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VIRGINIA DENTAL
Journal
Volume 92, Number 4 • October, November & December 2015

Meet our new President,
Dr. Richard Taliaferro

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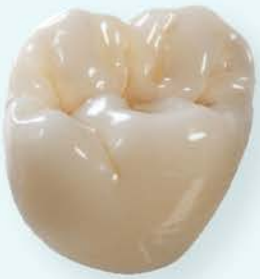

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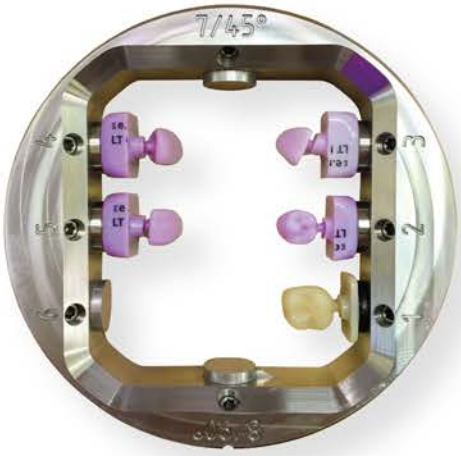

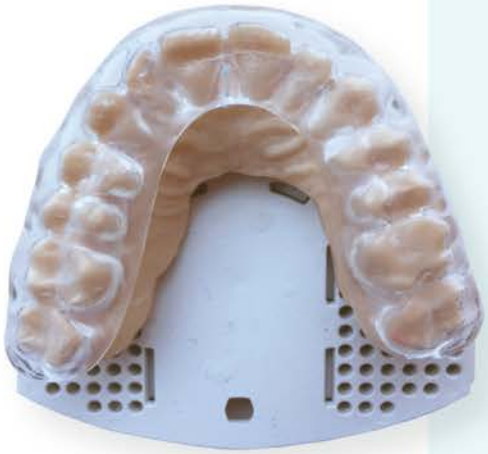

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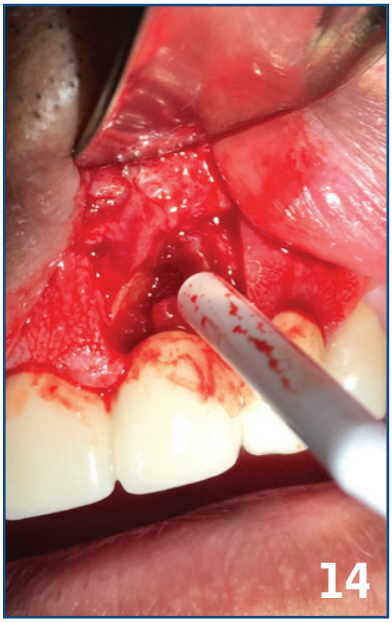

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Virginia Dental ASSOCIATION

VIRGINIA DENTAL JOURNAL

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

Volume 92, Number 4 • October, November & December 2015

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INTERVIEW WITH THE VDA PRESIDENT, DR. RICHARD TALIAFERRO

Virginia Dental Journal: Why do you want to be VDA President?

Dr. Richard Taliaferro: I feel blessed that I am a dentist. I have the same enthusiasm today to do dentistry as I did when I graduated. Dentistry has been good to my age group and especially to me. I want to insure that the younger dentists can continue to practice as we have. There are outside forces that are changing and trying to change how we practice. They are trying to dictate how we treat patients and they are attempting to add undereducated individuals to treat patients independently. I don't think that is good for dentistry and especially for the patients we serve. With my love of our profession, I believe I am ready to lead the VDA as we fight these outside forces.

VDAJ: What's the most pressing issue facing the dental profession today?

Dr. Taliaferro: It is more complex than one issue. The outside interests that I mentioned earlier in this interview include insurance companies, that are attempting to dictate treatment, by down coding or changing codes that we have entered on our claim forms. They are questioning the services that we provide, and making it more difficult for us to be reimbursed on a timely basis. Special interest groups, such as the Pew and Kellogg foundations, are pushing for midlevel providers, who will be trained as little as two years after high school, and they will be doing "simple" dentistry such as restorations and extractions independently. The frame work has been approved in three states, and other states are considering adopting these types of providers. These groups feel that midlevel providers are the same as nurse practitioners. Nurse practitioners are not doing invasive non-reversible procedures. The last issue that may be pressing us is our own complacency to fight back. We are seeing our membership numbers declining. We must keep our membership intact to fight the battle to keep dentistry the great profession that it is; not just for us, but especially for our patients.

VDAJ: If you could change one thing in the VDA right now, what would it be? Why?

Dr. Taliaferro: I wish we as leaders and staff could communicate better to our members the importance of the issues that are facing us, not only the ones I previously mentioned, but the ones coming down the road. We have the *Virginia Dental Journal*, and the *Chatter* to inform membership. We have an excellent website that is constantly being improved, but yet many members are either uninformed or uninterested in the information that we are trying to provide to keep them abreast of the issues facing them. We are constantly trying to find new ways and better ways to inform our membership. However it is a two-way street – members should read the materials we provide to be better informed.

VDAJ: Should the VDA seek legislation to force insurance companies to adopt a de minimus rule on covered procedures? What are the risks?

Dr. Taliaferro: In 2010 the VDA fought hard for legislation to prevent insurance companies from dictating the fees that they would allow on non-covered procedures. We fought hard and won the battle with lopsided victories in both the Senate and House. Insurance companies have skirted around the law by allowing 5% coverage on crowns and denture work, that with most plans if covered would be covered at 50%. Optometrists last year were successful in getting through a bill that had the de minimus clause that dictated a certain level of coverage, or else they could not dictate a provider's fee. This issue will be considered by the VDA House of Delegates at our meeting in Norfolk. I believe we should work to incorporate this into the original legislation that we fought for in 2010. Some have proposed that we also add in the event that the patient's insurance has been maxed out for the period; that they could not dictate fees on any services, as essentially they are not covered. I am concerned about adding that to the legislation. I believe that the insurance companies will fight us hard on that issue. If we are engaged in a major fight this winter in the General Assembly, it will cost lots of money with estimates ranging from $50,000 to $100,000 in lobbying efforts. In addition, it will involve lots of people engaging their senators and delegates both in Richmond and at home. If we are going to fight this battle we must be prepared to engage in a major battle on the Hill. I am willing to take on this fight if the membership wholeheartedly backs it.

VDAJ: Organized dentistry, the VDA included, has suffered a decline in membership percentage for many years. How can we reverse that trend?

Dr. Taliaferro: We must do a better job of informing our members of the value of VDA/ADA membership. I understand that some consider our membership dues expensive. However, I really believe it rests in the value that they feel they are getting for their dollar. It is very hard to satisfy everyone as we have young dentists who have certain desires, and older dentists that feel differently. We are constantly exploring ways to improve value

CONTINUED ON PAGE 4

40 UNDER 40

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

40 UNDER 40

DR. HARLAN HENDRICKS

Dr. Hendricks works with his father in Virginia Beach. In addition to their practice, he is Adjunct Faculty at VCU and volunteers at several local free clinics. He also loves to travel, with his most recent trips to Ghana and Ireland.

CONTINUED FROM PAGE 3

and to inform members of the value. For me personally, I receive much more value than it costs for the advocacy efforts that our profession engages. We are the last health profession that has not been taken over by outside interests. However, they are working very hard to take control of us. We must be engaged both monetarily and with numbers to win these battles.

We will focus a major part of our Strategic Plan this coming year on membership. Dr. Elizabeth Reynolds will be leading our Membership Council, and I am confident she and the council will do a great job. To reverse the trend in membership all of our members have to be involved by inviting and nurturing new members.

VDAJ: Studies of the VDA's own members have shown that dentists 3 to 10 years out of school are most likely to give up membership. How can this cohort be shown the value of organized dentistry?

Dr. Taliaferro: It is not easy. Young dentists today are graduating with a much larger debt than older dentist such as I had. Obviously, membership dues affect them more than a seasoned practitioner like me. When talking to younger dentists, I have heard and the surveys also show that they are interested paying off their debt, learning how to manage a dental practice and having someone advocate for them. The ADA/VDA is the only one that can do all three. The ADA recently negotiated a loan repayment program that will help young members greatly. We are starting in dental school to engage young members in events that will help them learn practice management. The ADA has business management programs that can help new members or even older members like me, manage our practices. We seasoned dentists must reach out to help our younger members and to invite younger dentists as members. When I visit with the young dentists and the dental students, I see bright, hardworking folks. If given the opportunity they will serve our profession well, both as practitioners and leaders.

VDAJ: Does corporate dentistry present a threat or an opportunity to the VDA? Explain.

Dr. Taliaferro: They present both a threat and an opportunity. The threat is in how they operate and do business. I don't think all dental corporations are bad. I do feel and have seen treatment plans from some corporate practices that are driven by quotas. I understand that we are running a business, but I do not feel we should see patients as a means of meeting certain numbers. Clinical decisions should rest on the patient being properly informed and educated on their options. If given that opportunity, the patient will make the right decision. It might not be the one we select, but it is right for them. Corporate dentistry also presents opportunity for the VDA. Lots of young dentists are working in corporate practices. We must not look down on them, even if we don't agree with their employers. We should invite them as members. If corporate practices do not treat dental employees well, they will leave. The will be more inclined to join our ranks if we treat them right. The ADA is working with several major dental corporations to develop a level of understanding. They have found that organized dentistry and the corporations agree on most issues. My understanding is that some of the corporations are resistant to signing off on not allowing quotas, etc. I know some members feel we should be fighting harder against dental corporations. However we are greatly restricted by anti-trust legislation. A lot of our concerns are looked upon by the government as being anti-competitive, even though we are actually trying to look out for the patient's welfare.

VDAJ: Where should the VDA seek its next generation of leaders?

Dr. Taliaferro: They are right there with us now. There are great young leaders at the dental school. We already have many young leaders that are active in the VDA. Dr. Terry Dickinson started a leadership group last fall, and has a new group starting in October. The emerging leaders are recommended by component leaders. They are taught many skills including practice management and various leadership skills. The participants in the program will have a thorough understanding of organized dentistry once they finish the program and they will also be better dentists.

VDAJ: Do you have mentors? Who are they? Why are they important in your profession and personal life?

Dr. Taliaferro: I have several folks who have influenced me and continue to influence me in my professional and personal life. First of all, my wife, Linda. She is my sounding board, my conscience, my cheerleader, my lover, and my best friend. I value her opinion on all aspects of my life.

My mother, although deceased since 1978, still influences me greatly. She was a nurse and a very caring person. I still ask questions about decisions I have to make, when I ask myself, "What would mama do in this situation?"

My high school track coach, Eddie Rhea. Eddie helped me turn my life around in high school. I was basically going through the motions in life before joining the track team my sophomore year. He taught me discipline and most importantly the value of hard work. He has fought Lou Gehrig's Disease (ALS) for several years and still inspires me.

My father in law, Kermit Early. I have known Kermit since 1974 when Linda and I started dating. He would probably be surprised to know that I am including him here. I have watched him over the years and really try to pattern my life after him.

Dr. Alfred Phillips, a retired dentist that I have known since 1994. Al and I have worked together for years with our nonprofit dental clinic in Winchester. I have consulted with him on several major dental and life decisions over the years, including my decision to run for President of the VDA.

Last but not least, Dr. Terry Dickinson. Terry is like the teacher we had in school, that everyone liked and gravitated toward. I am sure that many other leaders consider him a mentor. Terry is the person I go to when making difficult decisions, especially related to dental leadership. He is the dentist and person that I strive to be.

VDAJ: What does Dr. Taliaferro plan to be doing five years from now?

Dr. Taliaferro: Hopefully still practicing dentistry. I am 62 years old and I plan to practice until 70. I plan to stay involved in organized dentistry, and will be involved in the House of Delegates as a Past-President for 5 years. I want to keep volunteering with our local dental clinic and with a M.O.M. project. I have gone to Haiti in March with a mission team from the United Methodist Church the last two years. I will go in April this coming year. I am the only dentist on the team and do extractions and some education. My dream is to get a clinic established in the remote village where we work. Obstacles are many, as there is no electricity, no government assistance, and the people are poorly educated. However, they are rich in pride. It will be a few years before we can get a clinic that can do restorations and dental care as we in the United States are accustomed. I have learned from our local clinic and from working with the VDA, that you don't do these things alone. You pray and you involve others and the dream can be fulfilled.

MESSAGE FROM THE EDITOR

Dr. Richard F. Roadcap

Confusion reigns supreme when dentists prescribe antibiotics for patients with prosthetic joints. Despite an attempt in 2014 by the ADA Council on Scientific Affairs to update and clarify previous (2012) guidelines, practicing dentists often feel there are more questions than answers when deciding whether to prescribe prophylactic antibiotics for patients with prosthetic joint replacements (PJRs). In an article published in the January 2015 edition of the *Journal of the American Dental Association*, Sollecito et. al.[1] concluded 1) there was no evidence of an association between dental treatment and infection of prosthetic joints 2) antibiotic prophylaxis was ineffective and 3) prescribing antibiotics to patients with PJRs was not recommended. This seemingly commonsense advice has not, as many had hoped, laid the matter to rest, but instead has spawned even more complex and contentious debates over the propriety of what's called in most offices "premedication".

How did we get to this point? Prior to 2009, the American Association of Orthopaedic Surgeons (AAOS) and the ADA, in a 2003 "Advisory Statement", recommended prophylaxis for all PJR patients who were within two years of the date of surgery[2]. In 2009 the AAOS changed course and recommended that antibiotics be prescribed for all PJR patients for their entire life, and not just for two years.[3] In 2012 the AAOS and the ADA published jointly an evidence-based guideline that concluded dental procedures and prosthetic joint infections were unrelated. However the 2012 panel states this recommendation is based on limited evidence. The 2014 panel mentioned above was convened in part to quell the controversy which arose from the 2012 recommendations. The ADA Council (this time without AAOS participation) again recommended against prophylactic antibiotics for patients with PJRs.

It's no surprise that Sollecito et. al. generated lively discussion in the "Letters" section of JADA.[4] In the June 2015 issue six letters were summarized, and some of the comments follow below:

- A doctor from Wisconsin asks about liability should he decline to prescribe and infection results
- A professor at the Eastman Institute in Rochester asks for guidance if the patient can't remember their orthopedic surgeon, or if the surgeon can't be located
- A doctor in the VA healthcare system says dentists shouldn't have to ask orthopedic surgeons how to write a prescription, or have the surgeons write for them
- A faculty member at VCU notes that the AAOS has already declared the new (2015) guidelines to be at odds with the previous (2012) guidelines, and wonders about dentists' liability if they fail to consult each patient's orthopedic surgeon

The authors of the January article attempted, at length, to answer these concerns. They admitted that the 2012 statement was "not easily interpretable and elicited many questions from ADA members". Of particular interest to practicing dentists was their advice on dentist-physician communication:

> If the treatment is not urgent and the dentist wants to discuss an individual patient's circumstance, then it is recommended that the dentist delay care until he or she can discuss the treatment plan with the patient's orthopedic surgeon.

I interpret this sentence to say that if there's no emergency (most dental appointments are routine and not emergencies), the dentist must consult the orthopedic surgeon first before care is rendered, and consider the surgeon's advice on antibiotic prophylaxis. Earlier this year I created a document to be faxed to the patient's surgeon, citing the January 2015 publication, and asking for guidance on continued prescribing of antibiotics. My experience thus far has shown half of the orthopedic surgeons tell us to continue prescribing, and half don't respond to the fax. I know of only one instance in which the surgeon has advised us to discontinue antibiotic prophylaxis. My experience is limited to central Virginia, and the community of surgeons in other localities may hold different opinions.

Maybe our patients deserve better. I don't know. But they do deserve our best efforts, which seem to fall short. Were dentists somehow indemnified when writing prescriptions for PJR patients, I'd wager the number of scripts would decline dramatically. We'll never be released from liability, so a day when we don't have to ask a patient "Did you take your medicine?" is only a dream. And, what do I do in my own practice? I'm trapped in 2009: I still write prescriptions for PJR patients unless I have been released by the patient's orthopedic surgeon, although this practice seems to flout the January 2015 recommendations. Sollecito et. al. may have moved the needle, but ever so slightly. I'm still confused.

1 Sollecito TP, Abt E, Lockhart PB, Truelove E, Paumier TM, Tracy SL, Tampi M, Beltran-Aguilar ED, Franstve-Hawley J. The use of prophylactic antibiotics prior to dental procedures in patients with prosthetic joints. JADA. 2015; 146(1):11-16.

2 http://orthodoc.aaos.org/WinchesterOrtho/AAOS_On-Line__Antib.html

3 Viola TA. Antibiotic prophlyaxis: the debate over use in dental treatment continues. AGD Impact 2015; 43 (8): 16-20

4 Letters: prophylactic antibiotics. JADA. 2015; 146(6): 357-360

CORRECTION

VIRGINIA DENTAL JOURNAL
VOL 92, NUMBER 3
PAGE: 26

TITLE: DR. THOMAS UPSHUR TURNS 100

In this article Dr. Upshur's spouse was named as Diana when in fact her name is Betsy.

We would also like to clarifiy that Dr. Upshur is a past President of the Virginia Dental Association (1973).

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A PERPLEXING DILEMMA

Marvin E. Pizer, DDS, MA, MS, FICD; FACOMS (hon)*

An astute periodontist referred a 47 year-old, healthy white female to our office with the following information. The periodontist noted a 5x5 mm raised mass which did not respond to periodontal therapy, on the lingual gingiva between the cuspid and first bicuspid near the crest, on the right mandible. Radiographs revealed no evidence of bone or dental pathology. The periodontist wisely performed a biopsy and sent the specimen to the general pathologist. This was reported as "a well-differentiated squamous cell carcinoma which needs wider excision".

At this point the patient was seen in our office. (Figure 1) I took additional films, ordered blood chemistry and performed a thorough examination of the mouth, as well as a head and neck examination. Palpation of the gingival mass revealed a firm, fixed but non-bleeding tumor. It appeared as though the initial biopsy cut the tumor in half. (Figure 1) I next performed an excisional biopsy under local anesthesia and sent this tissue to our general pathologist at Alexandria Hospital, where the blood chemistry was evaluated and found to be normal. The pathology report from this pathologist read "pseudoepitheliomatous hyperplasia, fibrosis, and chronic inflammation, right lower gingiva". Now I have two diagnoses, one malignant and the other benign for this gingival tumor. I therefore began bringing these slides to the pathology departments of the hospitals where I did surgery and knew the competence of the pathologists. To my amazement the consensus was that I was treating a benign tumor of the gingiva. With some frustration I brought the slides to the Armed Forces Institute of Pathology in Washington, D.C. Their pathologists included general and oral pathologists – here there was complete agreement that this tumor was a "squamous cell carcinoma of the gingiva". As a final gesture I sent the slides to the chairman of Oral Pathology at the Virginia Commonwealth University School of Dentistry, whose valued opinion was "a well-differentiated epidermoid carcinoma".

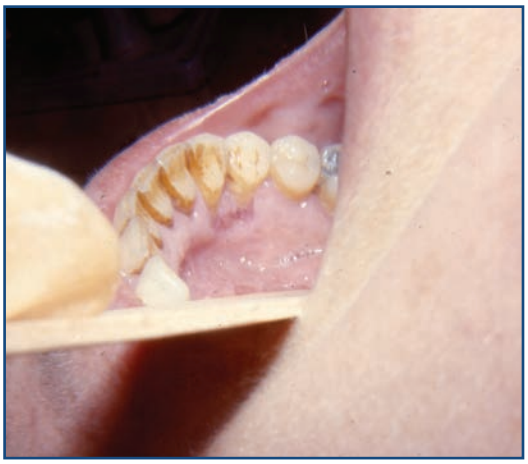
The next major decision involved the best surgical approach. I consulted fellow oral and maxillofacial surgeons and oral pathologists, and guess what? They each had different opinions. I listened carefully and decided to perform a marginal resection extending from the right lateral incisor to the first molars on the mandible.

Under conscious sedation and local anesthesia vertical incisions were made on both the buccal and lingual. The buccal flap was made to the depth of the mandibular sulcus and the lingual just below the floor of the mouth. Both cortical plates were exposed and with the dental drill the cortices were resected with horizontal resection below the roots of the teeth. The neurovascular bundle was left intact and the remaining inferior border measured about 1 cm wide.(Figure 2) By undermining the soft tissue on the buccal and lingual we attained a primary closure of mucosa on the occlusal aspect of the excision. Arch bars were attached to maxillary and mandibular dentition and with intermaxillary elastics we immobilized the mandible to prevent pathologic fracture. (Figure 3) The final pathology report read "vital teeth and associated bone and soft tissue – all normal". After three months the right mandible was ready for a removable prosthesis, and after one postoperative year the wound looked well-healed. (Figure 4) The patient was followed closely for the first five years and then on a semiannual basis for many more years.

*Formerly:

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

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



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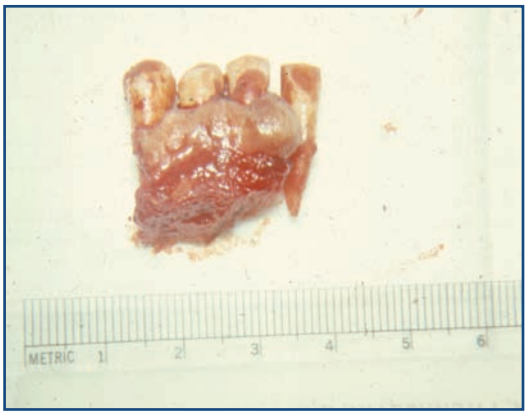

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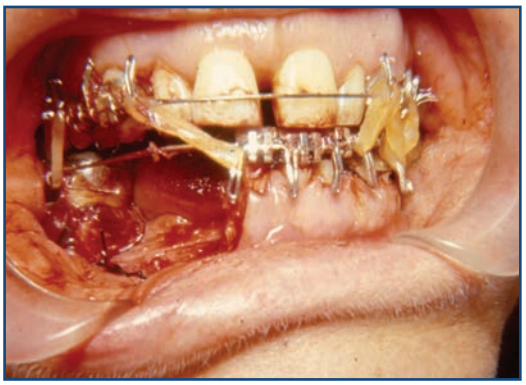

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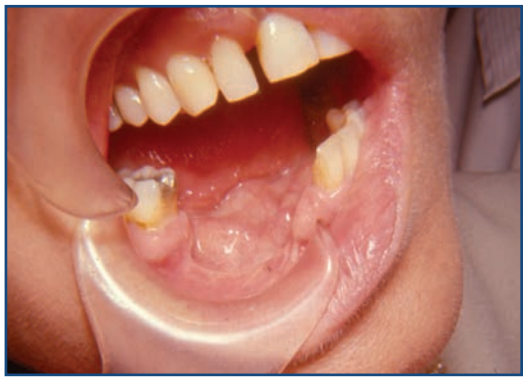

Figure 4

PRESIDENT'S MESSAGE

Dr. Richard Taliaferro

Mr. Speaker, Mr. President, VDA officers and Directors, members of the VDA House of Delegates, and guests. It is an honor to be on this podium in front of you this morning. I looked at a list of former presidents and saw many exceptional folks including two ADA Presidents, Dr. David Whiston and Dr. Ronald Tankersley. I know I have big shoes to fill. I want to thank Dr. Mike Link for laying the ground work for my year as President. Mike and I have worked closely this last year and his organizational skills and leadership have helped pave the way for my year as your President. I promise you that I will work my hardest and make the best use of my love and passion for dentistry and for our great professional organization.

Growing up I would have never dreamed of being in this position on this day. I did not have dentists in my family, nor did I have any family acquaintances, who were dentists. I was not a good student in early high school, and dug myself into a hole academically my first two and a half years. I was lucky to graduate with a low B average. Going into college my first objective was to stay there and hopefully graduate. Entering college, I would not have been considered pre-dental material. However, that is the great thing about America, we have the option of accomplishing a lot if we are willing to work hard. I did work hard in college and graduated Magna Cum Laude at Madison College, now JMU. Upon graduation, I entered the teaching profession and taught science for two years. Something grabbed at me during those first few years after college. I remember walking in the teacher's lounge about two weeks after school started that first year, and saw some of my former teachers who were near retirement, and I thought there was no way I would be in their place when I was their age. I enjoyed teaching and coaching, but I wanted something different. I decided to enter graduate school at MCV in pathology. Again, it only took me about 2 -3 weeks to realize that teaching at college level was not what I wanted to do.

