%**
7 (Shenandoah Valley)	33%	$30,000	$25,035	$279	83%
8 (Northern VA)	26%	$135,000	$117,772	$310	87%
Other Contributions			$500		
TOTAL	**31%**	**$375,000**	**$353,774**	**$293**	**94%**

TAKE POLITICAL ACTION FOR YOUR PROFESSION IN 2016

The challenge is to surpass a new goal of $375,000 this year! Why are these contributions so important??

The 2016 Virginia General Assembly begins their session this month. The VDA has several very important initiatives including an amendment to the 2010 non-covered services law, an amendment to the 2010 mobile dental clinic registration law and two budget requests- for MOM funding and for funding to help implement the Medicaid Deferred Compensation Program. More information on all of these issues can be found in this Journal.

Your involvement in VDA legislative efforts in 2016 is imperative. We encourage you to visit with your legislators on the Hill regarding the issues mentioned above. Also, send in your contribution to the Virginia Dental Political Action Committee (VADPAC), if you have not already.

You can make a contribution when paying your VDA membership dues or contact Laura Givens at 804-523-2185 or givens@vadental.org for more information on how to become more involved in VADPAC efforts. YOU can make a difference by effectively advocating for your profession.

VADPAC appreciates all contributors but wants to especially recognize those who have gone above and beyond the ordinary and, as such, should be acknowledged for their remarkable and generous contributions. VADPAC helps protect your practice and your ability to provide exceptional care to our patients. The following are recognized for their generous contributions.

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CREATE OPPORTUNITIES TO INCREASE REFERRALS

Bernie Stoltz

There are two types of marketing – internal and external. When done correctly and consistently, both can attract new patients to your practice. But of the two, internal marketing can bring you more of the type of patient you are looking for and they come to your practice with a foundation of trust already established.

Increasing referrals starts with building a practice full of patients who are happy with their clinical outcomes and their experience at your practice. Every patient contact is an opportunity to create a "wow" experience. And the more you "wow," the more motivated your patients will be to prove they "like" you by sharing their experience with friends and family and posting positive reviews online. A certain percentage of happy patients will proactively refer friends and family, which is great. But even better is to have a consistent and purposeful system within the practice, so all patients know you welcome and encourage referrals.

Get Comfortable

Every team member should feel comfortable asking for referrals. And in fact, they should feel it is part of their job responsibilities. Some may be uncomfortable asking patients for referrals and positive online reviews because they view it as asking patients for a favor. This is backwards thinking. If your team is 100% convinced the care and experience you provide is second to none, then they should view referrals as patients doing their own friends, family and colleagues a favor by connecting them to an incredible practice where they will get exceptional care.

Create Natural Opportunities

Every one of your patients should be aware you would like them to be an advocate and referral source for your practice. But, not every patient in your practice should be asked to refer friends and family. Yes, you read that correctly. If referrals are a system within the practice, a request for referrals should be included in all patient communication where it makes sense, like e-newsletters, new patient literature, and on your web and social sites. You can also place displays throughout your practice to encourage referrals (CareCredit has a great Referral Kit you may want to check out!). But, save proactive and personal requests for the right patients and for the right time.

The "right" patients are those who represent the type of new patients you'd most like to attract because people tend to know and refer people who are like them. These could be patients who belong to the same company, the same community or share similar behavioral characteristics such as a desire to achieve oral health. These patients are your connectors, your advocates. When you ask for referrals, make sure they know you appreciate them and consider them valuable to your practice.

> *"Mrs. Jones, we love having you as a patient at our practice and appreciate your trust in us. If we haven't mentioned it before, I want to make sure you know we would love to serve your family and friends as well because they are probably great patients just like you are. May I give you a few referral cards you can give to those you think might want the same level of care we provide you?"*

You can also recognize patient "anniversaries" – the date of the patient's first appointment at your practice – with a call, card or note of thanks and a referral request.

> *"Mrs. Jones, did you know today is our anniversary? Yes, it's been four years since you first came to Dr. Smith and we want to thank you and let you know how much we appreciate you! We would love to have a practice filled with patients just like you, so if you know anyone looking for a dental home, please know any friend of yours is a friend of ours."*

The "right" time and the best opportunities to ask for referrals is when you observe patients leaving your practice healthy and happy. Some of these opportunities happen naturally as patients compliment you, your team and your practice as they are checking out.

> *"Mrs. Jones, that is such a nice compliment. We work hard to treat you the way you deserve to be treated. And we appreciate patients like you. In fact, we'd love to have more patients like you. May I give you a few referral cards to give to family and friends?"*

You can also create these "natural" opportunities by seeking out compliments and proactively asking patients about their experience as they leave the practice. If they are complimentary, affirm their value to your team and ask for the referral. If they are not complimentary, take the feedback as constructive criticism and take the steps necessary to improve the areas they may have found less than satisfactory.

> *"Mrs. Jones, it was nice seeing you today. May I ask – how did we meet or exceed your expectations today?"*
>
> *"Well, I do have to say, Jane your hygienist was especially kind and sweet today."*
>
> *"You know, a lot of patients say that about Jane. And it makes us happy to hear how happy she made you. As you know, hygiene is very important to your oral health. If you have any friends or family who want to keep their teeth for life and may enjoy Jane as much as you did, we have referral cards you can give to them. Would you like a few?"*

Always Say "Thank You" at Least Twice

When patients refer friends, family and colleagues, it is an overt display of trust and advocacy – and you should celebrate it. A personal thank you is a must. When a new patient schedules their first appointment, always ask, "Whom may we thank for referring you to Dr. Smith?" Then immediately pick up the phone and call the referring patient.

> *"Mrs. Jones, it's Tonya from Dr. Smith's office. A friend of yours, Mr. Carter, just set up his first appointment and he told us you referred him! Mrs. Jones, thank you so much for giving us this opportunity to take care of one of your friends. We appreciate it – and we appreciate you!"*

Then, send the referring patient a thank you card or note and put a reminder in their file to thank them again the next time you see them. You may even want to host a "friends and family" event once a year where you celebrate all the patients who have referred others to your practice. Referrals are truly the highest compliment patients can give you. And they certainly can motivate your entire team to continue to excel, continue to provide a "wow" experience and continue to attract and retain patients as amazing as they are.

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THE TRIPLE THREAT DENTAL PRACTICE

By: Dr. James R. Schroeder

Definition: "Triple Threat" – noun; an individual who is expert or adept in three fields or skills, i.e., a football player skilled at running, passing, and kicking.

Reflecting on 35 years of experience in practice as I now engage with other practices with transitions and in business growth and development, sustaining a thriving practice involves change. A change that seems to evolve over time like our patients, the business and economic climate, and the industry we represent. The image that comes to mind is that multi-talented athlete that brings a high level of skills to the team-running, passing and kicking all done with the ease and grace of the skilled athlete.

