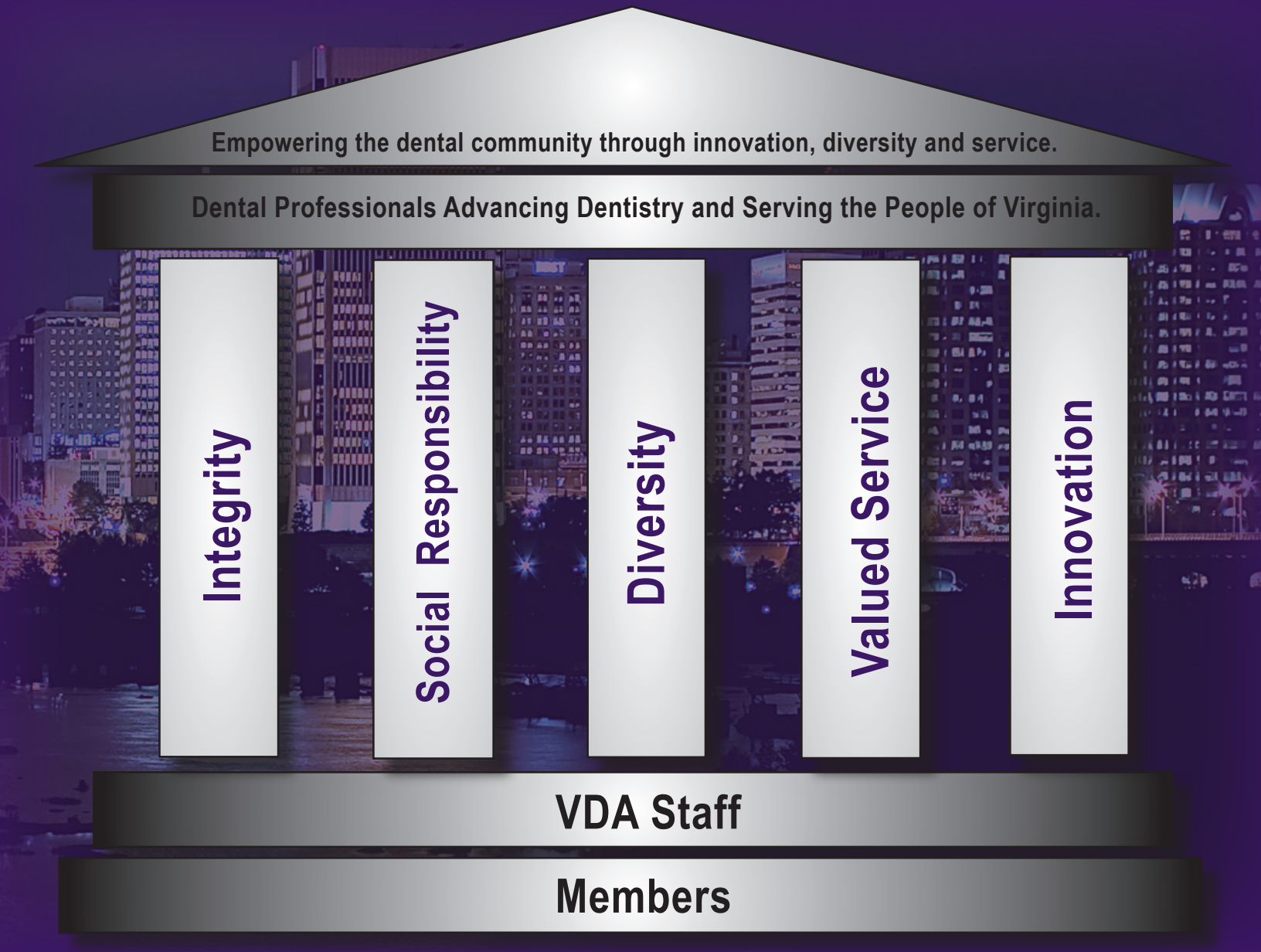
Volume 84, Number 1 • January, February & March 2007

VDA
Virginia Dental Association
JOURNAL



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As yet another member benefit, the VDA has launched a website. We encourage you to visit the site today and get up to date information on what's going on at the VDA!

www.vadental.org

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

Virginia Dental Association
7525 Staples Mill Road
Richmond, VA 23228

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Did you know....the VDA has a strategic plan for the future!

In this issue's cover we have attempted o provide a visualization of the different components of the VDA's strategic plan for 2012.

Foundation: **Members and VDA Staff/Elected Officials**

Core Values: **Integrity, Social Responsibility, Diversity, Valued Service, Innovation.**

Goal: **Dental professionals advancing dentistry and serving the people of Virginia.**

Vision: **Empowering the dental community through innovation, diversity and service.**

To obtain a copy of "VDA - 2012: Crafting a "Strategic Architecture for the Next Decade" contact Bonnie Anderson at the VDA central office. anderson@vadental.org 804-261-1610.

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VDA SERVICES

From the Editor

Dr. Leslie S. Webb, Jr.

As the new year begins, many of us set goals, make plans, or think about things we would like to do in the coming year. For 2007, I have ten suggestions that could help us as dentists and also benefit dentistry as a whole.

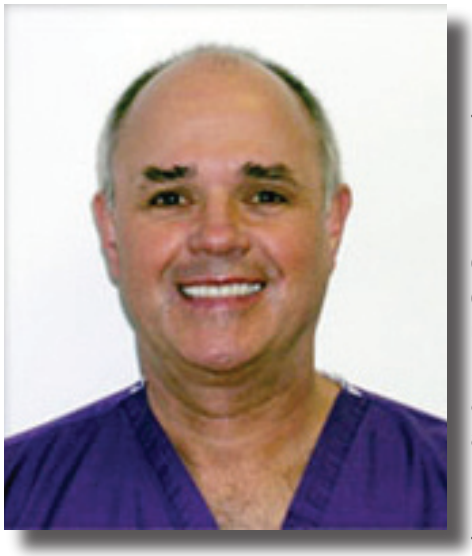
While reviewing this list, think about these and other things you can do in 2007 to make dentistry more fulfilling for you and the entire profession.

1. Support and promote an increase in hygiene and dental assisting training programs.
2. Become more involved in organized dentistry and attend more component and VDA programs.
3. Become more personally involved with your legislators and make PAC contributions to VADPAC and ADPAC.
4. Use the VDA website.
5. Report your problems with third party carriers to the VDA and ADA.
6. Use the ADA contract analysis service to aid you in evaluating third party dental insurance contracts.
7. Become more involved in MOM, D.D.S., Give Kids a Smile, free clinics and community dental efforts.
8. Support your dental school and dental education.
9. Mentor a new dentist in your area.
10. Talk about and promote DR to business owners, CEO's, CFO's and benefit managers who are patients in your practice. DR benefits employers, patients and dentists.

Now I challenge you to select some of the items above, or additional commitments of your choosing, and increase your participation in and support for your profession. Make 2007 a great year for dentistry in Virginia.

Letter to the Editor

Dr. W. Baxter Perkinson, Jr., DDS



Dear Editor:

The dream of dentists to be able to replace a diseased or otherwise failing tooth with a new tooth just like the one lost, has to date remained just that. Replacement of missing teeth by prosthetic means has been the standard and has never been as good as the patient's own natural tooth.

Dental research is now using stem cells harvested from the patient's own tissues of dental origin, such as dental pulp or nerve, tooth buds, soft tissues that connect bone to tooth and other oral tissues. These adult stem cells called unprogrammed mother cells, can even be found and used in the extracted tooth that is being replaced by the new tooth.

This means that there is no scarcity of finding these valuable cells since they come from the actual patient. There is no ethical controversy since these stem cells are not embryonic but adult.

This process referred to as tooth-tissue engineering begins when the stem cell is coaxed to become a small ball of cells that become a tooth bud and eventually a "biotooh" when placed in the recipient site.

This research has already been successfully in mice which mean the next step in this process will be on humans. This successfully occurring in a clinical setting by the dentist is decades away but is becoming a reality, not just a dream. The next generation of dentists may find this as routine as today's titanium implanted teeth.

The future of dentistry is exciting because of these developments in tooth replacement by stem cells. All this research can then be applied to help other researchers find ways to use the same information to replace or repair other body parts that would improve life and health in all areas of the body. This research could be a wonderful gift to mankind.

This is a progressive time for dentistry and for all of medicine. We should all encourage adequate support of this research since it has so many positive implications. I hope the new generation of dentists will see this dream become a reality.

Message From the President

Dr. Anne Adams

IF NOT YOU THEN WHO?

Two years ago Arturo Alberto Paulo Dugoni spoke to The Virginia Meeting about Leadership. Today it is even more important that we harness change and control our destiny. We have set our course with our Vision and our Mission.

Our VDA Vision: Empowering the dental community through innovation, diversity and service.

Our VDA Mission: The VDA: A Community of Professionals Advancing Dentistry and Serving the People of Virginia.

The really neat thing is that our children, our nieces and nephews want to be a part of the future of dentistry. Many of them are entering dental school and the practice of dentistry. What a nice compliment to have people who have seen what dentistry can do and want to be a part of a great profession. We must be ready to envision the future and anticipate the changes we need to improve and strengthen our profession. We must do everything to keep our profession moving forward.

Art Dugoni said "What role will you take? What will be the measure of your commitment? Our profession needs your competent leadership, your concerned involvement, and your vision for the future. You represent the very best of our profession. Are you willing to take some risks? We have all heard the expression, 'No pain, no gain,' 'No risks, no reward,' but for most of us, these are little more than words. The greatest hazard in life is to risk nothing-people who risk nothing, have nothing, and are nothing. "

"Only by taking some risks, exploring the unknown and stretching the envelope of the paradigms that shackle us can we accomplish our goals. The power to shape the future is earned through persistence. No other quality is as essential to success. Calvin Coolidge reminded us: 'Nothing in the world can take the place of persistence. Talent will not; nothing is more common then unsuccessful men with talent. Genius will not; unrewarded genius is almost a proverb. Education alone will not; the world is full of educated derelicts. Persistence and determination alone are omnipotent.'"

"Persistence is the sandpaper that breaks down all resistance and sweeps away all obstacles. It is the ability to move mountains one grain of sand at a time. Your persistence has been evidenced by your continued support of political advocacy."

Dr. Dugoni said that we need to change the status quo of our educational process, of our role in access to care, of our work force capacity, of our licensure paradigms, of our health care delivery model.

Dr Dugoni had certainly hit the nail on the head for what we are dealing with today. When I ask for your help, please think to yourself, we don't need help now but we need to be proactive to protect our wonderful profession and our patients. All of us need to participate so the burden is distributed amongst us all. Only then can we be a community with a common interest.

Don't forget to sign up for the Day on the Hill and January Committee Meetings. Contact your legislators, make an appointment to see them and let them know that you are there if they need support or information. The Day on the Hill will be on Friday, January 19, 2007. Mark your calendars and come and join us.

Don't forget that we will "Split" the meeting this year. We will have the Social/CE meeting in Norfolk, June 14-June 16, 2007. Don't forget to mark your calendars or PDAs and participate in the first CE/Social Meeting. We will have great CE, and fun activities for the whole family. See you in Norfolk.

The business meeting will be September 7-9 2007 in Fairfax.

As we come to the year end, let us get our life in order, set some goals, and take some time to look at our future and the future of our community of dentistry. Let us make things happen. Let us make a difference, if not for yourself, then for your legacy and your patients.

Have a wonderful holiday season, and a happy, healthy, prosperous new year!

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Mike Leavitt addresses the A.D.A.

United States Secretary of Health & Human Services

My wife Jackie and I had one of life's great privileges this year. We became grandparents for the first time. In fact, it happened twice. A friend explained why there is such a strong bond between grandparents and grandchildren. He said, "They have a common enemy."

I'm going to spare you pictures or stories of little Braden or Ava, but I want to tell you one way that it has affected me. I have begun to see the passage of time in a different way.

Standing at a hospital bed, I watched my son holding this tiny little soul, and suddenly I realized how quickly the past 25 years have passed. It was just yesterday that I held him for the first time.

The lesson: Time passes.

There is a phrase sociologists use: Demographics are destiny. Today, I want to talk about health care, and where the passage of time is leading and controlling our own national destiny.

I am 55 years old. When I was born, health care occupied between four to five percent of the total economy.

This year, when my grandchildren were born, one generation hence, our nation spends 16 cents of every dollar it generated in health care.

Time passes so quickly. It won't seem long before they are in the first grade. As they grow, we'll start going to their soccer games and dance recitals. And though it won't seem possible, they will turn nine years old. While that's happening, health care will continue grow. By then, it will be 20% of the entire economy.

It won't be long before I get that call, "Grandpa, I got my drivers license." It will happen, because time passes.

Before you know it, she will finish college and soon be holding a baby of her own. I'll be about 80 years old, and starting to think about retiring. If nothing has changed by then, health care will be nearly 30% of the economy.

Now, if you're like me, you are skeptical of logarithmic projections of current trends, because we all know that won't happen. We will have either fixed it, or our nation will have been eliminated from the economic competition. In a global economy, there's no place on the leader board for a nation that spends 25 or 30% of its entire economy on health care.

Why? Because any nation that devotes that much to health care will have neglected education and all the other things it takes to maintain economic leadership.

The human body has a warning system. It's called pain and when it occurs, we are motivated to do things we otherwise might not be willing to do.

The economy has the same warning system and people are feeling economic pain.

Consumers are feeling it in their paychecks. The teachers in my home state were given the biggest salary increase in many years, but the take-home pay of most went down because of health care costs. A recent survey of employees reported health care costs were the second biggest concern of employees, exceeded only by losing their job.

Employers are feeling it. They are finding it more and more difficult to compete with companies from other industrialized nations who devote less than half of what they do. You have all heard General Motors complain that the cost of a U.S. automobile contains more for health care than steel. I recently talked with the CEO of Starbucks Coffee, and he confided in me that they pay more for employee health care than coffee.

Doctors and hospitals are feeling it. You want to provide high quality care for your patients, but reimbursement rates are going down, costs are going up, and for reasons that are completely understandable, you worry about the future.

Enough about the problem: Let's talk solutions.

Today, I would like to talk about things we can do to ease the pain. I want to talk about a series of actions that the federal government is taking over the next two years that will initiate a decade-long reshaping of our health care system.

Before I do that, could we just acknowledge that intuitively everybody here knows the biggest reason health care costs are going up: We don't take good care of ourselves. Until we approach prevention and staying healthy with the same rigor we have for treatment after we are sick, a significant part of this problem will persist. We own that problem, every one of us.

There's another problem we have to own.

Our health care system is cost-blind, quality-deaf, and our payment system rewards the wrong things. The way our system works, nobody knows the cost and it's just about impossible to get an independent assessment of the quality.

Patients and providers alike need to know—in fact, we deserve to know—the quality of care we get or give.

How do we get there?

We might start by admitting that we really don't have a health care system. What we have is a large economic sector. There are millions of Americans who provide health care, or work in related businesses. But there is nothing that connects them into a system like every other economic system we have come to depend on.

We all depend on economic systems to make life work.

Virtually every person in this room has a cell phone. We bought our phone and service from different venders, yet we can call each other. Sellers aggressively competed for our business, but the system allows each one of them to optimize the value they give their customers.

Most of you flew here on an airline that aggressively competed for your business, but each used the same system to optimize the quality and price they could offer you.

I carry a bank card in my wallet and so do you. Banks compete aggressively for you to carry their card, and yet you can use an ATM or a computer anywhere in the world. They compete but use the same economic system to create value for those they serve.

Our task, over the next decade, is to organize our health care sector into an economic system that rewards choices that produce high quality, low cost care.

How would a system of competition based on value operate? For one thing—it must be transparent on cost and quality.

Today, if a patient needs a hip replacement, they are typically given a list of hospitals and doctors that the insurance company is willing to pay for. That's about all the patient knows.

Wouldn't it be better if the patient could be given reliable information on the number of similar procedures the provider had done during the last year? Wouldn't it be better if they could know the quality of the outcome and the price?

We need a system of competition in health care that is based on value. Value isn't just price; value is the combination of quality and price.

There are four cornerstones to a system of competition based on value.

The first cornerstone: Connected interoperable electronic health records.

The second: An independent assessment of the care a patient receives based on a standard set by medical specialists in the field.

The third cornerstone: Information on cost of care that is understandable and comparable.

The fourth cornerstone: Competition, incentives motivate. Given reliable information about quality and cost, patients, doctors, hospitals, and payers will make decisions that improve quality and reduce the cost overall.

Progress is being made on all four cornerstones.

Imagine walking into a bank to make a deposit in your savings account. The teller pulls a 5"x7" card from a green can that sits on the counter and records the amount of the deposit. Then a month later, the teller pulls the card from the can and calculates the interest earned.

Unthinkable, but 85% of all medical records are paper. What's more, those that are electronic are not interoperable.

For electronic health records to become interoperable, national standards are needed.

This is a problem faced and accomplished by every economic system including cell phones,bank cards, airlines, the internet. The good news: it is happening in health care, too. Measuring the quality of health care is the most challenging cornerstone, but progress is being made. Already, the AQA Alliance and Hospital Quality Alliance have developed quality measures for frequent procedures and conditions.

The biggest challenge goes back to a lack of electronic records. Quality measurement, in most clinical settings, is a nurse that comes in on a Saturday and surveys a two-foot-high stack of paper files to see which patients got their hemoglobin A1C checked or when an antibiotic was administered. That isn't a scalable model, and we have to get better at this.

The quality measures need to be developed by doctors. If the doctor and the patient don't accept the standard, the measure is meaningless.

The third cornerstone: Cost. Today, the health care system isn't organized in a way they can answer the question: How much will this cost? They simply don't know.

I had a conversation with one of the nation's governors recently who was recovering from a knee replacement. He told me about having breakfast with his surgeon. He asked the doctor how many similar operations he performed; the answer was several each week. "Do you have any idea how much they cost?" He said, "I really don't—eighteen or twenty thousand," he guessed.

No, the Governor told him, "It's $34,000 so far, and I don't have any of your bills yet." That is significant, because if you ask a health economist what the most expensive medical device in a hospital is, what do you suppose they will say? It's a ballpoint pen in the hand of doctor.

Different doctors, treating the same conditions with similar outcomes, range widely in the costs incurred by their patients. Without consciousness of cost, we can all lose sight of value.

The AQA Alliance in conjunction with the American Health Insurance Plans, are developing standards that will facilitate the measurement of

price-based on comparable episodes of care.

Undoubtedly the most important news on the development of incentives is the advent of pay for-performance measures. It is a near certainty that pay for performance will be part of the reimbursement scheme of nearly every large payer in the near future. Not only are incentives rapidly becoming part of the provider landscape, but they must also become part of the landscape for consumers as well.