My first year in graduate school, my dentist at home became ill with cancer and I decided to become a dental school patient. I was assigned to a junior dental student Tom Southard, whom some of you may know. Tom asked me what I would do after completing my degree, and my reply was I don't know, maybe I would consider a health profession. When Tom started talking about dentistry, something started to click. Maybe this is a career that would suit me. Tom and his wife Karen, also a dental student, encouraged me and I decided to apply and got accepted to the dental school at MCV. Dental school wasn't easy, but I enjoyed it. I worked hard in school and completed a GPR at Martinsburg VA center in West Virginia. During the residency, I knew I had landed in the right profession. There were only two dental residents at the facility and we got to tackle many procedures that were limited to specialists due to competition at other programs. I finished that program in 1984 and entered private practice and have loved every minute of dentistry since.

So I stand here this morning giving you an address, before I assume the office of VDA President on Sunday. For those of you who know Karen and Tom Southard you can thank them or condemn them for encouraging me.

I enter this position thinking about Harry Truman in 1945. Mr. Truman assumed the Presidency after Franklin Roosevelt passed away. He went to visit the family and to offer what help he could at their time of sorrow. Eleanor Roosevelt, in her blunt way quipped; "we don't need your help, you need our help, as you are now the President!"

I have prefaced my address today to emphasize the importance of being an American, the importance of extending an invitation, and the importance of seeking help in getting the job done.

Most dentists over the age of 40 have enjoyed a good career. We have been able to treat our patients ethically and in ways that we believe are best for them. We have made a decent income and we have not faced until recently intrusion from outside sources. In Virginia that has changed dramatically over the last 15 years. We have seen intrusion from third party payers that are forcing us to accept plans that infringe on our clinical decisions, and many do not allow us to make a decent income. In some cases we ae losing financially with each patient that we treat. We are seeing the penetration of corporate dentistry into private practice. I am not saying that major corporate dentistry is all bad, but I do have concerns when quotas are established. Let us make sure that patient care decisions are based upon the treating dentist that is looking that patient in the eye and discussing treatment, Not a Corporate Board!

We are dealing with access to care problems in the United States, and dentistry is now being looked at by outside entities to make improvements. These outside groups, seem to think that dentistry is a profession that anyone with a little amount of training, and I emphasize little; can do "simple dentistry". Now what is simple dentistry? Is simple dentistry an exam? Let's look for some holes and fix them. But, how big are those holes? Are we missing the small holes? What is that red spot there? Is it an ulcer or a cancer? Or how about that broken tooth, do you just grip it and rip it! They believe anyone can quickly learn to do what we do. We beg to differ.

This reminds me of dental school. In my fourth year oral surgery rotation, I had about

CONTINUED ON PAGE 10

CONTINUED FROM PAGE 9

50 extractions under my belt and wanted to do a more complex extraction. I was in the hospital clinic and had a patient with two partially impacted mandibular third molars. I presented the patient to the oral surgeon and he observed that the teeth were mesio-angular and right up against the second molars. He asked me to describe how I would proceed. I stated I would lay flaps and simply elevate the teeth out. Of course I had not taken into consideration that the teeth could not be removed except by surgery and sectioning. I assisted an oral surgery resident as he did the extraction and realized how difficult the extraction was, even for him. I have been practicing for over 30 years now and I am a pretty good judge of what I can and cannot do. However, it seems that most every day a procedure turns out to be harder or easier than I figured it would be. Do we really want to put poorly trained individuals in clinics doing these procedures independently? We think not.

Instead of allowing just anyone to do dentistry, let us look for the best folks to be our colleagues. Let us look in our practices for young folks to encourage to follow us in dentistry. One of the great feelings that I have had in dentistry, is having two patients in my practice enter dental school. One just finished dental school and graduated second in her class. The other is in his third year and I know he will be an exceptional dentist once he graduates.

We do need to be passionate about helping the needy and we need to explore the best ways to reach and help the needy. Instead of sending sub-par providers into the field, let us develop ways to deliver the best care to those needy patients. The Community Dental Health Care Provider (CDHC) is one way to do that. The CDHC will be an educated community member that will help patients navigate through the system. They will educate patients. We all know that proactive prevention is always superior to reactive treatment. In our community a group of dentists and community leaders established a non-profit dental clinic as on off-shoot of our Free Medical Clinic. We have three dental chairs, digital x-rays, and other up to date equipment to treat the needy. We know we have over 8000 eligible Medicaid patients, but we are having problems keeping our clinic open. A CDHC would be great in our area. We need to support the CDHC idea as much as possible.

I mentioned earlier in my address that America is the land of opportunity. However I believe it is more difficult to achieve that opportunity today than when I graduated from college. I graduated from dental school in 1983 with $20,000 debt. I graduated as an undergraduate with only a $1000.00 debt. Yes I had to work summer jobs and extra jobs during school, but I could do it. Today we see young folks accumulating up to $40 – 80 thousand in debt if they have no outside help; and that is for an undergraduate degree. Dental school being one of the most expensive educations will have the average debt between $200 and $250 thousand. How can someone pay off that debt, build a practice, raise a family, and save for retirement.

I know that some of you in my age group feel that we had to work hard to get where we are and they should do the same. The fact is that the opportunities we had are not as great for the generation having recently entered dentistry and about to enter dentistry. We owe it to our great profession, to insure that these new members can enjoy the great ride that we have had.

So how do we do it? How do we insure that dentistry remains the same great profession that it has been? How do we insure that our profession continues to rank high in all professions in public trust? How do we insure that we can deliver the best dental care without intrusion for our patients? How do we insure that we can practice as a dental professional, and live a good life, raise a family, and not be worried if we will outlive our retirement savings?

My friends and colleagues, it can be done, but it will involve a lot of work and perseverance. It kind of sounds like dental school, doesn't it? Dentists are a special group of people. We are meticulous, not afraid of hard work, willing to take a risk, and at times hard headed enough to know that we can get the job done, despite the obstructions that we face.

As I mentioned earlier in my address, we will not be able to do the job with a few good people. We will need lots of people to do the job. I truly believe that our great profession is at a critical crossroads. If we don't act quickly and successfully, our profession will suffer greatly, and the damage will either be non-repairable or at the least take several years to overcome.

Our emphasis this year will be on membership. Without a strong membership we are not relevant. We are limited in what we can accomplish with smaller numbers of members. It is impossible to achieve our large scale professional goals with a fragmented profession.

We will be meeting this fall to develop a three year strategic plan that will focus on membership. Our membership has dropped from 80% in 1983 to between 60 and 65%, depending on how you look at the figures. Talk to your friends in medicine and see how they enjoy their careers. You will find that they love their patients, they love medicine, but they hate everything else about it and many are simply fed up and retiring early. My friends, we have to insure that does not happen to us and our future colleagues.

As we develop our plan this fall, we will have goals for year one, year two, and year three, that of course will be tweaked each year. I ask that you support the plan and do your part to make it work. Your profession needs your help.

I am also instituting a challenge to this body today. I am challenging every member of this body to bring in one member this year. That person can be a person that has become a non-member, or inviting and welcoming a

person who has never been a member. Also, don't forget when you invite a new member that you nurture them early on. Think about it, if everyone meets this simple challenge, we will grow by 175 members this year. That would be a good start, but how about bringing in two new members?

Young members our efforts really include you. It is important that we have new members join to replace our retiring members. Keep in mind that this is YOUR organization and how we act now may determine your professional destiny. Please educate your fellow dentists on the importance of organized dentistry to the profession, but even more importantly to their professional success. United we will stand divided we will fall.

In addition to membership, we will focus our efforts on our finances. Your Board of Directors heard the message loud and clear from the membership last year that they were not pleased with an unbalanced budget. Dr. Steve Forte, our treasurer for the last three years has worked very hard to balance our budget. Having served on the Board of Directors for three years, I can tell you that it is difficult to balance our budget, and it is very complex. Several factors enter into the equation. First there are our revenue sources which are proceeds from member dues and proceeds from our for profit subsidiary, Virginia Dental Services. As you know Virginia Dental Services has signed on several vendors that provide services and materials to members and rebate back to us a percent of their profits. Although several members use these services, many do not. The less money we spend with our vendors the less we get back in rebates. One particular vendor B&B Insurance had been a major source of income for our association until the ACA or "Obama Care" came along. With the advent of the ACA, B&B's profits were drastically cut and their rebates have greatly decreased. You can help by using our vendors that in turn will result in more rebates to reduce our dues. Dr. Roger Woods and his group are constantly searching for vendors to help us reduce our dependence on dues, they deserve our appreciation and support.

Membership dues are a major component of our income. Even with steady membership numbers we are still engaging in a losing battle as many older dental members are deserving for their many years of service and are eligible for lower dues. We have younger members early in their careers who are eligible for lower dues to help them in the early years. With an aging population, this may only get worse. Lastly, small budget items such as fees to process credit cards have increased about $20,000 in one year. These small items all add to the cost of doing business as an association. Out new Treasurer will be looking at ways to build our reserves to offset these potential losses in income in the future.

Going back to membership we can solve a lot of our problems by increasing our membership numbers and maintaining them.

We also must be aware that we had to and will have to continue to spend money on advocacy efforts. Unfortunately in today's political climate money speaks. We don't buy votes with our political efforts. We invest in their ears. By supporting candidates, they listen to us and in fact in many instances solicit our opinion on bills and regulations that they are considering. In order to keep our profession strong we must continue with our strong advocacy efforts and that costs money. By the way, most of our efforts politically do help us, but the overwhelming majority of our actions are to improve our services for our patients. We know that if we treat our patients right, we will always be rewarded, and not just monetarily.

So, you see, it comes back to membership. We must keep our membership numbers strong to stay strong as an association. We need to realize that our numbers include lots of folks that have retired or are close to retirement. We have to understand that our younger dentists are having difficulty making ends meet early in their careers. We have to find ways to bring them into membership, to nurture them to insure that they are successful and to listen to their ideas as they become the leaders of tomorrow. My friends and colleagues, I see so many dentists that are not members that are bright, hardworking, caring folks, that we need; and they need us. Let us go after them to help them in their efforts to be better dentists; and let us pursue them as we dream about the future of our great profession.

Dr. Ron Tankersley, former ADA and VDA President, told me last fall that Presidents have very little power. We may be at the front, but without people working with us, we can accomplish little or nothing. This organization needs everyone to put the boots to the road and work to make and keep our profession strong.

I finish today by again stating my love and passion for dentistry and our great professional organization. I hope that you also have that same passion, and I ask for your support as we work together to keep the profession of dentistry the great profession that it is.

40 UNDER 40

DR. EDDY NORACHAI PHISUTHIKUL

A Board Certified Periodontist, runner and animal lover, Dr. Eddy Norachai Phisuthikul relocated to Falls Church after practicing in New Jersey for several years. He earned his degrees from New York University and Rutgers University. He takes pride in his profession.

VDA SERVICES ANNOUNCES NEW ENDORSEMENT – IMEDICOR

Elise Rupinski, Director of Marketing and Programs

VDA Services is pleased to announce the endorsement of iMedicor for secure electronic communications. The VDSC Board of Directors looked at a number of firms in the industry and identified iMedicor as a great solution for members who are looking for a way to communicate in a secure manner with both patients and colleagues. Dr. Roger Wood, President, Virginia Dental Services Corporation said about the endorsement: "This is an exciting new program that will assist members in the complicated arena of HIPAA compliance. Having a way to communicate electronically in a secure way is a necessity in today's healthcare environment."

iMedicor is a national provider of secure, HIPAA-compliant, software and consulting communication solutions for the healthcare community. iMedicor offers dentists, patients and other healthcare providers the use of a secure, HIPAA-compliant EHR platform and communications network that addresses current federal standards for security and interoperability as defined by Meaningful Use regulations. iMedicor also serves as a leading national Meaningful Use consultancy that assists doctors and dentists convert from paper to electronic health records (EHRs) while qualifying under Meaningful Use Federal Incentive Funding guidelines.

VDA Services has also negotiated a special member benefit to provide added value to VDA Members. Members will be eligible to receive a 30 day free trial, no set-up fee and a 35% discount off of the monthly subscription cost.

To find out more or to sign up for the iCore Exchange through iMedicor please call 888-810-7706 or visit signup.imedicor.com/vda/.

iMedicor

iCore Exchange

A WEEKEND IN WINTERGREEN

Dr. John "Cappy" Sinclair

There has already started to be a slight chill in the air, and in some cases the leaves may be starting to turn their brilliant fall hues. However, just a few months ago when the humidity and the temperatures were high, there were about 70 new dentists and dental students that gathered for a great inaugural new dentist CE summit at Wintergreen resort the first weekend of August…and I am just going to give all of those who were unable to attend a slight glimpse of what you missed!

We started with some great clinical CE regarding immediate-load implant cases in both full arch and single tooth scenarios from Drs. Karen McAndrew and Chris Richardson. As a new dentist, the one take-home for me was to find a good team to work with. As a young dentist I first tried to do everything, but after a while I started playing to my strengths and have tried to surround myself with a team of specialists that has the same standards and philosophies that my patients desire for a predictable outcome. In the world of internet reviews and high patient expectations, having a team that can deliver on all fronts is a lesson for all dentists, not only new ones.

Another piece of advice from Dr. Richardson was about continued learning and trying to stay on the cutting edge (no pun intended) as a periodontist. He showed us casework that he and a fellow periodontist have been doing with auto-transplantation of teeth in adolescents. I won't go into the details of auto-transplantation; however, I think that would be a great future journal article from him. It was great to hear from him that, even after 15 years of practice, he is always willing to practice just outside the comfort zone to keep the practice of dentistry fresh and exciting. It may not resonate with us now in the initial phase of our careers, but it's great advice for the future!

The stars of the morning on our second day were Drs. Bruce Hutchinson and Terry Dickinson who gave us insight on what organized dentistry does and how it impacts us in our daily practice. Dr. Hutchinson told about the great things that ADPAC is doing at the state and national level. Some involve student debt, a major concern for both new dentists and dental students alike. Dr. Dickinson gave us a preview of what the ADA has been doing to address the many concerns of new dentists as well as economic forecasting from the ADA's team.

The main event for the day was Dr. Chris Ramsey. Dr. Ramsey gave an interactive and informative presentation ranging in topics from dealing with esthetics and patient behavior, to insurance coding. One particular esthetic case that he presented left many of the dental students awestruck after he commented that a 10 unit temporary was fabricated in about 10 minutes. Many students commented that a single unit still takes at least twice that amount of time! However, he also emphasized that these types of results aren't just by chance. The real value of these cases is doing the comprehensive type of dentistry that each one of your patients deserves the moment they walk though your door. Armed with a plan and a checklist, the dentistry that we do could be predictable, enjoyable, and profitable.

That afternoon as the sun started to peak out from behind the clouds, we hopped on a bus and headed down the mountain to go check out two great spots, Bold Rock Cidery and Devil's Backbone Brewery. It was a great way to end a day and a half of fellowship and education. However, even though this was the end of the weekend, it could be the beginning of continued learning with my peers and the new dentist meeting!

Editor's Note: Dr. Cappy Sinclair, a VDA member dentist, practices in Virginia Beach and writes on subjects of interest to new dentists. Direct your questions to him at cappysinclair@gmail.com.

40 UNDER 40

DR. JATINDER S. KALER

Dr Kaler is motivated by the idea that "Dentistry is a blend of Art,Technology and Motivation". He likes to spend time with his patient and listen to their concerns.

DENTAL TOURISM, CAVEAT EMPTOR

By: Philip A. Gentry, D.D.S.*

Abstract:
Dental Tourism, in which patients travel abroad to have dental treatment, continues to increase in popularity. This is mostly to save money; however, this creates an ethical dilemma regarding continuation of care and follow-up treatment, as well as, who takes care of problems, should they arise. In this case report I discuss a patient who traveled to Bolivia to have a bridge made to save money.

Introduction:
A quick Google search for dental tourism will reveal a plethora of companies enticing one to book a dental vacation. DentalTourismExpert.com web site states: "Do you think your money is better spent: sitting in an expensive dental chair at home, or lying on the beach while a highly-trained dental specialist fashions your crowns or implants at less than half the going price?" (1) Dentaldepartures.com boasts that it has over 3700 dentists, in 1000 clinics in 33 countries. "Tens of thousands of patients have saved millions. Search by procedure, location, clinic, dentist, language spoken (and that's not even an advanced search). Free quotes are available in 8 currencies, one stop shopping, easy booking, and best price guarantee. Savings of 50-75% are standard." (2) Costaricandentalsolutions.com asks, "Why not experience the same high quality care at 50-70% savings while possibly enjoying a small vacation?" They stress how much closer to the United States Costa Rica is in contrast to distant destinations such as Thailand, India, or South America. (3) "With lush rainforests and jungles, breathtaking beaches, stunning volcanoes and misty cloud forests, Costa Rica is a living paradise and considered the jewel of Central America." (4)

How could one not want to visit beautiful Costa Rica, or any of these wonderful locations and have a fun vacation and get dental treatment done for half price, especially when all patients hear about is how expensive dental treatment is at home? While there are many excellent dentists all over the world, and fees are indeed lower in many other countries, it's the follow up care, maintenance, and long term patient commitment that are very important. One visit to a faraway dentist may have been a fun and positive experience. We are all free to choose inexpensive dental treatment; however, this may turn out to be more expensive in the long run. A single visit for dental treatment is not the same as long term dental care. (5)

Case Report:
A 63 year-old patient presented with a chief complaint of "sore gums". He had a bridge recently made by a dentist in Bolivia. (Fig 1) He said he had it made there because it was cheaper. The area buccal to the left maxillary central incisor was red and inflamed and painful to palpation. An examination was performed and periapical radiograph of the area was taken (Fig 2).

The patient was informed that there was a piece of the root present under the bridge. We discussed treatment options and benefits and risks. The patient agreed to allow me to cut a surgical flap and remove the root and try to save the bridge. The medical history was reviewed. The patient stated he had high blood pressure and was allergic to aspirin. The blood pressure was taken, and was 128/85. Two carpules of 1.7ml. 2% lidocaine HCL, 1:100,000 epinephrine were given. A number 15 surgical blade was used to cut a buccal flap (Fig 3). The thin buccal cortical bone was chipped away with a #9 Molt Periosteal Elevator to expose the roots. The root fragments and infective tissues were removed (Fig 4) and flap sutured with 2 size 4.0 non-absorbable sutures (Fig 5). The patient was prescribed amoxicillin 500mg, evert 8 hours for 10 days. The patient returned 10 days later for post-operative examination and suture removal. All was well and he felt fine.

The patient returned exactly three months from the date of the surgery to evaluate healing and have a photograph (Fig 6) and periapical radiograph (Fig 7) taken. The patient was totally asymptomatic and very happy with the results. The bridge was solid and had no mobility. The tissues looked normal and bone was filling in. Healing was excellent and the patient expressed his gratitude for saving his bridge. The patient was informed of the poor long-term prognosis of the bridge and to continue returning regularly for dental visits. Since he had no dental insurance and limited financial means, and a very nice man, I told him I would not charge for any of these post-operative visits, and work with him and keep the cost as low as possible to restore his smile in the future when the bridge fails.

Discussion:
With more and more of our patients traveling abroad for dental treatment, postoperative care and subsequent emergencies will need to be addressed by the local dentist in the US. Dental tourism treatment often involves extensive procedures over a short period of time. With this type of treatment, possible complications and need for follow-up care are one of the main concerns with dental tourism. (6,7) Although there are excellent dentists

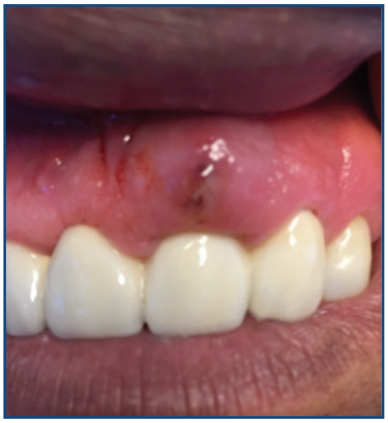

Figure 1. Painful, swollen buccal root area of tooth #9.

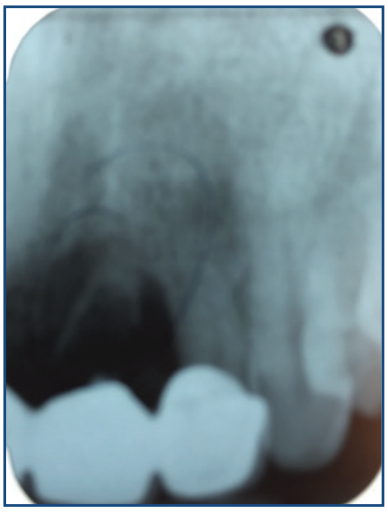

Figure 2. Radiograph of #9 area showing remaining root pieces.

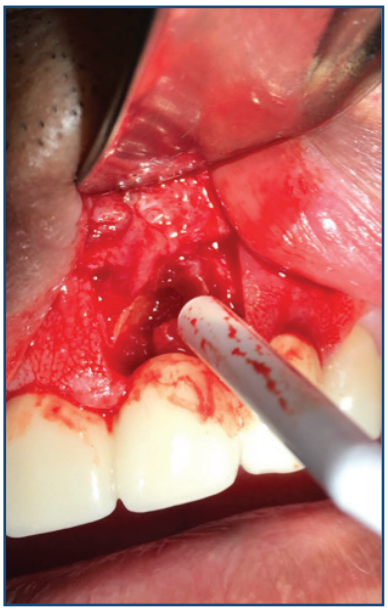

Figure 3. Surgical flap to expose infected tissues and root.

throughout the world, it is difficult to obtain clinical records and x-rays, and discuss the treatment with the dental tourism dentist. If the treatment was done nearby, or anywhere in the US, it is easy to call the previous treating dentist and discuss treatment. The American Dental Association defines dental tourism as the act of traveling to another country for the purpose of obtaining dental treatment. The patient has the freedom to choose where he or she obtains dental treatment. Ethically, the dentist should treat patients who received dental treatment outside the US the same as if the patient had been treated in any other practice. The dentist should explain to the patient their oral health condition and if an emergency develops as a result of the dental tourism treat the emergency, or refer the patient to another dentist to care for the emergency. Dentists should educate patients and explain to them their treatment options and costs. If a patient is considering dental tourism the dentist should discuss cost savings versus potential problems and follow up care and emergencies. (8)

According to the Academy of General Dentistry, there is no guarantee with treatment provided in foreign countries. If problems arise when the patient returns home, the resulting treatment may end up costing a lot more than what the original treatment would have been. According to the AGD, there are five major problems with dental tourism: 1) A large amount of dental work is done is a short period of time. 2) There may be communication problems if the dentist does not speak the same language. 3) There could be problems getting reimbursed from the dental insurance company. 4) Dentists in other countries may have less stringent standards than are found in the US and Canada. 5) There may not be laws, regulations and board review committees that oversee the foreign dentist. It may be difficult to take legal action in another country. (9)

Conclusion:

Although excellent dentists, good dental care, and beautiful beaches can be found throughout the world at lower prices, it is very important for patients to consider the benefits and risks of traveling long distances to save money on dental treatment. Is it worth it to fly far away from home to save 50%? Most dental treatment requires follow-up care, adjustments, maintenance, and future visits. How important is it for you to have a relationship with a local dentist you trust, and can stop by or call anytime to speak to should a problem arise, or if you have a question? What board of dentistry or legal recourse do you have if things do not work out? Who will take care of you? This must be considered, not simply the cost of a particular treatment.

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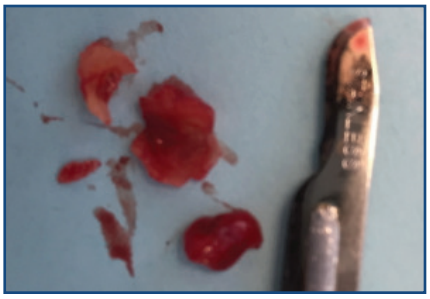

Figure 4. Root fragments that were removed.