I place this analogy before you as we look at the skills required in today's healthcare environment for the dental practice – and yes, once again I mention three, the TRIPLE THREAT: ***Technical*** skills, ***Leadership***, and ***Business***.

Upon graduation from dental school our focus has been directed toward acquiring our hand-eye coordination and technical skills and a base line for the basic sciences in understanding patient care. Placing the patient in the chair and doing the dentistry is our primary goal. The enormous paradigm shift is supporting the skills and knowledge that brings patient care-which includes the complete care of the patient – to a reality! Hence, the new requirement of a dental office is to be as adept as a "Triple Threat Athlete": an expert with the ***Technical*** skills, knowledge and skills for the ***Business*** side of the practice, and ***Leadership***!

One of the most important things we can impart to our colleagues entering the profession as well as those currently practicing is that we must expand our toolbox. We must become adept in the business and the leadership of that business beyond our dental skills or seek out the required expertise. Most of us have an affinity toward two of the three required skill sets, but spend little time or energy on the areas that drain us. An honest self-assessment of our strengths is essential in order for us to come to the realization of recognizing "what we don't know" and where we need to grow or seek counsel. Seeking professional expertise in the area of business (legal, accounting, etc.) and leadership development is not optional in today's multi-faceted business environment and the patients we serve.

One example getting everyone's attention is the recently posted state regulations and their expanding oversight. This not only needs your attention, but demands your leadership to ensure the compliance of all your staff. There are an increasing number of health care and business regulations that require our awareness to avoid legal consequences. An up-to-date office manual signed by the employee is mandatory. Without all team members onboard and being knowledgeable of your policy compliance with state and federal laws, you and your practice are exposed.

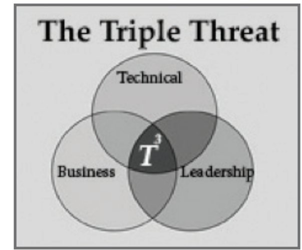
Although these are all very important, the current financial climate has also changed drastically. Dental students leave school with an average debt of $200,000. The complex intersection comes when a senior dentist seeking an exit strategy and wants to capture the value of his practice. For a successful transition to take place the skill set which includes leadership, business and dental expertise must be blended to allow for a win-win outcome.

The paradigm shift has taken place and the era of a 'Triple Threat' dental practice is not just being ushered into our profession, it's become a mandatory requirement for growth and success. It has also led to models of practicing dentistry such as large group practices and corporate management offices. For those who don't want to embrace the leadership and business components required for a thriving practice, other options are developing in the health care field. As I interface with practice transitions and coach dentists in building and growing their practices, in order to withstand the forces of change in multiple areas, I realize the set of skills necessary to navigate this journey is complex and multi-faceted.

The picture I am painting of a "Triple Threat" depicts the three critical areas the dentist must bring to the table:

TECHNICAL SKILLS

We are blessed with tremendous opportunities to expand and refine our dental skills through continuing education and study clubs beyond dental school. Our current graduates come to us with a limited skill base in need of mentoring and further development. General dentistry can be all you want it to be. Expanding and refining your skill set must be a lifelong pursuit to meet the expanding industry as new concepts are introduced and developed, and providing new services to the informed consumer. For the scope of this article I simply challenge you to do your self-assessment. Are my professional skills growing with the knowledge base of advancements that are taking place in our field?



LEADERSHIP

A. *VISION* – clarity, alignment and the ability to execute a plan

B. *COMMUNICATION* - skills that articulate patient needs and influence decisions towards positive health, while building a trusting relationship that leads to growth and referrals

C. *DEVELOPMENT* - with every student and dentist I work with I continue to emphasize the critical importance of professional growth and development. Hiring an employee is the beginning, the results will be highly dependent on your ability to develop and influence the individual to reach their full potential and serve your patients. The above does not happen by random chance. An intentional plan needs to be in place. So many offices are undermined by a negative employee who is holding the power, as it goes unnoticed, while the dentist is busy performing their technical skills.

When I poll students I ask them "How many have taken a course on building trust"? There is no response. The human relationship and its development are not optional and must be woven into the vision for the practice. Dental schools are attempting to incorporate the humanistic component into the curriculum recognizing that it must be woven into the complex fabric of the new dentist. It has now become a standard for accreditation.

Teaching at VCU gives me a perspective of how we are preparing the student with rudimentary dental skills. However, the leadership and business skill sets at graduation are woefully short. The hope is that we are instilling the hunger and recognition to be a lifelong learner.

D. *MANAGEMENT* – of the business cannot be escaped if we hope to have a well-run office. I put this under the category of leadership. You can delegate responsibilities, but you must "inspect what you expect". I find ignoring the inspection often results in management abuse or abdication by the doctor. The tail ends up wagging the dog.

Continued on page 48

Continued from page 47

BUSINESS

Like leadership, we must start with self-assessment. If we are honest, we may discover there are areas where we lack a working knowledge or understanding and are crucial in order to advance or even grow the business.

Study clubs with open sharing of best business practices recognize that there may be a better way to develop office systems for efficiencies and they offer a host of other resources. These are all available for the person seeking continuous improvement and profitability.

It's no secret (as I review office revenue statements) that insurance reimbursements are declining, resulting in extensive adjustments to your revenue stream. A systematic awareness of the revenue and expense columns requires your attention. A new face in the dental world is the appearance of the corporate structure along with other business models to leverage expenses. This external pressure demands more from the basic principles of our business and how it affects efficiencies. Every tool in our toolbox must be sharpened and tightened up in order to remain competitive. Everyone in the corporate world of dentistry knows the metrics for success which are measured daily. It ranges from very specific revenue streams to patient satisfaction surveys. Develop a working relationship with a savvy accountant so you are not in a position of saying "I wish I had known that!" How do I strengthen my office to have the skills and expertise of a ***Triple Threat*** athlete?

First, establish a planning time throughout the year of 2016, put it on the calendar and make this happen.

Nothing changes or happens without the dedicated time to make it happen:

1. Start with a written assessment of the three areas discussed. Consider an outside consultant if this type of project is totally outside your wheelhouse. Each skill, Leadership, Business, and Technical, deserve your attention if you want to take your practice to the next level. Be vulnerable and select two or three colleagues to have a discussion in these areas.
2. You can do anything, but you cannot do everything. Select one area to research and develop a strategy to grow and then apply your knowledge. Do this over a 1-2 month period. Once you have a plan in place involve your team and get their input and feedback. This will help to get ownership and support from your team. Where appropriate seek professional counsel outside the dental profession. Today's world of technology and information are ideal for people who are lifelong learners and want to expand their skill set or knowledge base.
3. Change in all three areas is constant. The critical question is "How will you respond?" Change is not optional and growth is a choice.

Choose to grow into a ***'Triple Threat'*** office.