When providers or patients have reliable information and a financial reason to care about value, the quality goes up and the price goes down. How would consumers actually get this information?

The collection and development of this information will have to be done in local and regional quality collaborations between payers, providers, and health plans. Dozens of these are now starting to form spontaneously, and we are working to weave them into a formalized network. As they begin producing information, consumers will get it from a variety of sources, ranging from their employer or insurance company, to web-based services that will begin to assemble it into helpful consumer sites.

I feel confident that none of us here is unrealistic about the difficulty. Changing the health care sector has proven to be hard. In fact, many people believe that there simply isn't enough political will to change health care.

I would suggest lack of political will isn't the problem. In fact, the opposite is true. It is my observation that there is an over-abundance of political will. Once any meaningful change is proposed in a legislative setting, everyone unholsters their political will and points at each other. A perpetual standoff is created among economic interests.

We need a new kind of leadership to solve this problem. The only force powerful enough to change the course of health care is consumer demand.

Over many years, large payers of health care have attempted to organize health care into a more rational system. They have not succeeded.

I believe their failure in large part is because the largest payer in world has not been part of the effort. I'm speaking of the Federal government.

Between Medicare, Medicaid, the Department of Defense, Veterans Administration, and the Office of Personnel Management, the Federal government pays for nearly 40% of the health care in America. Without Federal leadership, it is simply impossible for any group of payers to get to critical mass.

That has changed. On August 22 of this year, President Bush signed an Executive Order directing Federal agencies to make four important changes as a payer of health care. You will recognize them as the four cornerstones of a system of competition based on value.

First, if you desire to do business with the Federal government electronically, your organization will need to migrate to health information technology systems that are interoperable according to recognized standards developed collaboratively within the industry.

Second, if you desire to do business with the Federal government in the future, you need to adopt to quality standards currently being developed by the various specialty medical organizations.

Third, if you are an insurance company and want to do business with the Federal government in the future, we need you to organize your claims information in a way that we can create comparable episodes of care.

Last, we intend to begin moving to a system where at least part of the payment structure is a reward for high quality.

The President feels strongly that this isn't just the Federal government acting alone.

As Secretary of Health and Human Services, I have asked the nation's largest employers and unions to join with us in adopting the same four cornerstones.

It is happening. In fact, in March or April of next year when payers put out their requests for proposals for 2008, over 60% of the entire marketplace will include these changes as a significant part of their criteria.

No two-trillion-dollar sector organizes itself into an economic system quickly, but the process has begun. Electronic health record vendors will now need to adapt to provide interoperability. The medical community is organizing to measure and report quality.

Insurance companies are preparing to begin pooling claims data in episodes of care. The Federal government and other payers are standardizing pay-for-performance measures.

Within two years, competition based on value will begin to happen in some communities on frequent procedures and conditions. Within five years, the word "value" will be a standard part of the medical lexicon. In a decade, it will be ubiquitous.

In conclusion, let me acknowledge there is a lot of change here, and change is hard.

In a global economy, change is inevitable. There are three ways we could handle it.

We could fight it and fail.
We could accept it and survive.
Or, we can lead it and prosper.

This is the United States of America. We have become the strongest and most influential force in human history because we have been willing to lead. And lead, we will.

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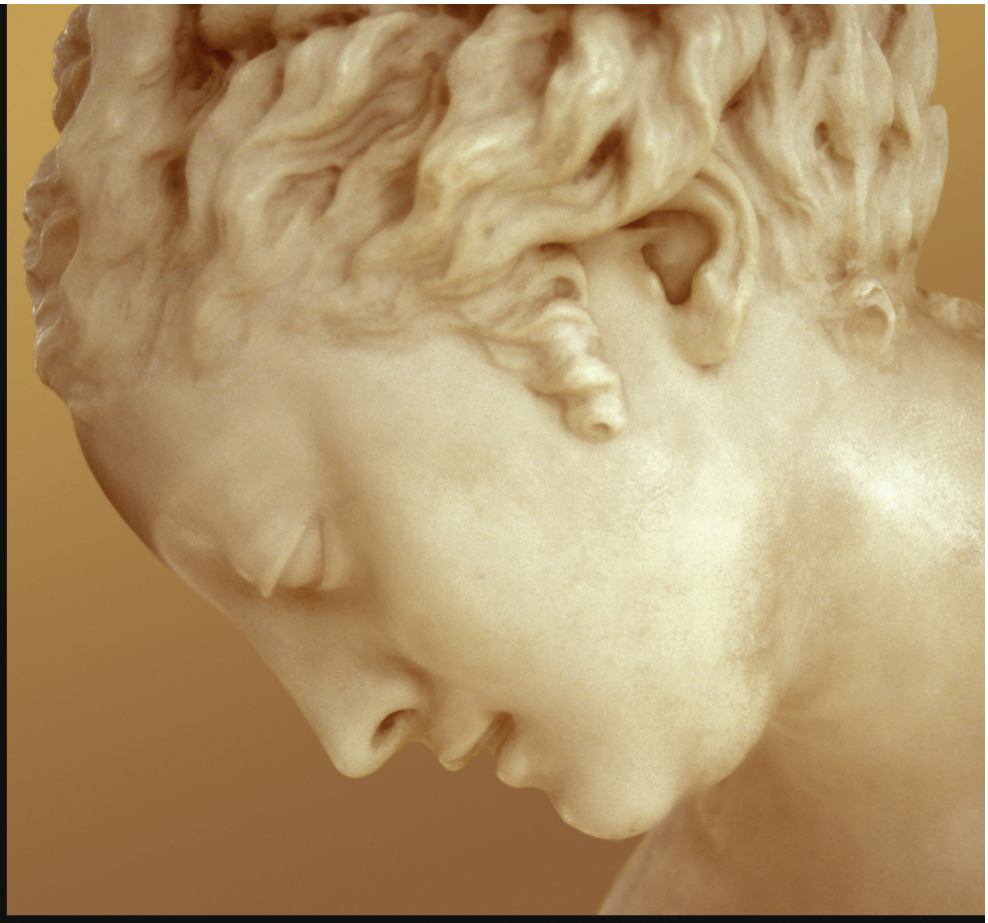
Photo by Chris Smith



Facial Analysis

The Key to Successful Dental Treatment Planning

G. William Arnett, DDS, FACD
March 30-31, 2007

When surgeons, orthodontists, and dentists correct occlusal discrepancies, a variety of facial results occur – some more successful than others. While facial improvement is often simultaneous with occlusal correction, facial decline can also be the unfortunate outcomes. Specific facial planning and treatment guidelines can assure predictable and positive, facial changes associated with occlusal correction. Participants will learn to discuss optimal goals of occlusal treatment, to define key steps in facial analysis, and to integrate facial treatment planning and occlusal treatment planning. This two-day comprehensive program is recommended for restorative dentists, periodontists, orthodontists, surgeons, and technicians. For more information about this or other courses offered through the Mid-Atlantic Center visit our website, www.mid-atlanticcenter.com or call 757-222-9843.

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The Roadmap to Guide Patients From Diagnosis to Acceptance

By Linda Miles

The journey from diagnosis to acceptance starts with educating patients and building trust. Along the way to the final destination – the dental chair – are three "stops" or critical components to maximizing treatment acceptance. Each stop is equally important and involves different members of the dental team. Just like a car has a steering wheel, an engine and tires, only when the team all works together, can the car move forward. So, are you ready to hit the road to increased production?

The Patient's First Stop: Education

The process of educating patients on the benefits of dentistry begins with the very first contact, and ends when the patient takes ownership of their dental needs. Until the benefit to the patient has been clearly communicated and understood there will be zero case acceptance. It's up to the dentist and the team to educate the patient and get their emotional "buy-in." Communicate the benefits of treatment. And, without using scare tactics, educate them on the consequences of not proceeding with treatment.

The "education stop" requires teamwork and good communication skills – including the ability to listen and discover what your patient's fears and roadblocks are. The doctor's role is to introduce the appropriate team members who will then skillfully guide the patient through the education, treatment plan, and fee process to gain treatment acceptance. The doctor should close the discussion by stating, "I'll look forward to seeing your name on the schedule real soon so we can get started," communicating the assumption that every treatment plan is going to be accepted.

Get patients excited about dentistry's new technologies and procedures for their smile! To achieve this, set a goal of making 75% of all doctor to patient communication about dentistry. Also, make a rule that each clinical person spend two-minutes talking with the patient on new ways to benefit their smile, sharing their pride in the doctor's work.

The Second Stop: Discussing Fees

This is the stop where, for many patients, the journey either ends or gets delayed. Seventy-five percent of case acceptance gets derailed during the fee presentation – much of it due to unreal patient expectations about treatment cost and insurance coverage. Patients want options to make oral care more accessible. So, it's important to let them know you have financing solutions to remove roadblocks to acceptance.

There are four different ways to present fees, depending upon the communication skills and strengths of the team. In the first, the doctor presents both the clinical part of the treatment plan and the total investment. In the second option, the doctor presents the clinical part, while an assistant discusses the financial. In the third, a treatment coordinator details both the treatment plan and the fees. And in the fourth, my favorite, both the treatment coordinator and the financial coordinator make presentations.

The financial coordinator starts by offering all payment options available, including cash, check, credit cards and monthly payment solutions like CareCredit. Don't make the patient ask for financial help. Many won't. They'll delay or decline treatment, and you'll never know why. Having a resource like CareCredit, especially with the Pre-Approval option that allows you to approve patients before their appointment, makes the entire fee presentation easier. Because you'll be confident that you can offer the patient the credit they need to get the dentistry done.

At this stop it's important not to let your patients hit a dead-end because of insurance issues. Many patients are co-dependent upon their benefit plan. An easy way to guide them to new thinking is to not use the word "insurance." Instead, call it their "benefit plan." Let them know it's only a partial reimbursement for basic care, but that 95% of adults need more than basic dentistry. Especially if they want to keep their teeth for life and have a healthier, attractive smile.

The Last Stop: Scheduling the Patient for Treatment

The final stop to increased production is scheduling the treatment. The patient is educated, informed, and we've given them a financing solution so they can move forward to oral health. It's time to schedule for success. Leave at least a half-day open every week to accommodate patients who need immediate treatment or have accepted a big case and want to get started right away. Create a sense of urgency. But, watch how you offer short-notice appointments. Consider saying you have an unexpected opening and ask your patient if they'd like to take it. If you would like more ideas on scheduling techniques that move the patient into the ultimate destination – the chair, log onto www.DentalManagementU.com. I'd be happy to send them to you.

The journey from consultation to chair, from diagnosis to acceptance can be a smooth ride, with few roadblocks, if you follow the right roadmap. Just remember the analogy of the car. It takes the entire team, working together, to get there. Bon Voyage!

THE Virginia MEETING

JUNE 14-16, 2007

Norfolk Waterside Marriott

Norfolk, VA

Something for EVERYONE to SEA!

Early Registration Begins Online ONLY

February 27, 2007

Visit WWW.VADENTAL.ORG

Virginia Meeting - 2007
Sneak Peek
"Get caught having a good time"

Welcome to the 138th Annual Meeting of the Virginia Dental Association.

Welcome to the "new" Virginia Meeting in Norfolk in June 14-17, 2007!! As the presence of water always conjures up refreshing and renewing images, so do we on the Local Arrangements Committee hope to be conjuring up some great Continuing Education and some wonderful family entertainment which will prove to be refreshing and a little different. Join us in June as we kick-off summer by hosting some excellent speakers. We are excited to have Dr. Jimmy Eubank and John Cranham who will be giving us insights on esthetics and occlusion. The Virginia Academy of General Dentistry will host Mike Detolla and you won't want to miss his talk on the top 10 crown and bridge mistakes. To enhance our slate of speakers, we will also host Jim Burns on Forensic Pathology, Janie Soxman on Pedodontic Emergencies, and an Invisalign certification course.

Families will be excited to set sail Friday evening, June 15, with President Anne Adams and crew on the *Spirit of Norfolk* for dining, entertainment, dancing, and sight seeing along the Norfolk harbor and the Naval shipyard. Then head to a baseball game with the Norfolk Tides on Saturday evening. While Continuing Education is presented, there will be plenty of opportunities to stay busy in the area that weekend with the **Virginia Beach Art Show** and **Jamestown** celebrating its 400 anniversary. Locally, visitors to Norfolk enjoy the Virginia Zoo, the Norfolk Botanical Garden, and Nauticus. Best of all, there will be no business at this meeting!! Remember the three "E's" for this new meeting format—Education, Entertainment, and Enjoyment. Please mark your calendars today and enjoy "pearls" from the CE, celebrate Virginia hospitality, dental education, and summer fun sailing with us in Norfolk—There will be SOMETHING for EVERYONE to SEA!

Dr. Claire Kaugars - LAC Chairman

DATES TO REMEMBER

Early Registration begins ONLINE ONLY **February 27, 2007**
get your Virginia Meeting Registration Brochure online

Registration Brochures will be mailed **mid-March 2007**

Pre-registraion DEADLINE **June 1, 2007**

Hotel Reservation DEADLINE **May 22, 2007**
remember to ask for the VDA room block for the best rate

2006-2007 Council of Sessions

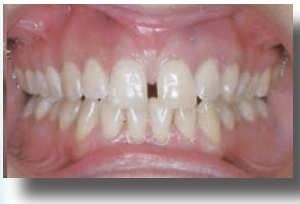
Chairman: Dr. Ted Sherwin
Dr. Kirk Norbo
Dr. Elizabeth Reynolds
Dr. David Black
Dr. Sharon Colvin-Washington

2007 Local Arrangements Committee

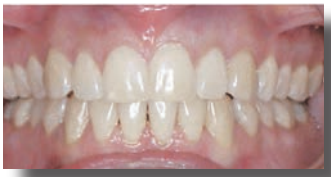
Chariman: Dr. Claire Kaugars
Sponsorship: Dr. Michael Abbott & Dr. Andrew "Bud" Zimmer
Exhibits: Dr. Ralph Howell
Social Events: Dr. Kit Finley-Parker & Dr. Emily Smith
Golf: Dr. Mike Link
Host: Dr. Anthony Pelsuo

invisalign®

LEARN HOW TO SMILE AGAIN.



Thursday, June 14, 2007 Information Course
Friday, June 15, 2007 Certification Course Part 1
Saturday, June 16, 2007 Certification Course Part 2



Invisalign patient photos provided courtesy of Dr. Rachael Silberstein.

Invisalign® Certification I *by Align Technology*

Course Description
This one and a half day course has been designed specifically for the general practitioner and staff that wishes to incorporate Invisalign® into their practice, or simply learn more about this orthodontic technique. Invisalign® is an esthetic orthodontic technique that corrects malocclusion using a series of custom-made, nearly invisible, removable aligners. Proven effective in clinical studies at universities and private practices nationwide, thousands of dentists are certified to treat patients with Invisalign®. Invisalign® combines diagnosis and treatment plans with advances in 3-D computer graphics technology to move teeth in stages. Patients wear a new set of aligners every two weeks, twenty-two hours a day, moving teeth gradually, week by week, millimeter by millimeter, until the desired results are achieved. Upon completion of this course, the practitioner and staff will be fully confident and comfortable in integrating Invisalign® into their practice. Tuition for the course covers the doctor and up to 4 auxiliary staff for the full-day course on Day 1, and the half-day course on Day 2 is intended for doctors only.

Educational Objectives
Invisalign Certification I will help teach attendees to:

- Identify a wide range of Invisalign case types, focusing on those that present the highest degree of predictability.
- Successfully complete the Invisalign case submission process.
- Acquire and enhance treatment planning and clinical skills necessary to effectively treat with Invisalign.
- Access the full range of Invisalign Support options designed specifically for the General Practitioner
- Execute effective internal and external practice building programs specifically developed for the Invisalign practice.
- Effectively select less-complex cases to help achieve the highest rate of success for the GP Practice.

FEATURED SPEAKERS

THURSDAY, JUNE 14, 2007

Dr. Mike DiTolla

Sponsored by the Virginia Academy of General Dentistry

"How To Correct and Prevent The Top 10 Crown and Bridge Mistakes" Course Synopsis

This seminar is a combination of photographs and live patient treatment video to illustrate methods to improve your crown and bridge restorations. This information applies to all-ceramic restorations as well as traditional ceramometal restorations, and also focuses on premium esthetic PFM's as well.

There were approximately 45 million crowns done in the United States last year, and according to Dr. Gordon Christensen, almost 90% of the impressions that dental laboratories received did not have clearly visible margins around the entire preparation periphery! A procedure performed this often clearly needs to be more predictable, and thus more profitable. Because of his unique arrangement with Glidewell Laboratories, Dr. DiTolla has access to the thousands of impressions and models they receive on a weekly basis, and he has done an exhaustive study of the preparation and impression techniques of American dentists. You will see the good, the bad and the ugly; and the compromises a laboratory has to make in these situations.

Friday, June 15, 2007

Dr. Jimmy Eubank

Superior Esthetics & Longevity with Anterior & Posterior Ceramic Restorations

The number one reason people go to the dentist today is to improve their smile. Patients want to look better and today dentists can deliver results that mimic nature. A natural result does not happen by accident. It happens because the dentist has educated themselves about the rules, tools and strategies of esthetics. They have also mastered the use of advanced materials and developed their artistic skills to a high level. However, delivering superior esthetics alone is not enough to insure long term success. It takes being able to deliver restorations that function comfortably over a long period of time. Longevity of esthetics restorations is the expected result of our patients. Predictable longevity is achieved by a practical understanding of occlusal principles and a knowledge of how to manage the forces that exist in each individual patient.

Saturday, June 16, 2007

Dr. John Cranham **Sponsored by Bay View Dental Laboratory**

The Cosmetic-Occlusal Connection

This program is designed to help the general practitioner take his or her dentistry to the next level. While many courses focus on the procedural aspect of dental treatment only, this seminar will help you visualize optimum dentistry from an aesthetic and functional perspective. Through Powerpoint and video demonstration each participant will learn to apply the timeless principles of the Dawson Center's Concept of Complete Dentistry series and to map out and sequence an appropriate course of treatment. Communication skills and scheduling techniques will also be reviewed in detail to increase your case acceptance rate, and get you doing more of the dentistry you would like to do! You will also learn to sequence cases optimally, when the patient's finances become an obstacle to optimum care. This course is a must for the Dentist who would like to do more elective esthetic, and advanced restorative cases.

Dr. Jane Soxman

Management of the Developing Dentition — Morning

Various issues and presentations may require intervention throughout the primary and mixed dentition. This course discusses preventive care, caries risk assessment, tooth/arch size discrepancies, eruption disturbances, space maintenance, upper airway obstruction and parafunctional habits. Specific guidelines for timing and treatment options will not only refresh knowledge but offer new perspectives.