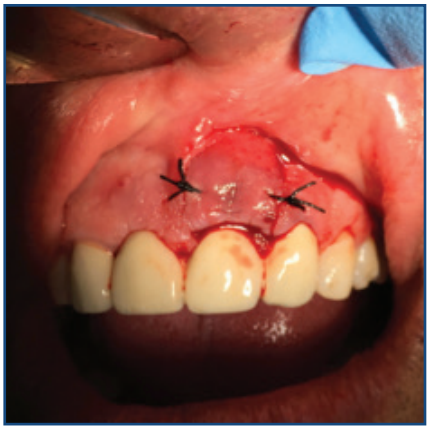

Figure 5. Sutured flap following surgery.

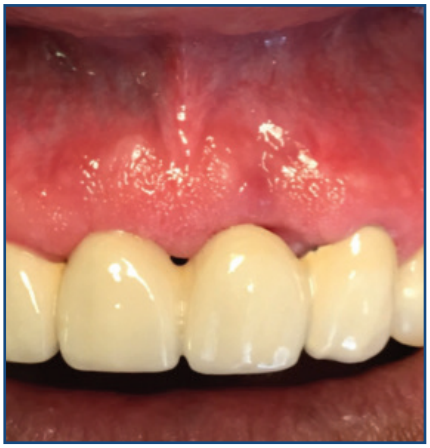

Figure 6. Three month post-op photo

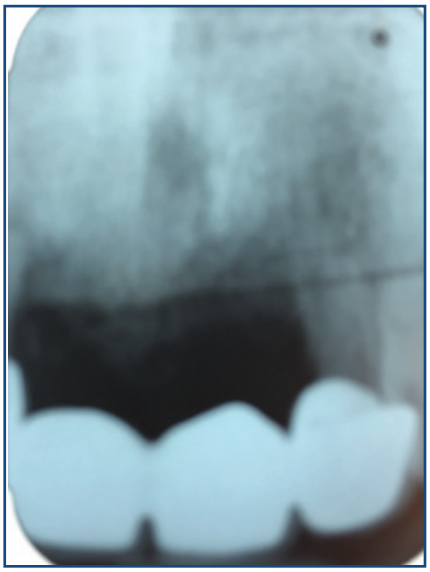

Figure 7. Three month post-op radiograph

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PATHOLOGY PUZZLER

Dr. John Svirsky

A twenty five year old white male presented to an oral surgeon for a painful lesion of the left lateral tongue of three week duration (figure 1). The patient stated it has not changed in size. His past medical history was reviewed and uneventful. However he smoked "recreational weed" twice a week. Previous surgeries included three anterior cruciate ligament repairs. A biopsy was performed.

Your differential diagnosis should include which of the following?

1. Pyogenic granuloma
2. Traumatic ulceration
3. Squamous cell carcinoma
4. Traumatic ulcerative granuloma with stromal eosinophilia
5. Salivary gland tumor
6. Foreign body granuloma
7. Granular cell tumor
8. Fungal infection

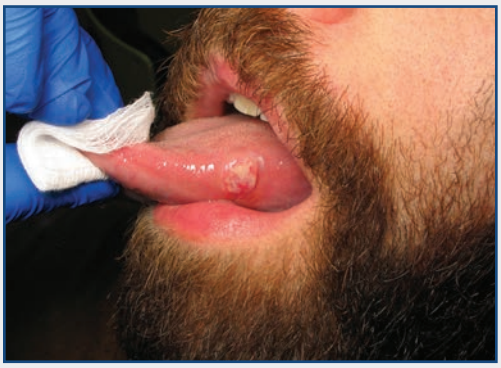

Figure 1

CONTINUED ON PAGE 18

ORAL SURGERY ABSTRACT:

MONACO G, DESANTIS G, PULPITO G, ANTONELLA GATTO MR, VIGNUDELLI E, MARCHETTI C. WHAT ARE THE TYPES AND FREQUENCIES OF COMPLICATIONS ASSOCIATED WITH MANDIBULAR THIRD MOLAR CORONECTOMY? A FOLLOW-UP STUDY. J ORAL MAXILLOFAC SURG. 2015; 73(7): 1246-1253

The purpose of the study was to determine the types and frequencies of complications for coronectomies performed on patients with impacted third molars in proximity to the inferior alveolar nerve. Coronectomies were performed in order to avoid neurologic injuries that may otherwise be occur in typical surgical extractions of such teeth. This was a prospective cohort study that analyzed 94 healthy patients ranging in ages from 18-70 (37 men and 57 women with an ASA Classification of I) treated in the dental clinic of the Department of Oral Surgery at the University of Bologna in Italy from December 2009 to June 2013. A total of 116 coronectomies of mandibular molars were performed (56 were full bony impacted and 60 were partially impacted). Other inclusion criteria were: (1) presence of at least one third mandibular molar that needed extraction for previous episodes of pericoronitis or periodontal disease distal to the second molar (2) the presence on panoramic film of at least one radiographic marker that was considered strongly predictive of close contact between the IAN and the third molar roots (e.g., increased radiolucency, narrowing, and interruption of the radiopaque border) (3) direct contact between the roots and the mandibular canal owing to the absence of cortical bone as evaluated by CBCT. Exclusion criteria were: (1) any systemic conditions that precluded surgical treatment (2) the use of antibiotics or anti-inflammatory agents in the 14 days before surgery (3) third molars with caries, endodontic disease or premature apices. In those patients immediate complications (within one month) and later ones (ranging from 2 to 36 months after the procedure) were investigated. The predictor variables examined via descriptive statistics, Kaplan-Meier analysis, and Cox hazards modeling in the study were: (1) experience of the surgeon (< 10 yr. or more than 10 yr. (2) length of surgery (3) types of third molars inclusion (4) patient age. In order to assess the postoperative complications the following outcome variables were examined : (1) neurologic injuries (2) postoperative pain (3) swelling (4) fever (5) alveolitis (6) pulpitis (7) root exposures (8) success rate of coronectomies and need for second surgery. During the three-year follow-up 28 patients (a total of 29 coronectomies) dropped out of the study or were lost due to lack of follow-up compliance. Results show that there were no cases of injuries to IAN or lingual nerve. Thirty complications were observed (25 within one month and 5 between the periods of month 2 to month 12). Surgeons with less than 10 years of training exposed patients to greater risk of complications (hazard ratio = 2.069; 95% confidence interval, 1.004-4.263). An overall 74% success rate at 6 months post operatively was demonstrated when considering all 8 success criteria. A second surgery was only needed in 6% of the cases. Of all the retained roots from the coronectomies, 80% showed postoperative migration. In conclusion this prospective cohort study demonstrated that coronectomies of impacted mandibular third molars considered to be at high risk for typical surgical extractions did not result in temporary or permanent injury to the inferior alveolar nerves or lingual nerves as well as an overall low risk for other complications. In 6% of the cases a second surgery was needed to remove root fragments that had migrated. The authors of this study, however, are recommending that additional studies be performed with larger patient samples to further investigate differences in postoperative complications in relation to the patient's age.

LUDMILS ANTONOS JR., DMD;
Resident, Department of Oral and Maxillofacial Surgery, VCU Medical Center

CONTINUED FROM PAGE 17

PATHOLOGY PUZZLER

Dr. John Svirsky

Considerations: Pyogenic granuloma, traumatic ulcerative granuloma with stromal eosinophilia

The clinical appearance with pain and short duration suggested a traumatic ulcerative type lesion. However the traumatic ulcerative granuloma with stromal eosinophilia, the pyogenic granuloma and the squamous cell carcinoma could not be excluded. The pain and short duration suggested a reactive/inflammatory process. A pyogenic granuloma could have this appearance and the patient's age and short duration suggested a benign process. Foreign body granulomas have a history of trauma/injury and typically are not raised and ulcerated. If the lesion was indurated, I would be worried about it being malignant. Salivary gland tumors are rare on the tongue and typically are deeper without ulceration and present for a longer time. Granular cell tumors occur on the tongue but are smaller, non-ulcerated and may be normal color or white surfaced. Fungal infections of the tongue are typically candidiasis which shows scattered white lesions and typically occur in other regions of the mouth concurrently. Other fungal infections such as histoplasmosis when they occur on the tongue could present with ulceration. However, they would be secondary to pulmonary disease.

The diagnostic biopsy revealed the following:

Histologic examination reveals sectioned soft tissue consisting of ulcerated mucosa showing transition to an infiltrating squamous cell carcinoma that involves the underlying connective tissue and striated muscle bundles.

The final diagnosis from the biopsied material is a well differentiated squamous cell carcinoma. (Figure 2-3) This tumor is more worrisome since it is invading striated muscle bundles (Figure 4). This diagnosis was a surprise based on the age, short duration (based on patient history) and uneventful medical history. The clinical appearance is compatible with a squamous cell carcinoma. Short duration squamous cell carcinomas are not painful and typically do not occur in 25 year olds. As we have been taught, "tumors do not read textbooks and the patient is a case of one".

This case was submitted by Dr. Dorcha Boisen, a graduate of the Virginia Commonwealth University Oral Surgery Residency Program, who is presently in private practice in Montrose, Colorado.

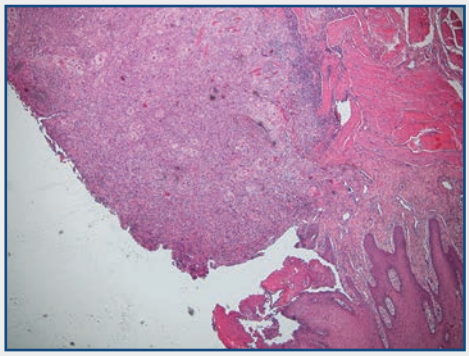

Figure 2

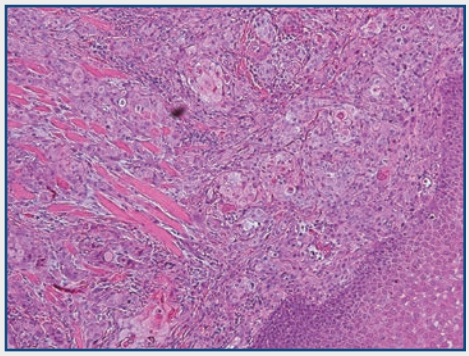

Figure 3

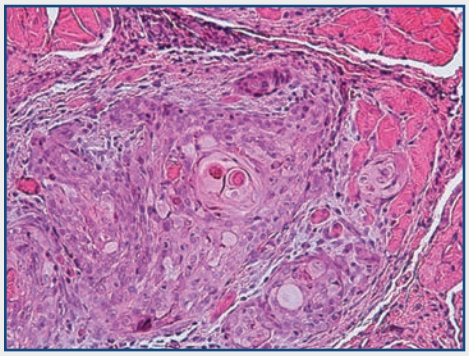

Figure 4

40 UNDER 40

DR. VERONICA F. MILLER

Dr. Miller graduated from Temple University's Kornberg School of Dentistry in 2003. She started her private practice in Vienna in December 2013. She currently lives in Vienna with her husband and three children.

ORAL SURGERY ABSTRACT:

GURGEL COSTA FW ET. AL. DOES THE PREEMPTIVE USE OF ORAL NONSTERIODAL ANTI-INFLAMMATORY DUGS REDUCE POSTOPERATIVE PAIN IN SURGICAL REMOVAL OF THIRD MOLARS? A META-ANALYSIS OF RANDOMIZED CLINICAL TRAILS. ANESTH PROG. 2015; 62(2): 57-63

This is a meta-analysis of randomized clinical trials evaluating the effectiveness of administering preoperative oral NSAIDS for management of postoperative pain after surgical extraction of third molars. NSAIDs act to reduce prostaglandin production and therefore pain. The peak concentration of prostaglandins associated with damaged tissue is between 3-4 hours, which is also the point of maximum post-operative pain. In order to evaluate the relationship between preemptive NSAID administration and postoperative pain, online electronic searches were conducted using PubMed. Inclusion criteria were as follows: NSAIDs administered orally prior to mandibular third molar extraction under local anesthesia, without acute symptoms, with the goal of preemptive analgesia. Exclusion criteria: Medicating with drugs other than NSAIDs, NSAIDS administered postoperatively, Medications not given orally, patients with preoperative pain, general anesthesia, methods of pain control other than medication, and use of an undocumented type of NSAID. Of the 704 articles that were obtained, 6 articles met criteria for review. The study included 420 patients, 171 men and 249 women, between the ages of 18.1-27.9 years old. NSAIDS that were used included celecoxib, ibuprofen, ketoprofen, diflunisal, and naproxen sodium. The data showed that there was no statistically significant difference in pain control with preoperative administration of oral NSAIDS (P=0.2227) with odds ratio of 2.3. One study by Al-Sukhun did show a statistical difference with the use of celecoxib. He concluded celecoxib (selective COX2 inhibitor) had a superior effect over ibuprofen (slightly more COX1 inhibition than COX 2.) A study by Aznar-Arasa et al showed statistical significance in pain reduction with use of ibuprofen, however this article was excluded, due to lack of numerical contingency data. Both of these findings suggest there is a positive relationship between preoperative NSAIDs and postoperative pain, which necessitates further studies for true correlation. Also, variations between the studies evaluated may have led to inconsistent data. These include differences in local anesthetic, concentration of vasoconstrictors, use of sedation, combinations of other medication, among others. While this meta-analysis shows no difference in preoperative NSAID administration reducing post-operative pain, it does suggest a relationship between NSAIDs selective for COX2 and increased effectiveness in pain reduction. A clinical study evaluating selective inhibitors of COX2 and effective pain reduction would be needed for this determination.

JASON M. WOOD, DMD; Resident, Department of Oral and Maxillofacial Surgery, VCU Medical Center

ORAL SURGERY ABSTRACT:

IGOUMENAKIS O, GIANNAKOPOULOS NN, PARARA E, MOUROUZIS C, RALLIS G. EFFECT OF CAUSATIVE TOOTH EXTRACTION ON CLINICAL AND BIOLOGICAL PARAMETERS OF ODONTOGENIC INFECTION: A PROSPECTIVE CLINICAL TRIAL. J ORAL MAXILLOFAC SURG. 2015; 73(7):1254-58

It is well established among clinicians that management of the causative tooth is of paramount importance in treating odontogenic maxillofacial infections. This study is the first to demonstrate through measurable clinical parameters that early removal of the causative tooth enhances resolution of the infection. From 2010-2013, the study separated participants with odontogenic maxillofacial infections, a total of 179, into two groups - an extraction group and a non-extraction group based on whether the tooth was determined to be non-restorable. The study deemed a tooth non-restorable if it had extensive carious decay, vertical tooth mobility, or root fracture. They excluded patients with non-odontogenic infections, poor immune status, and local tissue pathology including cystic lesions, osteonecrosis, and irradiation history. Also excluded were patients that had undergone any dental treatment to manage their infection. After separation into the two groups, the treatment algorithm was the same. All patients underwent established clinical protocols for incision and drainage as well as appropriate broad spectrum antibiotic coverage. Axillary temperature (maximum daily), white blood cell count, fibrinogen level, and C-reactive protein levels were recorded on admission and compared to the second post-operative day.

Similar to previous studies in the literature, this study found a statistically significant difference in the mean length of hospital stay, being shorter for the extraction group (5.37 days) compared to the non-extraction group (6.42 days). Importantly, the study also demonstrated that there is a biological association of extraction of the tooth with a faster resolution of the infection. The mean decrease of axillary temperature, white blood cell count, fibrinogen, and C-reactive protein was greater in the extraction group for each of these variables when compared to the non-extraction group. These results are more impressive when one considers that non-restorable teeth likely carry a larger bacterial load, which puts the extraction group in a unfavorable state prior to the study. The results are important because they justify sacrificing a potentially restorable tooth in the setting of a severe or life-threatening infection. They also demonstrate the importance of early tooth removal in the setting of suspected odontogenic infection and suggest increased weight should be given to extraction in cases where extraction is questionable.

DR. BRYAN WHEELER; Resident, Department of Oral and Maxillofacial Surgery, VCU Medical Center

ORAL SURGERY ABSTRACT:

OHKUBO K, SUSAMI T, MORI Y, NAGAHAMA K, TAKAHASHI N, SAIJO H, TAKATO T. TREATMENT OF ANKYLOSED MAXILLARY CENTRAL INCISORS BY SINGLE TOOTH DENTO-OSSEOUS OSTEOTOMY AND ALVEOLAR BONE DISTRACTION. ORAL SURG ORAL MED ORAL PATH ORAL RADIO ENDO. 2011; 111(5) :561-567

Traumatic injuries to the incisors often cause damage to the periodontal ligament (PDL). Without the PDL, the osteoclastic and osteoblastic activity will remodel the surrounding bone on the root surface resulting in ankyloses. In the growing child, vertical growth of the alveolar bone is facilitated by continuous eruption of the teeth supported by the PDL. An ankylosed incisor will fail to keep the eruption pace with the rest of teeth and halts in a position below the occlusal plane. This article presents a technique to mobilize the ankylosed incisor using distraction osteogeneis. The Procedure is performed as follows: First, a horizontal incision and dissection is made in the vestibule over the ankylosed tooth. Next, two vertical osteotomies are performed on either side of the ankylosed root, which are connected above the root apex with a horizontal osteotomy. It is important to preserve the palatal tissue which is the main source of blood supply to the dento-osseous segment. Once this segment is mobilized, an orthodontic arch wire with T loops is applied to the brackets placed prior to the procedure. After completion of 4-7 days of latency period, forces are applied to the ankylosed tooth using the T loops by bending them at each follow up visit. Each visit a small bend is applied; therefore, over the course of few weeks, gradual forces will result in tooth movement until it reaches the desired position. Once the distraction phase has completed, a stabilizing wire is placed to consolidate the segment in the new position. Other treatment options include extraction of the ankylosed tooth; however, this will result in a significant bony defect which is challenging to restore. Re positioning osteotomy may also be considered as an alternative; but the movement is limited by the stretch allowed by the palatal tissue and only few millimeters of advancement may be accomplished. The limitations of the latter two techniques are overcome by the distraction method, since not only the alveolar bone will be restored to the appropriate level but the gradual movement will also expand the surrounding soft tissue allowing for greater distance of advancement. Possible complications of the technique presented in this article include premature bony healing of the dento-osseous segment if orthodontic forces are not applied in a timely manner, which will necessitate an additional procedure to remobilize the segment. Another potential complication is relapse of the ankylosed tooth in infra- occlusion. This occurs if the child's growth continues after the distraction treatment has completed as the tooth will once again fail to erupt with the dental arch. In conclusion, this article presents a useful technique involving both the surgeon and orthodontist to manage traumatized ankylosed incisors in the growing child by providing restoration of alveolar bone and gingival margins to the appropriate level.

FAHAD ALSAAD, DDS; Resident, Department of Oral and Maxillofacial Surgery, VCU Medical Center

ORAL SURGERY ABSTRACT:

SHAH A, KWOK J, SPROAT, C.CORONECTOMY SEQUALE: A 5-YEAR FOLLOW-UP STUDY J ORAL MAXILLOFAC SURG 2015; 73(9)SUPPLEMENT: E10–E11

This was a 5-year retrospective observational cohort study, to determine the status of the coronected root following coronectomy procedures preformed on mandibular third molars (M3M) that exhibit radiographic signs of involvement with the inferior alveolar nerve (IAN). All coronectomies were performed at a single oral surgery location in London, England over the 5-year period and panoramic radiographs were taken preoperatively and post-operatively at follow-up appointments to compare and assess the overall degree and migration pattern of the coronected roots. Data collection included patient demographics, degree and angulation of impaction, incidence of infection and dry socket, nerve morbidity, calibrated measurements of root migration on radiographs, and the incidence of subsequent removal of the coronected roots. The study included 150 coronectomies, and there was a patient ratio of 2:3 male/female. The study showed that 61% of the coronected roots migrated coronally. Patients that were less than 30 years old exhibited higher degrees of migration. This study showed reported that there was less than a 4% dry socket and infection rate, a 5% rate of subsequent "problems" requiring removal of coronected roots, and a 0% incidence of IAN damage even on those that later needed coronected roots removed. Thus the study concluded that coronectomy is a safe option for M3M's that show radiographic signs of IAN involvement. Coronected roots may need to be removed at a later date after they have migrated coronally from the IAN, but this eliminates the potential to damage the IAN during removal of M3M's with IAN involvement.

V. PATRICK HALL, DMD; Resident, Department of Oral and Maxillofacial Surgery, VCU Medical Center

ORAL SURGERY ABSTRACT:

COSTA OENNING AC, SOUSA MELO SL, GROPPO FC, HAITER-NETO F. MESIAL INCLINATION OF IMPACTED THIRD MOLARS AND ITS PROPENSITY TO STIMULATE EXTERNAL ROOT RESORPTION IN THE SECOND MOLARS—A CONE-BEAM COMPUTED TOMOGRAPHIC EVALUATION. J ORAL MAXILLOFAC SURG 2015; 73(3): 379-385

This retrospective cross-sectional study was designed to evaluate CBCT images from a dental school database to investigate the presence of external root resorption (ERR) in second molars adjacent to horizontally or mesioangular impacted mandibular third molars. Other factors studied were age, gender, and depth of impaction. Images from a dental school database from 2010-2013 were evaluated. A total of 217 CBCT scans of patients were available. Scans included in the study required the presence of a mandibular second molar adjacent to a horizontal or mesioangular impacted mandibular third molar. Images of erupted third molars, impacted teeth with associated pathology, underdeveloped teeth (less than 2/3 root development), and carious second molars were excluded. Images included in the study were coded and shown to two trained oral and maxillofacial radiologists with at least 3 years experience in CBCT diagnosis. They were asked to consider the presence of ERR on the second molar as well as classify the impaction of the third molar by inclination (mesioangular or horizontal) and depth (using the classification of Winter, Pell and Gregory). Once ERR was identified, it was classified by location (cervical, middle, apical) and severity (mild, moderate, or severe). Severity was classified based on level of dentin involvement (mild involved less than half dentin thickness, moderate involved half of the dentin thickness, severe involved the pulp cavity). All analyses and records were performed independently by each observer. Disagreement was resolved by consensus in a second meeting. The Cohen k test was used to calculate interobserver agreement. All numerical data were compared using 1-way ANOVA statistics and by the Mann-Whitney test. The sample consisted of 116 scans, of 70 women and 46 men. The overall presence of ERR was 49.43%. Median age for ERR was 21-22 years old. There was no statistically significant differences in the detection of ERR by gender or third molar inclination (p >0.5). The k test showed excellent interobserver agreement. The conclusion drawn was that mesioangular and horizontal impactions have a greater overall potential for ERR. Class A and B impactions in patients older than 24 years old were more associated with ERR in adjacent teeth.

SAMIR SINGH, DMD; Chief Resident, Department of Oral and Maxillofacial Surgery, VCU Medical Center

40 UNDER 40

DR. WILLIAM MOORE

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ORAL SURGERY ABSTRACT:

BOULOUX GF, BUSAIDY KF, BEIRNE OR, CHUANG SK, DODSON TB. WHAT IS THE RISK OF FUTURE EXTRACTION OF ASYMPTOMATIC THIRD MOLARS? A SYSTEMATIC REVIEW. J ORAL MAXILLOFAC SURG 2015; 73(5): 806-811

This was a systematic review of current prospective studies in the literature, to determine whether young adults who elect to retain their asymptomatic third molars (M3) have a risk of undergoing one or more third molar extractions in the future. Online electronic searches were performed in PubMed, Google Scholar, and the Cochrane Central Register of Controlled Trials, and abstracts were manually reviewed by the authors to select those studies reporting on retained third molars. Inclusion criteria were as follows: English language publication, prospective study design, included more than 50 subjects, had recorded the number of subjects or M3s requiring extraction during the study period, had a follow-up duration of 1 year or more, included subjects aged 18 years or older, subjects had at least one M3 present at enrollment, subjects had only asymptomatic M3s at enrollment. Seven studies met the inclusion criteria; sample sizes ranged from 70 to 821 subjects, and the follow-up period ranged from 1 to 18 years. The primary predictor variable was the follow-up duration (recorded in years), and the primary outcome variable was either the number of M3s removed during the follow-up period or the number of subjects who required 1 or more M3s removed during that period. Data were analyzed using descriptive statistics.