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

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MAKING A DIFFERENCE FOR THE HOMELESS

Joel Rubin, President, Rubin Communications Group

Darlene was caring for her mother in Hanover County when her aunt kicked her out of the house.

Three months later on November 17, she turned up at Project Homeless Connect, an annual one day event at the Greater Richmond Convention Center where adults like Darlene could learn about jobs, housing, social security and receive medical and dental care. Darlene needed a painful tooth pulled.

Before the day was over, seven VDA member dentists had extracted hers and 113 other teeth, and along with 87 other volunteers, including 58 dental and dental hygiene students from VCU, Centura and other schools, had performed 66 exams, 27 cleanings, five gross debridements and more - $25,400 in total donated services.

"It's badly needed," said Sandston dentist Dr. Tom Cooke, who estimates he's participated in some 40 of these VDA Foundation Mission of Mercy or MOM projects over the past 16 years. "Whether it's from smoking, poor nutrition or simple neglect, we see some very bad cases of decay. The patients are very grateful for our help. All the hugs and handshakes make the treatment we give worth it."

Retired Henrico County dentist Dr. Don Wheless was also on the floor at Project Homeless. "Giving back is important," he says, a lesson not lost on Alexa Gruber, who has been a student MOM coordinator throughout her four years at VCU's Dental School. "It's a lot of work, because we have to order our own supplies like cups, gloves and gauze and then make sure we have enough people to assist the dentists," she said, noting that every student has to use his or her "personal time" to attend a MOM. Indeed each took either a morning or afternoon shift so as not to miss a clinic stint back at the school.

For Gruber, MOM has been not just a personal and professional accomplishment but also an inspiration. She will return to her native New Jersey after graduation, not just to work but also to start a similar program there. "Twenty six other states now have MOMs thanks to the model Dr. Dickinson started in Virginia. I want New Jersey to have one too."

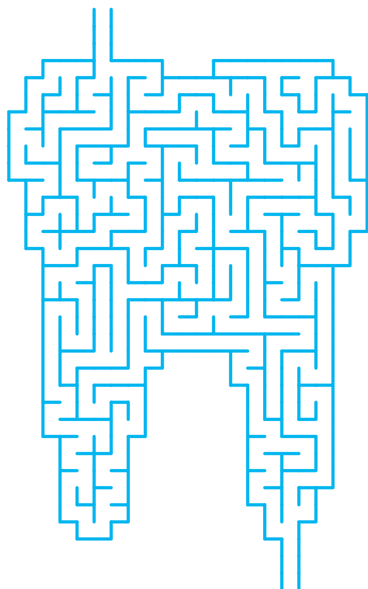
Kalpana Kalesweran and Shweta Kokate were actually working dentists in India before emigrating to the United States. They need two years in an American dental school to be able to practice here and hope VCU will accept them. In the meantime, they were assisting the volunteers at Homeless Connect. "It's good experience for us," says Shweta, "as well as exposing us to dentistry in Virginia."

What they are learning is that practitioners like Dr. Monroe Harris, who was MOM'ing this day along with LeTeseau Rockwell, Leah Fortune and Andrew Johnson from Virginia Oral and Facial Surgery in Petersburg, feel "blessed," in Rockwell's words, to be able to help.

Sadly many of those they treated in Richmond, like Amanda who was missing a tooth after "someone hit me in the mouth," will likely be back again. "We do see a lot of repeats," said Dr. Cooke, "and I wish they would stop drinking Mountain Dew and taking drugs. It really destroys their teeth."

Still Dr. Cooke will keep coming himself because it's "what we as dentists should do." ■

A HEALTHY DENTAL CAREER BEGINS



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RACHELLE LAWSON

Dentist: Dr. Nazanin Starns
Endodontist: Dr. Tricia Krause

Ms. Lawson is a single mother of two children dealing with a number of health issues and no support. Her dental issues compounded her difficulties. A number of her teeth were missing or broken. She suffered from abscesses, needed deep cleaning, root canals and crowns. We were able to connect her with two dentists to get the full care that she needed. During her treatment for dental care she was diagnosed with breast cancer, had a bilateral mastectomy and soon will begin chemotherapy. With all of her challenges, she took the time to send us photos of her beautiful smile and a Thank You note which she closed by saying “I am so grateful that you came to my rescue at such a vulnerable time in my life.”

NANCY RANDOLPH

Dentist: Dr. Allen Bernstein
Lab: Carey’s Dental Lab

Ms. Randolph came to us with a number of health issues which were severely exacerbated by her dental issues. Her doctor let us know that the necessity for dental care as it related to her health was urgent. We are grateful to Dr. Bernstein and his staff as well as Carey’s Dental Lab for providing the care that she needed. Ms. Randolph wrote us a lovely note which included the following: “My dentist (Dr. Bernstein) was a very pleasant, kind and caring person. The staff was the same way. The staff and Dr. Bernstein always made sure that I had transportation and was not stranded. I have gotten so many compliments about how good my teeth look. I had a little discomfort for the first day eating with them but since I have had no discomfort or pain. I am eating everything and smiling all the time (smile). God is good! I can’t thank you enough for your help and kindness.”

DENNIS HIGH

Dentists: Dr. Patrick Sprague and Dr. Scott Ruffner

Mr. High came to us in pain with several teeth that needed to be addressed. Some of the teeth which he thought would need to be extracted were saved and repaired, improving his smile. He was so pleased with his dental care that he said “if I could jump through the phone I’d give you a hug and a smooch!” In response to a question on our survey which asks “As a result of your dental work, what are you able to do today that you couldn’t do before?” he responded, “Smile! Eat what I want and no more pain!”

INTEGRATING ORAL AND OVERALL HEALTH IN GRUNDY

Tara Quinn, Executive Director, VDA Foundation

Since 2003, the Mission of Mercy (MOM) program has offered much-needed dental care to thousands in the remote, coal-country town of Grundy. While rich in natural resources, the Grundy area suffers with little to no regular access to dental health care. Though not the permanent answer to access to care, the MOM project has become the annual dental visit for many people in this area.

This year was no different. Despite the threat of Hurricane Joaquin to cause massive flooding throughout Virginia, scores of volunteers travelled to Grundy on October 2 for what was the 84th MOM project held since 2000. They served 320 patients, some of whom began their long wait for care the evening before – camping in the drizzly cold outside Riverview School.

But this year, the Grundy MOM project sought to achieve even more. Anthem Blue Cross and Blue Shield Foundation recently awarded the Virginia Dental Association Foundation (VDAF) a grant for $37,500 to both support the MOM dental clinic in Wise, and to design and implement a Diabetes Prevention and Management Education Program in Grundy. The Program, which aims to improve health outcomes for adults both with and at risk for Type 2 diabetes, was launched at Grundy MOM October 3. In addition to providing dental services at the Grundy MOM Dental Clinic, the VDAF is providing materials on diabetes prevention/management and smoking cessation as well as working with a select number of patients with Type 2 diabetes to manage their chronic condition and improve their overall health.