Behavioral Guidance for Pediatric Patients and Their Parents — Afternoon

Behavior guidance for today's child requires a new approach. Parents often intervene attempting to direct treatment. This lecture discusses age-appropriate expectations along with management techniques and improved communication skills for both our patients and their parents. Potential problems are identified with specific recommendations for more successful and less stressful visits.

Dr. Samuel Low

Empowering the Dental Team to Deliver "Quality" Periodontal Care

Periodontitis is the major contributor of tooth loss in dentistry. The practitioner can incorporate periodontal therapy into the overall treatment plan for quality comprehensive care. The seminar session will combine current research concepts with therapeutic techniques in a practice management format.
Course Benefits/Highlights: Collect data in a time efficient, standardized manner so that delegation will be effective. Determine the prognosis of restorative abutment teeth and develop a diagnosis to enhance quality of care. Develop and implement a non-surgical treatment plan utilizing the technology of ultrasonic systems. Enhance the decision-making process on evaluating surgery versus non-surgery with consideration of local and systemic delivery anti-microbial therapy. Establish a periodontal maintenance program with interaction between the dentist, hygienist, and the periodontist. Achieve case acceptance by establishing fees and utilizing effective insurance coding.

Fit for a Queen...

Visit Jamestown, the first permanent English settlement in America for America's 400th Anniversary. This is a pivotal moment in our history and every family should be a part of it. Many inspiring events and programs are planned in 2007, not to mention Queen Elizabeth II's first visit to the United States since 1957.

www.jamestown2007.org

New Dentist Social

Friday, June 15, 2007

A great time for you to meet and network with other new dentists and top VDA/ADA officials. Come ready to enjoy some light refreshments before you head off to the President's Party.

Tickets: $5

Oh..take me out to the ball game...

June 16, 2006 7:15 p.m.

Bring the entire family and join the VDA at Harbor Park.
Watch the Buffalo Bison and the Norfolk Tides battle it out on the baseball field.

Register for your discount ticket with your 2007 meeting registration.
Tickets: $7

The VDA takes over the Spirit of Norfolk...

Join the VDA President, Dr. Anne Adams

Friday, June 15, 2007

at the first ever President's party aboard the Spirit of Norfolk.

You'll know you're in for a special evening the moment you step aboard. Spend 3 hours cruising the Elizabeth River, dining at the Grande Dinner Buffet, and enjoying the Broadway-quality performances.

Boarding begins at 6:30 p.m.
Cruise Time: 7:00 - 10:00 p.m.

$25.00 per person (All inclusive)

Location: Just steps away from the Waterside Marriott

Successful VDA/VCU Partnerships Benefit Virginians

By: Martha Bushong

Close cooperation between Virginia Dental Association member dentists and the Virginia Commonwealth University School of Dentistry achieved remarkable results when the 2006 Virginia General Assembly funded a new building at the dental school. After a protracted budgetary process, with intense lobbying and educational efforts, the state legislature decided to allocate $9.15 million for construction of an additional dental school building at VCU. Often described by Dean Ron Hunt as "the budget coup of the decade," this partnership between the school and the dental association ultimately benefits Virginia by improving access to dental care for its citizens.

The increased space in the new building will accommodate growth in both its DDS and Dental Hygiene programs. The school plans to increase dental enrollment by 10 students per year with an emphasis on recruiting students for Southside and Southwest Virginia to help address workforce needs in those areas. The school will double the size of the dental hygiene class from 20 to 40 per year. Increasing the number of dentists and hygienists in the educational pipeline is only part of the workforce solution. The VDA also worked with Dean Hunt on other initiatives to enhance students' learning experiences. Together they successfully sought a change in the Virginia dental statutes in 2003 so that students could participate in private practice preceptorships. These off-campus preceptorships give students experience outside Richmond increasing their awareness of the quality of life and quality of practice in rural areas of the state. With the experience of actually living and doing dentistry in a small town, students can make better informed decisions about where they will chose to practice after graduation. The VDA/VCU partnership also resulted in a $2.1 million state appropriation in 2004 to help fund the new dental simulation laboratories at VCU. Simulation helps shorten the preclinical curriculum, getting students into clinical experiences earlier, creating time for a general dentistry emphasis in the final year, and resulting in a better prepared graduate.

"Nowhere else to turn. . ."

The VDA and Donated Dental Services receive phone calls and emails daily from people with chronic and acute dental needs but no way to cover the expense of treatment. They may be uninsured, underinsured, unemployed, elderly or disabled. DDS is their last resort as they have "nowhere else to turn." Priscilla recently emailed the VDA in desperation. Her 31 year old husband was in need of a kidney transplant and could not be placed on the transplant list until his dental needs were addressed. They were told the extractions would cost $2,000. Priscilla was the only one working to support her husband and two children. "No matter which way you look at it, we cannot not afford this. Please advise me of where to go. My children and I don't want to lose Dru. Please help us!!!" Dr. Charles Cuttino, one of over 500 Donated Dental Services volunteers and participant since the program's inception in Virginia in 1997, was contacted and he generously agreed to help. Dru's oral surgery has been completed and he is awaiting his new kidney.

Donated Dental Services
Virginia Dental Health Foundation

Dear Donated Dental Services,

"Thank you for enabling my husband and me to leap the huge hurdle that was standing in our way to our ultimate goal of a new kidney. Dr. Cuttino and his staff were wonderful to us. Dru had the teeth out yesterday and is very pleased with the way he was treated. He is doing very well.

Thank God for you and people like you. I just don't know what to say, thank you just isn't enough.

God bless you and all of your staff. To me and my husband you are Angels. Thank you so very much (with tears of joy in my eyes).

Dru and Priscilla

AFTCO is pleased to announce...

Larry McCoy, D.D.S.

has acquired the practice of

Wilson G. Harper, D.D.S.

Blacksburg, Virginia

Juan C. Loza, D.D.S.

has joined the practice of

Ralph A. Lazaro, D.D.S.

Great Falls, Virginia

B. Travis Bohrer, D.D.S.

has acquired the practice of

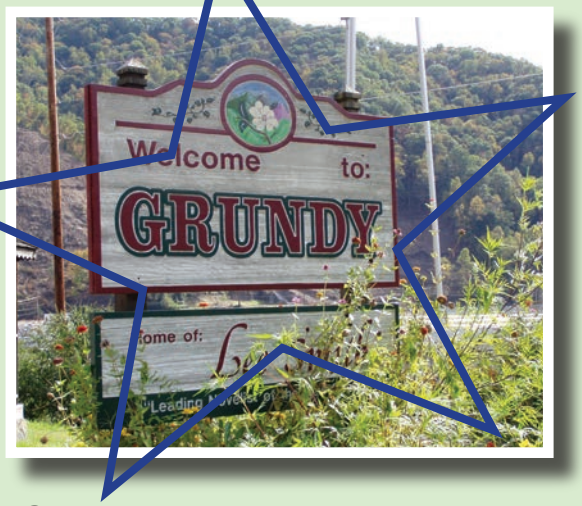
Caroline E. Ciotti, D.M.D.

& Anthony J. Ciotti, D.M.D.

Virginia Beach, Virginia

AFTCO is pleased to have represented all parties in these transactions.

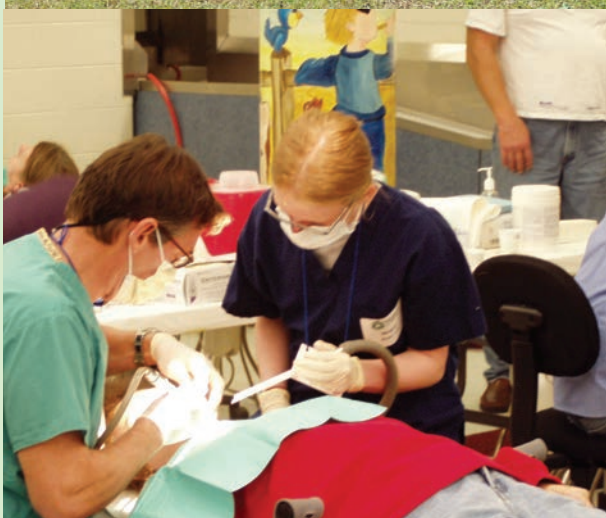
Missions of Mercy
Virginia Dental Health Foundation

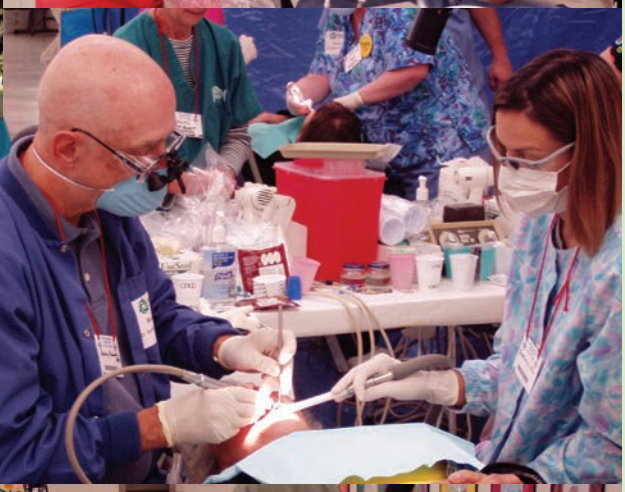


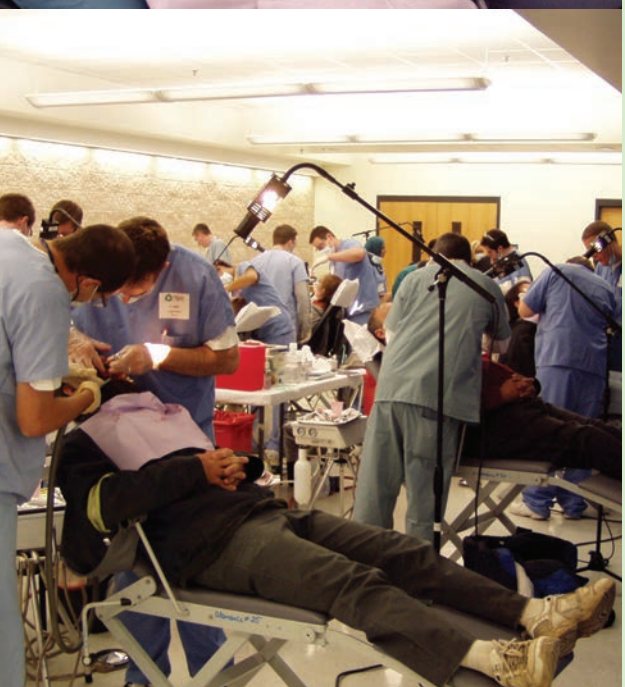
MOM Makes Third Appearance in Grundy, VA

Nestled in the mountains of beautiful Buchanan County, Riverview Elementary / Middle School was the site for the third annual MOM project. Southwest Virginia residents had another opportunity to receive free dental care on October 14-15, 2006 in Grundy, Virginia. Over 150 volunteers (from throughout Virginia, North Carolina, Ohio, Michigan, and Indiana) arrived on Friday to convert the school's cafeteria into a 34 chair dental clinic which would treat those who were uninsured, underinsured, unemployed, elderly and disabled. The 1 1/2 day dental clinic provided dental treatment (including 372 exams, 99 cleanings, 1,148 extractions, 527 fillings, 26 root canals and pulpotomies, and 308 x-rays) to 372 patients valued at $239,000!

Partnerships with VCU School of Dentistry, Remote Area Medical, St. Mary's Health Wagon, Henry Schein Dental Supply and many others made Grundy MOM 2006 a success! Thank you all!!







Upcoming MOM Projects

See page 22 to register or visit www.vadental.org

Northern Virginia MOM
March 16-17, 2007

Eastern Shore MOM
March 24-25, 2007

Roanoke MOM
May 4-5, 2007

Wise MOM
July 20-22, 2007

Grundy MOM
October 13-14, 2007

YOUR MOM NEEDS YOU...

MOM returns to the Eastern Shore for the seventh project in this area of Virginia on March 24-25th, 2007. The 1 ½ day project will be held at Nandua High School in Onley, VA. An estimated 600 patients will receive dental care including extractions, fillings, and cleanings.

Over 3,800 Eastern Shore residents have received free dental care valued at $1.4 million.

Volunteers are needed to staff 30 dental chairs and may register online at www.vadental.org.

Missions of Mercy
Virginia Dental Health Foundation

Become a part of the largest two and three day dental clinic of its kind.



M.O.M. will be an experience you will never forget. Make a difference in the lives of others.

Join the MOM Team!

I would like to volunteer at:

Northern VIrginia MOM 2007
- ☐ Friday, March 16, 2007
- ☐ Saturday, March 17, 2007

Eastern Shore MOM 2007
- ☐ Saturday, March 24, 2007
- ☐ Sunday, March 25, 2007

Roanoke MOM 2007
- ☐ Friday, May 4, 2007
- ☐ Saturday, May 5, 2007

Wise MOM 2007
- ☐ Friday, July 20, 2007
- ☐ Saturday, July 21, 2007
- ☐ Sunday, July 22, 2007

Grundy MOM 2007
- ☐ Saturday, October 13, 2007
- ☐ Sunday, October 14, 2007

I prefer to do:

☐ Fillings ☐ Sterilization
☐ Extractions ☐ Adults only
☐ Triage ☐ Children only

NAME

SPECIALTY

ADDRESS

CITY/STATE/ZIP

PHONE NUMBER EMAIL

LICENSE NUMBER

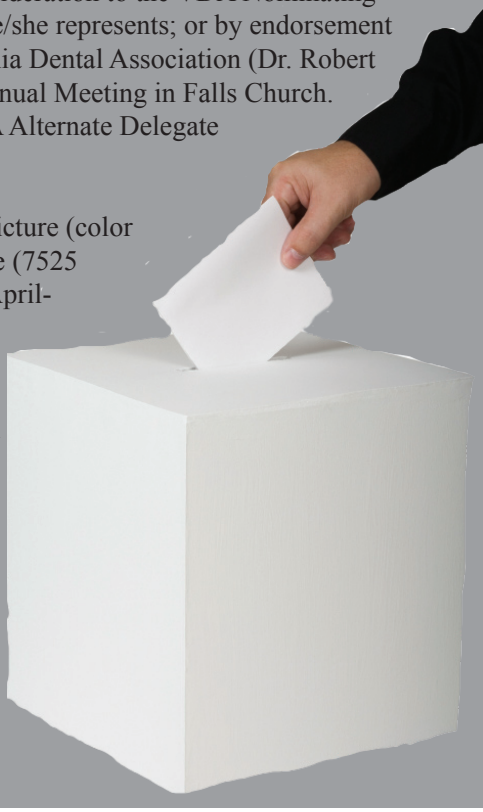
PLEASE NOTE: A COPY OF YOUR CURRENT BOARD OF DENTISTRY LICENSE MUST ACCOMPANY YOUR REGISTRATION! (VDA FAX# 804-261-1660)

For more information on the Mission of Mercy projects and to register online please visit us at www.vadental.org. Contact Barbara Rollins at VDA: 804-261-1610; email: rollins@vadental.org; FAX 804-261-1660.

Hope you can join us!

PUBLICATION OF CANDIDATE INFORMATION IN THE VDA DENTAL JOURNAL

Candidates for the elective offices of the Virginia Dental Association may be submitted for consideration to the VDA Nominating Committee by each component representative, on the committee, on behalf of the component he/she represents; or by endorsement of at least twenty-five members of the VDA, as verified by the Secretary-Treasurer of the Virginia Dental Association (Dr. Robert A. Levine, c/o VDA Central Office). The following positions are up for election at the 2007 Annual Meeting in Falls Church. President-elect; Secretary/Treasurer, three ADA Delegate positions (3-year terms) and five ADA Alternate Delegate positions (2-year terms).



All candidates must have submitted their CV's, biographical information, position papers and picture (color head shot preferred) to the attention of Dr. Leslie S. Webb, Jr., Editor, at the VDA Central Office (7525 Staples Mill Rd., Richmond, VA 23228) no later than February 28, 2007 for publication in the April-May-June issue of the *VA Dental Journal*. Forms of submission of candidate information have been mailed to all VDA component society presidents.

Candidates for the office of President-elect and Secretary/Treasurer will be allowed a maximum of 500 words. Candidates for all other offices will be allowed a maximum of 250 words. Candidates are asked to limit their biographical information to major accomplishments, but to include such pertinent data as education, memberships, honors, positions of leadership held in the ADA, VDA and component societies, and community leadership activities. Due to space limitations, the Journal Editor will reserve the right to condense biographical information, if necessary.

Should you have any questions regarding the *VA Dental Journal* criteria, please contact Dr. Les Webb at (804-282-9781). If additional Journal submission forms are needed, please contact Shannon Jacobs at (804) 261-1610 or jacobs@vadental.org.

75TH ANNUAL

Nation's Capital Dental Meeting

APRIL 19–21, 2007 ◆ WASHINGTON CONVENTION CENTER

HIGHLIGHTS

- Springtime in Washington
- Hygiene Program
- Participation Clinics
- Lunch & Learn
- Table Clinics
- The Night Photo Tour

FEATURED CLINICIANS

Raymond Bertolotti, D.D.S.
Composite Bonding

Suzanne Boswell
Practice Management

Harold Crossley, Ph.D.
Pharmacology

Jennifer de St. George
Practice Management

John Molinari, Ph.D.
Infection Control

Clifford Ruddle, D.D.S.
Endodontics

Michael Siegel, D.D.S.
Hearts, Joints and Hypertension

Bruce Small, D.M.D.
Restoratives / Esthetics

Charles Wakefield, D.D.S.
Dental Materials

Don't miss this opportunity to visit the Nation's Capital! Join friends and colleagues at the 2007 Nation's Capital Dental Meeting and take advantage of all this capital city has to offer!

For further information, or to register online, visit our website at www.dcdental.org

For a preliminary program, complete and return to:

DC Dental Society, 502 C Street, NE
Washington, DC 20002-5810
202-547-7613 FAX: 202-546-1482

NAME

ADDRESS

CITY

STATE ZIP

No Registration fee for ADA member dentists!