The mean incidence rate for M3 extraction of previously asymptomatic third molars was 3.0% annually (range 1 to 9%). The cumulative incidence rate for M3 removal ranged from 5% at 1 year to 64% at 18 years. The reasons for extraction were: caries, periodontal disease, and other inflammatory conditions. The management of asymptomatic third molars is controversial. While some investigators have advocated for retention of third molars until the clinical signs and symptoms dictate a need for removal, others have advocated for early removal of third molars given the potential for caries, pericoronitis, and periodontal disease. A systematic review by the Cochrane Collaboration in 2012 failed to provide insight and concluded that the evidence was insufficient to support or refute the removal of third molars to prevent future problems. In contrast, this systematic review of published studies has identified a tangible and measureable risk of future third molar extraction among patients who chose to retain asymptomatic and disease free third molars at the baseline examination. Although the annual risk was low (3.0%), the cumulative lifetime risk was found to be considerably greater (64%) in this study.

GEORGE Y. SOUNG, DDS; Resident, Department of Oral and Maxillofacial Surgery, VCU Medical Center

ORAL SURGERY ABSTRACT:

NGUYEN E, GRUBOR D, CHANDU A. RISK FACTORS FOR PERMANENT INJURY OF INFERIOR ALVEOLAR AND LINGUAL NERVES DURING THIRD MOLAR SURGERY.J ORAL MAXILLOFAC SURG 2014;72(12): 2394-2401

The purpose of this study was to assess the incidence of and risk factors for permanent neurologic injuries to the inferior alveolar (IAN) and lingual nerves (LN) following third molar removal. A patient database associated with a Clinical Incident Review Process at the Royal Dental Hospital of Melbourne from January 1, 2006 to December 31, 2009 was assessed. Pre-operative clinical and radiographic data were collected to aid in identification of predictive risk factors for IAN and LN injuries. These included age, gender, operator type, method of anesthesia, lateral spatial relation, depth of impaction, ramus relation, root morphology, and radiographic proximity to the inferior alveolar canal on orthopantomogram. All operations were performed under general anesthesia or local anesthesia by different operators. Patients were allocated to operators based on estimated surgical difficulty and risk. Operators were classified as staff dentist, basic surgical trainee (BST; first year of oral and maxillofacial surgical training), advanced surgical trainee (final 3 years of oral and maxillofacial surgical training), or an oral and maxillofacial surgeon. Patients who experienced altered neural sensation in the distribution of the IAN or LN were followed at 2 weeks, 1,2,3,6 and 12 months post-operatively. Over the four-year period, 11,599 mandibular third molars were removed in 6803 patients. Of these, 10,160 involved surgical removal. Eighty-one patients who sustained 84 neurologic injuries were included in the study. The incidence of IAN injury was 0.68%, and the incidence of LN injury was 0.15%. Risk factors identified in the study that predicted increased risk of IAN injury include increasing age(≥25 years old), surgery performed by staff dentists as opposed to OMS trainees or specialists, surgery performed under general anesthesia, and teeth with mesioangular impaction. No statistically significant factors for permanent LN injury were identified. However, risk factors approaching importance included surgery performed by staff dentists, general anesthesia, and distoangular impaction.

GRAHAM H. WILSON, DDS; Resident, Department of Oral and Maxillofacial Surgery, VCU Medical Center

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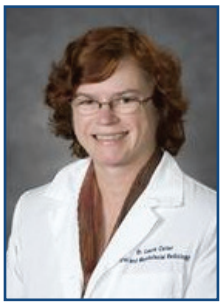
DR. JIMMY LEE

Recently, my family and I moved to Charlottesville and opened Lee Family Dentistry, formerly the practice of Dr. Joseph Waff. We are happy to be back, cheering on the Wahoos with our twin boys Samuel and Ethan!



ANATOMIC VARIANT OR PATHOLOGIC PERIL?

Laurie Carter, D.D.S., Ph.D., Professor and Director, Oral and Maxillofacial Radiology, VCU School of Dentistry

Abstract
Failure to discriminate normal from abnormal may have catastrophic results. Nature is replete with variations and a number are to be found interpreting radiographic anatomy of the head and neck. A prerequisite for diagnosis of pathology is complete knowledge of the normal. The purpose of this article is to highlight some of the anatomic variations of normal which can appear on dental radiographs. Discussion will focus on how the anatomic variation has led to the altered appearance of the structure on imaging with an eye to preventing overdiagnosis and unnecessary further workup of the patient.

Fovea
The main insertions of the superior head of the lateral pterygoid muscle are not into the TMJ disk, but directly into the condylar head.[1] In some patients the pterygoid fovea is a significant concavity on the anteromedial aspect of the condyle. Because the bone is less dense there, more radiation is transmitted to the image receptor. The well-developed fovea appears as a solitary, unilocular, well-defined, ovoid radiolucency with regular edges on the anteromedial aspect of the condyle (Figure 1). This radiolucency has been called a condylar pseudocyst because it has a cystic appearance in bone, but is merely a variant of normal. Prevalence of a well-developed fovea ranges from 1.5-1.8% of the population.[2]

Bifid condyle
Considered a rare incidental finding, a mandibular condyle may be bifid mediolaterally or anteroposteriorly.[3] This may be limited to a delicate notching in the condylar head or may present as two separate, lobulated condyles (Figure 2). It has been postulated that the residua of embryonic fibrovascular tissue on the developing condylar head gives rise to bifid condyles.[4]

Medial sigmoid depression
Langlais et al provided the first description of the radiographic appearance of the medial sigmoid depression in 1983.[5] This anatomic depression, located on the medial aspect of the ramus, is just inferior and anterior to the lowest point of the sigmoid notch (Figure 3). It is radiolucent because the bone is thinner there so more radiation is transmitted to the image receptor. The borders of the

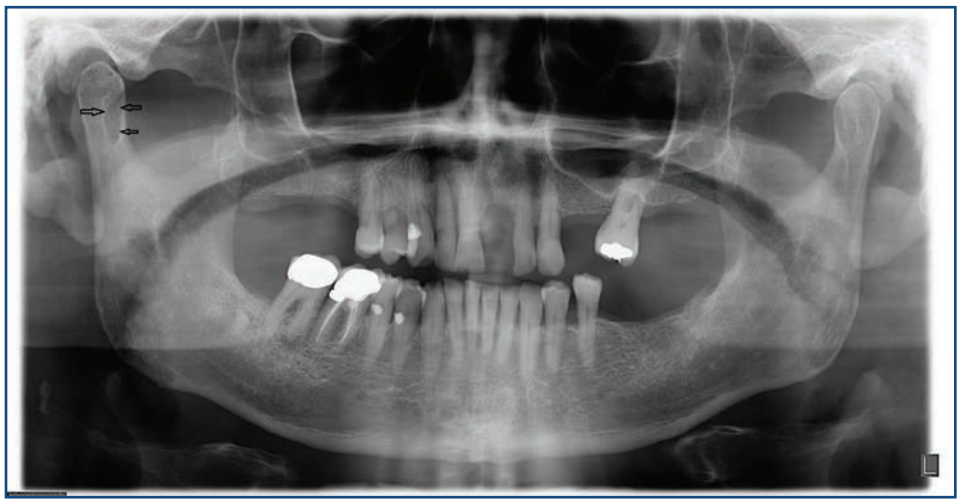


Figure 1

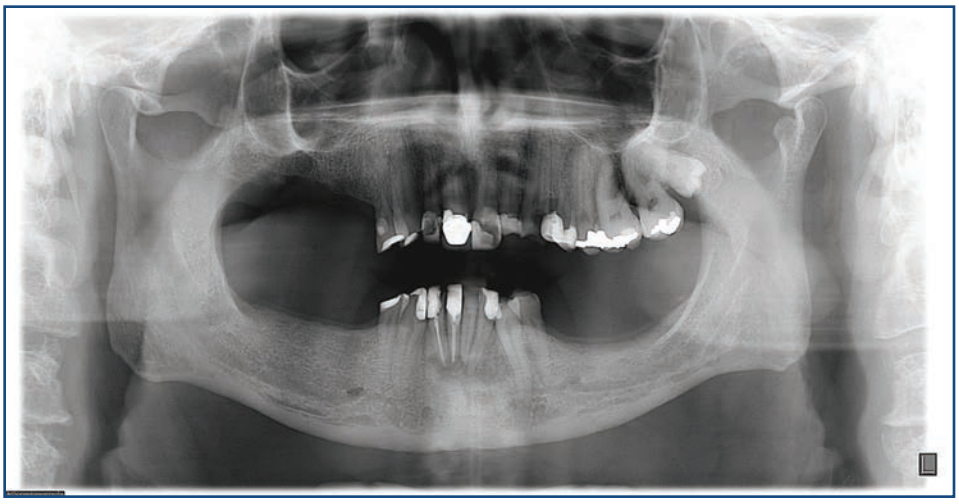


Figure 2

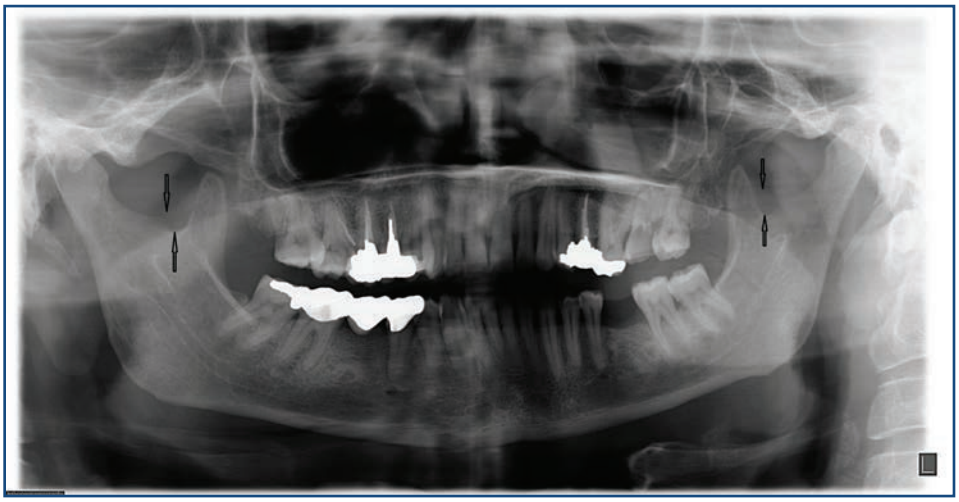


Figure 3

depression are smooth and regular. The shape of the depression follows functional demands as the medial and posterior attachments of the temporalis muscle are inserted into the ramus in this region. While the medial sigmoid depression is a variant of normal anatomy, its presence increases the likelihood of complications during orthognathic surgery as the thinner bone makes splitting the ramus more difficult.[6]

Prominent antegonial notching

Upward curving of the inferior border of the mandible immediately anterior to the gonion is termed antegonial notching.[7] Patients with parafunctional habits develop masseteric hypertrophy. The consequent muscle imbalance pulls on the muscle insertions into bone at the gonion and results in the development of prominent antegonial notching and lumpy excrescences at the gonion (Figure 4).

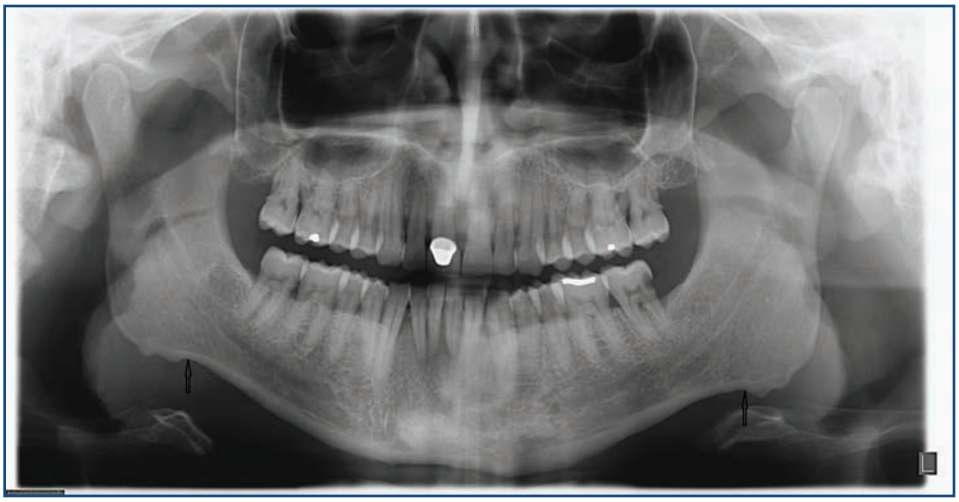


Figure 4

Submandibular fossa

The submandibular fossa is a depression on the lingual surface of the posterior mandible, and presents as a diffuse radiolucency inferior to the mylohyoid line, which houses the submandibular gland (Figure 5). The submandibular fossa is present in approximately one third of the population.[8] Failure to obtain cross-sectional imaging during dental implant treatment planning may lead to lack of awareness of this lingual undercut with potentially serious complications. Lingual cortical perforation may be followed by entrance into the floor of the mouth and arterial hemorrhage.

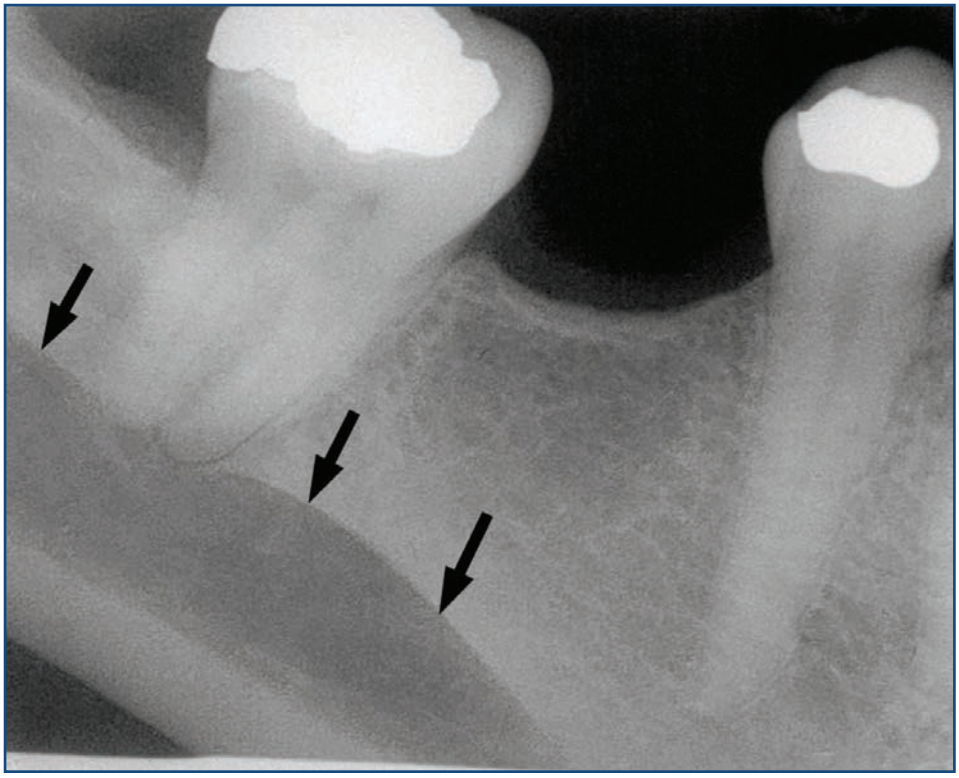


Figure 5

Zygomaticotemporal suture

The zygomaticotemporal suture is a complex anatomic feature, with interdigitating facets between the zygomatic and temporal bones.[9] On panoramic radiographs, the suture is usually so fine that it cannot be visualized. However, in some patients, the suture is quite wide and may be mistaken for a fracture, especially if there is a coincident traumatic episode (Figure 6).

Zygomatic air cell defect (ZACD)

In some patients, mastoid air cells undergo exuberant overproliferation, and accessory air cells creep superiorly and anteriorly into the root of the zygomatic arch and articular eminence.[10] ZACD may have a unilateral or bilateral presentation and appears as a unilocular or multilocular cyst-like radiolucency (Figure 7). ZACD is nonexpansive, nondestructive and the area should be symmetrical and asymptomatic. It is important to remember that air spaces are potential pathways for the spread of pathologic processes. Moreover, the ZACD renders the temporal component of the TMJ more fragile and inherently weaker mechanically. Inadvertent violation of ZACD during surgery or trauma could produce communication with the infratemporal or middle cranial fossa.

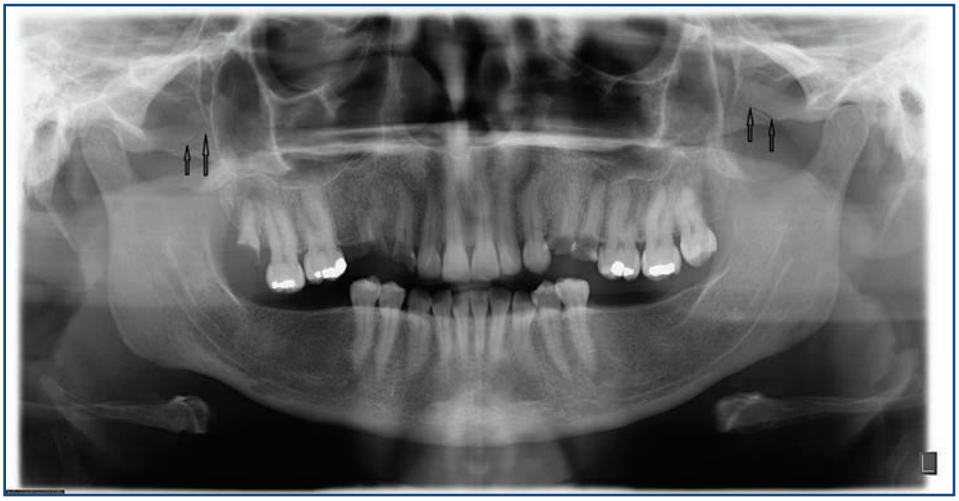


Figure 6

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Transverse foramen of C2

In all the cervical vertebrae, there is a foramen in each transverse process (called the transverse foramen), which allows for transit of the vertebral artery, venous plexus and a nerve plexus into and out of the skull.[11] In all but C2, the transverse foramen has a vertical orientation. However, because the transverse foramen in C1 are more laterally positioned than those of the other cervical vertebrae, the transverse foramina of C2 are oriented obliquely to allow for the change of course of the neurovascular bundle.[12] This is seen on panoramic radiographs as a solitary, well-defined (and sometimes corticated) round radiolucency in the body of C2 (Figure 8). Because of this appearance, it may arouse suspicion of a cyst in bone. However, the transverse foramen of C2 regularly appears on panoramic radiographs and dental professionals who use this imaging modality should be familiar with its presence.

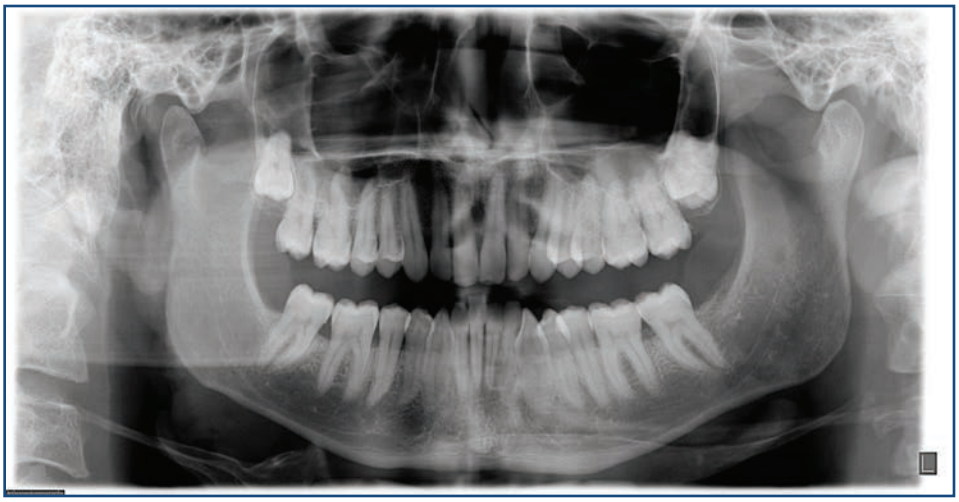

Figure 7

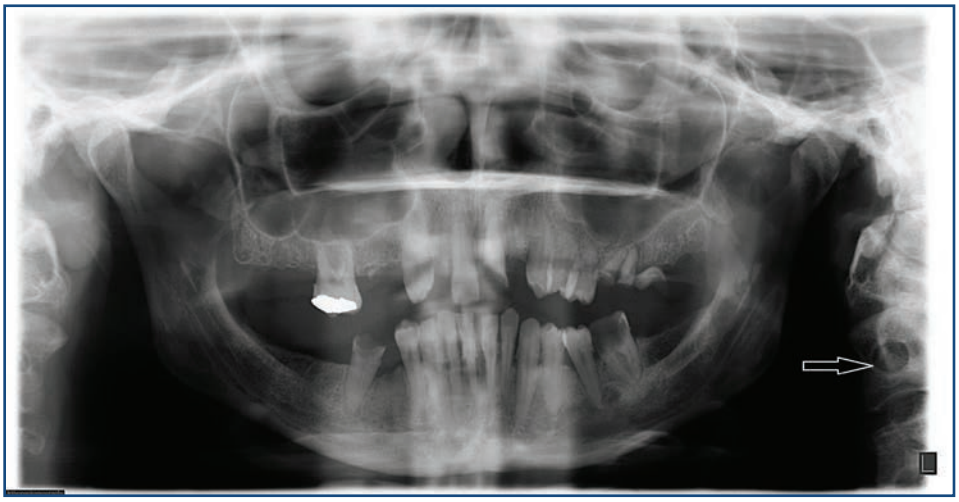

Figure 8

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Figures

Figure 1. Arrowheads depict the fovea on the patient's right condyle.
Figure 2. Bifid left condyle
Figure 3. Arrowheads indicate medial sigmoid depression bilaterally.
Figure 4. Arrowheads indicate prominent antegonial notches bilaterally. Distal to these are several excrescences produced by masseteric hypertrophy.
Figure 5. Arrows indicate the submandibular fossa inferior to the mylohyoid line.
Figure 6. Arrowheads depict the zygomaticotemporal suture bilaterally. The suture on the patient's left side is notably wider.
Figure 7. Multilocular radiolucencies in articular eminence bilaterally are zygomatic air cell defects.
Figure 8. Arrow points to the transverse foramen of C2.

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ETHICS: TRUST THE CODE

By: Dr. A. Garrett Gouldin; Member, Ethics and Judicial Affairs Committee

The first sentence in our American Dental Association's Principles of Ethics and Code of Professional Conduct reads as follows: "The dental profession holds a special position of trust within society." Dictionary.com defines a position of trust as the obligation or responsibility imposed on a person in whom confidence or authority is placed.

Then, in the second paragraph of our Code, we are reminded that "Members of the ADA voluntarily agree to abide by the ADA Code as a condition of membership in the Association. They recognize that continued public trust in the dental profession is based on the commitment of individual dentists to high ethical standards of conduct." So, public trust of dentistry is inherently tied to our individual commitment to ethical behavior – makes sense - but is there any proof, and do patients really pay attention? We are dentists, we like data.

I was interested to read in the ADA News (July 15, 2015) an article that summarized the findings of a survey commissioned by the Association's Council on Ethics, Bylaws and Judicial Affairs. The recent survey questioned 1,000 people to determine if patient's awareness of our Code of Ethics, and whether or not a dentist was a member of the ADA, influenced their decision to become a patient of that dentist. Remarkably, 75% of those surveyed suggested that whether or not a dentist was a member of the ADA would influence their decision to choose the dentist, and furthermore, 69% are more inclined to select an ADA member dentist when they are aware that we follow a Code of Ethics. Surprisingly, 67% of those surveyed did know if their dentist was an ADA member.

The article concludes by suggesting that member dentists have the Code available and visible in their office, and that they post the Code on their website. What a novel idea, and given the results of this survey, who could argue? Every dentist I know publicizes that they are a member of the ADA, but I have never seen the Code, or even a link to it, on a colleague's website. So, why not double down by making our Code readily available to our patients, a clear indication that we are aware of, and that we stand behind, the published ethical principles of our profession?