A recent Virginia Department of Health report indicated that persons with diabetes have an increased risk for eye and dental problems, and that annual exams for both eye and dental are recommended. Furthermore, in a survey of the period from 2005-2009, the Lenowisco Health District (of which Grundy is a part), saw one of the highest rates of diabetes in Virginia - with a rate of prevalence of 11.7%.

Patrick Finnerty, president of the VDAF, stated, “More and more studies show that periodontitis can make diabetes worse, and diabetic patients with severe periodontitis have greater difficulty maintaining normal blood sugar levels. The VDAF is most grateful to the Anthem Foundation for its generous support of our work on this important health issue and we look forward to further collaboration with them going forward.”

The Diabetes Prevention and Management Education Program will run through May, 2016, and serve patients from around the Grundy region. The Program Coordinator, a licensed pharmacy intern, is providing educational materials and workshops, direct assistance, access to diabetes management supplies, and serving as a liaison to other clinical resources available in Appalachia. To broaden access to available resources, the VDAF is partnering with the Appalachian College of Pharmacy and Mountain Care Clinic in Oakwood, the American Diabetes Association, and the Health Wagon in Wise to implement the program.

“Anthem is proud to support the Virginia Dental Association Foundation in this innovative program,” said Maureen Dempsey, M.D., senior clinical officer for Anthem Blue Cross and Blue Shield. “Oral health is integral to overall health. By working with the VDAF to support the Missions of Mercy and further link dental care to general health, we can help those in need get access to dental care and in turn, positively impact the prevention and management of other chronic conditions like diabetes.”

Through the 12 completed Grundy MOM projects completed so far, over $4.6 million in dental services have been provided for 5,475 patients. In the coming years, the VDAF looks forward to broadening our impact to improve both the oral health – and overall health – of the people of Appalachia. ■

Dr. Steven Carroll, wife Lisa, daughter Jessalin and members of his Portmouth dental office traveled to Grundy MOM to provide restorative care to many of the 320 Southwest Virginia residents.

“We enjoyed meeting the wonderful folks at Grundy and assisting them with their dental care. We all worked hard but we had a lot of fun too!?” Lisa Carroll

Upcoming MOM Projects

NOVA MOM (March 11-12, 2016)
Northern VA Community College

VA Beach MOM (April 30, 2016)
Green Run High School

Special Olympics (June 11, 2016)
University of Richmond

Wise MOM (July 22-24, 2016)
Wise County Fairgrounds

Grundy MOM (October 1-2, 2016)
Riverview Elementary/Middle School

Homeless Connect
(November 2015 date TBD)
Greater Richmond Convention Center

To volunteer: Register online at www.vdaf.org

Donations: www.vdaf.org

Through 85 completed MOM projects

59,053 patients have received dental care

Valued at $38.3 million in free services

Made possible by 23,055 volunteers!

2015 MOM Project Report

Suffolk MOM (February 2015)
559 Patients Treated — $510,861 Donated Treatment

Northern Virginia MOM (March 2015)
877 Patients Treated — $546,368 Donated Treatment

Special Olympics MOM (June 2015)
123 Patients Treated — $ 29,896 Donated Treatment

Wise MOM (July 2015)
1,181 Patients Treated — $1,171,655 Donated Treatment

Grundy MOM (October 2015)
320 Patients Treated — $371,242 Donated Treatment

Homeless Connect (November 2015)
66 Patients Treated — $25,400 Donated Treatment

TOTALS: Completed 2015 Projects— 6
Total Patients Treated— 3,126
Value of Donated Dental Services— $2,655,422
Total # Volunteers— 2,129
Average value of care received per patient— $849.46
Total # dental procedures— 17,930

2000-2015 MOM Project Totals

- Total Completed Projects— **85**
- Total Patients Treated— **59,053**
- Value of Care— **$38.3 million**
- Total # Volunteers— **23,055**
- Average value of care received per patient— **$648.61**
- Total # dental procedures— **299,740**

Procedures	Donated Treatment
Exams	59,053
Cleanings	13,269
Gross debridements	3,236
Fillings	57,370
Extractions	112,488
Root canals/ pulpotomies	2,005
X-rays	32,224
Fluoride (topical/ varnish)	7,182
Complete dentures	1,554
Partial dentures	195
Sealants	843
Stainless steel crowns	238

MOM—Bringing Access to Dental Care for Virginians

THREE KEYS TO INCREASED INTERNET VISIBILITY

Lance McCollough

The internet is a very crowded marketplace of ideas, information, conversations and business. Getting your dental practice noticed by potential patients is difficult to say the least. Too often searches for your dental practice don't lead to your website. Sometimes the top listings have similar names, but sometimes they're simply unrelated. How would you like to know three ways to upgrade the online visibility of your dental practice's website?

Bigger Is Better. Believe it or not, search engines tend to rank sites with more pages higher in search results. Is there a magic number? No, but any expansion helps. Begin with basic pages – about, contact, services, insurance, bios, etc. Then follow a strategy to add more – blog, links, testimonials and so on. The deeper page structure of your site should help increase your search engine ranking. It's important to make sure your site maintains a well-planned hierarchy and clear navigation. Each new page should have unique titles and meta descriptions as well. If search engines get confused while cataloging your site your search results will suffer. Finally, create useful, interesting and relevant content on your new pages. You want to give your visitors a reason to click through to each of them. The stickier your website the better it will reflect on searches.

Blog is a Verb. Having a blog doesn't do you any good if you don't blog on a regular basis. Do not use a separate domain to host your blog. Put it on your dental practice's domain. This will help you easily increase your website's page count. It's not necessary to blog every day to get noticed. A couple new, original posts per month will work – more will work better. Google's search engine algorithm measures frequency of updates as well as how recently you last updated your blog.

Blog about things your patients and potential patients find interesting. While you may be an expert on crowns, your patients may be bored by an article on the different processes for fitting a crown. However, articles such as Types of Smiles and How to Read Their Meanings, When It's Time to Consider Braces for your Preteen, or the Best Toothpastes and Brushes for your Money might get some shares and likes. Don't be afraid to turn comments on. Patient engagement is very important. Plus, you can delete a comment if you get trolled.

Make it easy for your patients and potential patients to share your articles. Cross-promote your posts on all of your dental practice's social media platforms. You want shares, likes and links. The shares and likes will boost your social media presence and the links will boost your site's search ranking.

Reviews Matter. The importance of review sites for your home page's search engine optimization (SEO) is gaining attention. These sites increase your online footprint. The more reviews you have on a site the higher it may rank during an online search. Review sites offer an opportunity to create synergy between your onsite and offsite SEO efforts with reciprocal links. Be sure to ask visitors to your website to follow the link and leave a comment about their experience on the review site. Search engines will not rate these links as highly as natural link building through editorial, but they will take notice so long as you don't duplicate the reviews on your practice's website. Search engines don't like duplicated content.