2006 VADPAC CONTRIBUTORS

Component 1
Tidewater
Benjamin Anderson
Richard Arnaudin
James Baker
Daniel Barton
Morton Brownstein
Lawrence Cash
Jack Cherin
Stanley Chickey
Jerry Clarke
Harold Demsko
Thomas Dilaura
Howard Dorfman
Thomas Dusek
Melvin Ford
Frank Gigliotti
Arthur Glick
Stephen Goldstein
Klaus Guter
Gary Hartman
Barry Herman
Michael Ireland
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Marvin Kaplan
C.M. Mahanes
Kenneth Marinak
Stanley Mason
Demetrios Milonas
Dennis Pirog
Robert Pope
Shaun Rai
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Holman Rawls
James Reske
Gregory Schrumpf
William Wingfield
Jonathan Wong

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Donald Moskowicz
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Ken Yandle

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Michael Gore
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Mark Hebertson
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David Major
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Peter Murchie
Walter Murphy
M. M. Neale, Jr.
Robert Neighbors
Clinton Norris, Jr.
David Nyczepir
Alan Padgett
Stephanie Pirok
James Pugh
William Redwine
David Sarrett
Allen Schultz
Stephen Spainhour
E. T. Spaur
Henry Stewart
David Swisher
Frank Wade
Paul White, II
Odie Whitlow
Jeffrey Willams
Stuart Wolff

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William Deyerle
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Julian Fields, IV
David Fitzgerald
Richard Golden
Ralph K. Greenway
Ralph N. Greenway
Donna Helton
Charles Jenkins
Penny Lampros
Jesse Mayhew, Jr.
Larry Meador
D. M. Parker
Joseph Penn
Jeffrey Riley
Amy Rockhill
Heidi Sherman
C. F. Smith
Charlton Strange, Jr.
Michael Woods

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Richard Copenhaver
B.N. Cox
Matthew Glasgow
Robert Hoskins
Carla Keene
James Kilbourne, Jr.
Perry Mowbray, Jr.
Nancy Perkins
David Ritchie
Robert Schuster
Julie Stubbs
Paul Stubbs
William Thompson
Dennis Torton
David Wilson

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Teresa Baisey
Robert Binda
Robert Binda, Jr.
Ted Galbraith
Steven Garrett
W. B. Hanna
Benjamin Hanson
Frank Jones
Frances Kray
Wallace Lutz
Berkley Pemberton
Scott Ruffner
William Sutherland
Jon Trabosh
Charles Wallace
David Wheeler

Component 8
Northern Virginia
J. David Alachnowicz
Robert Argentieri
Gary Avakian
Marjun Ayati
Edward Bernhart
David Bertman
Christopher Bonacci
Joseph Bosco
Hentry Botuck
Stuart Broth
Thao Bui-Nguyen
Mitchell Bukzin
Karen Callahan
Paul Callahan
Albert Citron
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Paul Conrad
William Crutchfield
Byron Dixon
Kristen Donohue
Mark Egber
Candace Evans
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John Good
Michael Green
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Gary Hartz
Edward Hindman, Jr.
Nicholas Ilchyshyn
Ralph Jordan
Savitha shnamoorthy
Frederick Krochmal
Peter Lanzaro
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Stanley Levin
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Robert McDonald
Katherine McGrath
Scott McKinney
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Russell Mullen
William Nanna
Diem Nguyen
Arthur Novick
Kendra Novick
Michael O'Shea
Warren Pace, Jr.
Mark Perez
Richard Pollock
E. A. Reeves, III
Thomas Richards
Aureilo Roca
Clark Rogers
William Ryals
Theresa Shannon
Stephen St. Louis
Paul Supan
Marcus Swann
Charles Varipapa
Anthony Viscomi
William Weinkam, Jr.
Lois Wilson
Douglas Wooddell
Bruce Wyman

Chang Yi

2006 Commonwealth Club Contributors

Component 1 Continued

Anthony Peluso
Gail Plauka
Richard Quigg
James Rhodes
Leslie Richmond
Rod Rogge
John Ross
David Rowe
James Rutlege, III
George Sabol
Stephanie Santos
Anthony Savage
Randolph Savage
Oscar Self, Jr.
Vernon Sellers
Michael Sharrock
Harvey Shiflet
Walker Shivar
Robert Simmons
Theodore Smith
William Tabor, Jr.
Gary Taylor
Ned Taylor
Bennett Thomas
Jayme Tomchik
Stanley Tompkins
Britt Visser
Robert Wernick
Walter Wexel
Julian Willis, III
Ernest Witte
Tarek Zaki
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Thank You to everyone who contributed in 2006!

Employee Benefits:

Flexible Spending Accounts

In the last several years, the cost of healthcare benefits has been increasing by double digit figures putting a lot of pressure on business owners who provide medical coverage to their employees. This pinch is being felt in large and small companies including dental offices. As the most sought after employment benefit, offering major medical coverage is a way to attract and keep the best employees in your dental office and to protect you and your family, but increasingly, more costs are shifting from the employer to the covered individuals. How can your dental office help your employees with these additional out-of-pocket costs?

One way is to look into alternatives for healthcare coverage to enhance the benefit you provide. *FlexSystem* Section 125 FSA Plans can be an attractive way to help you and your employees pay your portion of healthcare costs with pre-tax dollars.

What is FlexSystem?

FlexSystem is an IRS Code Section 125 Cafeteria Plan that is a flexible spending account wherein covered individuals can use pre-tax contributions to fund their *FlexSystem* account and then use these dollars to pay for qualified medical expenses. With *FlexSystem*, your office would use a Third Party Administrator (TPA) to set up and administer the plan to ensure tax code compliance. *FlexSystem* is a great supplemental benefit to your existing health insurance, or can be used without a major medical insurance plan in place.

How does it save money?

FlexSystem can save covered individuals money by allowing them to pay for out-of-pocket medical expenses with pre-tax dollars. Participating businesses can also save an average of $150 per employee per year in payroll taxes based on savings in Social Security taxes that do not need to be paid on employee wage contributions to *FlexSystem*. These savings to dental office and all individuals covered under the plan can be significant and can help you and your employees afford medical treatments that will keep everyone on the dental team healthy and satisfied with your benefits plan.

How does it work?

FlexSystem allows employees to select an amount to fund their plan through payroll deduction to be used to pay for qualifying medical expenses on a pre-tax basis. These pre-tax dollars will accumulate in the FlexSystem account and can be used for qualified expenses for covered individuals and their dependants. Section 125 Plans, also known as Flexible Spending Accounts,"can be structured to include a variety of benefits.

B&B Insurance Associates, the VDA's recommended insurance agency for nearly 7 years, is happy to assist you in evaluating whether your office can benefit from FlexSystem. B&B works with a large number of VDA Members and is happy to work with you to determine if this or another alternative benefit could be right for your office. ***Please contact B&B at 877-832-9113 to discuss FlexSystem or any other insurance needs***.

Dental School News

The VDA thanks the following people for taking the time to share their knowledge and experiences with the dental school students.

The Virginia Dental Association sponsored a "Smart Start Program" for the freshman dental students on September 29, 2006. Dr. Ben Adams, 16th District Representative for Committee for the New Dentist, flew in from Greenville, SC for an engaging power point presentation on finances. The students many concerns and questions regarding finances and student loans were thoroughly addressed by Dr. Adams. Hopefully the students left with a better understanding/ knowledge of student debt and its impact upon their future practice options.

The Virginia Primary Care Association sponsored lunch for over 70 dental students on November 1, 2006, for a 'Lunch and Learn' held at the VCU School of Dentistry. Many thanks go to Thomas Gaskins, from Virginia Primary Care Association, Dr. Elizabeth Barrett, Oral Health Promotion Unit Manager from the Division of Dental Health, Herbert J Cummings, Director of Operations of the Vernon J Harris Health Center, Dr. Sheilandice M. Holmes, Dental Director of the Vernon J. Harris Medical Center, and Dr. Rana Graham, Dental Director of the Daily Planet. All speakers did a wonderful job, explaining the different options/opportunities that were available for students that were interested in practicing dentistry in Access to Care areas.

Long Strange Trip

By: Dr. Brien Harvey

Those of you who know me, or perhaps have read a few of my offerings over the years, should not be surprised when I admit to being a bit of a Dead Head (as in fan of legendary rock band Grateful Dead, not as in dull-witted slacker).

Recent experiences have underscored the possibility that Grateful Dead lead guitarist and vocalist, the late Jerry Garcia, might have been singing to me personally, with his most classic line from the band's most classic song, *Truckin'*: "What a long, strange trip it's been."

I just wonder, here in 2006, how he knew what would be going on in my life when he first sang that song more than 30 years ago. Did he really know in advance that Adam and I would choose to drive 1,500 miles in 21 hours on our way to Adam's second year at the University of Puget Sound? Well, probably not, but it sure seemed like it about 1,400 miles into the trip.

Our road trip was definitely long, and it got pretty strange as exhaustion set in, but if this editorial was about my trip with Adam, it would be just about done. I guess I could add a comment or two about my 911 call while driving through LA/Pasadena/Valencia somewhere between 1:00 a.m. and 2:00 a.m., which was just warming us up for the sun rising over beautiful Sacramento, followed some hours later by the truck stop in Eugene. Ultimately, though, the piece would be short, allowing my readers to agree that my trip was long and somewhat strange, followed by an unavoidable: "So what?" Not wanting to disappoint in this fashion those of you who *do* read my comments every now and then, I suspect you will not be surprised as I head off down another long, strange journey through our current maze of dental acronyms: DHAT, ADHP and CDHC. So, let's get truckin'.

This particular long, strange trip begins with a (seemingly) simple question: "Whose job is it, anyway?" That is, whose job is it to provide dental care for those patients in need of same? Whose job is it to restore teeth with cavities? Whose job is it to extract teeth, deciduous and permanent? Whose job is it to undertake pulpal therapy and place stainless steel crowns for kids? Faithful readers, depending on whom you ask these days, the answers could lead you on a long, strange trip.

Some years ago, public health types in Alaska, including the Indian Health Service (HIS) and the Alaska Native Tribal Health Consortium (ANTHC), decided that their constituents did not deserve to have (allowing your editor a bit of inflammatory hyperbole here) their dental treatment needs taken care of by dentists. Sure, there are tremendous geographic and cultural challenges, the water is bad, and up to 50% of the caloric intake is derived from sugar-laden beverages. Yes, yes, yes, a thousand times, yes, the situation was and is horrific. But before continuing, I will offer a bit of an aside.

In Alaska, the tribes have electively surrendered their sovereignty, organizing as Alaska corporations. Nonetheless, if we were to look at their corporate charters, and the mandates within the IHS, I am confident we could find language compelling that the healthcare needs of the Alaska Natives falling under their jurisdiction shall be met. I doubt if we would find language stating: "…unless there are geographic challenges" or "…unless disease prevalence is high" or "…unless culturally competent dentists cannot be found." No, the facts of this case are simple, even if the problem itself is not. The entities responsible for assuring adequate dental care for their constituents, including and not necessarily limited to the IHS and the ANTHC, failed to do their job, and failed miserably.

Meanwhile on this long, strange trip, the Alaska Dental Society (ADS) tried to help by developing an "Adopt a Village" program aimed at putting volunteer dentists into places where the "responsible entities" had failed to satisfy their mandate to provide access to dental care. Even though the program was very successful, resulting in reduced decay rates lower than the national average, the program was terminated by the natives.

Recently, the American Dental Association has begun advertising a volunteer program, putting volunteer dentists into dental clinics in Minnesota and North Dakota. Why, you might ask, was Alaska not included in the sites for volunteer service? Because even though back in 2004 there were over 150 ADA volunteer dentists who signed up to go to Alaska, these same "responsible entities" have not allowed even one dentist volunteer into the region in order to help. The cynic in me cries out that they were and still are manufacturing and magnifying a crisis in order to be able to propose and justify a short-cut. Do I need to add: "at a terrible cost to their constituents?"

"Whose job is it, anyway?"

More than four years ago, our "friends," the "responsible entities," decided that the best solution for their problem would be to send local high school graduates to New Zealand for two years of training, thereby granting them certification as Dental Health Aide Therapists (DHAT). The DHATs are now practicing in Alaska, and their treatment regimens include caries excavation with permanent restoration placement, "simple" extractions (I sure wish that I knew with complete certainty, in advance, which of my extractions were going to prove to be simple) and pulpal therapy with stainless steel crown placement in children. I ask you, my readers, which six-year (or greater) portion of your college education was unnecessary in preparing you for these sorts of procedures, particularly when undertaken on children with rampant caries? In Alaska, the "responsible entities" answer my "whose job is it" question with a simple "DHAT," at least some of the time.

Sensing an opportunity based upon the hand-wringing over access to care, and perhaps to nobody's surprise, the leaders of the American Dental Hygienists' Association (ADHA) have their own answer to the "whose job is it" question. Drum roll, please…

Surprise, surprise, surprise… ADHA claims the answer is "hygienist." Not just any hygienist, mind you. No, this job calls for an Advanced Dental Hygiene Practitioner (ADHP). Ask if your hygienist is a member of the ADHA, or if they know one who is. See if you can come up with the July issue of *RDH*, their journal, and take a look at the "headquarters" portion beginning on page 11. Then look at the section on Provision of Primary Care under the heading Competencies. You will find quotes such as: "prescribes medications used for pain management," "extract simple/uncomplicated teeth," "provide primary restorative oral health care" and "intercept potential orthodontic problems." Sounds like dentistry (and the "Competencies" of dentists) to me. For cryin' out loud… they've been heading this direction for more than 20 years now. If all of the dentist-envy hierarchy of the ADHA, clearly representing a tiny minority of the practicing hygienists in America, would have just gone to dental school when this occurred to them, they could all be doing the things they want to do by now.

In America, we hold many truths to be self-evident. As dentists and as a dental association, one collective, incontrovertible, self-evident truth is that invasive, cutting dental procedures should be done by dentists. When "responsible entities" fail in their obligations to provide access to dentists and dental care -- whether in Alaska or Arizona or anywhere on American soil -- the only reasonable option is to expand their efforts and creativity in order to get their constituents together with dentists.

Clearly, there is an issue over access to dental care for portions of America's population. As I have written repeatedly over the years, the bulk of this issue revolves around an access to adequate funding. Please permit me to quote myself: "Show me an area with demand for dental services and adequate funding for that demand, and I'll show you an area with dentists." Sure, many factors can affect the level of funding necessary to be "adequate" and Alaska presents considerable challenges. Even so, my conclusion in reference to the Alaska issue is that the DHAT program represents a masterful case of subterfuge. Apparently the "responsible entities" do not care enough about their constituents to allocate adequate resources to get them the care that they need, even though many of the Alaska Native Corporations are reputed to be absolutely flush financially. They just don't want us to know it.

Two significant problems impact delivery of care in remote, sparsely-populated settings. The first is the historic lack of effective preventive programs. The fact is, allowing your children to get 50% of their calories from sugary drinks is child abuse. We cannot drill and fill our way out of this problem. If we keep doing what we have been doing, we will keep getting what we got. Ten years from now we will be expressing concern about the epidemic of untreated disease in underserved areas. We must turn off the spigot of sugar, improve availability of good water, with fluoride, and teach people how to care for their mouths. We must improve prevention of disease.
The second principal problem in remote sites, those with populations too small to support or warrant an on-site dentist, is the efficiency of delivery. When dentist days are dedicated to travel, setting up portable equipment, working out equipment problems, screening and triaging for priority dental care, the average number of patient treatment contacts per dentist-day can dip as low as three. Yep, you got it -- a sea of untreated dental disease and only three patients per dentist-day actually receive treatment. Okay, so you must be getting weary by now, but I implore you to stay on this long, strange trip with me. We're almost there.

This past September 9, your AzDA House of Delegates took a proactive step in helping to solve these problems of ineffective preventive services in underserved areas along with inefficient delivery of services. We approved, in concept, development of a program designed to train a mid-level dental provider, the Community Dental Health Coordinator (CDHC). Our actions were taken in anticipation of the ADA House of Delegates approving a resolution this month in Las Vegas authorizing development of a CDHC curriculum and procurement of funding for three prototype training sites. The idea revolves around the CDHC living in areas that historically have lacked adequate access to care, implementing preventive programs and remaining on-site to monitor the effectiveness of these programs. The CDHC also will triage patients with untreated dental disease, lining the patients up (figuratively and/or literally) for their treatments. When the dentist arrives or, conversely, when travel to the dentists is coordinated for the patients, it is entirely reasonable to expect increased efficiency in the delivery of dentist-provided services. Truly a win-win outcome, particularly over the long haul as effective preventive services begin to impact positively the incidence and prevalence of dental disease.

The rational frame of reference does not find answering the "whose job is it, anyway" question difficult or challenging. One word will, in fact, suffice: "Dentists." It is a shame that many entities responsible for assuring adequate access to dentist-provided treatments have abdicated this responsibility, choosing instead to obfuscate the issue in order to recruit public opinion supporting their shortcuts. Rest assured that we, your AzDA leadership, will continue to do our best to call them on this issue while taking specific, substantive steps to help correct their failures. Stay tuned. This is just a stopover on our long, strange trip because after we, as the Grateful Dead sang, "…sit down and patch [our] bones," we will "get back truckin' on."

Dr. Brien Harvey has a private practice in Periodontics in Tucson. He is Editor of INSCRIPTIONS and invites VDA members to email him at brien@azda.org

School of Dentistry Receives Largest Gift in History

By: Martha Bushong

The Virginia Commonwealth University School of Dentistry received the largest gift in its 113 year history when alumnus Dr. W. Baxter Perkinson, Jr. unveiled a check representing a pledge for $2.5 million at the annual Friends of Dental Education Dinner at the Virginia Museum of Fine Arts in October. Perkinson's unrestricted gift will advance the school's mission components and help insure its place among the nation's best dental schools.

In making the gift, Perkinson said he hoped to strengthen the rich partnership he enjoys with VCU and the School of Dentistry. "For much of my life my involvement with VCU and School of Dentistry has been a big part of who I am and what I do. I am thrilled to be able to make this gift and give back to a place that has given so much to me and my family."

Three of Perkinson's four children and a son-in-law followed him in earning DDS degrees at his alma mater. His daughter Catherine and her husband Jamie Crichton graduated in 2000, his son Will graduated in 2002, and his son Tyler graduated in 2006. "I am pleased that three of my children chose to go the dental school at VCU, too."

"Perkinson's service to VCU has been extraordinary." Dr. Eugene Trani said, "His generous contributions of time, energy and financial gifts have made a significant impact on this university becoming a world-class research institution."

For his commitment the University and the School of Dentistry plans to name its newest building in Dr. Perkinson's honor. Groundbreaking is expected in fall 2007.