VDA FOUNDATION WELCOMES NEW TEAM MEMBERS

TARA QUINN, VDA FOUNDATION - EXECUTIVE DIRECTOR

Tara Quinn is the new Executive Director for the Virginia Dental Association Foundation. Most recently, she was the Executive Director of the Capital Region Land Conservancy, a private, non-profit land trust dedicated to serving Virginia's Capital Region.

Ms. Quinn has served the nonprofit sector in executive, fundraising, outreach, advocacy, program and volunteer management roles for organizations working in the areas of conservation, community development, the arts, and international educational exchange. She also has over 10 years experience in marketing, communications, business development, and human resources for professional services firms and earned the Certified Professional Services Marketer designation in 2003. She has a BA in Political Science from the University of North Carolina at Asheville.

As a Virginia resident since 1996, Ms. Quinn is thrilled to lead the VDAF in furthering its impact on Virginia's vulnerable and underserved populations. She looks forward to collaborating with its many partners to broaden the collective scope of these efforts and to bring relief and hope to those who need it most.

JULIE BITTNER ERICKSEN, VDA FOUNDATION - PROGRAM MANAGER

Julie is the new Program Manager for the Donated Dental Service (DDS) and Give Kids a Smile (GKAS) programs at the VDAF. With degrees in English and Fine Arts she has experienced a variety of paths which include computer programming and system management, architectural design, and communication coaching. Her experience in the medical and dental safety net began in 2006 when she helped open a free medical and dental clinic in the basement of her church. She worked there in many capacities over six years. Julie previously worked as the Dental Opportunities Champion at the Virginia Health Care Foundation and finds herself right at home in this role with the VDA Foundation.

Through the Donated Dental Service program, we connect elderly and disabled applicants all over Virginia, with significant financial constraints to dentists and specialists in their private practices. This unique approach to accessing dental care makes the DDS program more convenient for volunteer dentists and allows patients to have the same experience as the dentist's other clients.

Through the Give Kids a Smile program, on the first Friday in February, Virginia dentists, along with other dental professionals from across the country, provide free oral health care services to thousands of underserved children. A program of the American Dental Association, Give Kids a Smile focuses on offering oral health education to all children while providing free preventive and restorative care to the kids that need it most.

FIVE MILLION RESONS WHY HIPAA MATTERS

Robert McDermott, iMedicor President & CEO

The Federal Government continues to tighten its enforcement of Health Information Portability and Accountability Act (HIPAA) laws. The penalties for violations are staggering; one (1) incident could put a practice out of business. They range from $50,000 per page to a maximum of $1,500,000 per patient. A HIPAA Privacy Rule infraction can also be considered a criminal act, lead to prosecution by the Department of Justice and jail time ranging from 1 to 10 years in addition to the large monetary fines.

VIOLATION TYPE	EACH VIOLATION	REPEAT VIOLATIONS/ YR
Did Not Know	$100 - $50,000	$1,500,000
Reasonable Cause	$1,000 - $50,000	$1,500,000
Willful Neglect- Corrected	$10,000 - $50,000	$1,500,000
Willful Neglect-Not Corrected	$50,000	$1,500,000

*HIPAA Section 160.404 of the HITECH Act.

Penalties now apply to a wide range of healthcare providers and their subcontractors. Ignorance is no excuse and you can be penalized.

IS YOUR PRACTICE PROTECTED?

Several standards must be met for an electronic messaging system to be HIPAA-compliant. When selecting a messaging system, make sure it implements the following technical safeguards:

1. **Access Control - HIPAA 164.312(a)(1)**
   - Unique user identification
   - Emergency access procedure
   - Automatic logoff
   - Encryption and Decryption
2. **Audit Controls - HIPAA 164.312.(b)**
3. **Integrity - HIPAA 164.312(c)(1)**
   - Mechanism to Authenticate Electronic PHI
4. **Person or Entity Authentication - HIPAA 164.312(d)**
5. **Transmission Security- HIPAA 164.312(e)(1)**
   - Integrity Controls
   - Encryption

Another feature to look for when selecting an email messaging system is inclusion of the “Direct” data-exchange protocol. “Direct” is the Federal standard for secure messaging and allows you to send HIPAA-compliant, encrypted email to people outside your network via the internet. It uses a 2-step verification system, checking for two unique identifiers. “Direct” protocol gives a sender confidence that an email recipient truly is the intended recipient. If you receive an email from someone@direct.com, you can be confident the email is coming from a verified source—not an imposter.

This article is provided by iMedicor, a national provider of comprehensive secure communications solutions for the healthcare community. iMedicor offers dentists and other healthcare professionals the use of a HIPAA-complaint communications network that addresses current Federal standards for security and interoperability. iMedicor has been endorsed by VDA Services. For more information on HIPAA and compliant communications, contact a representative at 888.810.7706 or salesinfo@imedicor.com. To sign up, VDA members are invited to visit https://signup.imedicor.com/vda/.

WHEN FACED WITH A MALPRACTICE CLAIM, WHO DO YOU WANT IN YOUR CORNER?

When your career and reputation are on the line, you want the strongest dog in your corner. Many dentists don't realize how important their dental malpractice insurance is until they need it most. Medical Protective has over 100 years of proven experience, national expertise and a balanced defense that focuses on ***your best interest***. And, today, more than ever, the big financial strength, integrity and powerful backing of a Warren Buffett Berkshire Hathaway Company are crucial to the quality of your dental malpractice protection.

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DENTAL INSURANCE: FRIEND OR FOE?

Dr. James R. Schroeder

There is no question our dental profession as we know it is rapidly changing and business as usual will not suffice to remain on the cutting edge.

The external force from "dental insurance," and the impact it is having on our profession needs to be explored. Dental insurance was hailed as a tremendous benefit for patients and doctors many years ago. Employers were able to provide a benefit to their employees that allowed them to gain access to the valuable benefit of preventative dental care and services for the treatment of dental disease. Another external force our patients face is that every product advertised in the media includes a beautiful smile elevating their desire for the services offered by our profession. The dentist has enjoyed the increased awareness of the patient base that is now able to seek oral health care through having dental insurance.

So yes, dental insurance has been part of a very successful partnership within the dental profession bringing a tremendously high level of oral health to many populations in our country that did not have that option previously.

But, **where are we trending today?** The practices that Leadership by Design supports in transitions, growth and development reveal some very alarming trends that cannot be ignored. The scope of today's article is to challenge you to do the following:

1. A full assessment in your practice of the facts for each insurance company you have agreed to be participating provider.

   Does your insurance administrator have a current contract available to review the benefits between the patient and dentist? This needs to be part of her job description. As insurance companies hold the dentist accountable the dentist/ staff must hold the insurance company accountable.

How can we do this effectively?

Intentional determination and persistence by the dental team that includes accurate recordkeeping must be part of the process.

It starts with timely and careful documentation of the services provided by each insurance carrier:

a.) Reimbursement for services included in the contract

b.) An accurate list of dentists on the providers list that are not deceased or retired

c.) Documentation of timely reimbursement of claims submitted

d.) Documentation of a licensed qualified dentist reviewing claims that have been denied and appealed

e.) Documentation of the current fee schedule being used and the date it was last updated.

The State Corporation Commission/ Bureau of Insurance licenses, regulates, investigates and examines insurance companies, agencies and agents on behalf of the citizens of The Commonwealth of Virginia. (https://www.scc.virginia.gov/boi) They are here to serve you when there is failure of insurance companies to deliver the contractual services agreed upon. Dental practices should become familiar with the rules and regulations as stated on the website.

2. What are the write-offs from the fee schedule for various services?

   The dentist must track this metric by each insurance company if they intend to make accurate decisions. How many patients have been seen in the last year under each contract? The dangerous trend I see in the wide scope of practices across Virginia is 25-50% write-offs are becoming common. The write-offs are approaching the total staff salaries and benefits in many offices. It is not uncommon for me to work with solo dentists who are writing off as much as $300,000.00 annually.

   A dentist is not at the negotiating table when contracts are developed between the employer and insurance companies. The benefit package often plays second fiddle to the cost of the program when being evaluated by the employer. I served on a large school board for 7,000 employees and vetted health benefits proposals. The low bid for dental benefits often is awarded the contract. Neither the provider nor what they will be reimbursed for was provided. The dentist needs to understand the reality of the market place.

   The fear that grips many practices is "I must participate even if I am not covering my expenses to do the procedures."
   Many procrastinate on making the tough decision to drop programs that are not sustainable for a profitable practice. These kinds of important decisions require strong leadership that can lead both staff and patients. Do your patients come to you because you are on their insurance program or because your team consistently provides an exceptional experience every time they come to the office?

   Creating this type of culture is critical in order to generate a strong "word of mouth referral" especially if you are considering the reduction of participation in different insurance programs. As mentioned earlier, starting with a fact based assessment and developing a solid plan is a good start that will take you in the desired direction. All aspects should be considered on an individual practice by practice basis with a clear vision laid out of what lies ahead. Where do we go from here?

   A recent article in the *Virginia Dental Journal* highlighted a new business model bringing over 60 practices together providing strength in numbers. It is important to sit down with your insurance administrator to make sure it is understood that business as usual will not suffice. Provide him/her with the tools (contracts, training, etc.) to develop the communication skills with the Commission on Insurance when it is necessary.

3. Connect with ADA Benefit Plan Analyzer.

   This is a great benefit you have as an ADA member. For $160.00 this plan can be purchased through the ADA Store, and if applied correctly can be an outstanding business tool. The Analyzer will run "What If" scenarios for plans you are either currently using or under consideration. Analyze the cost and benefit before you pull the trigger on

CONTINUED ON PAGE 32

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participating with an insurance program. There are other roads to building your practice beyond saying "yes" to every insurance contract.

If you say "yes", then train your staff to keep accurate records and hold the insurance companies accountable to the terms of the contract. Most offices are not maximizing the use of their software programs in filing for insurance. Turnover of staff often results in the loss of continuity in the use of software and efficient filing of insurance claims.

Having a trainer come into the office annually can result in an excellent return on your investment.

This article is to challenge you –

1. What is the current status of insurance in your practice?
2. What steps you can take to strengthen your position and not be a passive victim? Make insurance participation an asset not a liability.
3. What resources you can use to increase your knowledge base to hold insurance companies accountable and develop your staff?

It is a great profession, but it is not for the faint of heart. Explore your choices, develop your leadership skills and move forward with a plan. Please feel free to call for further conversation on this topic.

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

40 UNDER 40

DR. ASSAL ASSADI-MOGHADAM

From Studio Art to working in private practice at Optimal Dental Center in Reston and Fairfax, I get to incorporate my artistic skills into dentistry everyday since becoming a Jumbo alum from Tufts University in Boston, MA in 2013!

HOW TO CHOOSE THE BEST SEO AGENCY FOR YOUR PRACTICE SEPARATING FACT FROM FICTION

Lance McCollough, Founder and CEO, ProSites

Want people to easily find your dental practice in an online search? You may have heard that search engine optimization (SEO) can solve your problems. Unfortunately search engine marketing is an ever-evolving beast that can make doing it well very difficult and time consuming. Where does that leave you? It's time to find a SEO provider to focus on your business' needs which will give you time to focus on your patients and simultaneously help you grow your business.

Finding the best SEO agency for your dental practice can be difficult. Before you begin you should first learn to separate SEO fact from SEO fiction.

FICTION: SEO can guarantee specific results. First page here we come!

FACT: If a company guarantees you first page placement, they're lying. SEO cannot guarantee specific results. However, a legitimate SEO firm can implement white-hat SEO strategies based on your business goals, specialties, geographic location and competition.

FICTION: Optimize keywords and add meta-tags – you'll be at the top of searches in no time.

FACT: First, there is no such thing as a quick fix in SEO. Second, it's important to find a SEO provider that stays up-to-date with SEO standards. While updating meta-tags won't hurt your visibility, search engines don't place as high of a priority on all meta-tags. The ones that do still carry weight are title tags, H1 (heading) tags and alt tags. Hire a SEO firm that can speak to changes in search engine algorithms and the associated impact on your SEO campaign. They should be able to communicate in layman's terms the essential components of their strategy and what are the associated key performance indicators. You should expect to receive regular reporting that shows you metrics on traffic, visits, referrals, bounce rates, keyword ranking, and top performing pages. They should also be able to explain positive or negative trends and actions taken or recommended to achieve strong performance.

Remember, SEO is not magic. Rather it is part art, part science. A solid SEO strategy takes three to six months to gain traction with the search engines, reveal trends, and produce competitive results.

FICTION: SEO is SEO. If we did it for one company we can do it for any company.

FACT: One size does not fit all. Every industry has different clients, competition and regulations. If your agency doesn't understand one of these, how will they understand your practice? Your SEO agency should grasp the specifics of your industry and your business goals. Don't waste valuable time bringing them up to speed on what is, and what isn't, acceptable in your industry. If you choose a SEO agency that's well versed in your business niche they can show you case studies from businesses similar to yours and clearly explain what it takes to get results.

FICTION: The more links the better.

FACT: Yes – links are good, but an improper link strategy can actually get you banned from Google. Your SEO agency should have a plan to engage appropriate third-party sites. Blindly blasting out links, spamming forums and making comments on blogs will only raise red flags and could get you penalized by the search engines. Make sure links are relevant to your business, and then accumulate them naturally. It will take time to do it right.

FICTION: Cool site. It looks like a winner!

FACT: Looks can be deceiving; they can also be wasted unless you have relevant content, written for the user experience, not just to attract the search engines. The search engine algorithms place incredibly high value on relevant content. This also makes the difference in terms of site visitor engagement. First you need to get them to your site, then you need to keep them. Make sure your pages include appropriate calls to action and multiple methods of contact. After all, what's the point of increasing traffic to your site if you can't convert that traffic into new patients?

The more users engage and click through your site the more your SEO will improve. These are measurable indicators.

BE CHOOSY

Don't put off finding a SEO firm. You'll only be putting off business growth. Do your research and ask direct questions to gauge whether they'll meet your expectations. A qualified SEO firm won't be intimidated. If you'd like to learn how ProSites can tailor a SEO strategy for your dental practice, contact us to schedule a personal consultation at 888-932-3644.

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VDSC ANNOUNCES NEW WELLNESS PROGRAM TEMPLATE FOR DENTAL OFFICES

Elise Rupinski, Director of Marketing and Programs

The VDSC is pleased to announce the development of a new template program to assist dental offices in the development of an in-office membership club style program for patients who do not have dental insurance. The idea for the program is that dental offices can create a completely customized program for their offices that can be an alternative for their patients who do not have an insured dental benefit. Patients pay an annual membership fee and with that they are afforded certain services that the dental office chooses to include. Then the office can offer patients that are members discounts on other services not covered by the annual membership fee.

Dr. Kirk Norbo of Purcellville chaired the VDSC Task Force that developed the new resource and he said "One of the great things about this program is that the program is completely customizable and offices can determine exactly how they want to structure their plans. My office launched a program in May of 2014 and it has been extremely well received by our patients that do not have insurance." The program provides a way for non-insured patients to save money on their dental care and can help to encourage them to come into the office for regularly scheduled care.

The VDSC has developed a number of documents that can be customized and used by dental offices to start their own plan. The documents have undergone extensive review and are designed to provide a quick and easy way for any office to start a program. The program is available for a cost of $250 for VDA Members (non-member price is $995).

The program includes:

- **Sample Membership Terms**
  - Including optional terms and a variety of important terms that should be considered to be sure the program is easily understood by patients.
- **Sample Brochures**
  - For both new and existing patients.
- **Educational Webinar**
  - Hear from four office managers who provide step by step instructions for how to start a program, put the program into your practice management system and how to talk with patients about the new practice offering.

In order to purchase the program, members do have to sign a usage agreement with the VDSC by contacting Elise Rupinski (rupinski@vadental.org; 804-523-2184).

MEDICARE ENROLLMENT/OPT OUT UPDATE

Laura Givens, VDA Director of Legislative & Public Policy

- **Medicare Enrollment/Opt Out Enforcement Date Extended to June 1, 2016**
  The Centers for Medicare & Medicaid Services (CMS) delayed enforcement of the Medicare Part D prescriber enrollment requirement to June 1, 2016. In order for Medicare Administrative Contractors to process enrollment applications or opt out affidavits prior to the enforcement date, **CMS urges prescribers to submit the appropriate paperwork by January 1, 2016.**

- **Medicare Advantage Plans Through Insurance Companies**
  If you treat patients with Medicare Advantage plans, this is important for you to read!

  Dentists must be enrolled with Medicare in order to prescribe drugs covered by Medicare Advantage plans and to receive payment for treating patients with these plans. Dentists who opt out of Medicare cannot submit claims to Medicare Advantage plans. It is important for dentists who have patients with Medicare Advantage plans through insurance companies to be aware that they will not be paid for Medicare Advantage plan services if they choose to opt out. They will be unable to charge patients for Medicare Advantage services.

  There have been dentists who opted out of Medicare prior to knowledge of this effect on Medicare Advantage plan coverage. CMS (or your Medicare Administrator) does not allow the retraction of an opt-out affidavit after 90 days so dentists are locked into this after that grace period has expired until the two year affidavit period ends. If you are in the position where you have opted out of Medicare and now realize with this information that you would need to enroll so that your Medicare Advantage patients can receive coverage, you would need to track the two year time period and, at that time, terminate the opt-out and enroll as an ordering/referring provider. In the meantime, your office would need to verify the patient's ID card if the member has a Medicare Advantage plan and, if so, you would know that you cannot get paid for that plan. This is obviously a big concern and the VDA has asked the ADA to address this issue with CMS.

- **Medicare Opt Out/Enroll Resources**
  Visit www.ada.org and/or www.vadental.org for many resources to help you make the best decision (opt out or enroll) for your practice and how to appropriately opt out or enroll by January 1, 2016.

VDA'S LEGISLATIVE DAY ON THE HILL:

MARK YOUR CALENDAR FOR JANUARY 22, 2016

Every year, dentists from around Virginia and dental students from across the street gather in Richmond for the VDA's annual Day on the Hill.

What do policy makers really know about our profession and our practice challenges? Who better to tell them than you!

Breakfast will be at the Omni in downtown Richmond at no cost to you and our Day on the Hill is over before lunch.

Mark your calendar now for January 22, 2016! We look forward to seeing you in Richmond.

VIRGINIA DENTAL POLITICAL ACTION COMMITTEE (VADPAC) UPDATE

Laura Givens, VDA Director of Legislative & Public Policy

Component	% of 2015 Members Contributing to Date	2015 VADPAC Goal	Amount Contributed to Date	Per Capita Contribution	% of Goal Achieved
1 (Tidewater)	28%	$45,500	$27,827	$242	61%
2 (Peninsula)	**34%**	**$27,500**	**$29,645**	**$319**	**108%**
3 (Southside)	**31%**	**$14,000**	**$20,215**	**$245**	**144%**
4 (Richmond)	36%	$67,750	$65,530	$277	97%
5 (Piedmont)	31%	$30,000	$24,215	$260	81%
6 (Southwest VA)	**41%**	**$25,250**	**$26,120**	**$379**	**103%**
7 (Shenandoah Valley)	34%	$30,000	$25,275	$288	84%
8 (Northern VA)	26%	$135,000	$99,407	$293	74%
Other Contributions			$500		
TOTAL	**31%**	**$375,000**	**$318,734**	**$286**	**85%**

Total Contributions: $318,734

Must Raise $56,266 to Reach Goal

2015 Goal: $375,000

VADPAC would like to recognize components 2, 3 and 6 for surpassing their goals for the 2015 year. As we near the end of this year, we are so appreciative to all who made contributions. We still have the potential to reach our goal. Have you made your contribution yet for 2015? If not, there is still time! Please call Laura Givens to make a contribution over the phone at 804-523-2185 or email her at givens@vadental.org to be sent a form. VADPAC has the potential to grow substantially in the coming years but we need to have the collective support from VDA members.

Dues will be mailed soon for 2016 and we urge members to submit contributions when sending in your 2016 VDA dues payments. Your contributions are imperative to securing the livelihood of the practice of dentistry.

WHEN YOU GIVE TO VADPAC, YOU ARE RAISING THE VOICE OF DENTISTRY.

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

VADPAC FUNDRAISERS

VADPAC Fundraiser for Delegate Kirk Cox

VADPAC hosted a very successful fundraiser for Delegate Kirk Cox on July 14th at the Swift Creek Mill Theatre in Colonial Heights. As a result of the strong leadership from Dr. Sam Galstan and steering committee members, the event was attended by nearly 50 VDA members, friends and guests. Delegate Cox is the House Majority Leader representing the 66th district, and has been a tireless public servant and a leader that we can count on to advocate for common sense solutions facing our Commonwealth. This event was a great opportunity for VDA members to thank him for his hard work on our behalf.

Additional 2015 Fundraisers

Other fundraisers this fall will be held in Midlothian to honor and support Delegate Lee Ware (Chairman of the House Finance Committee and Key Member on the Commerce & Labor Committee), in Centreville for Delegate Tim Hugo (Republican Caucus Chairman & Key Member on Several Committees), again in Centreville for Senator Dick Saslaw (Senate Minority Leader) and in Suffolk for Delegate Chris Jones (Chairman of the House Appropriations Committee).

VADPAC appreciates VDA member involvement in steering committees to make these fundraising events successful.

VADPAC IN ACTION

Dr. Eddie Longman (L) visited with Paul Krizek, who is running for the 44th House District Seat in Virginia. Dr. Longman expressed support on behalf of the VDA.

Dr. Norman Marks (L) visited with Senator Ryan McDougle and expressed his support on the VDA's behalf. Senator McDougle represents the 4th Senatorial District in Virginia.

VDA Board of Directors member Dr. David Black and VDA member Dr. Stephanie Vlahos attended an event for David Suetterlein at Congressman Bob Goodlatte's home in Roanoke on July 31. Mr. Suetterlein is running to represent the 19th Senatorial District in Virginia.

MEMBER AWARDS & RECOGNITION

DR. SAMUEL W. GALSTAN

Lifelong Learning and Service Recognition

Academy of General Dentistry

DR. STEPHEN B. ALOUF

The John E. Gardner, DMD Award

Bradley Free Clinic, Roanoke

Send your "Awards & Recognition" submissions for publication in the *Virginia Dental Journal* to Shannon Jacobs, VDA Director of Communications Email: jacobs@vadental.org

40 UNDER 40

DR. KATIE SOUTHWELL LEE

My husband Jimmy and I met in dental school at VCU. After practicing in Hampton Roads for several years, we just moved back to my hometown of Charlottesville. I am currently finishing up an Endodontic Residency at VCU.

NEARLY 1,200 VIRGINIANS COME FOR FREE DENTAL CARE AT 16TH ANNUAL WISE MOM

Hannah McNew and Amanda Gladstone

In the early hours of July 17th, Terri Stewart was among several hundred people standing in line for up to five hours, with her children in tow, at the Wise County Fairgrounds. But they were not there to play games. Terri was waiting to be seen by dentists during the opening day of the 16th annual Mission of Mercy project, put on by the Virginia Dental Association Foundation.

Dental care is a high-demand health service, and many Southwest Virginians need it badly. At MOM clinics, volunteer dental teams provide a host of free services from general cleanings and exams to fillings, extractions, and root canals.

"The way it works is you pick one and that's what you have done that day cause there's so many people," Stewart said. "So, it's pick and choose."

While her children receive free dental care in the community through Medicaid, adults like Stewart are not as lucky. That's why MOM clinics are so imperative in impoverished areas.

VDA executive director and MOM clinic founder and so-called "trail boss," Dr. Terry Dickinson, predicted an average of 3,500 teeth would be extracted over the three days. "Think about that, 3,500 teeth within two and a half days. This gives some idea of the extent of the problem that we see in this region."

Roughly four hundred volunteers from across Virginia, including dentists, hygienists, dental assistants and students from Virginia Commonwealth University and other schools, came to this year's MOM in Wise. They traveled at their own expense, set up the clinic on Thursday, and then treated patients Friday, Saturday and Sunday, outdoors under a tent.

"By the time they get to us, so many of them, they're just decayed off at the gum line," said Dr. Dickinson. "We see things that you do not see in dental school or in practice."

By the time the dental teams had completed their work, they had seen 1,181 patients and provided nearly $1.2 Million in donated care, including 1,569 fillings and yes, over 3,500 extractions. The volume of procedures means that the demand for services continues, meaning VDAF and MOM will be back in Wise for a 17th consecutive year next July.
"Dental care is crucial because there is such an unmet dental need out here," said Teresa Owens Gardner, director of The Health Wagon and Remote Area Medical event coordinator. "Dr. Dickinson and the MOM project are absolutely my heroes in life. The compassionate care that they deliver is unprecedented, and it means so much to the community."