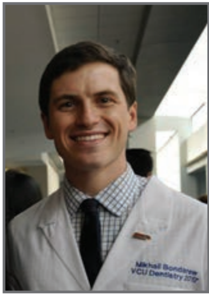
Yelp and Google+ are popular review sites which often perform well in searches. They also happen to be free. Claim your listing and set up your practice's profile. With that step finished you're ready to have patients leave reviews. Yelp and Google+ have policies prohibiting the solicitation of reviews and use algorithms to limit how many reviews can post over given time periods. However, there are ways to encourage your patients to leave reviews. These two are usually effective:

- Place a notice on the backside of your patient's appointment cards requesting that they leave feedback about our service.
- Send follow-up emails to patients shortly after their appointments asking that they rate their experience.

Many small businesses find it difficult to keep up with website management, SEO and online marketing. After all, time is limited and boosting your online presence is a process that takes time. The steps above are just three of many possible ways to make your dental practice more visible. Based on case studies and experience a qualified digital marketing firm can tailor an online strategy to your dental practice's goals and expectations. To learn how ProSites can help you boost your online presence, contact us for a personal consultation at 888-932-3644.

PROSITES®
Website Design and Internet Marketing

DOING IT YOUR WAY



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

Dentistry is a profession full of challenges. We strive every day to solve the problems of the head and neck. We spend hours of our time learning signs and symptoms, diagnoses, and many more hours providing indicated treatments. As all licensed doctors practice, they have the privilege to plan and execute their proposed treatment plans. Making these decisions can be challenging, but each individual clinician can proceed confidently, having thoroughly planned.

As developing practitioners, students like myself are intentionally placed into nearly identical situations. However, we lack one critical element: autonomy. This often serves as a great asset, allowing us to learn from established professionals, be wrong, displace treatment decisions, and most importantly create fail-safes. We can confidently provide treatment knowing that our actions are correct because our attending faculty have given us their coveted “swipe” of approval. Yet this level of governance may also supersede our own opinion.

My life as a dental student is rich in diagnosis and techniques. This affords students with easy access to the most current or empirical information. Information is often so new or different from previous standards that it hasn’t been transmitted throughout or collectively adopted by the entire profession, thus creating a knowledge gap. This gap and our incomplete autonomy sometimes coalesces to form moments of moral conflict.

In our student clinics, we are expected to provide the best possible treatment while seamlessly aligning with our attending’s method of practice. While much of the time our methods align, the rare occasions when they do not pose a unique challenge. We are left with an ethical dilemma. We legally and culturally only have the privilege to operate at our attending’s order. We highly respect our attending’s decisions, but we are taught specific principles and to have our own opinion. In these circumstances, it seems we are forced to choose between following orders or striving to practice nonmaleficence and beneficence. I don’t believe any attending intentionally harms anyone, but in many circumstances health can be achieved through a variety of treatments. Each practitioner is taught to individually identify, evaluate, and select the best treatment according to our patient’s desires and known outcomes. Thus when mandated to perform an alternative, it feels wrong -- not because it’s actually harmful, but because our perceptions, experiences, and education are different.

Because there are many laws, guidelines, cultural norms, and personalities at play, resolutions of these situations can be complex. While potentially uncomfortable to address, we cannot let these obstacles prevent us from delivering outstanding patient care. I believe these conflicts are best addressed through collaborative, respectful, and ongoing dialogue. We’ll all learn a lot about each other, different perspectives and maybe even a little more about dentistry. ■

Peer Reviewed ◆ Members-Only Benefits ◆ Supporting the VDA

By utilizing the VDA Services endorsed vendors below, VDA Members receive special benefits and discounted pricing while supporting the VDA and its programs — nearly $3 Million in support has been provided to the VDA, VDAF, VCU School of Dentistry and others! Help Us, Help You!

B&B Insurance—Insurance Agency
877-832-9113; bb-insurance.com

Bank of America—Credit Cards
800-932-2775; bankofamerica.com

Bank of America Practice Solutions — Practice and Equipment Financing
800-497-6076

ProSites—Website Design
888-466-7975; prosites.com/vda

Miles Global — Dental Consulting
877-343-0909; milesglobal.net

Demandforce—Marketing & Communications
800-210-0355; demandforce.com/vda

Medical Protective—Malpractice Insurance
877-832-9113; medpro.com

OneMind Health—Revenue Cycle Management
866-633-1090; onemindhealth.com

Paychex — Complete Payroll Services
800-729-2439; paychex.com

CareCredit—Patient Payment Plans
800-300-3046 ext. 4519
carecredit.com/dental

SolmeteX— Amalgam Separators
800-216-5505; solmetex.com

Transworld Systems—Collections
804-201-7606;transworldsystems.com

Association Gloves —Gloves and Masks
877-484-6149; vdaservicesgloves.com

Worldpay — Credit Card Processing
804-836-6798; worldpay.us

iMedicor — Secure HIPAA Communications
888-810-7706; signup.imedicor.com/vda/

VDA Services is a service mark of the Virginia Dental Association. VDA Services is a program brought to you by the Virginia Dental Services Corporation, a for-profit subsidiary of the Virginia Dental Association.

WELCOME NEW MEMBERS

Karen Clendenen, VDA Membership and Meeting Coordinator

TIDEWATER DENTAL ASSOCIATION

Gayatri Raina – Chesapeake - Temple University 2008

Ann-Marie Funda - Virginia Beach - Medical College of Virginia 1986

Chester Mayo, Jr. - Virginia Beach - University of Louisville 2015

Amr Sheta - Norfolk - Nova Southeastern University 2011

Michael Trudeau - Carrollton - University of the Pacific 2002

Scott Engle - Virginia Beach - University of Maryland 2014

Gibson Harrell - Chesapeake - Virginia Commonwealth University 2001

Patrick Holmes - Virginia Beach - Virginia Commonwealth University 2009

Jonathan Wong - Virginia Beach - Southern Illinois University 2009

PENINSULA DENTAL ASSOCIATION

William Broas - Newport News - Georgetown University 1976

Donald Robinson - Hampton - Howard University 1985

SOUTHSIDE DENTAL SOCIETY

Phillip Prater - Blackstone - Ohio State University 2008

Sumayra Mohiuddin - Midlothian - Virginia Commonwealth University 2008

RICHMOND DENTAL SOCIETY

Joseph Fusaro - Spotsylvania - University of Maryland 1995

Rani Koganti - Glen Allen - New York University 2009

Jaisri Thoppay - Richmond - India-Tamil Nadu Govt. Dental College 1998

Erika Lentini - Richmond - Georgia Regents University 2011

Carlos Smith - Henrico - University of Michigan 2007

Shinjni Razdan - Fairfax - Virginia Commonwealth University 2013

John Reynolds - Richmond - Virginia Commonwealth University 2012

Darchelle Braxton - Newport News - University of Louisville 2008

Stan Szubiak - Richmond - Indiana University 2007

PIEDMONT DENTAL SOCIETY

Rose Satterfield - Danville - College of Medicine and Dentistry of New Jersey 1975