Virginia General Election Results

November 7, 2006

US SENATE	Votes	Percent
James Webb (D)	1,175,606	49.59%
George Allen (R)*	1,166,277	49.20%
Gail Parker (IG)	26,102	1.10%

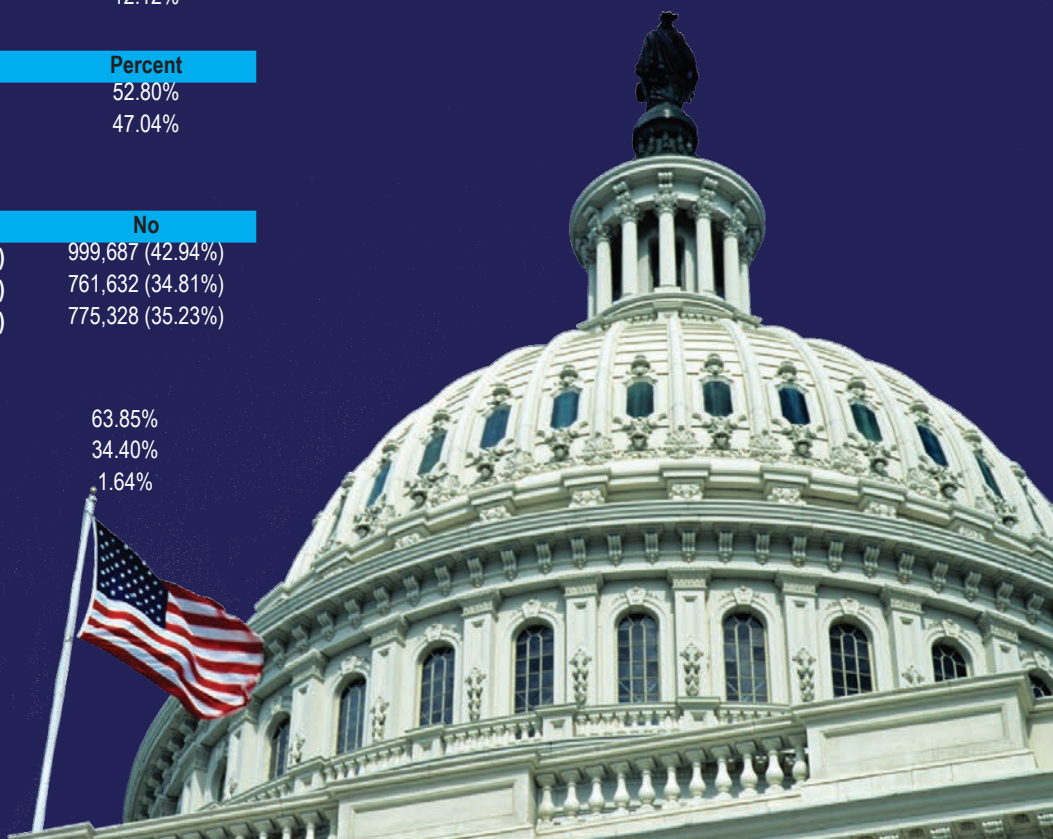
US CONGRESS	Votes	Percent
1st District		
JoAnn Davis (R)*	143,889	62.96%
Shawn O'Donnell (D)	81,083	35.48%
Marvin Pixton III (IG)	3,236	1.42%
2nd District		
Thelma Drake (R)*	88,777	51.27%
Phil Kellam (D)	83,901	48.45%
3rd Distirct		
Bobby Scott (D)*	133,546	96.08%
4th District		
Randy Forbes (R)*	150,967	76.12%
Albert Burckard (IG)	46,487	23.44%
5th District		
Virgil Goode (R)*	125,370	59.11%
Al Weed (D)	84,682	39.93%
Joseph Oddo (IG)	1,928	0.91%
6th District		
Bob Goodlatte (R)*	153,187	75.09%
Barbara Jean Pryor (I)	25,129	12.32%
Andre Peery (I)	24,731	12.12%

House of Delegates HD 50	Votes	Percent
Jackson Miller (R)	7,900	52.80%
Jeanette Rishell (D)	7,039	47.04%

Ballot Initiatives	Yes	No
1. Marriage Amendment	**1,328,537 (57.06%)**	999,687 (42.94%)
2. General Assembly Powers	**1,426,248 (65.19%)**	761,632 (34.81%)
3. Property Tax Exemption	**1,425,143 (64.77%)**	775,328 (35.23%)

US CONGRESS	Votes	Percent
7th District		
Eric Cantor (R)*	163,706	63.85%
James Nachman (D)	88,206	34.40%
Brad Blanton (I)	4,213	1.64%
8th District		
Jim Moran (D)*	144,700	66.40%
Tom O'Donoghue (R)	66,639	30.58%
Jim Hurysz (I)	6,094	2.80%
9th Disrict		
Rick Boucher (D)*	129,705	67.76%
Bill Carrico (R)	61,574	32.17%
10th District		
Frank Wolf (R)*	138,213	57.32%
Judy Feder (D)	98,769	40.96%
Wilbur Wood (L)	2,107	0.87%
Neeraj Nigam (I)	1,851	0.77%
11th District		
Tom Davis (R)*	130,468	55.45%
Andrew Hurst (D)	102,511	43.57%
Ferdinando Greco (IG)	2,042	0.87%

* Incumbent Candidate



Welcome New Members

December 2006

Tidewater Dental Association
Dr. Zeyad Mady graduated from University of Illinois at Chicago School of Dentistry in May 2006. Dr. Mady is currently practicing in Virginia Beach with Konikoff Dentistry.

Dr. Martin Justin received his B.S. in chemistry from the Virginia Military Institute in 1991. He then obtained his DDS from MCV School of Dentistry in 1995 and graduated from the endodontics residency at Temple University School of Dentistry in 1997. Dr. Martin had been practicing from 1997-2006 in the Northern Virginia area. In April, he moved down to Virginia Beach so his wife and children could be closer to their family. Dr. Martin recently opened his office in October 2006. When not in the office, Dr. Martin enjoys surfing and cycling and most of all spending time with his wife and two sons.

Dr. David Throckorton graduated from VCU School of Dentistry in 2006. He then completed his GPR from Hampton VAMC in 2006. Dr. Throckmorton is currently practicing in Virginia Beach, VA.

Dr. Tasha Willoughby graduated from University of Tennessee Dental School in 2005. Dr. Willoughby is currently practicing dentistry in Virginia Beach, VA.

Northern Virginia Dental Society
Dr. Jamie Childress graduated from VCU School of Dentistry in 2005. Dr. Childress is currently practicing dentistry in Warrenton, VA with Dr. Vincent Murray.

Richmond Dental Society
Dr. Maynard Phelps graduated form Harvard School of Dental Medicine in June 2006. Dr. Phelps is currently practicing dentistry in New Canton, VA at the Central Virginia Health Services.

Dr. Gabriel Martin graduated from VCU School of Dentistry in May 2006. Dr. Martin is currently practicing dentistry in Ashland, VA.

Dr. Adam Hershkin graduated form Temple School of Dentistry in 2001. He then completed his certification as an Oral Surgeon. Dr. Hershkin is now practicing in Richmond, VA with Drs Niamutu, Alexander, Harris, PC.

Dr. Trisha Krause graduated from Tufts University School of Dental Medicine in May 2003. While at Tufts, Dr. Krause was active in the American Student Dental Association and through her involvement she participated with several ADA committees including the councils on membership and insurance and also the Commission on Dental Accreditation. Following graduation, she entered a general practice residency at Brigham and Women's and Mass General Hospitals. Dr. Krause then relocated to Richmond, VA and entered an endodontic residency at VCU School of Dentistry where she received a master's degree in June 2006. Dr. Krause lives in Richmond and is a sole practitioner in a practice limited to endodontics.

Dr. Sanjay P. Bhagchandani received a B.S. in Biology from Duke University in 1998 prior to receiving his dental degree from Tufts University School of Dental Medicine in 2003. Dr. Bhagchandani worked as an associate in Boston for one year and then returned to his hometown of Richmond, Va in the summer of 2004. Dr. Bhagchandani currently is an associate with Dr. Maury A. Hubbard, Jr. and Dr. Sam English, II.

Dr. Shaman Al-Anezi graduated from VCU School of Dentistry in 2001. He then completed his AEGD Certificate in June 2004. Dr. Al-Anezi is currently at VCU School of Dentistry in the Dept of GP.

Southside Dental Society –
Dr. Kendall Morris graduated from VCU School of Dentistry in May 2006. Dr. Kendall is currently practicing in South Hill, VA with K.W. Morris, Ltd.

Piedmont Dental Society
Dr, Edward Ulrich, Jr. graduated from the University of Tennessee College of Dentistry in 1975. Dr. Ulrich is currently practicing dentistry in Hardy, VA

Shenandoah Valley Dental Association
Dr. David Coon graduated from Baylor College of Dentistry in 2004. He then completed his Certificate in Endodontics from Baylor College of Dentistry in 2006. Dr. Coon is currently practicing as an endodontist in Charlottesville, VA, with Dr. John

In Memory Of...

Dr. Larry Hensley	LA Crosse, VA	October 2, 2006
Dr. Robert H. Loving, Sr.	VA Beach, VA	September 29, 2006
Dr. Walter E. Kilbournre	Chester, VA	October 31, 2006
Dr. Donald Martin	Pulaski, VA	November 1, 2006
Dr. Phillip Handy	Lynchburg, VA	May 7, 2006
Dr. I. S. Myers	Martinsville, VA	June 10, 2006
Dr. Robert S. Burford	Richmond, VA	August 7, 2006
Dr. Fred Cornett	Pittsboro, NC	November 21, 2006
Dr. Floyd D Herbert	Leesburg, VA	June 2006

On February 2, 2007, hundreds of dental volunteers will reach out to provide much needed dental care and education to children. Please join us and volunteer for Give Kids

Last year 7,834 children from throughout the Commonwealth received $306,124 in free dental care as part of the National Give Kids a Smile initiative and Children's Dental Health Month.

National Children's Dental Access Day

If you would like to become a part of this important initiative for children's access to dental care, contact your Component Secretary to find out about events in your area or consider organizing an event at your office or a local school.

Please remember to report your Give Kids a Smile activities to your Component or to the VDA central office. Thank you to all participants!

Public Health Notes

Dr. Karen Day

Dr. Lisa Syrop, community water fluoridation coordinator for the Division of Dental Health (DDH), Virginia Department of Health (VDH) worked with the VDH Office of Drinking Water, Virginia Rural Water Association, and the Salem Water Treatment Plant to hold the first community water fluoridation training center course November 14 –15, 2006 in Salem, Virginia. The long-term goal of the training center is to assure the quality of community water fluoridation for the Commonwealth. During this training at Salem Water Treatment Plant, waterworks operators were educated regarding the dental benefits and methodology of community water fluoridation. The waterworks operators also received hands-on laboratory training regarding testing and monitoring fluoride, calibrating several fluoridation systems, and improving safety response with a mock spill drill.

In areas where community water fluoridation is not possible, Sharon Logue, RDH manages a voluntary topical school fluoride rinse program, which can reduce dental caries up to 15%. During the 2006 school year, 46,700 children in 212 schools and 50 counties participated. The participation rate increased by 1,000 children in 15 schools from the prior school year. Much of the increase was due to five part time dental hygienists working in the southwest region of the state. They are responsible for the topical fluoride rinse program in the following counties: Washington, Smyth, Grayson, Wythe, Bland, Carroll, Floyd, Pulaski, Roanoke, Halifax, Mecklenburg, and Brunswick.

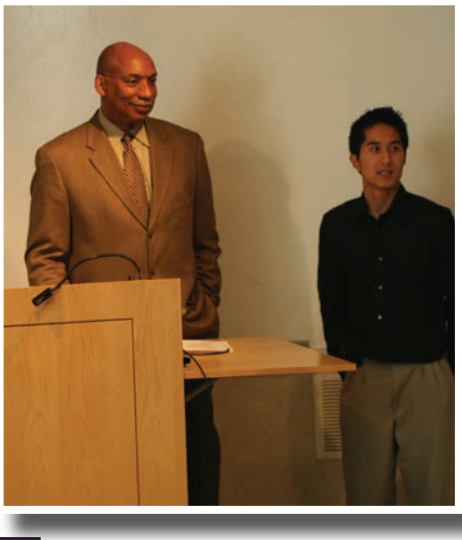
In an effort to reach African-American men who may not have regular dental visits, Tonya McRae, RDH partnered with the American Cancer Society to bring educational materials, information, and screenings into the Richmond community. The Virginia Oral Cancer Barbershop Project was a grassroots, pilot program aimed at promoting oral cancer awareness to in the Richmond area. Through this program 23 barbers and stylists were trained to disseminate information about oral cancer to their clientele. Participants were given pre- and post-tests during the training. Equipped with knowledge about oral cancer, a comprehensive curriculum, and educational materials to display in their shops, the barbers were charged with the task of informing their clients about oral cancer. Over a three-month period, these barbers documented 1,137 clients who were educated about oral cancer. The shops also highlighted screening opportunities in the dental community, including one scheduled at the Crossover Free Clinic. The clinic provided their facility, supplies, and personnel to register patients and sterilize instruments. DDH provided a dentist and hygienist to perform the screenings as well as toothbrushes, floss and educational materials. One cancerous lesion was found in a man who had received the information about oral cancer and the free screening and had concerns about a lesion in his mouth. Several other patients were scheduled to return to Crossover to be seen by the oral surgeon for further evaluation of suspicious areas. Overall, this project was a success. Educating over 1,100 African-American men and confirming one case of oral cancer that may have gone undetected is a major accomplishment. The barbers took a personal interest in oral cancer education and in their role as health ambassadors. Many barbers reported that clients were performing the self-exam and that some had discontinued tobacco use. In addition, two barbers staffed a booth at a community event and health fair to disseminate information that they had received at the training. The next Oral Cancer Barbershop Project will take place in Norfolk, Virginia in the spring of 2007. For further information, call Tonya McRae, RDH, at (804) 864-7785.

VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment

VCU Lunch & Learn

Quoc Lu

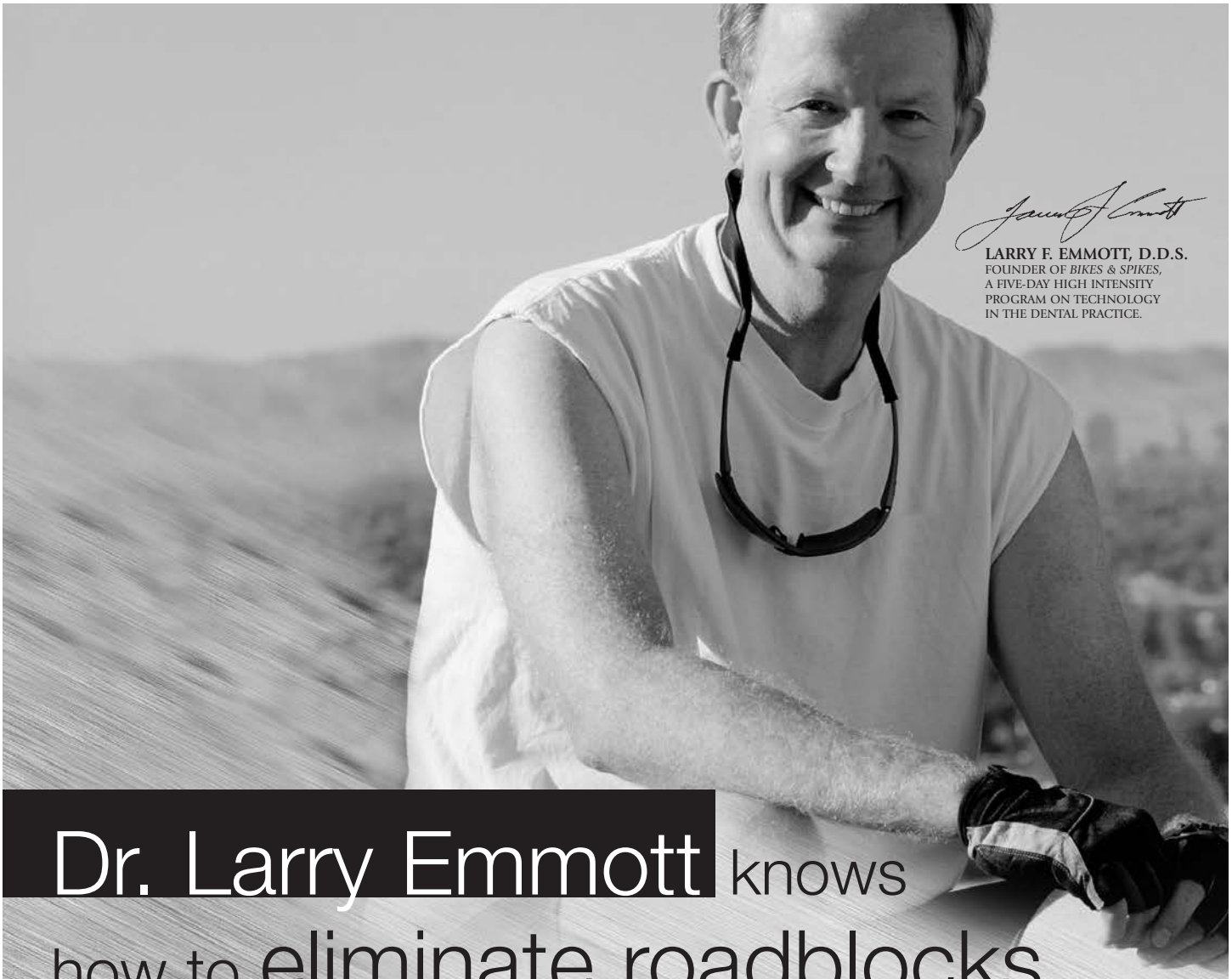
27 November, 2006 – In dental school, students are taught the fundamentals of oral healthcare. Curriculums are built around comprehensive lessons on the techniques and sciences behind dental procedures, including how to take into account medically compromised conditions and dental emergencies. However, patients are also comprised of a wide range of backgrounds, differing by culture, socioeconomic status, disability, gender, and age. The way we interact with patients influences how well we can treat them.



SAME (Social Awareness and Multicultural Education) was founded by VCU dental students to supplement the curriculum by exposing us to cultural competency, access to care, and healthcare disparities. The purpose is to teach students how best to properly communicate with their patients to give them the customized care that they need.

SAME celebrated their kickoff event on Monday, generously sponsored by the VDA, by bringing in keynote speaker Dr. Napolean Peoples. Dr. Peoples is the Director of the Office of Multicultural Student Affairs at the VCU Monroe Campus, and has extensive experience in cultural issues. He has a degree in Psychology and has authored papers and given speeches on cultural competency. Dr. Peoples spoke of the different levels of prejudice and how cultural competency stems from a (mis)understanding of the individual in regards to their race, ethnicity, socioeconomic status, disability, age, etc., and how this knowledge would affect communication and treatment.