Hannah McNew is a student at UVA-Wise. Amanda Gladstone is a student at Virginia Tech.

BY THE NUMBERS

1,181 - Patients treated
$1,171,655 - Value of donated care
177 - Cleanings/debridements
3,527 - Extractions
1,569 - Fillings
1,082 - X-rays
177 - Fluoride varnishes
55 - Root Canals
63 - Complete dentures
35 - Partial dentures
16 - Denture adjustments
43 - Denture relines
16 - Denture repairs

THERE'S JUST SOMETHING SPECIAL ABOUT WISE...

Devon Bortz

There's something extraordinary about the MOM dental clinic held each year in Wise. When I was 12, and first joined my mother as a volunteer, I had no idea what I was getting myself into. I could never have prepared myself for what I witnessed taking place. I never expected to meet so many remarkable people whose dedication and commitment to making the clinic a success would leave such a lasting impact on my life.

Every year, when I return to the mountains of Wise, I spring out of bed to the alarm set at 4:15AM. My mother laughs as her child, who any other day of the year would sleep in as late as possible, frantically dresses and jumps in the car to head to the fairgrounds. I'm not sure what it is about this one weekend that makes me a completely different person, but I do know that I've never seen this version of myself during any other occasion.

When I first made the six hour plus trip to Wise, Virginia, I was registered to volunteer in the childcare tent, supervising children whose parents were undergoing dental, medical, or vision work. But there was something pulling me towards the dental section, and by Saturday I was handing out crackers and water bottles in the extractions and oral surgery tent. Over the years, as I learned to read x-rays, number teeth, identify cavities, fillings, crowns, bridges, gum disease and more, I quickly became enthralled by the world of dentistry. And when Dr. Juan Rojas, a VCU dentist who triaged patients in the extractions tent, offered to let me assist him, I eagerly gloved up and dove head in.

For a long time, I thought that it was dentistry that drew me back to Wise every year. But over the years, as I begin applying to colleges and considering my career, I've realized that it isn't just the practice that captivates me so. Instead, it is the vital sense of making a real difference in so many lives: a sense of being needed.

If it was all you'd ever known, how would you know teeth could last a lifetime? If your grandparents and parents had dentures by 30, how would you know that wasn't the way it was supposed to be?

In Wise County, teeth are a hassle. They are nuisances that are best removed as early as possible. Dentures are a dream that rarely becomes reality. Buckets are filled with extracted teeth, bloody mouths are stuffed with gauze, and prescriptions are filled that for most would cost more than two months' pay. I knew poverty in Southwest Virginia was widespread, I just didn't know how devastatingly tragic it really was. I've stood in the pouring rain for 15 hours straight, my hands inside a dozen mouths and my feet soaked to the bone. I've run patients back and forth across the fairgrounds in the blazing heat, producing half my body weight in sweat. I've held out my hands to receive a mouthful of bloody gauze. I've helped stitch up the gums of a man whom I know will stick a cigarette in his mouth the next day, opening his gums to infection and tearing apart the sutures. I've seen children and young adults have full mouth extractions of teeth rotted by years of poor nutrition, tobacco use, and neglect. And I would do it a thousand times again.

Because there's something special about Wise.

This year, one woman sat outside the oral surgery van for more than an hour, a complacent smile stretched across her face. "I'm waiting to thank my hero," she told anyone who asked. Waiting for Dr. Dan Laskin to finish with a patient, she went on and on to the 14 year old girl next in line for extractions about the man she believed to be a saint. "After more than a year of Ensure and mashed potatoes, that man saved my life," she continued.

And that's what's so special about Wise.

It's the lasting impact on people who are so incredibly grateful.

It's the appreciation gained for everything I've been given that so many lack.

It's the chance to make a difference.

MOM REACHES OUT TO VIRGINIA'S VETERANS

A. Carole Pratt, DDS; Senior Advisor and Confidential Assistant,
Virginia Department of Health

Something new was under the dental triage tent on the Wise County Fairgrounds when the Virginia Dental Association Missions of Mercy clinic opened this July. The VDA in cooperation with the Virginia Department of Veterans Services (DVS) for the first time surveyed clinic participants in an effort to identify veterans who were seeking care at the MOM clinic and who might be eligible for dental and other health care benefits available through the Department of Veterans Affairs (VA). Representatives from the regional DVS office were on site to assist veterans with questions about benefits, dental and otherwise, and offer enrollment help where needed.

Dental treatment is available from the VA to certain Veterans and is based on a variety of factors determined by law. In some cases, available dental benefits extend to extensive care while in others dental treatment may be limited.

Eligibility for VA outpatient dental care is categorized into classes and is not the same as for most other VA medical benefits. Some Veterans are eligible for care and have not applied for benefits, and those individuals are the ones the survey at the MOM clinic attempted to reach. Virginia is the state with the fastest growing veteran population.

The Department of Veterans Services reports that of the veterans identified, all who requested it have received follow up contact. DVS extends thanks to the VDA for partnering with them to improve care for Virginia's veterans. For many veterans from southwest Virginia, this has made all the difference!

LOCAL UVA-WISE STUDENT SEES CAREER IN DENTISTRY

Jack Nauss

I have spent the last 20 years of my life living in Wise, which is a small rural community located in one of the poorest regions in the United States. As a result, for most of my life I have witnessed many of the challenges that financially-deprived individuals must face every year, including affording to pay for quality healthcare. The cumulative sympathy that these observations have aroused in me, along with my growing desire to invest my time and abilities back into the community that originally invested in my growth and development, sparked my interest in volunteering through Remote Area Medical (RAM) as a general volunteer at the Wise event in 2014. During this event, I did anything that I could to assist the Missions of Mercy (MOM) volunteers in the dental tents, since I was entertaining the idea of pursuing a career in dentistry at that time. As a result, I sincerely enjoyed fulfilling the tasks that were set before me and being a part of the RAM team. Nonetheless, I wanted to be responsible for doing more for the people that were being served. I knew that I had more to give to them and I was eager to do so. Consequently, at the close of the 2014 Wise event, I knew that I both wanted to pursue a career in dentistry and that I wanted to continue to work with the MOM/VDA Foundation for the rest of my life.

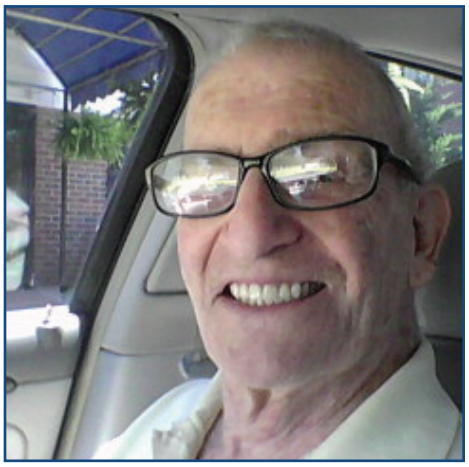
In April 2015 I was fortunate to meet one of the VCU student coordinators for the MOM projects at VCU's pre-dental day. I was ecstatic when she informed me that pre-dental students could volunteer through MOM. This was news to me; nonetheless, it was good news. I saw it as an opportunity for me to do all that I could to help the dental team. In addition, I knew it would allow me to observe and better prepare myself for the roles that I will one day play as a volunteering dental student and then a volunteering professional. Thanks to the help and guidance of this very kind and special 4th year VCU dental student I was able to apply through VCU to volunteer with MOM at the 2015 Wise event. Upon being selected to be a pre-dental student volunteer, I was extremely excited to contribute my joy and work ethic to the dental team that was bringing care to members of my community, but I could not have imagined how fulfilling this experience would be for me.

Naturally, I find the tasks of preserving ones' smile and/or ensuring their ability to chew effectively extremely fulfilling, since the aforementioned functions have been extremely important to me since I was a child, who possessed both a mischievous smile and a seemingly unceasing appetite. As a result, learning about dentistry and watching it in practice always excites me. Nonetheless, during the 2015 MOM project, I was experiencing more than just excitement. I was experiencing personal fulfillment in a way that I had never experienced it before. For the first time in my life, I was drawing so much motivation from how good I felt about what I was doing that food and rest were entirely unimportant to me and seemed unnecessary. During the days of operation, I completely lost all regard for myself. I only cared about making patients smile and doing all that I could to help the dental team. Incredibly, my personal experience was not unique. Every single MOM volunteer appeared to be doing exactly what I was doing and feeling exactly what I was feeling, and that touched my heart. I think there is nothing more wonderful than being a part of a team of compulsive smilers, who are both irrationally positive and extraordinarily dedicated in their endeavors to humbly serve others.

Through my experiences with the MOM patients I discovered that I am truly good at interacting with people from my area. I had the ability to encourage and work with them in a way that other people could not. They were responsive to my personality, and they trusted me. Therefore, one of the most important revelations that I had while I was volunteering with the Missions of Mercy team this year was that I wanted to come back to Wise to take over a practice when I finish dental school. I now know that working with patients from this area will provide me the opportunity to obtain personal fulfillment through my daily work.

Donated Dental Services
Virginia Dental Association Foundation

THE FACES OF DONATED DENTAL SERVICES



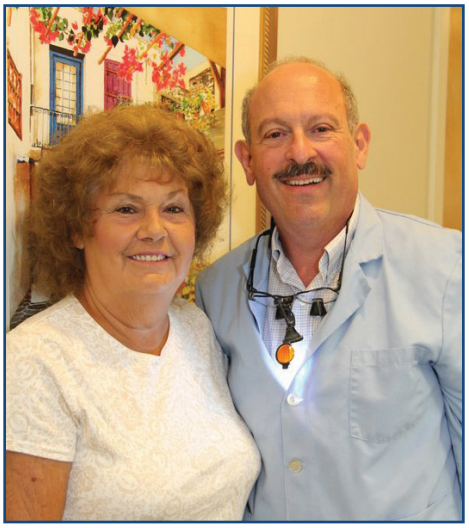
PAUL GILENSON

Volunteer Dentist: Dr. Henry Stewart
Volunteer Dental Lab: Nu Technologies Dental Lab

Paul Gilenson was born in November 1926 of immigrant parents. He grew up in New Jersey, and in 1944, barely of age, he enlisted in the army, specifically the paratroopers. Paul was on only his second combat jump when he was captured by German troops. According to his recollection, upon his capture an SS officer wanted him shot, but the young soldier who had charge of Paul disobeyed that order. Paul was briefly in a prison camp, but when the enemy discovered his Jewish heritage, he was immediately transferred to a concentration camp. By the grace of God, this was April,1945, and in approximately one month this camp was liberated by the Allies, and Paul survived.

Paul had a full career in the hardware business and retired in his early eighties, with limited retirement savings. He is widowed and currently lives in an assisted living home in Henrico. I can tell you he had very few teeth remaining when the process was begun to get him dentures. Although, as Dr. Henry Stewart has constantly forewarned Paul that there will be an adjustment process, he (Paul) is VERY GRATEFUL to have "teeth" to work with, and, if you know Paul, to grin with.

Again, I express the heartfelt thanks of Paul, his family and many friends for your kindness in giving him a somewhat easier time of things in his twilight years.



ROBERTA WRIGHT

Volunteer Dentists: Dr. Tony Agapis, Dr. Paul Brinser
Volunteer Dental Lab: Lab One, Norfolk

Roberta was in pain with multiple infected teeth and perhaps worse, in her opinion, embarrassed about her appearance. We decided a complete maxillary immediate denture and a partial mandibular denture would get her smiling again. With the help of donated services of Dr. Paul Brinser, of Southside Oral and Facial Surgery and Karen at Lab One dental lab in Norfolk, Roberta got her self confidence back.

This case took minimal time and effort and a few dollars worth of materials but in my opinion a great way to help the community in the comfort of my own office. Roberta has become a spokesperson for our practice as have other patients referred by Donated Dental Services. I encourage anyone interested in making an important contribution to their community, especially in the Chester, Southside, Tri-Cities areas, to take on just one donated case this year. You get to pick the case you feel most comfortable with and work with volunteer specialists and labs and help make a difference.

TIMOTHY LAMM

Volunteer Dentists: Dr. Marc Gamache, Dr. Robert O'Neill
Volunteer Dental Lab: Fitz Dental Lab

Mr. Timothy Lamm was first seen as a patient in the Virginia Family Dentistry Chester office in 2013. He had developed a painful toothache which we extracted at his first appointment. Dr. Marc Gamache gave Mr. Lamm a treatment diagnosis of a complete denture.

Finances were an issue and at this visit he let us know that he could not afford dental treatment for himself. We knew that Mr. Lamm is the primary caregiver to his adult son Shawn who has Downs' Syndrome. Timothy has diligently brought Shawn into our office for regular checkups since 2012 and always paid.

We wanted to help. Virginia Family Dentistry works with the Donated Dental program and we thought that Mr. Lamm would qualify for their program. In January 2015 we received paperwork that Timothy was next up to receive treatment and Dr. Gamache accepted his case. We created a treatment plan that included removing his remaining teeth and replacing them with dentures.

With the help of Dr. Robert O'Neill at Southside Oral and Facial Surgery and Mr. Jerry Vick of Fitz Vital Dental Lab who are both participants in the Donated Dental program as well, we were able to give Mr. Lamm his smile back.

We at Virginia Family Dentistry feel that we have helped a truly worthy individual and given him a better quality of life.

A FRAMEWORK OF PARTNERSHIPS

Lyubov Slashcheva, D2016[1], Gail Kim, D2016[2], Dave Pawlowski[3], Lynne Taiclet, DMD[2], Matthew Cooke, DDS, MD, MPH[1,2,3]

1. Virginia Commonwealth University, School of Dentistry
2. University of Pittsburgh, School of Dental Medicine
3. Special Smiles of Virginia, Healthy Athletes Program

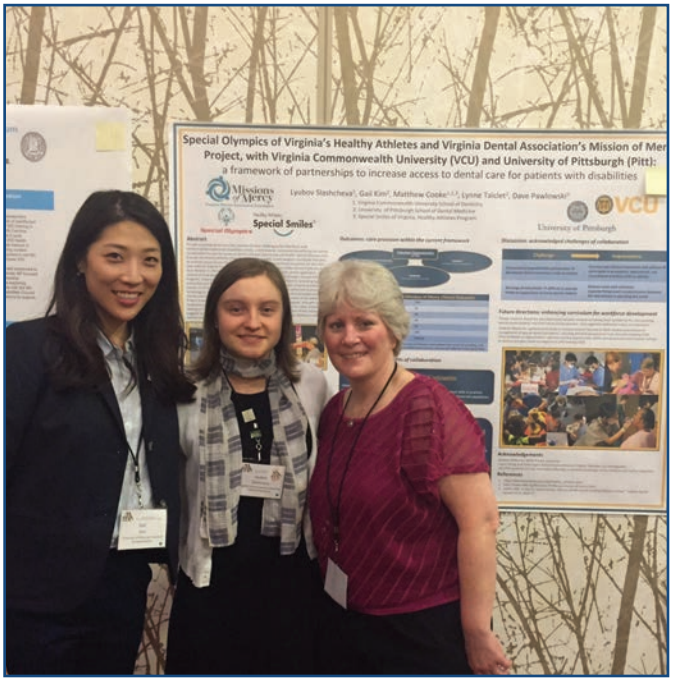
Comprehensive dental care is consistently a challenge for individuals with intellectual/developmental disabilities (I/IDD). A shift towards community-based living further complicates access. Special Olympics (SO), through the Healthy Athletes Program, is the largest public health program worldwide that aims to increase access to care for I/IDD. Special Olympics Virginia continues to partner for the 15th year with the Virginia Commonwealth University (VCU) Delta Sigma Delta Dental Fraternity and local dentists in offering screenings, mouth guard fabrication, fluoride varnish application, and referral to local dentists for treatment. In 2011 Special Olympics Special Smiles joined forces with the Virginia Dental Association's Mission of Mercy Project (MOM) to provide an infrastructure for needed preventive and therapeutic services to the athletes onsite at the summer games.

For the past two years, volunteers have included both Virginia Commonwealth University and the University of Pittsburgh dental students. Several years into implementation of these partnerships, outcomes focused on care provision to I/IDD are celebrated. Strengths and weaknesses have emerged. As a result, best practice recommendations for other entities seeking to replicate the initiative are discussed. Student perspectives from different institutions further suggest there may be opportunity to augment the existing curriculum and encourage additional inclusion of special care dentistry in the dental professional training experience.

A Dynamic Initiative:

The evolving framework: Special Olympics Healthy Athletes offers services to I/IDD in more than 130 countries providing access to care for a population that shares unique health disparities around the world.[1] The Missions of Mercy Project has been providing exceptional oral health services to underserved Virginians since 2000.[2] Virginia Special Olympics incorporated its first Healthy Athletes program in 2001, focusing on oral health through the Special Smiles program. Incorporating the MOM Project into this infrastructure in 2011, Virginia became a pioneer in providing comprehensive oral healthcare services to special needs patients.[3]

Curriculum within which student volunteers are trained: Virginia Commonwealth University School of Dentistry offers students training in Special Needs Dentistry in the third year Medical Management course and devotes a year-long Literature Review course to Special Needs populations. The University of Pittsburgh School of Dental Medicine offers training in Special Needs Dentistry in a third year Special Needs didactic course and required clinical rotations during both the third and fourth year curriculum in the Center for Patients with Special Needs. The Center is devoted to treating patients with intellectual, developmental, acquired, behavioral and complex medical conditions. Optional selective clinical rotations are also offered at both schools.



L-R: Gail Kim, Lyubov Slashcheva, Dr. Lynne Taiclet

Outcomes: care provision with the current framework

About 158 volunteers, comprised of oral healthcare professionals, dental students and staff gathered, at the Virginia Special Olympics Summer Games with the common goal of providing oral care to I/IDD. A total of 123 athletes received $29,868 in dental care totaling 463 procedures, including exams, cleanings, x-rays, extractions and restorations.

2015 Virginia State Games Missions of Mercy *Clinical Outcomes*	
Exams	123
Supra-gingival scaling/prophylaxis	91
Radiographs	63
Extractions	37
Restorations	56
Special Olympics athletes receiving serves	123
Total value of serves rendered	$29,896
Note: The Special Smiles Program of Healthy Athletes Special Olympics International also rendered screening, oral hygiene instruction, fluoride varnish, and mouth guard fabrication serves that are not reflected in the above data	

Table 1. 2015 Virginia State Games Mission of Mercy *Clinical Outcomes*

Discussion: realized benefits of collaboration

Patient-centered synergy: Joining the Special Olympics Healthy Athletes Special Smiles Program with the MOM Project benefits athletes by establishing a continuity of care for oral health needs identified in the screening phase. Onsite dental care helps eliminate incomplete referrals and provides an accessible opportunity for athletes to learn about proper oral hygiene practices and become introduced to dental treatment if they do not regularly access oral healthcare services.

Workforce development: Overall, students from both VCU and Pitt found volunteering for this event valuable. They were able to interact with SO athletes and provide dental care, utilizing traditional and advanced techniques of behavior guidance. Direct interaction with athletes allowed students insight into the oral health disparities that this vulnerable population experiences.

Dental students from the two institutions,

also, worked with local dentists and with each other, offering the opportunity for students from different programs to gain a different perspective. The synergistic effect of engaging both dental academic institutions in this initiative encouraged students to further seek training and service opportunities involving I/IDD.

Discussion: acknowledged challenges
Because Virginia SO Summer Games events were scheduled throughout the day, there was inconsistent patient flow through the care system. The intermittent flow of patients between events led to pauses in opportunity to provide clinical care. Therefore, the clinic was not utilized to its maximum potential, resulting in decreased clinical experiences. In order to maximize interaction with athletes, volunteers were encouraged to engage in non-clinical interaction through participating in preventive, educational, and recreational activities with athletes.

Future directions: enhancing curriculum for workforce development
Students found the described event valuable towards increasing their confidence for incorporating special needs into their future private practice. Additional modalities of preparation via didactic resources and clinical opportunities, may better prepare the dental provider. Optional book study clubs or seminar sessions focused on both medical and behavioral management of I/IDD in the dental setting, including practical perspectives from clinicians were suggested to expand foundations of knowledge on I/IDD. In addition, rotations within private practice and hospital settings to observe and gain hands-on experience with treating I/IDD would serve as valuable enhancements to existing curriculum components. The described framework is an exceptional introduction to oral healthcare for I/IDD, however, barriers to care for special needs patients continue.

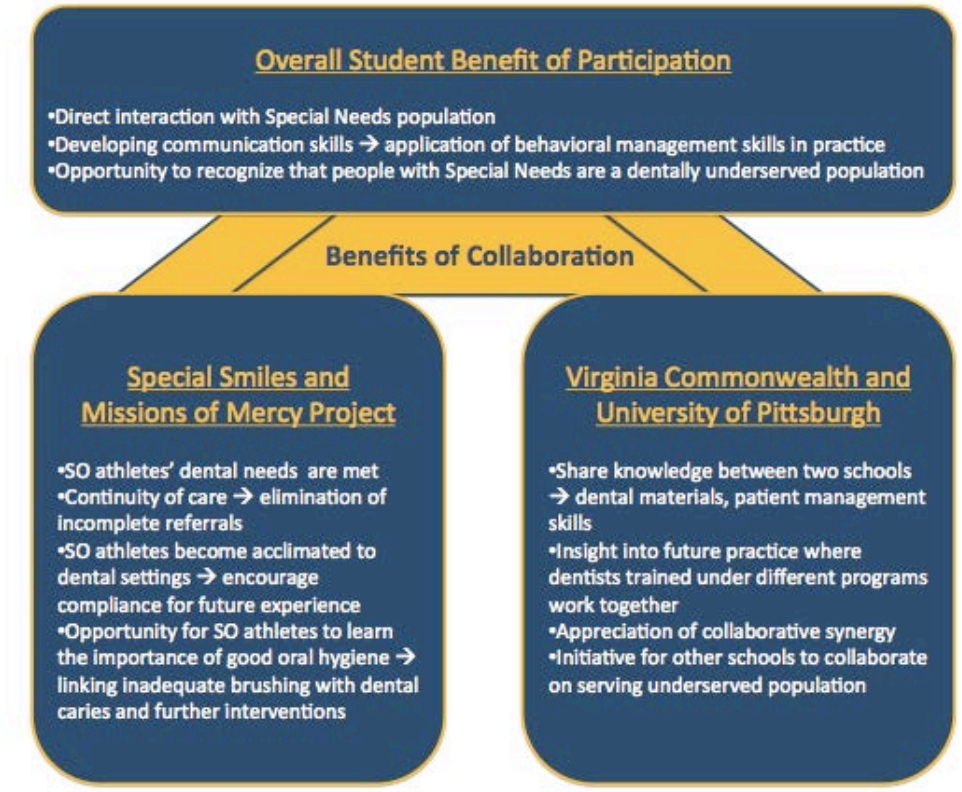


Chart 1. Benefits of Collaboration

Acknowledgements
Barbara Rollins for MOM Project outcomes; Lance Cheng and Delta Sigma Delta Omicron Omicron Members for photography; VCU/Pitt students (N=11) for interviews reflecting on benefits/challenges of the initiative and further directions

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CARE ENOUGH TO PROVIDE AN EXCEPTIONAL PATIENT EXPERIENCE

Debra Engelhardt-Nash

In dentistry, care is a verb, not a noun. We care about our patients and care about people. And the way we care directly impacts the patient's experience which, in turn, directly impacts case acceptance and patient retention. Providing exceptional care is a process of purposeful actions that requires thought, effort, engagement by the entire dental team, and ongoing monitoring and evaluation.