Jenna Chalk - Lynchburg - University of North Carolina 2011

Kevin Keating - Martinsville - Virginia Commonwealth University 2012

SOUTHWEST VA DENTAL SOCIETY

Scott Scharnhorst - Radford - Ohio State University 2012

Glenn Evans - Radford - Roseman University 2015

Jay Owen - Bedford - Virginia Commonwealth University 2014

SHENANDOAH VALLEY DENTAL ASSOCIATION

Ryan Buckwalter - Charlottesville - Virginia Commonwealth University 2009

Julia Guerrier - Charlottesville - Howard University 2013

Jessica Moore - Charlottesville - University of Maryland 2013

Brian Poulsen - Lexington - Marquette University 2014

NORTHERN VA DENTAL SOCIETY

Nadgie Ortiz Diaz - Sterling - University of Puerto Rico 1999

Eva Swenson - Burke - University of Aarhus (Denmark) 2010

Brian Van Slooten - Arlington - NJ University of Medicine & Dentistry 2009

Adeline Yuh - Vienna - Herman Ostrow School of Dentistry of USC 2002

Tyler Yi - Falls Church - New York University 2008

Janice DeVito - Gainesville - Tufts University 2013

Mallory Grossman - Arlington - State University of New York at Buffalo 2014

Shwetha Rai - Gainesville - Virginia Commonwealth University 2008

Joan Rhee-Yoo - Herndon - Ohio State University 2009

Navjeet Ubee - Clifton - Howard University 2014

Jayamole Zachariah - Ashburn - Howard University 2014

Nassir Barekzi - Reston - Virginia Commonwealth University 2006

Gunjan Harmani - Woodbridge - University of Florida 2001

Ann Kemp - Annandale - Boston University 2006

Gregory Lakas - Arlington - Georgetown University 1978

Maryam Monfared - Arlington - Virginia Commonwealth University 1991

David Paino - Vienna - University of Maryland 2004

Richard Runkle - Centreville - Ohio State University 1963

Bindu Vemaraju - Aldie - New York University 2013

Continued on page 56

Continued from page 55

Therese Chu - Ashburn - Columbia University 2005

Stephanie Grace Djeu - Washington D.C. - Harvard 2004

Hedieh Kousedghi - Vienna - Boston University 2015

Shaghayegh Madani - Fairfax Station - Howard University 2010

Jorge Way Rodriguez - Alexandria - University of Maryland 2011
Moutaz Abdeen - Spingfield - Virginia Commonwealth University 2000

Ashraf Adam - Falls Church - Sudan - Khartoum University 2003

Keri Giron - Arlington - University of Missouri, Kansas City 2008

Jennifer Kim - Chantilly - University of Florida 1999

Christiana Markova - Arlington - Harvard University 2012

Mayur Patel - Woodbridge - Howard University 2009

Shehzad Sheikh - Sterling - Tufts University 2005
Jamil Sowan - Arlington - Russian Federation/ Tver State Academy of Medicine 1998

Bryan Zopp - Warrenton - Virginia Commonwealth University 2013

Kevin Smith - Hagerstown, MD - University of Maryland 1988

LEADERSHIP, DIVERSE MEMBERSHIP GROUPS CRAFT STRATEGIC PLAN

Dr. Benita A. Miller

"I joined organized dentistry because as a solo practitioner, I am only one voice. However, organized dentistry gives me the opportunity to give input into decisions and the advancement of our profession rather than being a silent bystander!"

Young dentist: "I joined the ADA when I moved to Virginia from out of state. Mostly, I wanted to meet dentists and specialists in the area, to form both working and personal relationships. I feel like being a part of a community is a key part of our profession."

The VDA is one of the most respected constituent societies in the ADA. We are perceived as being on the cutting edge of our dental profession. We have started a number of initiatives in Virginia that have spread to the rest of the country – our MOM projects, "non-covered services legislation" to name a few. We are the group the ADA often calls upon to start pilot projects or to follow our lead. Why? We have thoroughly engaged officers and Board leadership, a visionary Executive Director, highly dedicated VDA staff, and volunteer dentists who give generously of their time and talents on councils, committees, and task forces to serve our membership. Our ability to remain relevant hinges upon the success of our ability to anticipate the coming changes and to develop proactive strategies.

On Saturday October 24, 2015 VDA officers, Board of Directors, component leaders, rising young leaders from each component, and VCU dental students met to discuss our most pressing challenges and to craft a forward looking strategic plan to best address these challenges. Over the years our membership has become more and more diverse, and it was great to see representation from all of our diverse groups working together to address the needs of all of our members, in particular our younger members.

Both new and experienced practitioners cite personal relationships as one of the most critical factors in belonging to organized dentistry.

How do we strengthen these relationships to keep our profession strong and relevant? The following value propositions are those that were found to be most valued by the various planning groups:

- The VDA's ability to advocate on behalf of all dentists, regardless of their practice model or specialty
- The VDA's opportunities to help members succeed professionally and personally
- Tangible benefits provided by the VDA, including skills, technology and better purchasing power for members
- The VDA's efforts to convene members – in person and via the Internet – to share knowledge and create lasting professional connections

This year's overriding theme encompassed how to strengthen our personal relationships and how to more effectively communicate all of the tangible resources available to VDA members. The group developed Strategic Goals and accompanying Focuses and Strategies to address major areas of concern: New Dentist Members, Non-Renewing Members, Faculty Engagement, Member Diversity, and Financial Concerns. The following is an outline of strategic goals developed:

New Dentist Members
Strategic Goal: By creating new

opportunities for new dental professionals to connect, learn and grow, the VDA will become a relevant resource for a new generation.

Non-Renewing Members
Strategic Goal: By developing a genuine feeling of community among members and by making the financial benefits of VDA membership clear and tangible, the association will remain vital to dental professional at every stage of their career.

Faculty Engagement
Strategic Goal: By strengthening our personal and professional connections to the faculty and administrative staff at VCU, we will ensure a strong, two-way partnership that benefits our profession.

Member Diversity
Strategic Goal: By better understanding the needs of diverse populations of dental professionals, the VDA will increasingly provide clear value to their professional and personal success.