The audience consisted of dental students, graduate residents, the advancement office, and associate professors.



LARRY F. EMMOTT, D.D.S.
FOUNDER OF *BIKES & SPIKES*,
A FIVE-DAY HIGH INTENSITY
PROGRAM ON TECHNOLOGY
IN THE DENTAL PRACTICE.

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"What we want for patients is not necessarily what insurance covers. That's why CareCredit® is such a big deal. It helps patients get the care they want by eliminating the issue of cost, which is the biggest roadblock to case acceptance.

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THE VIRGINIA DENTAL ASSOCIATION IS PLEASED TO ANNOUNCE

VDA CE Online

The Virginia Dental Associations' new CE Online is another member benefit sponsored by VDA Services. CE Online will allow general dentists, specialists and dental team members the flexibility of earning CERP recognized CE credits at their convenience.

Some of the Virginia Board of Dentistry requirements for continuing education

- A dentist shall be required to have completed a minimum of 15 hours of approved continuing education for each annual renewal of licensure.
- Continuing education credit may be earned for verifiable attendance at or participation in any courses, to include audio and video presentations, which meet the requirements or your licensing or regulatory agency.
- Effective June 29, 2006, a dentist who administers or dental hygienist who monitors patients under general anesthesia, deep sedation or conscious sedation shall complete four hours every two years of approved continuing education directly related to administration or monitoring of each such anesthesia or sedation as part of the hours required for licensure renewal.
- Continuing education hours in excess of the number required for renewal may be transferred or credited to the next renewal year for a total of not more than 15 hours.
- CE course must be relevant to the treatment and care of patients (Clinical courses in dentistry or dental hygiene, patient management, legal and ethical responsibilities, stress management). Unacceptable courses would include but not limited to estate planning, financial planning, investments, and personal health.

Log on to view course abstracts:

www.vadental.org

Once there, go to the side (left) navigation bar and click on 'Online CE'.

***It is the responsibility of each registrant to verify the CE requirements of his/her licensing or regulatory agency.**

VDA SERVICES

ADA C·E·R·P
CONTINUING EDUCATION RECOGNITION PROGRAM

VDA Award Nominations

The Board of Directors Awards Subcommittee selects recipients for VDA awards which are presented at the Annual Business Meeting of the Virginia Dental Association. In order to select those who are most deserving of these honors, we would like to ask for your help in identifying potential recipients. Nominations for awards may be made to the Awards Subcommittee by individual members of the VDA or by components. Please submit nominations to the VDA Awards Subcommittee, attention Bonnie Anderson, at the VDA Central Office (7525 Staples Mill Rd., Richmond, VA 23228) by April 30, 2007.

Dental Team Member Award The nominee must be a dental team member of a VDA dentist. This award may be presented to multiple recipients only when worthy candidates are recognized. The nominee(s) should demonstrate that she/he holds the profession of dentistry in highest regard, promotes the interest and betterment of the profession through the team concept of dentistry and has five or more years of experience in the dental field.

Emanuel W. Michaels Distinguished Dentist Award This award is presented to a member dentist who has demonstrated outstanding service, leadership and dedication to the profession of dentistry and for the improvement of the health of the citizens of Virginia. This award is presented only when a worthy candidate is recognized by the President and approved by the Awards Committee.

New Dentist Award This award is presented yearly to a VDA member who has been in practice ten years or less. This award is only presented when a worthy candidate is recognized. The nominee must have demonstrated leadership qualities through service to dentistry.

Special Service Award This award is presented to a non-dentist who has demonstrated outstanding service, support and dedication to the profession of dentistry. This award is presented when a worthy candidate is recognized.

Virginia Dental Association
Board of Directors
Actions in Brief
November 2, 2006

The following items were considered:

1. A motion was made, seconded and passed to support the following regulation:

Registered nurses or licensed practical nurses under the immediate and direct supervision of a registered nurse and pursuant to an oral or written order or a standing protocol, issued by a dentist or a doctor of medicine or osteopathic medicine, may possess and administer topical fluoride varnish to the teeth of children age 6 months to age 3 years. Such protocol shall conform to standards adopted by the Virginia Department of Health.

2. Background: Dr. Vincent Mascia has already received the support of the ADA and is asking that the VDA support his application for a Robert Wood Johnson Grant as well. The grant would allow him to study access to care issues and policy.

A motion made, seconded and passed to support Dr. Vincent Mascia's application for the Robert Wood Johnson Grant.

3. Background: Project Access in Roanoke is an urgent care model giving emergency dental care to patients in private offices or the Bradley Free Clinic. A long term goal would be to link qualifying Project Access patients into the DDS program.

A motion was made, seconded and passed that the VDA should become a partner in the work of Project Access in Roanoke.

Reported as Information Only:

4. The Board of Directors, through Chuck Duval, VDA Lobbyist, is sending a written response to the Attorney General's Regulatory Review Commission showing justification of regulations: 18 VAC 60-20-200 - Utilization of Dental Hygienists, 18 VAC 60-20-250 - Registration of Oral and Maxillofacial Surgeons and VAC 60-20-260 - Profile of Information for Oral and Maxillofacial Surgeons.

5. The Thomas Nelson Hygiene Program has already been approved by the State Council of Higher Education. The VDA will seek a budget amendment for funding during the short session of the General Assembly. The session is in January 2007, but requests need to be in by December 11, 2006.

VCU School of Dentistry Remarks

Dennis P. Gallagher

I would like to begin this afternoon with several questions:

How is it that money is appropriated to expand your dental school?

What has to happen so that more children receive Medicaid-sponsored dental services?

How does a new definition of dentistry become law?

Where does new simulation equipment come from?

The answer to all these questions is the same: POLITICS.

Now, to test my contention: do you think that the average person could answer the kinds of questions I just asked? I've found that my neighbors can't, and I'm willing to bet that yours can't either.

So, what we have in our communities and neighborhoods is no real idea about the connection between politics and, for example, funds for an expanded dental school.

But, it's just this connection that I want to discuss with you now.

Look up any definition of politics and you'll see that politics is described as the "doing" of something: managing a government, shaping health care policy, influencing public opinion. In other words, politics is action.

So, politics, then, is about getting things done: fixing potholes, getting the trash picked up, passing the town budget, securing funds for an expanded dental school.

Thus, politics in its simplest terms is the connecting of different elements to realize an objective. Harry Truman said it best: *The objective and its accomplishment is my philosophy.*" The objective and its accomplishment is my philosophy.

Now, I realize that all of you appreciate this little civics lesson this afternoon, but I also know that you're wondering what in the world it has to do with you and your professional life.

The answer is actually very simple: I want you to become involved in the political action efforts of the Virginia Dental Association. I want you to make the connection between your professional life and the politics of Virginia or the politics of wherever you practice.

The basis for my request is simple.

Involvement in the political process is the only way to control your professional life. Political action is also the only way to control your business life.

In other words, if you want to control your destiny, you must get involved in the VDA political action program.

What's the alternative?

The alternative is that legislators, lobbyists and bureaucrats will make decisions for you: Decisions about your practice, about your employees, about your colleagues, about your patients and about your income.

At the present time, the Virginia General Assembly divides oversight of the dental profession between the Senate Committee on Education and Health and the House committee on Health, Welfare and Institutions.

The Chairman of the Senate committee is a sports promoter. The only healthcare professional serving on this Committee is Richmond Senator Benjamin Lambert, an optometrist and a great friend of the dental school.

The other Senators are, in no particular order: a service station operator, school administrator, former local government official, nursing home owner, two attorneys, an insurance salesman, a pharmaceutical lobbyist, furniture store owner, a retired high school principal, a former teacher and a computer contractor.

On the House side, the chairman of the principal subcommittee regulating your profession is a stockbroker. His colleagues include: a chiropractor, a neurologist, two attorneys, a college administrator, an insurance salesman, a Federal Government retiree and a former telephone company employee.

Every one of these legislators is a dedicated public servant; none of them are dentists. Many of these legislators own, manage or work in business; none of them own, work in or manage a dental practice.

The point here should be obvious: do you want to control the future of your profession and your business life, or do you want a chiropractor, good man though he may be, making these decisions?

Now, if you're thinking that the VDA and its lobbyists can safeguard your professional and business interests, think again.

I've been in this business for more than twenty years and I have never, ever seen a legislator meet with a lobbyist when a constituent was waiting. Countless times, my lobbyist colleagues and I have been ontime and thoroughly prepared for a scheduled meeting with a legislator only to wait outside while a constituent – any constituent – visits with Senator Y or Delegate X.

Why does this happen?

It occurs because legislators want four things from constituents and lobbyists alike: Your vote, your money, your knowledge, and access to your neighbors' votes.

Now, a lobbyist can provide money and some knowledge, but few lobbyists can deliver votes back home and fewer still can provide access to your neighbors and their votes. And no lobbyist can match the kind of knowledge that a practicing dentist can bring to an issue affecting his or her profession.

But you might say: *"Yeah, Denny, that's all well and good, but my Senator never has any opposition so he or she doesn't really need my vote, and the VDA will contribute campaign money. You can provide some information about dental issues – I mean, after all, that's what you're paid for – and as for my neighbors: Well, they won't vote for this guy anyway."*

Well, let me disabuse you of that cop-out. Several years ago, the VDA undertook the task of re-writing the legal definition of dentistry. We wanted, in broad terms, to have the law of Virginia accurately reflect what the profession had become in all the years since the original definition had been on the books.

Our specific objective, moreover, was to have the legislature enact a definition

of dentistry that would enable oral surgeons to practice their profession without having to worry that modern techniques then in use would run afoul of the law.

As you might imagine, this initiative ignited a fire storm of protest from the Medical Society of Virginia and, especially, plastic surgeons. At the end of the day, the VDA won that battle, and those of you here today will take advantage of this new definition.

And we won that fight, not with lobbying expertise, but with personal political relationships developed by dentists with legislators and with the professional knowledge of dentists and oral surgeons who came to the General Assembly and helped to pass this legislation.

The VDA lobbying team didn't, couldn't, produce these results. It fell to practicing dentists from back home and dental school faculty who came to the Capitol to share their professional knowledge and expertise with legislators. Later, these legislators would vote overwhelmingly in support of the VDA's legislation.

Several years ago, the VDA and its member dentists worked with the Dental School Foundation, VCU lobbyists and dental students to secure funding for the purchase of new dental simulation and virtual reality equipment.

Importantly, the Foundation agreed to provide the bulk of the funding needed to purchase this equipment, a generous commitment secured through the cooperative efforts of the Foundation leadership and the VDA.

This is the kind of real world political effort which can almost never fail: the private sector stepping forward with a substantial financial commitment to connect with public sector funds to advance the interests of the state's school of dentistry. In other words, all the elements of a successful political campaign were brought to bear to secure this funding: Willing legislative leaders like Senator Lambert, highly motivated graduates of the School of Dentistry and the member dentists of the Virginia Dental Association and its team of lobbying professionals.

The same expertise was also brought to bear in the 2006 session as the VDA, Dean Hunt and Dr. Jim Revere of the dental school worked successfully to secure funds to expand the dental school by almost 54,000 square feet. The results of these political efforts: More dentists, more hygienists, more designated laboratory space and expanded research capabilities.

In each of these instances, for all of these bills, practicing dentists and dental students joined with the Virginia Dental Association to connect the dots of practical politics and pass legislation for the betterment of the dental profession.

I want to close by encouraging each of you to join your colleagues and associate yourself with the political action efforts of the Virginia Dental Association.

You never know when that non-dentist might be voting on your livelihood ...

'*Leadership Tomorrow*' University

Is Looking For YOU!

In preparing our association for the future, we are seeking members who might be interested in leadership positions for the future and who would like to take part in discussions of how best to prepare this association for the uncertainty that we surely face.

You may not have considered getting involved in the association in the past but perhaps today you feel like you have something to offer the profession which has given so much in return to you. If so, we are interested in talking to you about attending this 3rd annual leadership training/ mentorship program that will take place in the Richmond area April 13th (1/2 day) and 14th, 2007. This will be a day filled with communication, community and learning – all about what it takes to be a leader for the profession, for your community, for your practice.

If you envision yourself as one of the leaders of tomorrow or would like more information, please contact Dr. Terry Dickinson (VDA Executive Director) at 804-261-1610 or dickinson@vadental.org

DENTAL DIRECT

Make a New Year's Resolution to Improve Cash Flow and Reduce Receivables in Your Office

By understanding and promoting Dental Direct Reimbursement and Assignment to your patients and office staff, you can have a direct effect on your bottom line. Dental Direct Reimbursement and Assignment plans are dental benefits, NOT dental insurance. The concept is based on fee-for-service dental benefits with no networks to join, no fee schedules to adhere to and no complicated claim forms and pre-authorizations.

Started in the mid 1970s by an orthodontist who was looking for an alternative to traditional third party payers, Dental Direct Reimbursement was embraced by the ADA and the VDA in 1996 as the recommended dental benefit of organized dentistry. Dental Direct maintains the dentist-patient relationship and provides a quality dental benefit that allows patients to visit the dentist of their choice and receive the treatments deemed necessary by their dental professional.

A patient with Dental Direct Reimbursement will visit any dentist of their choice and simply pay for their treatment at the time of service. They are charged your office's fees for these services, there is no fee schedule. The patient will submit proof of payment for reimbursement to their employer or plan administrator. Claim forms, pre-authorization, aged receivables and collection hassles are eliminated.

With Dental Direct Assignment, patients visit the dentist of their choice, and following the treatment, the dental office submits a simple claim form to the plan administrator. Offices are reimbursed promptly for their services, often within one week in Virginia!

One easy way to help improve your practice and to reduce administrative hassles in your office is to educate and promote Dental Direct. By educating and promoting Dental Direct Reimbursement and Assignment to your patients and staff you can help increase the number of Dental Direct patients you see. If any of your patients are interested in learning more about Dental Direct, simply call Elise at the VDA at 800-552-3886 and the VDA will send information and contact them about Dental Direct. Please remember that Dental Direct is only for groups, not individuals.

For more information on Dental Direct, please visit www.vadental.org or call the VDA today. By taking these simple steps, you can make a commitment to improve your practice in 2007!

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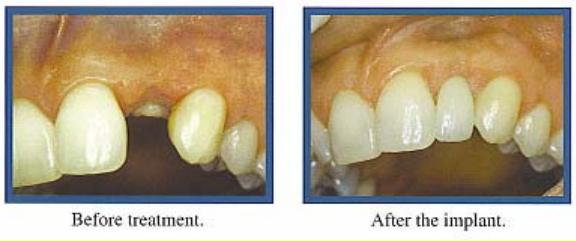

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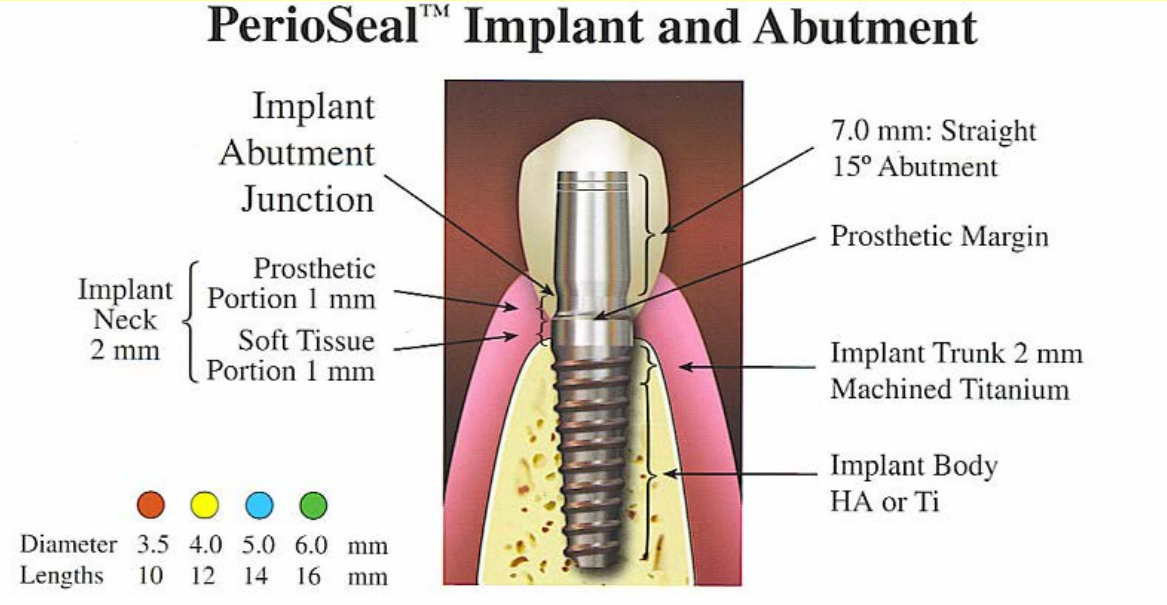

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News

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BarrierMed is a leading supplier of high-quality, non-latex gloves that provide protection and comfort for dentists and dental team members. With a growing number of patients with allergies to latex, BarrierMed's products can provide superior protection without latex. VDA Members are able to get great discounts on a number of gloves available from BarrierMed. **Please call BarrierMed at 407-771-4424 to place an order today!**

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Coming Soon:

On-line Continuing Education

A new, on-line CE library that will be available soon on **www.vadental.org**. The CE library will provide access to hundreds of online CE hours to members of the VDA. The platform will be easy to use and will be a great way to stay up to date on the latest in continuing education. Courses will be offered on a number of topics and will be available for a small fee. Course work will be available for up to one year and you can print completion certificates right from your computer for easy record keeping of your annual CE credits. More information will be posted soon on **www.vadental.org**!

2006 VADPAC FUNDRAISERS

Virginia Delegate Phil Hamilton and Senator Edd Houck

By: Morgan Bailey

VDA Lobbyist, Chuck Duvall, and Executive Director, Dr. Terry Dickinson, thank Delegate Phil Hamilton for his support of VDA issues.

Dr. McKinley Price hosted the fundraiser for Del. Hamilton.

Del. Hamilton speaks to the crowded room VDA working with the legislative process.

This fall, the VDA hosted two fundraisers for a pair of legislators who have helped the profession of dentistry and our patients tremendously at the Virginia General Assembly. Delegate Phil Hamilton who represents Newport News and James City County was feted at a well-attended event in his district. The event was hosted by Dr. McKinley Price, and drew dentists from Delegate Hamilton's district and others who live in Tidewater and Richmond area coming to express their gratitude for Del. Hamilton support of VDA issues.