In a thriving, busy practice, there never seems to be enough time in the day. Unfortunately, this busyness may cause the team to focus on getting things done instead of caring for patients. If our tone and communications with patients seems rushed and distracted, patients may feel unimportant to the practice. Take a breath and then a few minutes to purposefully communicate with patients, especially during these touch points:

1. **The telephone introduction**. Over the phone, patients have no idea what your day has been like or if you are busy or not. They cannot see your body language or the seven things sitting on your desk waiting to be done. So, if you are distracted and focused on getting off the phone to attend to something else, they may interpret your words and tone negatively. It only takes a few moments to be warm and welcoming before you get down to the business of gathering insurance information and scheduling appointments.
2. **The in-practice greeting**. When a patient guest comes into the practice, they should be greeted by name with the attitude that comes from understanding the patient has choices and the team appreciates the patient has chosen them.
3. **The patient/doctor introduction**. Take the time to respectfully introduce new patients to the doctor. "Mrs. Jones, I'd like to introduce you to Dr. Smith. As I mentioned, Dr. Smith has been doing amazing dentistry for more than 15 years. Dr. Smith, this is our new patient, Mrs. Jones. Mrs. Jones was referred to our practice by her friend, and our long-time patient, Mrs. Brown."
4. **The treatment and financial conversation**. Patients should always be introduced to ideal dentistry. They may choose to phase treatment, but they need to know you care for their oral health and want what's best for them. Patients should also be introduced to all payment options if they have an out-of-pocket expense. If you accept financing through a credit card like CareCredit, let them know and then let them choose what's best for them.
5. **The post-appointment follow-up call.** A personal follow-up telephone call to the patient is a great way to demonstrate how much your team cares. Many practices routinely call the patient after a hygiene or restorative appointment. But the best opportunity to make an impact on the patient relationship is by calling after the new patient examination and consultation. New patients may have questions or concerns and when the office calls to provide additional information or just let the patient know they are available, patients' expectations are exceeded.

Caring Requires Consistency

I recently walked in the gift shop of a high-end hotel to buy a bottle of water. After waiting at the cash register for a few moments, I walked to the back of the shop to find someone to ring me up. What I found was the hotel employee ranting to herself about how much she disliked her job. Was she having a bad moment? Yes. But her words and attitude significantly and negatively impacted my perception of the hotel and my overall satisfaction.

A patient's experience in a dental practice can be impacted similarly if their interaction with just one team member is negative. Caring is a team effort. People tend to pick up and absorb the emotions around them. When your team is consistently warm, engaging, excited and appreciative, patients will tend to be the same. When one team member is having a "bad day," they can easily "infect" other team members and patients. So be diligent in caring enough to help each other have positive interactions with patients. You'll be surprised how infectious good moods can be, too.

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WELCOME NEW MEMBERS

Karen Clendenen, VDA Membership and Meeting Coordinator

TIDEWATER DENTAL ASSOCIATION

Brian G. Briesemeister – Suffolk – Howard University 2015

Brittany B. Casteen – Portsmouth – VCU 2015

Michelle Anne Galloway – Norfolk – Howard University 1985

Michele L. Graham – Chesapeake – VCU 2015

Stephen P. Haupt – Virginia Beach – VCU 2015

Fotina Lefta-Hoskins – Virginia Beach – University of Kentucky 2013

Asra Javeed – Virginia Beach – Boston University 2008

Maryam Malik – Norfolk – University of Louisville 2015

Joshua Matthew Lohr – Norfolk – University of Maryland 2015

Bernadette Mabanglo-Samson – Virginia Beach – VCU 2009/University of Maryland 2011

Mark D. Newman – Virginia Beach – VCU 2006

Tiffany Nightengale – Newport News – University of Louisville 2006

Carolyn A. Norton – Virginia Beach – University of Florida 2014/University of Chicago 2015

Angela Gomez Romero – Virginia Beach – Ohio State University 2015

PENINSULA DENTAL ASSOCIATION

Ashley Barrineau – Suffolk – University of Maryland 2014/University of Washington 2015

Nidhi Jaiswal – Williamsburg – VCU 2015

Patrick Wyatt – Williamsburg – VCU 1979

SOUTHSIDE DENTAL SOCIETY

Louis Formica – Prince George – VCU 2015

Rachel F. Leister – Chester – VCU 2015

Thomas J. White – Chester – VCU 2015

Brittany Wright-Graves – Norfolk – VCU 2012

RICHMOND DENTAL SOCIETY

Matthew H. Aldred – Richmond – VCU 2010/ UVA Hospital 2012

Reem I. Alhussain – Richmond – VCU 2015/2017

Naser Alkandari – Richmond – VCU 2015/2016

Farheen Amina – Henrico – VCU 2015/2016

Husain Aseeri – Richmond – VCU 2015

Stephen Matt Beecroft – Spotsylvania – Case Western Reserve University 2009/Vanderbilt University Medical Center 2012

Danielle E. Easterly – Richmond – VCU 2015/2017

Stephen J. Fintel – Richmond – VCU 2015/2016

Thomas F. Glazier – Richmond – VCU 2012/2015

Ashley A. Harman – Richmond – VCU 2013/ Children's Hospital Med. Ctr. Cincinnati 2015

Krista I. Harriman – Richmond – VCU 2015/2018

Carolyn Kelly-Mueller – Richmond - University of Pittsburgh 1988/Allegheny General Hosp. 1989/University of Pennsylvania 2013

Tara Marie Kraisinger – Richmond – VCU 2015/2018

Shravan Kumar Renapurkar – Richmond – Boston University 2010/University of Minnesota 2014

Stuart Laningham – Mechanicsville – VCU 2015

Autumn Mayers – Mechanicsville – VCU 2015

Anna L. Moore – Richmond – VCU 2015/UVA 2017

Bibek Nakarmi – Richmond – VCU 2015

Majid Naser – Henrico – VCU 2015

Reba M. Oley – Richmond – VCU 2015

Ashlyn Price – Ashland – VCU 2015

Shahreyar Sayyar – Glen Allen – VCU 1998

Jacob L. Sheppard – Midlothian – VCU 2015

Robert G. Steadman – Richmond – VCU 2015

Alexa Vinson – Richmond – VCU 2015

John H. White – Richmond – VCU 2015/2018

Matthew A. Winheim – Richmond – VCU 2015/2016

PIEDMONT DENTAL SOCIETY

Rachel Brinkley – Danville – VCU 2015

Shelli Boucher – Lynchburg – University of Connecticut 2013/VCU 2014

Nicole M. DeShon – Martinsville – University of Pittsburg 2011/West Virginia University 2014

Rachel Eames Gatewood – Chatham – VCU 2015

Kwang Kim – South Boston – VCU 2010

Benjamin McDonald – Daleville – VCU 2015

Amanda Meade – Martinsville – VCU 2012

Victoria F. Yeager – Lynchburg – VCU 2015

SOUTHWEST VA DENTAL SOCIETY

Catherin Mansdoerfer – Radford – VCU 2015/2016

Sonya K. Martin – Hillsville – VCU 1995

SHENANDOAH VALLEY DENTAL ASSOCIATION

William Goodwin – Fishersville – VCU 2011/ University of Cincinnati 2015

Bradley Hammitt – Orange – VCU 2015

Nicholas B. Hill – West Virginia University 2007/2008/Temple University Hospital 2013

Lavika Mor – Charlottesville – Dasmesh Institute of Research & Dental Sciences (India) 2009/Miami Valley Hospital 2014

NORTHERN VA DENTAL SOCIETY

Jameena Abdulkareem – Reston – UCLA 2015

Saira Ahmad – Falls Church – VCU 2015

Cristian Alcantara – Fairfax – Peru University 2005/Howard University 2014

Paola S. Annoni-Patel – Arlington – Columbia University 2015

Manisha K. Chawla – Arlington – Howard University 2015

Alice Chiu – Centreville – Temple University 2014/St. Luke's Hospital 2015

Wesley H. Citron – Arlington – University of Pennsylvania 2012/Lutheran Medical Center 2015

Emily Day – Vienna – VCU 2015

Jeanna Devasia – McLean – VCU 2015

Nicholas F. DiBenedetto – Falls Church – U. at Buffalo School of Dental Medicine 2011/ SUNY Upstate Med. Univ. 2012

Monica Truong Dinh – Annandale – VCU 2013/FL-Nova Southeastern 2015

Margaret Enoch – Alexandria – VCU 2006

Mobolaj Falaiye – Annandale – University of Detroit-Mercy 2015

Giannina Galliani – Falls Church - Peru University 1999/University of Maryland 2006

Ibrahim Haron – Annandale – Kuwait University 2009/Emory University 2015

Amber Z. Hasan – Centreville – Temple University 2015

Ahmad Hawasli – Burke – Egypt-MSA(Oct Univ. for Mod Sci & Arts) 20014/University of Maryland 2015

Alan Ho – Springfield – VCU 2013/Washington DC Medical Center 2014

Polina Iarikova – Alexandria – University of Maryland 2015

Constance Jin – Vienna – University of Pennsylvania 2011/U. at Buffalo School of Dental Medicine 2014

Alain Jureidini – Arlington – (Lebanon)Saint Joseph University 2010/Columbia University 2014

Madhusudhan Kasipathy – Herndon – NYU 2008

Gurpreet Kaur – Alexandria – VCU 2015

John Khouri – Gainesville – University of Pennsylvania 1994/Howard University 2000

Sheila N. Mazhari – McLean – Nova Southeastern University 2012

Narmeen Minhas – Arlington – Rutgers 2012/ Ellis Hospital 2013

Caitlyn R. Nuger – Oakton – University of Maryland 2013/St. Christopher's Hosp. for Children 2015

Nhu-Quynh T. Phung – Burke – Temple University 2015

Jason Pulac – Sterling – University of Michigan 2009/Illinois Naval Dental Center 2010

Josephine Salumbides – Alexandria – VCU 2013/PA-York Hospital 2015

Evelyn T. Samuel – Falls Church – University of Alabama 1999

Deepti Sareen – Fairfax – University of Michigan 2015

Christina N. Shaw – Sterling – University of Connecticut 2014/University of NC 2015

Lauren Simon – Manassas – VCU 2012

Matthew W. Stringham – Fairfax – VCU 2015

Lydia Sumner – Gainesville – VCU 2013/ Howard University 2014

Wenhui Sun – Fairfax – University of Connecticut 2014/Summa Center 2015

Bjorn Thorsen – Fredericksburg – Columbia University 2014/VA Med. Ctr., Washington, DC 2015

Kowshik R. Vaddi – McLean – Boston University 2007

Andrew H. Vo – Manassas – VCU 2015

Danny M. Vo – Annandale – Medical University of South Carolina 2014/Lutheran Medical Center 2015

Qing Xu – Falls Church – VCU 2015

Lauren Zollett – Alexandria – Ohio State University 2011/Boston University 2015

IN MEMORY OF:

NAME	CITY	DATE OF DEATH	AGE
DR. MONTAGUE L. MARTIN	NEWPORT NEWS	JUNE 21, 2015	UNKNOWN
DR. WILLIAM R. PARKS	YORKTOWN	MAY 21, 2015	UNKNOWN
DR. DANIEL R. RHODES	CHESTERFIELD	MAY 9, 2015	53
DR. MATTHEW A. CAMPBELL	ANNANDALE	MAY 5, 2015	83

ADA TRUSTEE'S CORNER

JUNE 2015 BOT MEETING

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

I began my work with a Future of Dentistry Workgroup Meeting, having been appointed by Dr. Feinberg. This was in response to H Res35 and B Res 156 that we adopted at our December Board of Trustees (BOT) meeting. Below you can see the background information and the timeline.

Background: At the September 2014 meeting, the Board considered the Council on Dental Education and Licensure Supplemental Report 1 to the House of Delegates: A Comprehensive Study of the Current Dental Education Models as well as a report and recommendation to the Board to consider a Future of Dentistry Study by 2020. The Board supported the Council's Resolution 35 to the 2014 House of Delegates calling for a study of the current dental education models. The Board also agreed with the Council that there may be significant value in more deeply investigating dental education and practice trends so that organized dentistry plays a proactive role in shaping and adapting to these likely new realities of the future of dental practice. Accordingly, the Board adopted Resolution B-110 in September 2014:

B-110. Resolved, that ADA Board of Trustees explore with appropriate ADA agencies, the need for a "Future of Dentistry" study by 2020 to analyze dentistry's role in the future health system, including implications for the role of dentists and allied dental personnel, dental practice models, and dental education models.

At its December 2014 meeting, the Board noted that Resolution 35H-2014 adopted by the House of Delegates and assigned to the Health Policy Institute (HPI) and the Council on Dental Education and Licensure with a directive that results be reported to the 2016 House of Delegates. The Board further discussed next steps regarding Resolution B-110 – Future of Dentistry Study by 2020.

To begin the process, the Board adopted Resolution B-156:

B-156. Resolved that a work group be appointed by the President composed of representatives of the Board of Trustees, Council on Dental Education and Licensure, Council on Dental Practice and Council on Scientific Affairs, and be it further

Resolved, that the work group be charged with: (1) making a recommendation to the Board on whether to move forward with the study, (2) suggesting parameters for the study, (3) developing a plan for conducting the study, and (4) estimating the financial impact, and be it further

Resolved, that the work group report back to the Board in October 2015.

The work group studied the 2001 Future of Dentistry Report and identified many activities that the profession has pursued since the release of the 2001 Report. Those activities and initiatives are summarized in the Overview of 2001 Future of Dentistry Report. While many of the recommendations were implemented, the work group noted that no system was put in place to monitor outcomes.

The face-to-face meeting proved to be very productive and the workgroup came up with some recommendations that will be presented to the BOT at our next meeting. After the Board has deliberated on these recommendations I will be able to report on this subject in my next Trustee Report.

Our standing committees of the Board continued their thorough work during the weekend. This allowed the Board as a whole to be both efficient and productive.

On Sunday, we took time to explore our Medicaid initiative. We were joined by representatives from National Dental Association, Hispanic Dental Association, American Association of Women Dentists, and the Society of American Indian Dentists who shared their organizations' perspectives on this important issue. We appreciate their involvement in our discussions and hope to continue to work with them. While we discussed how we can address problems with Medicaid through working with the states and through coalitions, it is clear that funding remains a fundamental problem. We discussed the Emergency Room referral program, which provides a good example of both what works and the problems we face with Medicaid. Virtually every state is involved in the ER referral program and it involves natural coalitions, because everyone recognizes the problem. However, as with Medicaid in general, funding remains the stumbling block. We asked the Board workgroup (of which I am a member) addressing Medicaid to consider our efforts on this issue and to report back to the Board on where we should be focusing our efforts. Based on their efforts, we have been informed that staff will narrow the focus on those Medicaid reform activities which seem to be working.

Over the last several years, we have all heard complaints about the search function our members face when using ADA.org and the Board members have been just as frustrated as our members. At this meeting, we agreed to fund development and implementation of a new search tool, which we expect will greatly enhance our members' experience. We can expect to see results on the website by the end of this year.

Our Diversity and Inclusion Committee presented a new toolkit to help trustees advance diversity and inclusion in their districts. This was a huge undertaking and we all thank them for their effort in this endeavor. In addition, the Board approved the 2015-2016 class of the ADA Institute for Diversity in Leadership as well as three alternates. I hope to have future positive information on this project in later reports.

We are all well aware of the tremendous burden student debt has on our new dentist members and the effect that it could have on their career choice. Previously, we had asked the Board's Student Debt Workgroup to investigate approaches to this problem and what role the ADA could play in addressing this problem. The Workgroup has made tremendous progress on this issue. At this point, the details of our next steps must remain confidential.

The Board addressed the needs of our members and potential members employed in the large group practice context. We all recognized the need to engage in dialogue on this matter, always remembering that our ultimate goal is to protect both our members and the public. A workgroup will be formed, which Dr. Feinberg will appoint, on DSO (Dental Service Organizations) Practices, to advance the interests of dentists. We look forward to future work on this issue remembering that the ADA should strive to provide member value to all members regardless of the practice setting that they choose.

Dr. Perry Tuneberg, chair of CODA (Council on Dental Accreditation), attended our meeting and briefed the Board on current developments within CODA. This provided us with a valuable opportunity for dialogue between CODA and the Board of Trustees. Dr. Tuneberg's efforts were appreciated and gave the Board better insight into CODA'S activities.

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A key responsibility of the Board is to monitor the Association's performance. This responsibility has been made easier for us with the advent of a new format for our Quarterly Management Report. This was the first report we have received in this format and our Executive Director assured us that additional changes and improvements will be made in the future. The Board thanks the Strategic Planning Committee for its initial review of the report and suggestions for improvement. We reviewed the report and had the opportunity to question staff about it. Part of our review related to our membership numbers and the failure of many states to remit dues in a timely manner.

Dr. O'Loughlin and Mr. Robinson presented the latest information on our membership numbers. There is some evidence that our market share erosion is accelerating in some states. This presents a very serious risk to the Association. And our problems are not limited only to the new dentist. For example, our non-renew rate is increasing across all age groups. One obvious concern is the uneven level of member value and service from state to state and local society to local society, and our limited ability to influence behavior at these levels. We are developing tools to help us address this issue by offering assistance to states based on each state's needs. Another concern is the broad range of membership dues because of the different dues structure of components and constituents across the country. One of the main reasons for non-renewal is the cost of membership and we all know that the ADA has not raised its dues in three years.

Closely related to our market share concerns is the growing share of the market employed in DSOs or other large group practice models. While the exact number of dentists practicing in this model is still difficult to identify with precision, we do know that among those we can identify, our market share is just at or below 50%. Clearly if this model continues to grow in the market, it will have a significant impact on our ability to reach our strategic plan goal of 70% market share.

Mr. Robinson, our Vice-President of membership, and his staff also reviewed survey results of former members who chose not to renew ADA membership last year. Over 40% of those surveyed cited financial reasons for not renewing. Over 50% of new dentists surveyed cited cost or financial issues as the reason. Another lesson from the survey is that some who do not renew do so because they may not see the need to belong to more than one professional organization. We will use what we have learned from the survey to help us focus on non-renewals to better target vulnerable members and increase our retention rate.

Our Strategic Planning Committee also addressed pricing issues and we passed a resolution urging the council on membership to consider several initiatives relating to pricing of membership. We look forward to the council's consideration of the SPC report.

We also learned that remittance of dues by states to the ADA has fallen far behind prior year numbers. We are closing this gap, but it remains a concern. Staff has been contacting states about this. In many states, there are both capacity issues at the state level to effectively handle dues remittances and a financial need for some states to hold on to the money for as long as possible. Dr. O'Loughlin is working with our Legal Division to identify barriers in our Bylaws that make it more difficult for us to address this and related membership issues.

We were also introduced to our new vice-president for the Science Institute, Dr. Marcelo Araujo. He explained for us his plans for the future of that institute. The work of the Science Institute includes two important member benefits, the Professional Product Review and the EBD Center. Of course, it also includes the ADA Seal program. Dr. Araujo explained his plans to reinvent and reinvigorate that program. We all look forward to working with Dr. Araujo into the future and welcome him to the ADA team.

Our Information Technology Committee offered a demonstration of a new ADA member mobile application. This will allow members quick access to many on-line ADA member benefits, including the member directory, career center and discussion forums. The mobile app will be rolled out over the rest of this year. We thank the IT Division and the IT Committee for this exciting development.

Action for Dental Health is an important initiative of the Association. The results to date are promising. ADH is designed to change the terms of public debate around access issues. No longer will we allow Kellogg or Pew set those terms in a vacuum. Moreover, ADH represents a more comprehensive approach to the access issue, providing more and better care to the American public.

The Board addressed the Choosing Wisely campaign. After a rocky start, we seem to be back on track regarding the process for development, review and approval of key statements. Revised statements are being prepared after extensive input from various ADA councils, as well as outside groups. Once the revised statements are ready, which will be very soon, the CAPIR steering committee will provide another opportunity for input from stakeholders. Eventually, the Board will have the final say on the statements when CAPIR formally forwards them to the Board. We thank the steering committee and council for their work on this project. As liaison to CAPIR this year, I can tell you first hand of all of the hard work that has gone into this project.
On our last day of the meeting, we looked at new data on the "busyness" problem. We have all heard stories about dentists having too much free-chair time in their offices and this data validated that. Dental office visits across the country have declined approximately 9% over the last six years, and this is despite the growth in the U.S. population and the increase in the number of dentists. The two leading reasons identified from the data are perceived financial barriers and a perceived lack of need for care.

We discussed at a high level our options in the face of this data, including possible collaboration with outside organizations. We discussed the fact that this topic requires more consideration before decisions are made, but that process has started and will continue at a future strategic discussion.

40 UNDER 40

DR. KAMALJIT KAUR

Dr Kaur uses a mix of art and technology to improve her patient's health. She likes to meet her colleague dentists and likes to share new ideas and vision. Dr Kaur is married to Dr Kaler and they have two beautiful daughters Reet and Rhea and they both enjoy working together at Kay Dental Care.

ADA TRUSTEE'S CORNER

AUGUST 2015 BOT MEETING

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

Once again, we had a very productive meeting of the Board of Trustees. We began our work with two days of productive committee meetings. The work of the standing committees of the Board (prior to the full Board Meeting) allows for a more gainful and efficient meeting.

On Sunday, Dr. Bernard Meyerson, IBM's Chief Innovation Officer, gave us a fascinating presentation on innovation. Dr. Meyerson talked to us about big data and the need for every organization to use this kind of data in powerful ways. The key to innovation in the future will be the ability to effectively analyze big data. Dr. Meyerson offered us some compelling examples of how big data can be used to generate real, positive results. He challenged the ADA to look for innovative ways that we can use the data that we collect to positively affect our membership.

The remainder of our Sunday morning was spent in collaboration with the New Dentist Committee. The NDC is key to our ability to understand the wants and needs of new dentists in general. The NDC provided us with a series of insightful case studies that offered this perspective to us in a useful way. Jobs, electronic communications (e.g., ADA.org), student debt, monthly dues processing, job boards, career and business guidance were some of the key themes from our time with the NDC. We then turned our collective focus on how the NDC and Board members can work together to make a difference on our common goals. This was also a focus of our small group dinners on Saturday. Among the ideas generated were: take the idea of a simplified application and dues payment process back to our states; address the licensure portability issue; better communications among the NDC member, trustee and state leadership; support membership by DSO-employed dentists; the "Easy Button"; and make the membership dues value measurable in dollars and cents.

The entire Board of Trustees thanks the NDC for this important opportunity to meet and collaborate.

Our main item of business for this meeting was completing the work on the budget for its submission to the House of Delegates. Board Report 2 (the budget) will be posted shortly after the first group of House materials. I am especially pleased that we were able to propose a budget with a zero dues increase again while still investing in our priorities for next year. The deficit in our budget will be funded through our anticipated 2015 surplus and if necessary, ADA reserves, which at 59% remain above our target level of 50% of annual budgeted expenses.

We also began our work on resolutions and reports that will be presented to the House of Delegates. As part of this work, we have taken the first steps to tackling the issue of added sugar consumption by presenting a proposal on this to the House. We forwarded to the House our nominations for our councils, committees and commissions. These and other reports have already been posted on ADA Connect. I would urge all of the delegates and alternate delegates to begin now to start reading the reports and resolutions so that we can be thoroughly considered when our Caucus meets in Hilton Head, S.C., in October 2015.

As part of our work, we also approved a report asking the House to allow the Board to pursue pilot projects that would otherwise be blocked by the bylaws. These pilots would be limited in time, be regularly reported to the House and would allow us to try out new programs quickly. The proposal does not authorize structural changes, such as elimination of a council or office. This is an important action to allow us to react to a quickly changing environment in a more efficient and timely way to find out quickly what programs may work and what may not work; thereby saving the association both time and money.

After much work by CAPIR and its workgroup, we approved five science-based statements as part of the Choosing Wisely campaign. We also took the necessary steps to assure effective oversight of this campaign as it continues to move forward.

Our Foundation is an important part of the work of the Association. The Volpe Research Center is the home within the Foundation for basic research. Because of important recent changes there, Mr. Gene Wurth and Dr. Thomas Hart, the new director of the research center, made a presentation to us on the important work being done there and plans for the future. We thank the Foundation and Dr. Hart for the important work being done for the future of the ADA and the profession.

Our efficiency at this meeting allowed us to devote time on our last day addressing key strategic financial questions. We have now provided our Executive Director, Dr. O'Loughlin, with important guidance, asking her to provide the Board with a proposed balanced budget as part of the budget development process in the future. Our work on this will continue.

Lastly for your information, the BOT will meet just prior to our 16th District Caucus meeting. I am sure that we will consider more resolutions that will be presented to the HOD. I am told that the new resolutions should be posted no later than the Friday that our meeting begins. I am sure that our Caucus Chair, Dr. Watson, will expect our delegates and alternates to be prepared to discuss these new resolutions as they come in. We are also looking forward to visits on Saturday night and Sunday morning from the President-Elect candidates.