Each goal has two to three strategic focuses and accompanying strategies. ■

ADA TRUSTEE'S CORNER

JUNE 2015 BOT MEETING

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

Since my last article the 2015 House of Delegates has taken place and I will devote most of this article to the messages that were delivered to the Delegates and Alternate Delegates. First I would like to commend our 16th District Delegation on their dedication and careful deliberations of all of the resolutions that we were presented both at our caucus in Hilton Head, S.C. and at our Annual Meeting in Washington, D.C. The South Carolina Delegation was a great host and all that attended had a wonderful time. Likewise, Washington, D.C. proved to be a great choice for ***America's Dental Meeting***. I would also like to thank our Delegation Chair, Dr. David Watson for a superb job in leading us through our deliberations.

We opened our first session of the HOD with the speeches from the three candidates running for President Elect of the ADA. Subsequently on Monday morning Dr. Gary Roberts from the 12th District and the state of Louisiana was elected as our President-Elect. Dr. Roberts in his address to the HOD emphasized that the more unified we become, the brighter the future of our profession becomes. He stated that this would require increasing market share by re-energizing the Power of Three to better serve our member needs.

The candidate speeches were followed by the Report of the President to the HOD. Dr. Feinberg's message was simply stated: that everything we as an association does for our members must support our core purpose and values. We must continue to add value for our members. Membership and membership share is still a work in progress, but she feels that progress is being made and our efforts are beginning to pay off. She added:

> "This year's membership loyalty survey showed that in the past three years, our members have become more loyal, they are more likely to stay members, and they are more likely to recommend membership to others."

These are all very good signs of that point toward positive membership retention and recruitment and a possible beginning to a turnaround to the trend of membership share decline.

On Monday our ADA Executive Director's message to the delegates concentrated on how the ADA must make it easier for a prospective member to join and how we must remove the barriers to easy direct membership. Dr. O'Loughlin said that we have to change what we are doing and that includes our governance:

> "I believe we need to be an organization that possesses an innovative mindset, not a status quo. The innovation mindset requires that we see each other as trusted partners—volunteer leaders and staff alike. This partnership stands on the values of integrity, excellence, science, being member centric and ensuring the health of the public. This partnership demands much of us: gossip, politics of divisiveness and personal agendas have no place in our quest to possess an innovative mindset. We have to act with confidence, determination and political courage. We have to stay the course. To have courage."

We must have this innovative courage and if we do our members are more likely to stay members, more likely to find value at the local level and our members will be more loyal than they were yesterday.

Finally on Tuesday morning Dr. Carol Summerhays of California was installed as the new President of the American Dental Association. Her message to all of us was to seize the moment together, embrace challenges and opportunities and make the most of the possibilities that lie ahead.

As you can see the common thread in all of these messages is membership and the importance that membership growth will play in the long term viability and sustainability of our association. I want to close this article by sharing with you a true story that I experienced. It convinces me what I already knew; that the best way and maybe the only way to grow membership is at the local level with a one-on-one conversation with a nonmember.

Earlier this year while attending the Washington Leadership Conference I was having a conversation with a prominent ADA member about our loss of membership share and how we could turn the trend around. We both agreed that it was at the component level that we could best build membership value. Then to my surprise this member boldly said, "I can tell you right now that I could go speak with twenty non-members tomorrow and convince 19 of them to join." Well I am sure that most of you could guess what my first thought was, although I didn't say it out loud, "Then why don't you go do it?"

I shared this story when I addressed the North Carolina House of Delegates this past May at their Annual Session. Afterward one of the delegates came to tell me that he appreciated my story, but just how frustrated he was that in the town that he practiced in 8 out of the18 dentists in that town were not members of the ADA. He took the initiative to go and speak to all 8 of the nonmembers and to his disappointment and somewhat exasperation he could only get 4 of them to join. I calmly looked him in the eye and simply said to him, "Can you imagine what would happen if every member went to eight nonmembers and succeeded in getting four to join?" He said, "Well, I guess I never thought of it that way."

We could solve our membership problem if we had more members that actually took the same initiative that this member took. As the saying goes all politics is local, well I believe we can also say that all membership growth is local.

My New Year's challenge to you is go seek out a nonmember, share with them what ADA membership means to you and just simply ask them to be a part of our great organization.

You may be surprised that all you have to do is ask! ■

MEMBER AWARDS & RECOGNITION

MELINDA GULLOTTI
Dental Team Member Award
Virginia Dental Association

KIM ISRINGHAUSEN
Special Service Award
Virginia Dental Association

DR. CASSIDY TURNER
New Dentist Award
Virginia Dental Association

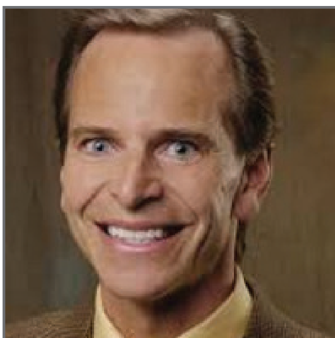
DR. MARK CRABTREE
Emanuel W. Michaels Distinguished Dentist Award, Leadership Award and Presidential Award
Virginia Dental Association

DR. MAYNARD PHELPS
Leadership Award
Virginia Dental Association

DR. STEVEN FORTE
Leadership Award
Virginia Dental Association

DR. DAVID ANDERSON
Leadership Award
Virginia Dental Association

DR. DAVID BLACK
Presidential Award
Virginia Dental Association



DR. BRUCE DEGINDER
Presidential Award
Virginia Dental Association

DR. BRUCE HUTCHISON
Presidential Award
Virginia Dental Association

DR. FRANK IUORNO
Presidential Award
Virginia Dental Association

DR. ROBERT LEVINE
Presidential Award
Virginia Dental Association

DR. JUSTIN NORBO
Presidential Award
Virginia Dental Association

DR. KIRK NORBO
Presidential Award
Virginia Dental Association

DR. ROGER PALMER
Presidential Award
Virginia Dental Association

DR. J. TED SHERWIN
Presidential Award
Virginia Dental Association

MEMBER AWARDS & RECOGNITION

INTERNATIONAL COLLEGE OF DENTISTS

Fellows

Standing L-R: Drs. Bryan Brassington, Brenda Young, David Jones, H.J. Barrett, Paul Patterson, and Charles Jenkins.

Seated L-R: Drs. Michael Hanley, Thomas O'Hara, Sharone Ward, Joseph Bernier-Rodriguez, Elizabeth Bernhard, and Roger Palmer

AMERICAN COLLEGE OF DENTISTS

Fellows

L-R: Drs. Edwin Lee, Tegwyn Brickhouse, Kit Sullivan, Cynthia Southern, and Lori Wilson

VIRGINIA DENTAL ASSOCIATION

Fellows

L-R: Drs. Bruce Overton, Sujit Mohanty, Mary Dooley, and Stephen Radcliffe

VDA CO-HOSTS 2016 BIG SKY SKI & LEARN SEMINAR

The Virginia Dental Association will join several other states in hosting the 2016 Ski and Learn Seminar at Big Sky Resort in Big Sky, Montana. The meeting begins on Wednesday, March 16 and continues through Wednesday, March 23. Other state dental associations who have co-sponsored the trip include Alabama, Indiana, Kentucky, Maryland, Missouri, Montana, Oklahoma, South Dakota and Tennessee.