Dr. and Mrs. John Rose from Fredericksburg opened their beautiful home for another successful event for Senator Edd Houck who represents Spotsylvania County, parts of Fredericksburg and several other surrounding counties. Dentists from Richmond through Northern Virginia attended the fundraiser to show their support of Senator Houck.

Both candidates gave an informative and entertaining update on the politics of Virginia and what might be expected in the 2007 General Assembly.

Dr. John Rose hosted the fundraiser for Senator Edd Houck at his home in Fredericksburg.

From left to right: Karen Rose, Dr. John Rose, Dana Houck, Sen. Edd Houck, VDA President Dr. Anne Adams, and Dr. Charlie Cuttino.

Everyone smiled for the camera as the fundraiser wound down for the evening.

VCU's Dr. Jim Revere attended the fundraiser to thank Sen. Houck for supporting the VCU School of Dentistry expansion.

2006 REPORT OF THE VIRGINIA DELEGATION TO THE ADA

Reported By: Dr. M. Joan Gillespie

The 2006 Virginia Delegation Members are, Delegates, Anne Adams, David Anderson, Richard Barnes (Vice-Chair), Charles Cuttino, M. Joan Gillespie (Chair), Bruse Hutchison, Rod Klima, Gus Vlahos, Les Webb, Edward Wiesburg, and Alternate Delegates, Alonzo Bell, Mark Crabtree, Ralph Howell, Ronald Hunt, Kirk Norbo, McKinley Price, Elizabeth Reynolds, Ted Sherwin, Neil Small and Roger Wood.

The Delegation met during the VDA Committee Meeting in January in Richmond and in June in Virginia Beach. The Delegation proposed several resolutions including one proposing dental insurance benefits for certain medical conditions and one regarding funding for direct reimbursement.

In September, the Virginia Delegation joined the North Carolina and South Carolina Delegations (the 16th District) in Myrtle Beach to discuss all of the resolutions to be presented at the ADA Annual Session. The officers of the 16th District represent the 3 states, Dr. Ed Parker, South Carolina (Chair), Dr. Bettie McKaig, North Carolina (Vice-Chair) and Dr. M Joan Gillespie, Virginia (Secretary Treasurer).

In October Drs. Tankersley, Crabtree, Vlahos and Gillespie accompanied by Dr. Dickinson attended the Southern Leadership Conference in Atlanta. Representatives from Alabama, Florida, Georgia, Mississippi, North Carolina, South Carolina and Virginia, discussed the ADA resolutions relative to individual state concerns.

The 16th District Delegation attended the House of Delegates at the ADA Annual Session which was held in Las Vegas in October 2006. The House of Delegates passed 2 resolutions that call for an expanded dental workforce team. There is still much work to be done, but basically the resolutions created two new dental team members and offer a guide that individual states can use to expand duties for allied dental personnel.

Members of the Delegation attended the Commission of Dental Accreditation open hearing and the District Delegates participated in the ADA's Mega Issues Discussion.

The entire VDA Delegation would like to thank Dr. Les Webb for his dedication and many contributions during all of the years that he has served on the Delegation.

The Virginia Delegation will be meeting in January 2007 at the VDA Committee Meetings in Richmond.

Legislative Update

By: Dr. Scott Berman

The VDA had a successful year in 2006. During the legislative session we secured funding, $11.7 million, for the VCU School of Dentistry to begin planning for physical expansion to include a new building. This will allow expansion of the dental and dental hygiene classes; as well as, additional laboratory research space. A four-story 53,600 square foot facility is planned. The expanded classes will not only augment the dental workforce to increase access to dental care in the Commonwealth, but would afford additional research into oral cancer and dental biomaterials.

We also introduced our own version of a dental hygiene/local anesthesia bill that was written with the exact wording passed by the VDA House of Delegates. This will allow hygienists to administer local anesthesia under the direction and supervision of a dentist.

Assignment of benefits, allowing dentists and oral surgeons to have their patients assign their benefits to the dentist and allow for balance billing, was not adversely affected this session, but was at risk. The VDA monitors all legislation that might impact the relationship between dentists and their patients. This session there was legislation put forward by emergency room physicians to allow them to do the same thing. Heavy lobbying by the insurance companies and ER physicians surrounded these bills. We emphasized to legislators that whatever happened with these new bills, we wanted to make sure dentists were not affected. Fortunately, all measures were defeated or carried over to the next session.

Medicaid for dentistry has undergone several positive changes in the last few legislative sessions. Funding has been increased tens of millions of dollars, phone call responsiveness has been significantly improved through separate funding for a call center, and the dental program is now separate from the managed care medical Medicaid program and is an autonomous fee-for-service entity.

Our success in the legislature is due to several factors. Our efforts through direct contact with legislators, especially our Grassroots Day on the Hill in January, is one reason. The effective efforts put forth by our excellent lobbyist Chuck Duvall is another. And the success of our own PAC is another.

VADPAC, our state political action committee, has been recognized as the leading contributor among business and industry groups in the 2005 election cycle. Unlike 2005, where only the state House of Delegates was having an election, in 2007 the state Senate will be also. That's 140 House and 40 Senate races. To continue to have that kind of clout in the future, our PAC will need to be well funded. It is that clout, created by contributions, that makes legislators receptive to our lobbyist and individual dentists.

For 2006, VADPAC contributions did not quite reach our goal of $285,000. We will need strong support in 2007 to catch up. Our PAC is really an insurance policy to make sure we can practice the way we see best without onerous government regulation, and to insure that we can give our patients the very best treatment. If you have concerns about licensure, dental education funding, access to care, the threat of alternative dental providers, HIPAA, OSHA or assignment of benefits, this is the best way to protect those concerns. Please consider all this when you make your annual VADPAC contribution. Your support is greatly needed and very much appreciated.

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Oral Health Needs of Virginia Schoolchildren by HMO Region

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Abstract

Purpose: This study examined differences in oral health status and dental treatment needs by HMO regions in Virginia.

Methods: The Division of Dental Health (DDH), Virginia Department of Health (VDH), completed the 1999 Virginia Oral Health Needs Assessment (VSOHNA) with the cooperation of the Virginia Department of Education. The survey used a probability proportional to size (PPS) sample design in selecting school children from public schools in the Commonwealth of Virginia. Surface (DMFS/dfs) and tooth-level (DMFT/dft) data were collected as indicators of dental disease on all children. Child-level data was also recorded for each student consisting of age, race, gender, enrollment in a free and reduced lunch program, medical insurance status, dental insurance status, and history of dental visits. A descriptive and regression analysis was completed to examine the relationship between HMO regions and oral health status indicators.

Results: The survey included more than 5,000 children in 200 schools and 52 school districts. The mean DMFT/dft levels were 1.47 (.33) and 1.7 (.03), respectively. The mean level of untreated decay (dt) for all schoolchildren was 0.66 (0.01). First graders had the highest levels of untreated disease at 0.71, while third graders had a mean of 0.66. The Central region of the state appeared to have the highest level of untreated decay.

Conclusion: There were no significant differences in the percentage of "caries-free" children between the HMO regions. Untreated dental disease of Virginia schoolchildren varied according to the region in which they lived.

INTRODUCTION

Over 22 million children of school age or younger are affected with tooth decay, making it the single most common disease of childhood that is either not self-correctable or amenable to a course of antibiotics (1). For an estimated 4-5 million children, tooth decay interferes with daily routine activities. It has been estimated that 51 million school hours per year are lost due to dental related illness (2). Despite the reduction in cases of caries recently, more than half of all children have caries by the second grade and about eighty percent have caries by the time they finish high school. Since the early 1970's, the cases of dental caries in permanent teeth have declined tremendously among school-aged children. This decline is the result of various preventive regimens such as community water fluoridation and increased use of fluoridated toothpastes and rinses.

However, the proportion of untreated dental caries of school-aged children has increased in the primary dentition among children aged 6 to 8 years old. 52% of children aged 6 to 8 years had dental caries experience in 1988-94 (3). The pain and infection of rampant dental disease can result in impaired speech development, failure to thrive, absences from and inability to concentrate in school, and reduced self-esteem (4, 5).

The assessment of oral health status for Virginia's schoolchildren is very important in planning public programs that deliver dental services to children in this state. The Division of Dental Health has had a major role in the collection, analysis and reporting of oral disease data in Virginia since the early 1950's. Long-term studies show that the oral health status of children in Virginia has improved due to preventive measures such as fluoridation. However, the percentage of children with unmet dental needs has not significantly improved. Additionally, studies continue to show that decay is disproportionately distributed with more than 80% of the decay in only 20% of the child population (6). The Division of Dental Health supports the collection, analysis and reporting of oral disease data through: collection and analysis of the oral disease status of school children through statewide and community surveys, collection and analysis of adult oral disease status

through the Center's for Disease Control and Prevention Behavioral Risk Factor Surveillance System, assisting in the determination of Dental Health Professions Shortage Areas, and evaluation of population-based programs, such as the school fluoride mouth rinse program (7).

A needs assessment process seeks to identify the following: (1) the extent and types of existing and potential problems in a community (2) the current system of services available (3) the extent of unmet needs, underutilized resources or short coming of the service delivery system. It is the initial step in the development of a comprehensive oral health program. The assessment process is used to identify target populations at greatest risk for oral disease and which face geographic and cultural barriers to accessing oral health care. Determining oral health status is a necessary step in improving comprehensive, community-specific oral health programs for populations (8).

The purpose of this study was to examine differences in the oral health status of Virginia schoolchildren by Health Maintenance Organization (HMO) region as defined by the Virginia Department of Medical Assistance Services.

METHODS

The Division of Dental Health (DDH), in the Virginia Department of Health (VDH), completed the 1999 Virginia Oral Health Needs Assessment (VSOHNA) with the cooperation of the Virginia Department of Education. The aim of this study was to provide a descriptive account of the oral health status for Virginia schoolchildren. Secondly, a cross-sectional study design was used to examine the relationship between dental caries levels and unmet dental needs of schoolchildren in different geographic regions of the state of Virginia.

Sample and Data Collection

This study was a secondary data analysis utilizing a pre-existing data set to examine dental caries, fluorosis, and oral hygiene in Virginia's schoolchildren. The dental disease data came from the 1999 Virginia Statewide Oral Health Needs Assessment. The sampling strategy used for the oral health survey of Virginia schoolchildren was a multistage cluster sample with both systematic and random sampling. Informed consent and questionnaire data was obtained from parents with participating children. Figure 1 represents the existing HMO regions in Virginia.

This data set contains no unique or individual identifiers. An oral health examination of n=5360 school children in Grades 1, 3, and 10 was conducted. The survey included more than 5,000 children in 200 schools and 52 school districts. Each child received an oral health examination by a dentist using explorers and mirrors and no radiographs were taken. Surface (DMFS/dfs) and tooth-level (DMFT/dft) data were collected as indicators of dental disease on all children. Decayed, Missing and Filled teeth/surfaces were documented for the permanent dentition, while only decayed and filled teeth were documented for the primary dentition. This difference in documentation was due to the inability to distinguish between exfoliating primary teeth versus those extracted due to decay. Examiners were trained and calibrated. Child-level data was also recorded for each student consisting of age, race, gender, enrollment in a free and reduced lunch program, medical insurance status, dental insurance status, and history of dental visits.

Statistical Analysis

A descriptive analysis was used to measure the prevalence of aspects of dental disease in Virginia in comparison to national statistics. A descriptive and a regression analysis were completed to examine the relationship between HMO regions and oral health status indicators. In the regression analysis, the dependent variables were the prevalence of caries (DMFT/dft) and dental needs (DT/dt). The independent variable was the HMO region. The Central region was assigned to be the referent category for comparisons.

RESULTS

Primary Dentition

41% (se=1.50) of all schoolchildren were caries-free in their primary dentition. 56% (se=1.84) of all first graders were caries-free, and 39% (se=0.96) of all third graders were caries-free. The mean levels of decayed filled teeth (dft) for all schoolchildren were 1.70 (se=0.03). Third graders had the highest levels of dft at 1.71 when compared to the first graders who had a mean of 1.56. The mean level of filled teeth (ft) in the primary dentition was 1.04 (se=0.04). Third graders had the highest levels of filled teeth at 1.06 (se=0.02), while first graders had a mean of 0.85 (se=0.07). The mean level of untreated decay (dt) for all schoolchildren in the primary dentition was 0.66 (se=0.01). First graders had the highest levels of untreated disease at 0.71 (se=0.08), while third graders had a mean of 0.66 (se=0.01).

Permanent Dentition

53% (se=8.14) of all schoolchildren in the permanent dentition were caries-free. 46% (se=5.70) of all tenth graders were caries-

free, while 91% (se=1.81) and 88% (se=2.38) of all third graders and first graders were caries-free, respectively. Tenth graders had the highest level of DMFT with a mean of 1.73 (se=0.27). The mean level of missing teeth (MT) for all schoolchildren was 0.06 (se=0.02). The mean level of untreated decay (DT) for all schoolchildren in the permanent dentition was 0.47 (se=0.28). Tenth graders had the highest levels of untreated disease at 0.56 (se=0.30), while third graders had the least with a mean of 0.03 (se=0.03).

HMO Regions

41% (se=1.50) of all schoolchildren in the primary dentition were caries-free for all HMO regions. 56% (se=1.84) of all first graders were caries-free and 39% (se=0.96) of all third graders were caries-free. For all HMO regions the mean level of decayed filled teeth (dft) was 1.70 (se=0.03). The Southwest region of the state had the highest level of decayed filled teeth with a mean of 1.99 (se=0.13). Third graders in the Southwest region had the highest level of dft with a mean of 2.20 (se=0.29). The mean level of filled teeth for all schoolchildren in the primary dentition was 1.04 (se=0.04). Third graders in the Southwest region had the highest level of filled teeth with a mean of 1.65 (se=0.41). NOVA had the lowest level of filled teeth with a mean of 0.73 (se=0.03). The mean level of untreated decay (dt) for all HMO regions was 0.66 (se=0.01). The Central region of the state appeared to have the highest level of untreated decay in the primary dentition with a mean of 0.72 (se=0.18).

53% (se=8.14) of all schoolchildren in the permanent dentition were caries-free for all HMO regions. The mean level of untreated decay (DT) for all HMO regions was 0.47 (se=0.28). NOVA appeared to have the highest level of untreated decay with a mean of 1.45 (se=0.11). The Central region appeared to have the lowest level of untreated decay at 0.03 (se=0.01).

Differences in Dental Caries Outcomes by HMO Region

A regression analysis was completed to make statistical comparisons between the HMO regions and dental caries outcomes. In the primary dentition, there were significant differences between regions with the Southwestern region having significantly more decay, missing, and filled (dft) teeth (p=0.0323) than the other HMO regions. There were no differences between regions for untreated dental decay in the primary dentition.

In the permanent dentition the NOVA region (p=0.0000) has significantly more Decayed, Missing, and Filled teeth, while the Roanoke region (p=0.0442) has significantly less Decayed, Missing, and Filled teeth than the other HMO regions. In terms of untreated dental disease, the NOVA region (p=0.0000) has the highest levels of Decayed teeth, followed by the Southwestern region (p=0.0020), and then the Roanoke region (p=0.0004). The Blue Ridge, Central, and Hampton Roads regions did not significantly differ from one another.

DISCUSSION

This study examined differences in the oral health status of Virginia schoolchildren by HMO region as defined by the Virginia Department of Medical Assistance Services. According to the Virginia Statewide Oral Health Needs Assessment (VSOHNA), Virginia schoolchildren experienced similar levels of dental caries as schoolchildren nationwide.

In the VSOHNA results, 53% (se=8.14) of all schoolchildren in the permanent dentition were caries-free. 46% (se=5.70) of all tenth graders were caries-free, while 91% (se=1.81) of all third graders were caries-free. The mean level of Decayed, Missing, Filled Teeth (DMFT) for all schoolchildren in the permanent dentition was 1.47 (se=0.33). Overall, there was no difference between males and females. Tenth graders had the highest level of DMFT.

According to Healthy People 2010, 52% of children aged 6 to 8 years had dental caries experience in 1988-94. In this Virginia Statewide Oral Health Needs Assessment (VSOHNA), 41% (se=1.50) of all school children in the primary dentition were caries-free. 56% (se=1.84) of all first graders were caries-free, and 39% (se=0.96) of all third graders were caries-free. Third graders had the highest dft. The differences in levels of caries-free teeth between the primary and permanent dentitions could be the result of several mechanisms; the longer duration of the primary teeth in the mouth, the child's increasing dental IQ with age, and increasing parental oral health education.

Dental Disease and HMO Regions

The VSOHNA study found that the Southwestern region had significantly more decayed and filled (dft) teeth (p=0.0323) than the other HMO regions in the primary dentition. There were no differences between regions for untreated dental decay in the primary dentition.

However, in the permanent dentition there were significant differences between regions for both caries experience and untreated decay. The following differences were noted: NOVA (p=0.0000) had significantly more Decayed, Missing, and Filled teeth, while the Roanoke region (p=0.0442) had significantly less Decayed, Missing, and Filled teeth than the other HMO regions. In contrast to the primary dentition in terms of untreated dental disease, significant differences were observed between HMO regions.

Specifically, NOVA region (p=0.0000) had the highest levels of Decayed teeth, followed by the Southwestern region (p=0.0020), and the Roanoke region (p=0.0004). The Blue Ridge, Central, and Hampton Roads regions did not significantly differ from one another.

The differences noted between the results from the primary and the permanent dentition could be attributed to preventive regimens such as water fluoridation, which varies among the different geographic regions of the state, could contribute to lower levels of tooth decay in the permanent dentition. Also, access to providers who care for younger children may be lacking uniformly amongst the different HMO regions. This could be a reason why there were no significant differences noted for untreated dental caries in the primary dentition.

Untreated Dental Disease and HMO Regions

The oral health assessment results helped us identify target populations within different geographic regions of the State. The Central region of the state appeared to have the highest level of untreated decay in the primary dentition. In the permanent dentition, NOVA appeared to have the highest level of untreated decay, while the Central region had the lowest level.

According to the VSOHNA, dental caries levels varied according to ethnicity and HMO region. Therefore, the populations, which are most at-risk for untreated decay, such as Asians in the primary dentition and Native Americans in the permanent dentition, can be targeted. Also, different geographic regions can be targeted which have higher levels of untreated decay. According to the survey data results, there were no differences between regions for untreated dental decay in the primary dentition. However, in the permanent dentition, NOVA (p=0.0000) had the highest levels of untreated decayed teeth.