40 UNDER 40

DR. WILLIAM R. MONACELL

As coowner of Midlothian Family Dentistry, I've had a blast watching our practice grow since being an associate here in 2005. The cases I get most excited about involve implants and/or cosmetics. As usual, it's a great day to be a dentist!


THE Virginia MEETING
A Program of the Virginia Dental Association
September 14-18, 2016
The heart of Virginia's waterfront ™
welcomes you back.

VDA ACTIONS IN BRIEF

Board of Directiors June 26, 2015

1. Approved: A resolution that the VDA continue the PR campaign for another 3 years. Member cost per year - $235.00.

2. Approved: The 2016 VDA budget as submitted.

3. Approved: A resolution that it will be VDA policy that in the absence of a contested election (and there are no nominations from the floor at the opening session of the Business Meeting) there will be no on site voting during The Virginia Meeting.

4. Approved: The Council on Government Affairs recommendation that the VDA pursue legislation to amend the current non-covered services law to include a de minimus clause similar to the 2015 optometrist bill.

5. Approved: The Council on Government Affairs recommendation that the VDA pursue legislation that would exclude FQHCs and Virginia free clinics from the requirements for mobile dental clinic registration.

   Background: To add language to a clause in the mobile dental clinics regulations stating who is exempt (FQHCs and free clinics for the state of Virginia).

6. Approved: The following Bylaw Amendment:
   Article VII, Section 6

   5. New Dentist Committee

   a. Membership: The Committee shall be composed of one member from each component society who shall have received a D.D.S. /D.M.D. degree less than ten years before the time of selection. An additional member shall be a voting student member of the American Student Dental Association at the VCU School of Dentistry who shall be appointed by the President of the Association, in consultation with the Dean of the VCU Dental School. The term of membership shall be two years with a maximum of two consecutive terms. Additional non-voting student members shall be appointed by the President of the Association, in consultation with the Dean of the VCU Dental School. At-Large committee members up to a limit of eight can be appointed by the current chair of the committee for a term of one year.

   b. Duties: It shall be the duty of this Committee: (1) to assist in design and implementation of recruitment and retention programs directed to new practitioners; (2) to study and determine the current needs and concerns of new practitioners; (3) to promote and develop policies and programs that respond to new practitioners' needs; and (4) to promote the involvement of new practitioners in organized dentistry. The Committee shall meet at least two times a year and additional meetings scheduled at the call of the chair.

   c. A Mentoring Subcommittee will be appointed to plan lunch and learn functions at the dental school focused on practice transitions and to carry out other duties as directed by the New Dentist Committee. The Subcommittee will report directly to the New Dentist Committee.

   d. Mission Statement: The mission of the VDA New Dentist Committee is to help new dentists succeed by assisting them with a successful transition from student to dentist, encouraging membership and volunteer involvement in organized dentistry, providing member value through resources and education to meet their needs, facilitating networking opportunities and by fostering new dentist leadership development.

Reported as information only:

7. Approved: A resolution not to reinstate the $1,000.00 yearly stipend to the Virginia Dental Assistants Association.

8. Approved: A resolution to give a $500.00 sponsorship to the Virginia Oral Health Coalition's 2015 Oral Health Summit.

9. Referred: To the ADA Delegation, the following recommendation from the Dental Benefits Programs Committee:
   Support for HR 1185 (RAISE Health Benefits Act of 2015)
   Allow families to carry over all unused Health Flexible Spending Arrangement (FSA) funds from year to year; raise the savings cap from $2,500 to $5,000 per year and; allow for an additional $500 to be added to the cap for each dependent beyond two.

10. Approved: A resolution to respectfully decline the offer from the DC Dental Society to participate in their 2016 meeting.

11. Approved: A resolution that the VDA have a discussion with the VDHA to look at the possibility of an agreement on the role of hygienists in improving access to care.

12. Approved: A resolution approving the Memorandum of Understanding between the Virginia Dental Association and the Virginia Dental Association Foundation.

VDA ACTIONS IN BRIEF

Board of Directiors — September 16-20, 2015

1. Approved: A motion directing the VDA Executive Director to consummate a relationship with "Leadership by Design" based on previously established communication.

2. Referred: To the Council on Government Affairs - concerns regarding licensing test for specialists coming into the state as noted in a letter received from Dr. McKinley Price. The Council is to determine how this should be addressed i.e. statutory change.

3. Approved: The following 2015-2016 appointment:
   A. Parliamentarian: Dr. A. J. Booker
   B. Journal Editor: Dr. Richard F. Roadcap
   C. Executive Director: Dr. Terry D. Dickinson
   D. Legal Counsel: David Lionberger, Esq.; Scott Johnson, Esq.

4. Approved: The 2015-2016 VDSC Board of Directors was approved:
   Voting Members: Dr. Roger Wood, President, Dr. Stephen Radcliffe, Vice President, Dr. Rodney Klima, Secretary/Treasurer, Dr. Alonzo Bell, Dr. Fred Coots, Jr., Dr. Frank Crist, Jr., Dr. Ralph Howell, Jr., Dr. Wally Huff, Dr. Bruce Hutchison, Dr. Jeffrey Levin, Dr. Robert Levine, Dr. Kirk Norbo, Dr. Gus Vlahos, Dr. Leslie Webb, Jr., Dr. Edward Weisberg, Dr. Andrew Zimmer; Non-Voting: Dr. Steven Forte, liaison, Dr. Ted Sherwin, liaison, Dr. Lanny Levenson, advisory, Dr. Harvey Shiflet, III, advisory, Dr. Cynthia Southern, advisory.

MINUTES

146th Annual Business Meeting — September 20, 2015

1. President Michael J. Link called the meeting to order and the flag pledge was recited.

2. "I Am" video was presented.

3. The following deceased members were remembered:
   Component 1: Ira Gould, Thomas U. Hopkins, Steven W. Perand, Holman C. Rawls; Component 2: Thomas J. Forgeng, Montague L. Martin, William R. Parks, Thomas R. Parrott; Component 3: Daniel R. Rhodes; Component 4: Rudolph H. Bruni; Component 5: Leon A. Lackey, C. Wellsley Smith; Component 6: William E. Cline, William R. Henley, David R. Stanton; Component 7: Peter S. Yeatras; Component 8: Matthew A. Campbell , Michael J. Collins, Theron L. Dikeman, Robert E. Horgan, H. Jackson Payne, Robert P. J. Sabatini.

4. Recognition was given to:
   2015 VDA Fellows Inductees: Mary T. Dooley (1), Omar A. Abubaker (4), Sujit K. Mohanty (4), Bruce W. Overton (4), Stephen S. Radcliffe (4), Ronald N. Vranas (4).

   2015 Recipients of Life Member Certificates: Component 1: Philip A. Blythe, C. G. Clayton, Stephen E. Konikoff, James E. Krochmal, Jan E. Miller, Mark S. Sorin, Gary E. Taylor; Component 2: Mitchell A. Avent, Daniel M. Babcock, Donald D. Cooke, John H. Speegle, James D. Watkins; Component 3: Thomas M. Coghill, Michael R. Hanley, Roger A. Palmer, Richard F. Roadcap; Component 4: Jeffrey P. Blair, Clarence Campbell, III, G. Woodworth Johnson, John W. King, Brockton A. Livick, Patricia A. Moss, Robert Penterson, Arden M. Sterling, John E. Ward, Barry Weiss, M. Walter Young; Component 5: Charles E. Conklin, Jr., Michael J. Davis, Michael L. Jones, James P. Julian, C. W. Kirby, James K. Muehleck, Albert L. Payne, Arthur T. Silvers; Component 6: William O. Armour, Glenn A. Harrison, John K. Robertson; Component 7: James R. Farmer, Conrad A. Helsley, Robert D. King, John H. Neumann, Craig C. Stoner, Craig A. Zunka; Component 8: Barry C. Argintar, John D. Bramwell, John A. Bell, Jr., John H. Coker, Jr., David A. DeBenedetto, Robert H. Dewitt, Eric J. Forsbergh, Gregg A. Helvey, Robert A. Lebonitte, Sanford Montalto, James E. Rasmussen, Michael Rotter, Bruce T. Sallen, Terryl A. White Gene Y. Woo.

5. The following VDA awards were presented:
   Dental Team Member: Melinda Gullotti
   Emanuel W. Michaels Distinguished Dentist Award: Mark A. Crabtree, D.D.S.
   New Dentist: Justin R. Norbo, D.D.S.
   Leadership: Mark A. Crabtree, D.D.S., Maynard P. Phelps, D.D.S., Steven G. Forte, D.D.S., David D. Anderson, D.D.S.
   Presidential Citations: David E. Black, D.D.S., Mark A. Crabtree, D.D.S., Bruce DeGinder, D.D.S., Robert A. Levine, D.D.S., Bruce R. Hutchison, D.D.S., Frank P. Iuorno, Jr., D.D.S., Justin R. Norbo, D.D.S., Kirk Norbo, D.M.D., Roger A. Palmer, D.D.S., J. Ted Sherwin, D.D.S.
   Leadership Tomorrow Certificate Program Certificates: Drs. : Adrian Laxa, Ammar Sarraf, Andrew Hinkle, Anne Newman, Brigid Mooney, Caitlin Batchelor, Cassidy Turner, Christine Karapetian, Daniel Stockburger, David Jones, Dipa Patel, Erika Anderson, Frankie Carlos, James Cornick, Joseph Bernier-Rodriguez, Joy Phelps, Mark Armanious, Maynard Phelps, Randy Owen, Sarah Dowd, Sarah Wilmer, Sayward Duggan, Tonya Parris-Wilkins, Tyler Perkinson

6. Bruce Hutchison, VADPAC chair, gave a committee update and announced the following VADPAC awards:
   Category A – Small Component Membership

Percentage of members who contributed to VADPAC (41%)	Component 6
Percentage of Commonwealth Club Members (32%)	Component 6

Minutes - continued from previous page

Category B – Large Component Membership
Percentage of members who contributed to VADPAC (36%) Component 4
Percentage of Commonwealth Club Members (20%) Component 8

The Governor's and Apollonia Club members were recognized.

7. The Golf Tournament winners were announced.

8. The following election results were announced:
President Elect – Vince Dougherty
Secretary/Treasurer (2 year term): J. Ted Sherwin
ADA Delegates (3 year terms) – David C. Anderson, Vince Dougherty, Samuel W. Galstan, Elizabeth C. Reynolds
ADA Alternate Delegates (2 year terms) – Paul T. Olenyn, Danielle H. Ryan, Cynthia Southern, Gus C. Vlahos, Stephanie N. Vlahos.
David C. Sarrett, VCU School of Dentistry Dean, was appointed to another term by the VDA Board of Directors.

9. The out-going component presidents were recognized:
Mary T. Dooley (1) Donald W. Cherry (2) Robert J. O'Neill (3)
Alfred J. Certosimo (4) Kevin Snow (5) Christopher W. Thurston (6)
Corey Burgoyne (7) Fernando Meza (8)

10. The president installed the newly elected VDA officers, ADA delegation members and the following component presidents:
Carmen A. Cote (1) John R. (Randy) Owen (2) David L. Keeton (3)
Frank P. Iuorno, Jr. (4) Carrington W. Crawford (5) Christopher Davenport (6)
Corey Burgoyne (7) Kimberly A. Silloway (8)

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

12. Michael J. Link presented in-coming president, Richard L. Taliaferro, with the president's pin.

13. Richard Taliaferro presented Mike Link with the past president's pin, the VDA Torch Bearer Award and the ADA Constituent President's Plaque.

14. The meeting was adjourned.

ACTIONS IN BRIEF

44th House of Delegates — September 20, 2015

1. Approved: It will be VDA policy that in the absence of a contested election (and there are no nominations from the floor at the opening session of the Business Meeting) there will be no onsite voting during The Virginia Meeting.

2. Approved: A resolution that the VDA pursue legislation that would exclude FQHCs and Virginia free clinics from the requirements for mobile dental clinic registration.

3. Approved: The following amendment to the Bylaws – New Dentist Committee
   Article VII, Section
   5. New Dentist Committee
      a. Membership: The Committee shall be composed of one member from each component society who shall have received a D.D.S. /D.M.D. degree less than ten years before the time of selection. An additional member shall be a voting student member of the American Student Dental Association at the VCU School of Dentistry who shall be appointed by the President of the Association, in consultation with the Dean of the VCU Dental School. The term of membership shall be two years with a maximum of two consecutive terms. Additional non-voting student members shall be appointed by the President of the Association, in consultation with the Dean of the VCU Dental School. At-Large committee members up to a limit of eight can be appointed by the current chair of the committee for a term of one year.

4. Approved: The following VDA Policy:
   The mission of the VDA New Dentist Committee is to help new dentists succeed by assisting them with a successful transition from student to dentist, encouraging membership and volunteer involvement in organized dentistry, providing member value through resources and education to meet their needs, facilitating networking opportunities and by fostering new dentist leadership development.

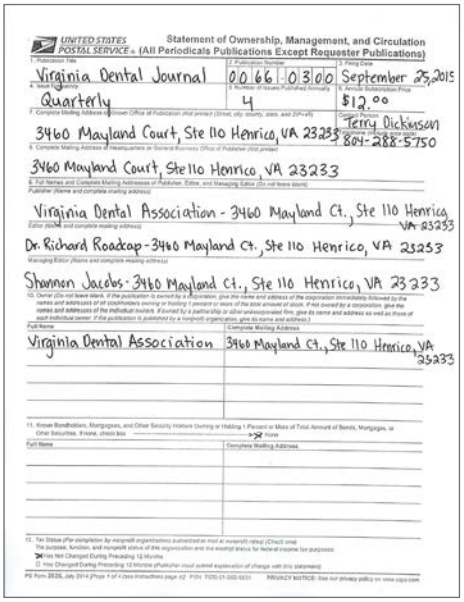
5. Approved: A resolution that the VDA pursue legislation to amend the current non-covered services law to include a de minimus clause similar to the 2015 optometrist bill.

6. Approved: A resolution that the VDA continue the PR campaign for another 3 years. Member cost per year $235.00.

7. Approved: The 2016 VDA budget as submitted.

8. Approved: A resolution that the VDA strongly urges the ADA to encourage the DOD and Tricare to continue to improve the dental health of all military and military beneficiaries by maintaining high standards and appropriate benefits during acquisition and consideration of bids from insurance companies.

UNITED STATES POSTAL SERVICE - STATEMENT OF OWNERSHIP


Statement of Ownership, Management, and Circulation
(All Periodicals Publications Except Requester Publications)

1. Publication Title: Virginia Dental Journal
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Publisher: Virginia Dental Association - 3460 Mayland Ct., Ste 110 Henrico, VA 23233
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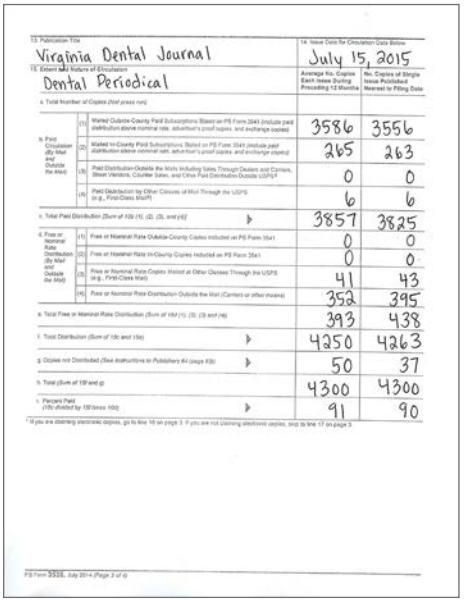
11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities: None
12. Tax Status: Has Not Changed During Preceding 12 Months
PS Form 3526, July 2014 (Page 1 of 4) — PRIVACY NOTICE: See our privacy policy on www.usps.com


13. Publication Title: Virginia Dental Journal
14. Issue Date for Circulation Data Below: July 15, 2015

15. Extent and Nature of Circulation	Average No. Copies Each Issue During Preceding 12 Months	No. Copies of Single Issue Published Nearest to Filing Date
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b. Paid Circulation (By Mail and Outside the Mail) (1) Mailed Outside-County Paid Subscriptions Stated on PS Form 3541 (Include paid distribution above nominal rate, advertiser's proof copies, and exchange copies)	3586	3556
(2) Mailed In-County Paid Subscriptions Stated on PS Form 3541 (Include paid distribution above nominal rate, advertiser's proof copies, and exchange copies)	265	263
(3) Paid Distribution Outside the Mails Including Sales Through Dealers and Carriers, Street Vendors, Counter Sales, and Paid Distribution Outside USPS®	0	0
(4) Paid Distribution by Other Classes of Mail Through the USPS (e.g., First-Class Mail®)	6	6
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(2) Free or Nominal Rate In-County Copies included on PS Form 3541	0	0
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(4) Free or Nominal Rate Distribution Outside the Mail (Carriers or other means)	352	395
e. Total Free or Nominal Rate Distribution (Sum of 15d (1), (2), (3) and (4))	393	438
f. Total Distribution (Sum of 15c and 15e)	4250	4263
g. Copies not Distributed (See Instructions to Publishers #4 (page #3))	50	37
h. Total (Sum of 15f and g)	4300	4300
i. Percent Paid (15c divided by 15f times 100)	91	90

16. Electronic Copy Circulation

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c. Total Print Distribution (Line 15f) + Paid Electronic Copies (Line 16a)		
d. Percent Paid (Both Print & Electronic Copies) (16b divided by 16c × 100)		

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17. Publication of Statement of Ownership
If the publication is a general publication, publication of this statement is required. Will be printed in the Oct. 15, 2015 issue of this publication. Publication not required.
18. Signature and Title of Editor, Publisher, Business Manager, or Owner: Dr. Terry Dickinson, Executive Director, Business Manager — Date: September 25, 2015
I certify that all information furnished on this form is true and complete. I understand that anyone who furnishes false or misleading information on this form or who omits material or information requested on the form may be subject to criminal sanctions (including fines and imprisonment) and/or civil sanctions (including civil penalties).
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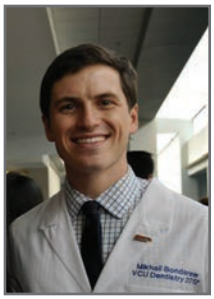

FIGHT OR FLIGHT

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

Think about the busy lives dental professionals lead. If you're like me, you begin to list all the distresses in your life. Studying for exams, setting denture teeth, coordinating patient care, and navigating the bureaucracy of school are at the forefront of this student's mind. After school, everyday things come to mind: paying bills, routine domestic chores, answering emails, feeding oneself, creating personal time, and the list goes on. As I think about those tasks dyspnea, diaphoresis and tachycardia start. However, a few special moments have occurred recently that helped return me to homeostasis.

One of these moments occurred last week. As I was frantically restoring a tooth resembling the Mt. St Helen's destruction, conveniently nestled in hemorrhagic gingiva, I found myself contemplating my decision to become a dentist. At this same time, a group of well suited and chipper applicants passed by my operatory. Seeing them triggered flashbacks of my own interview experience. You remember it. That time in life where you were so eager, you would have donated a paired organ to be accepted… or maybe that was just me. Anyway, the comparison of these two moments highlighted my ironic transition and my temporary ingratitude. It's during these brief moments of self-awareness where I encourage you to sit back and reaffirm that your current struggles and those previously mentioned distresses are in fact, eustresses.

Being a dental student is an amazing opportunity. The current dental student has access to so many avenues for professional growth and development. The technical training is greatly advancing. With recent acquisition of digital scanners, CAD/CAM, and access to video recorded lectures and demonstrations, the classroom is advancing at fiber optic speeds. A movement for interdisciplinary cooperation is leading us into classrooms with health and wellness professionals of all types. Our academic deans have heard the alumni calling for more practice management education and consequently we're hearing lectures from practicing dentists across the country.

I believe the immediate access to the faculty is one of our greatest opportunities. Information regarding all aspects of life flow effortlessly through the halls and are accessible by a simple conversation. Each day I am surrounded by seasoned clinicians and researchers eager to share pearls of information, provide mentorship, and stimulate those neurons. The variety of knowledge is so immense that it almost eliminates the need to consult every student's best friend: the first paragraph of Wikipedia. This daily access to information is so valuable and now having experienced it, I can understand why many practicing dentists often pay these same faculty members for CE.

We're getting free Amazon Prime, discounts at local restaurants, and most important, an excuse for why you're still in college after 6 years or in my case 10 (don't judge). All jokes aside, being a dental student has some great benefits like free or discounted membership for each level of tripartite membership, CE courses, representation and networking, and free professional publications, like JADA, "ADA News", and… this very *Virginia Dental Journal*!

These benefits come with a price. Just being accepted is highly competitive. The class of 2019's average GPA was 3.6, with average academic DAT score or 20 (Gottlieb). These applicants are also averaging 400 shadowing and 600 research hours (Gottlieb). Rapidly advancing knowledge also presents its own challenges. The increased volume of presented material increases the quantity, variety and frequency of examinations. The D2s are currently enrolled in 16 classes that offer 34 cortisol-releasing exams. The cost of education alone is enough to stimulate the fight-or-flight response. The price tag of this out-of-state student's education will accrue to an excess of $400,000. According to Honda's website, that's roughly the cost of 18 new Honda Accords. Our profession and society expects a lot of us. As healthcare providers we are held to a higher moral standard and will be held accountable for any lapse in judgement. Our organized profession strongly desires our continued participation through membership and activism while other aspects of life are competing for our time. All of these make each minute of our day valuable, and determining just how to spend it, is a task all its own.

Dentistry is a profession filled with stressful challenges. There are general challenges that affect everyone, and many more personal ones that create an individual gauntlet for every participant. Throughout these moments of strife, it's easy to become myopic and distressed. However, with self-reflection, luck, and appreciation, you'll be reminded that those are the milestones of our careers.

Works Cited

Gottlieb, Riki. Personal Interview. 15 Sep 2015.

www.automobiles.honda.com. 15 Sep 2015.

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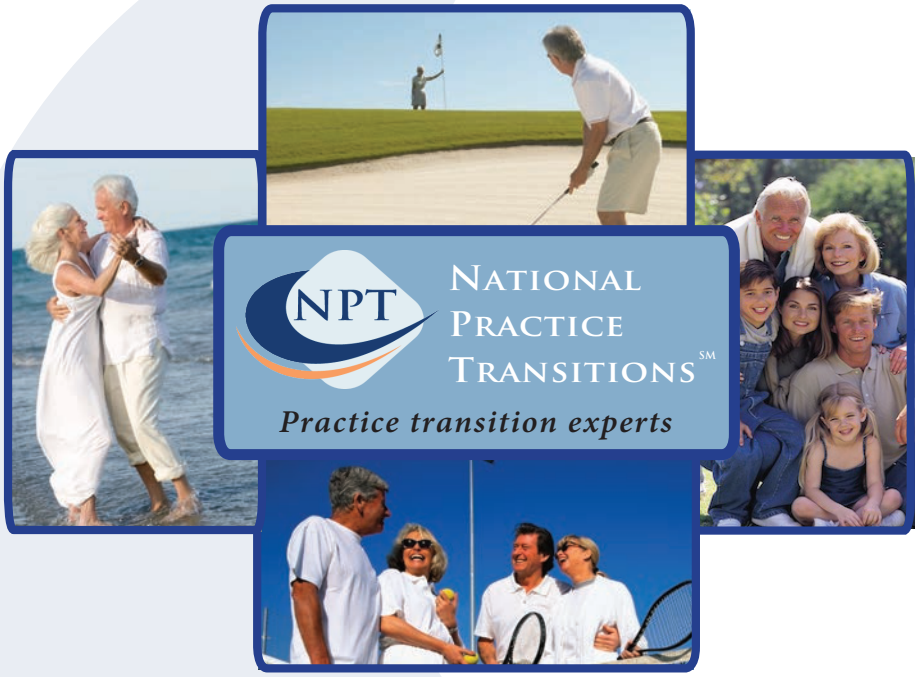

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DR. AMANDA KUHN

I'm a mom first and a pediatric dentist second. I try to bring that same attitude to the office each day. How would I want my child to be treated? What would make them comfortable and excited? A genuine smile is a great start.