This will be our twelfth consecutive trip to Big Sky. Nearly fifty dentists from fourteen states participated in the 2015 trip.

Montana is known for its vast, beautiful landscapes and at Big Sky, there's no exception. Big Sky is one of the largest and most compelling mountain resort experiences in North America. With recent acquisitions of the Moonlight Basin and Spanish Peaks resort areas, Big Sky Resort boasts more than 5,750 acres of skiable terrain with 4,350 vertical feet, 23 chair lifts and 10 surface lifts. Annual snowfall averages 400 inches and there are no lift lines. Big Sky is truly the "Biggest Skiing in America."

CONTINUING EDUCATION

Sixteen hours of continuing education will be held on Thursday and Friday (March 17-18) and Monday and Tuesday (March 21-22). Morning sessions will be 7:30 until 9:30 a.m. and afternoon sessions will be 4:30 until 6:30 p.m. This schedule will allow you to enjoy skiing on program days! Speakers and topics will be announced soon. Complimentary daily breakfast is included with group lodging, and will also be provided for registered attendees staying off-site on seminar days.

LODGING

Huntley Lodge - This three-story hotel was part of the late NBC news broadcaster Chet Huntley's original vision. With recent remodeling, it is as tasteful as it is convenient. The Huntley complex includes a fine dining room, lounge, coffee cart, concierge, shops, ski storage, meeting rooms and Solace Spa.

Shoshone - Shoshone combines the service of a hotel with the comforts of a condominium. This recently remodeled seven-story landmark is attached to the Yellowstone Conference Center and Huntley Lodge. Solace Spa, shops, espresso cart, and Kids Club are located in the lobby.

The Summit - This 10-story luxury complex combines the convenience of a hotel with the amenities of a condominium. Flexible lock-offs allow for many sleeping configurations. The Summit melds European sophistication with Western style with three high-capacity lifts within 100 yards of the entry.

Powder Ridge – These handcrafted cabins offer roomy floor plans, modern amenities, and old world charm. Located on the north end of the Mountain Village, you can access skiing via secluded trails and bridges. Enjoy cozy fireplaces, private outdoor hot tubs, and a kitchen all nested in the pines on the flanks of Lone Peak. The Powder Ridge Cabins are great for families and groups. Private vehicles required.

TRANSPORTATION

Located just 45 miles south of Bozeman, Montana, and only 18 miles north of the Yellowstone National Park border, the resort is easily accessible via jet service into Bozeman on Northwest, Delta, United, and Skywest Airlines. Ground Transportation is available by way of rental car or shuttle.

RESORT AMENITIES

Located at the base of Lone Mountain, the complex includes meeting rooms, an amphitheater, a scenic Main Dining Room, Chet's Bar, two outdoor heated pools, jacuzzis, saunas, a health facility, tennis and volleyball courts, a massage studio, and retail shops all in the same area. Next door is the Mountain Mall, providing additional restaurants/bars, shops, and services.

SKIING AND RECREATION

The skiing at Big Sky is truly legendary. The experience is based on huge vertical, tremendous elbow room and breathtaking scenery. The facts tell the story -- two mountains, 3,600 acres, seventeen lifts, 400 inches of light, dry snow annually, no lift lines and the nation's 2nd largest vertical drop of 4,350 feet. Group ski rates will be available for registered attendees.

And when you're not skiing, the Big Sky area offers plenty of winter activities like snowmobiling and wildlife viewing in Yellowstone National Park, snowshoeing, sleigh ride dinners, ice skating, free children's aprés ski activities, or relaxing with a spa treatment from the Solace Spa.

HOW TO REGISTER

For registration information contact the Alabama Dental Association by calling (800) 489-2532, fax (334) 262-6218, or email niel@aldaonline.org. For lodging information and rates call Big Sky Resort at 800-548-4486 and tell them you are with the Alabama Dental Group. ■

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MEMBER SPOTLIGHT - DR. NEIL SMALL

Dr. Chris Spagna; Associate Editor, Component 8

At our annual business meeting on September 9, 2015, the Northern Virginia Dental Society was proud to recognize Dr. Neil Small with our highest honor, the Lifetime Achievement Award. Dr. Small graduated in 1978 from the University of Buffalo graduate school of endodontics, where he currently serves as an assistant professor teaching literature and board review to graduate endodontic students. Dr. Small was also an assistant professor of endodontics at his alma mater, Georgetown University School of Dentistry until its closure in 1990.

His faculty position at Buffalo he says, is one of his favorite things in retirement. “Nothing though compares to spending time with my family and three grandchildren.” Dr. Small also enjoys the outdoors – fishing in Canada for northern pike in July the past 20 years and running in the Marine Corps 10K race the last 10 years. “I’m not as fast as I used to be”, but really there is very little that slows this man down.

Dr. Small grew up in Brooklyn, N.Y., the son of Russian immigrants, and was the first in his family to go to college. As a biology major in college, he had plans to be a virologist and never dreamed of a career in dentistry. Encouraged by his friends to apply, he says it was one of the best decisions he ever made.

“This profession has given me so much. It’s a gift, and when given a gift, you need to say thank you and give back,” he says. Dr. Small is especially proud of his work on the local level in the community through the MOM Projects of the Northern Virginia Dental Society and with the Northern Virginia Dental Clinic, providing dental care to those who would otherwise be unable to afford such care. He also finds it particularly rewarding helping to guide and encourage younger dentists to get involved in organized dentistry, “They are our bright future.”

Throughout the course of his long and distinguished career, Dr. Small has been recognized in many ways. He has been honored as a Diplomate of the American Board of Endodontics, as well as a Fellow of the American College of Dentists, International College of Dentists, Pierre Fauchard Academy, American Board of Endodontics, and the VDA.

In addition to having a successful career as a practicing Endodontist, Dr. Small’s membership involvement within the dental community included positions as a past president of the Northern Virginia Dental Society, chairman of the Patient Relations Committees of the Northern Virginia Dental Society and the Virginia Dental Association, and as a member of the Board of Directors of the Virginia Dental Association.

Dr. Small’s life devotion to his profession and his countless contributions to the dental community are deeply appreciated. The Northern Virginia Dental Society expresses a heartfelt thank you for all he has done and continues to do for the betterment of our community and to preserve the integrity of profession. Congratulations Dr. Small, for an honor you so truly deserve. ■

40 UNDER 40

DR. NEELAM DUBE

Dr. Neelam Dube is a general dentist at Neibauer Dental Care in Gainesville. A native Chicagoan, she went to dental school and did a general practice residency in New York City, and now enjoys practicing in Northern Virginia.