The 1999 Virginia Statewide Oral Health Needs Assessment (VSOHNA) measured the burden and distribution of oral health disease. The oral health assessment process sought to identify the extent and types of existing and potential problems in a community or geographic regions, the current system of services available, and the extent of unmet needs, underutilized resources, or barriers to the service delivery system. Preventive programs to help reduce overall caries experience could be implemented in specific Virginia geographic regions. Examples of these programs consist of community water fluoridation, rural school water fluoridation, application of dental sealants, fluoride mouth rinse in elementary schools, and integration of educational activities for schoolchildren, teachers, and dentists. Treatment programs for untreated decay could also be established, such as mobile vans at schools and treatment provided through local health departments or community health centers. This will help build comprehensive, community-specific oral health programs for the target populations, and aid in the education, prevention, and treatment programs that target children at greatest risk for oral diseases.

CONCLUSIONS

1) Dental Caries rates (dft/DMFT) of Virginia schoolchildren significantly differed according to HMO region.

2) In the permanent dentition, untreated dental disease significantly differed according to HMO region, while it did not differ in the primary dentition.

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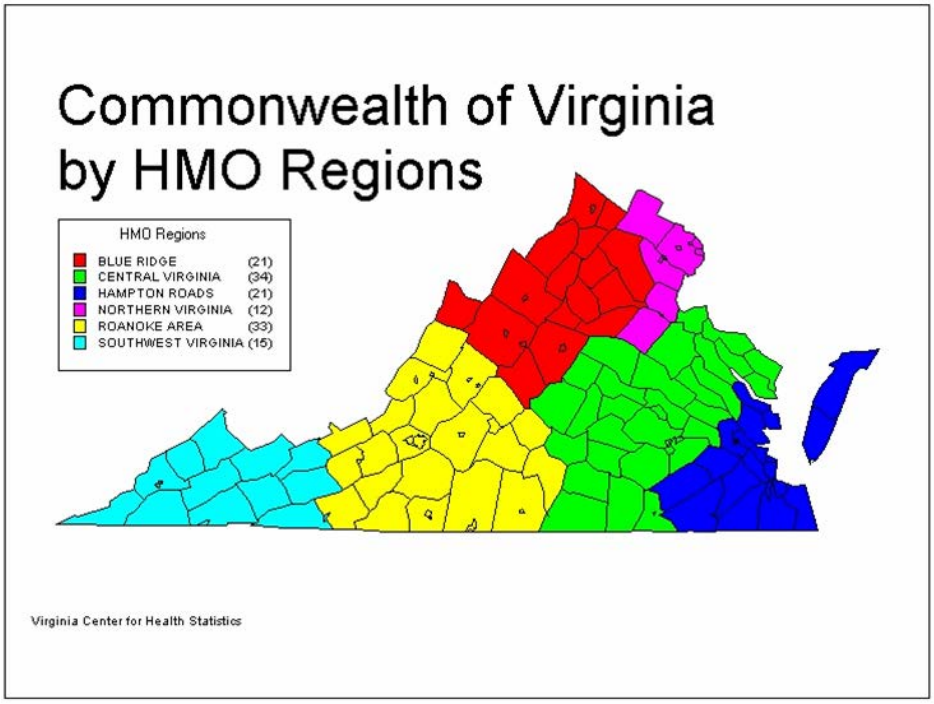


NEW OFFICERS FOR: Virginia Associations of Orthodontists - 2006

The Virginia Association of Orthodontists annual meeting was held at the Tides Inn Resort in Irvington. VAO is a non-profit organization of 269 orthodontists in Virginia. All officers are members of the Southern Association of Orthodontists, the American Association of Orthodontists, the American Dental Association, and the Virginia Dental Association.

New Officers are:

President, Dr. Anthony Savage of Virginia Beach
Dr. Savage received his dental degree from Virginia Commonwealth University
and his orthodontic education from the University of Louisville. He opened his orthodontic practice in Virginia Beach in 1984. He is in practice with Dr. Britt Visser and Dr. George Sabol. Dr. Savage is board certified by the American Board of Orthodontics.

President-Elect, Dr. Norm Prillaman of Lynchburg
Dr. Prillaman received his dental degree from the University of North Carolina and his orthodontic education from the Medical College of Virginia. His orthodontic practice is in Lynchburg.

Secretary-Treasurer, Dr. David Morris of Hayes
Dr. Morris received a D.D.S. from the Medical College of Virginia and his orthodontic education from Columbia University. He opened his orthodontic practice in Hayes in 1991. Dr. Morris has a satellite office in Gloucester.

Past-President, Dr. William E. Crutchfield, II of Chantilly
Dr. Crutchfield received both his dental and orthodontic education from the Medical College of Virginia. He opened his orthodontic practice in Chantilly in 1987. He is board certified by the American Board of Orthodontics.

Directors are: Dr. Richard Byrd of Richmond and Dr. Damon DeArment of Winchester.

Orthodontists are dental specialists who put braces on the teeth of adults and children to build esteem by making their faces look better and improve their dental health by helping them bite correctly.The Southern Association of Orthodontists is one of eight regional subgroups of the American Association of Orthodontists. Founded in 1921, the SAO includes the states of Alabama, Florida, Georgia, Kentucky, Louisiana east of the Mississippi, Mississippi, North Carolina, South Carolina, Tennessee, Virginia and West Virginia. The purpose of the non-profit organization is:

- To advance the art and science of Orthodontics,
- To encourage and sponsor research,
- To strive for optimal standards of excellence in Orthodontic education and practice, and
- To make significant contributions to the dental health of the public.

For further information, please contact Sharon Hunt at 404-261-5528.

Component NEWS

Component #1
Tidewater Dental Association

NO NEWS TO REPORT

Component #2
Peninsula Dental Society

Dr. Ben T. Steele, Associate Editor

Greetings from the Peninsula! The past few months have been a delightful time for Component Two. Our esteemed president Elizabeth Bernhard has gotten us off to a magnificent start. The CE gave members the opportunity to learn more about different topics such as Lava restorations and impressions troubleshooting, TMD/Orofacial Pain, and updates in OSHA. The earlier part of 2007 will bring more interesting topics to discuss. For example, Dr. Hugh McCormick will present "Dentistry and the Heart Patient". Equally important, Dr. John Svirsky will give us interesting information during our All Day CE course entitled, "Oral Pathology for the Joy of It: You are the Object of My Infection."

The Virginia Meeting in Roanoke was a major highlight for the Peninsula Dental Society. In the House of Delegates, Component Two had full representation. In addition, McKinley Price will serve another 3 years as the component's representative to the executive board, while Mike Link was elected ADA alternate delegate. Lastly, one of our esteemed colleagues, Richard Barnes, was awarded the Emanuel Michaels Distinguished Dentist Award.

Members of the component participated in Peninsula Dental Days by providing free dental services to underserved populations in the community. This worthwhile event was hosted by the Peninsula Christian Clinic. The positive impact that the Peninsula Christian Clinic is having on the community is being highly recognized. In fact, there has been funding awarded to the center to hire a full-time dentist and dental assistant.

Being aware of and involved in the state legislative process is important to members. McKinley Price gave members an opportunity to meet and interact with one of our local legislators by hosting a social event for delegate Phil Hamilton. President Elizabeth Bernhard is currently encouraging us to meet at the Capital in January to interact with legislators about concerns and interests related to dentistry.

We hope everyone has a great Holiday season and a productive and prosperous year in 2007.

Component #3
Southside Dental Society

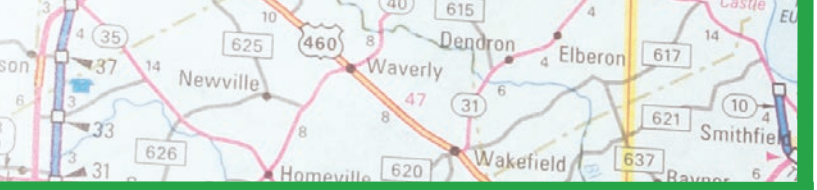
Dr. Mike Hanley, Associate Editor

Greetings from Southside,
If you had a great Fall, I hope you've recovered by now! Things are falling into place in our component. We had a very informative all day course on implants. And don't forget to check your calendar for our upcoming OSHA update and CPR certification sometime in February.
What a great VDA annual meeting in Roanoke! The accommodations, classes, weather, entertainment, food, golf, need I go on? Super job by Terry and the entire staff – Thanks. And yes, Elvis is still living in Las Vegas. I saw him eating what I assumed to be a very high dollar steak because, after all, he "loves meat tender". After my wife got done with the vendors in the ADA Marketplace, I had no more money to lose in the slots. It was a dizzying display of technology. And how can every product we use, can be made just a little bit better ever single year?
Our component was saddened to hear of the sudden death of Dr. Larry Hensley. He practiced in Southside, Virginia, for many years and served our component as President in the mid 80"s.
It is not too late to contact Sam Galston and join us in making GKAS Day on February 2, a big success. Dr. Farrington can screen and provide all the patients we need. It gets bigger and better every year, so consider joining us.
And, finally, Dr. David Ellis has found another way to lower his overhead. He has been using a lab in Russia to do his crowns……He needs to read the fine print: They are using Polonium, not Palladium, in their high noble metal crowns.
See you in February.

Component #4
Richmond Dental Society

Dr. Gregory A. Cole, Associate Editor

Component 4 has held several successful membership meetings this fall. In October, we had Dr. Bob Holsworth, director of the Center for Public Policy at Virginia Commonwealth University. He spoke about the local, state, and national political races and the November elections. At November's meeting, Dr. James Burns of the VCU School of Dentistry's Oral Pathology department spoke about forensic dentistry and techniques used to identify bodies based on dental records. On November 17th, an all day CE program sponsored by the VDA and VDSC was held in Richmond, featuring Dr. Martin Goldstein. We are looking forward to seeing members from other components at the 2007 VDA Committee Meetings here in Richmond. Best Wishes to all for a Happy New Year!



Component #5
Piedmont Dental Society

NO NEWS TO REPORT

Component #6
Southwest Virginia Dental Society

NO NEWS TO REPORT

Component #7
Shenandoah Valley Dental Association

By Rick Taliaferro, DDS, President-elect

Greetings from both sides of the Blue Ridge. On behalf of the SVDA, I hope you had a wonderful year in 2006, and are ready to enjoy a happy, healthy, and successful 2007.

Please mark your calendars for several continuing education meetings that we have scheduled. On **March 30, 2007**, our spring meeting will feature Anita Jupp of the Advanced Dental Education Institute. Her lecture, "A View from the Outside—What Patients Really Think About Your Office," is certain to be an entertaining day of learning for the entire dental team. We will once again meet at Blue Ridge Community College. Be on the lookout for registration information early in the New Year. Register early and receive a discount!

I have arranged two meetings during my tenure as president. On **October 12, 2007**, Dr. Richard Wynn, a pharmacologist from the University of Maryland, will give us a pharmacology update. Dr. Wynn writes a monthly column for the Academy of General Dentistry. He delivers his material in a very interesting and informative manner. His material is understandable and not overly technical. Hygienists would benefit from attending this meeting also. You will leave well informed.

On **March 28, 2008**, we will have Dr. Michael Miller of Reality Publishing as our speaker. *Reality* has been published since 1986 and has an excellent reputation with both academicians and wet-fingered dentists like us. His talk will focus on new materials and techniques for their use. If you are familiar with his publications, you will find this lecture very enlightening.

The officers for the 2006-2007 year are: Dr. Jay Knight, president; Dr. Rick Taliaferro, president-elect, Dr. Jared Kleine, vice-president; Dr. Harry Sartelle, secretary-treasurer; Dr. J. Darwin King, director; and Dr. Ron Downey, immediate past president. I know I speak for all of us when I encourage you to become a more active and involved member of our component this year. We value your input!

Component #8
Northern Virginia Dental Society

NO NEWS TO REPORT

All component submission are submitted on a volunteer basis by your secretary. To learn more about upcoming events in your component, please contact your component secretary.

CLASSIFIED ADVERTISEMENTS

GENERAL DENTIST VIRGINIA BEACH:

Immediate opportunity for a full-time associate with a potential buy-in option. Excellent opportunity for recent graduate or experienced dentist to join a two-office practice. Friendly, caring office with well-trained staff providing general and cosmetic dentistry. Competitive salary and benefits offered. Contact the office of David L. Jones, 2236 General Booth Blvd., Virginia Beach, VA 23456 at (757) 427-9300, fax (757) 427-0685.

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Work in the beautiful Shenandoah Valley and be close to Washington, D.C. amenities. Growing Free Clinics seek one or two caring dentists to deliver four days of care per week between two sites. A great opportunity for a new grad or semi-retired dentist who wants to avoid the expense and hassle of running a business and still earn a competitive salary.
Please email your resume to Vicki McClelland at vmcclelland@ntelos.net or P.O. Box 44, Winchester, VA 22604 or fax to (540) 662-5321. For more information, call Pam Murphy at (540)459-1700.

Wanted:

Hand instruments for dental missions especially margin trimmers, spoon excavators & surgical also battery-operated handpiece. Any donation appreciated! ddannerdds@aol.com

Herndon area-GP/Family practice seeks dental associate. Competitive salary, VA license reqd. Fax resume to the office of Dr. Liz Cristofano 703-793-1789.

Professional Services Associate Dentist

Senior dentist retiring from a two dentist, fee – for – service practice. No managed care. High quality dentistry, highly profitable. Seven operatories in a beautiful new facility. Associate position that can lead to partnership. Enjoy life in a medium sized city in the beautiful Blue Ridge Mountains. Contact Dr. Gary Roach, 5004 Brambleton Ave., Roanoke, VA 24018, 540-774-1019.

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to join our busy, multi-specialty practice with locations in Fredericksburg, Manassas and Stafford. We offer our patients complete dental care with dedicated General Dentists in each location and Specialists on staff in Orthodontics and Periodontics. This is an excellent opportunity for the right person to join our winning team. Generous benefits package available. Please fax resume to (540)710-7403 or e-mail to KristiBejarano@aol.com.

Associate/Partner Wanted Virginia Beach, VA – Fast-paced family practice; all phases of comprehensive care. Relocating to new practice - 10 ops/4,100 sq. ft. Biolase; Air abrasion; Intraoral & digital cameras; Clinical computers; Digital X-rays. Seek associate for eventual ownership. Visit www.transdent.com or call Mercer Transitions at 1-800-588-0098.

Temporary Dental Help Needed:

Busy LA Crosse, VA practice is looking for a general dentist to fill in until the practice is sold. Please call 1-434-757-7300 if interested.

For Sale:
Dental Practice, LA Crosse, VA

Busy well established thirty-five year practice. Large one story building 32'X66". Four operatories. Quiet small town/rural neighborhood. Progressively growing area adjacent to South Hill, VA. Intersedction of I95 and US 58. Twenty minutes from lake. 1-434-757-7300, FAX 1-434-757-4453.

Practices For Sale - Northern Virginia

Sterling- 4 ops. Shopping center, modern, digital. Grossing $350K. Also Burke- 3 ops, professional condo. Modern grossing $550K. Fee for service. Ashburn0 4 ops modern shopping center. Polcari Associates (800)544-1297

Williamsburg

Three operatory, turn-key dental office for sale. Ready to move in. Great opportunity for new practice or satellite. Please contact Stacie 757-221-0249.

Associate Dentist - Virginia Beach

Associate dentist position available in our family practice in Virginia Beach, Virginia. Percentage compensation with a partnership potenial. Contact us at (757)499-3522 and fax your resume to (757)497-1022.

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Classified advertiseing rates are **$40** for up to 30 words. Additional words are .25 each. The classified advertisement will be the **VDA Journal** and on the **VDA Website** - www.vadental.org. It will remain in the Journal for one issue and on the website for a quarter (3 months) unless renewed. All advertisements must be prepaid and cannot be accepted by phone. Faxed advertisements must include credit card information. Checks should be payable to the Virginia Dental Association. The closing date for all copy will be the 1st of December, March, June, and September. After the deadline closes, the Journal cannot cancel previously ordered ads. The deadline is firm. As a membership service, ads are restricted to VDA and ADA members unless employment or continuing education related. Advertising copy must be typewritten and sent to: Journal and Website Classified Department, Virginia Dental Association, 7525 Staples Mill Road, Richmond, VA 23228 or faxed to (804)261-1660 or emailed to jacobs@vadental.org.

The Virginia Dental Association reserves the right to edit copy or reject any classified ad and does not assume liability for the contents of classified advertiseing.

Conscious Sedation to General Anesthesia: A journey not an event.

Enteral Sedation, Conscious Sedation and General Anesthesia: Education for Everyone

The Virginia State Dental Board regulations changes took effect on June 29, 2006. The new **Regulations** made it officially legal to allow ancillary personnel with documented advanced training to assist in the administration and monitoring of office conscious or deep sedation and general anesthesia. They specifically stated in regulations: **Part IV Anesthesia, Sedation and Analgesia, 18 VAC 60-20-135 (Ancillary personnel)** that anesthesia courses for a certified anesthesia assistant (CAA), given by AAOMS and ADSA were acceptable. Also mentioned in section **60-20-190** under nondelegable duties, #7, are the changes involving anesthesia monitoring. The **Regulations** also refer to the 'anesthesia team' in **60-20-110e and 120f** for interesting supporting information about the treatment team. See www.dhp.virginia.gov/dentistry for more information.

There are 2 programs available: 8 hour certifying course for dental assistants, hygienists and ancillary personnel and a 4 hour **recertifying** course for dentists and office personnel (see **18 VAC 60-20-50** for the continuing education requirements by the Board). The venipuncture courses will primarily be hands on in an office setting. Practice of office emergencies related to IV placement will also be addressed.

The Virginia Dental Society of Anesthesiology, component of the parent organization ADSA, is going to have Dr Robert Campbell (formerly Professor of Anesthesiology in the Department of Anesthesiology at VCU/MCV and American Dental Association, Anesthesia Advisory Committee H member) to be the primary lecturer in the certifying programs listed below.

Certifying course Fee $150	8 hours	May 5, 2007	8 am- 4 pm Saturday
Recertifying course Fee $100	4 hours	May 5, 2007	8 am-12 pm Saturday

Location **The Place**: located west of downtown Richmond at Innsbrook
4036-C Cox Rd Glen Allen, VA 23060

Venipuncture courses Fee $50	2 hours	January 20, 2007 March 10, 2007	9 am-11 am Saturday 9 am-11 am Saturday

Location **Grove Park @ Va Dental & Anesthesia Associates** 11551 Suite A, Nuckols Rd.
Glen Allen, Va.23059

Send registration fee along with the date(s) and program type and name of the attendee(s) as you wish it to be printed on the certificate to: Virginia Dental Society of Anesthesiology
11551 Suite A Nuckols Rd. Glen Allen, Va 23059 or call and ask for Jenni Scarth, Secretary of the VDSA at 804-273-6818 for more information (space is limited for all courses)

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