Virginia Dental Journal

Volume 90, Number 3 • July, August & September 2013

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Virginia Dental Journal

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

Volume 90, Number 3 • July, August & September 2013

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MESSAGE FROM THE EDITOR

Dr. Richard F. Roadcap

Failure is a part of life, and a part of the dental profession. Dentistry suffered two widely-publicized setbacks recently with the defeat of a referendum in Portland, and a US Fourth Circuit Court of Appeals decision against the North Carolina Board of Dentistry. With 60% of the voters saying "No", Portland, Oregon maintained its status as the largest city in the US without fluoridated water. Three previous referenda, the first in 1956, yielded the same result, and the city council's attempt to begin fluoridation two years ago was met with a petition placing the question on the ballot. Although every major healthcare and civic organization supported adding fluoride to Portland's public water supply, and backers outspent opponents by 3 to 1, the measure went down to defeat in a landslide. Adopting the moniker "Clean Water Portland" the opposition called for "keeping chemicals out of our water", saying the science behind fluoridation was flawed. Opponents not only cited cost in the May 21 referendum, but also raised the issue of access-to-care, calling for "greater use of dental therapists at a fraction of the cost of dentists"[1]. The danger inherent in the outcome of this recent vote is not an increased DMFT in the Willamette Valley. Fluoride opponents, emboldened by the Portland results, will carry their crusade to other communities, hoping to gain the ear of sympathetic aldermen, or create hysteria among the electorate.

Ten days later, on May 31, the Richmond-based US Fourth Circuit Court of Appeals ruled in favor of the Federal Trade Commission in its battle with the North Carolina Board of Dentistry. The judges ruled that the Board could not claim an antitrust exemption as a state agency. The decision stated that the Board was not directly supervised by the State of North Carolina, and represented only the professional interests of dentists.[2] The Board had sent cease-and-desist letters to operators of teeth-whitening services offered by non-dentists, and the FTC ruled this was anticompetitive behavior. Judge Barbara M. Keenan noted that had North Carolina Board dentist members been appointed by elected state officials (Virginia's Board of Dentistry members are appointed by the Governor), the case against the Board would have been much weaker. It remains to be seen if this case has far-reaching implications, or is specific only to the North Carolina Board's actions. We've all seen in recent years teeth-whitening kiosks at the mall, or in warehouse clubs. About two years ago, a dental chair materialized at the barbershop I frequent, only to disappear a few months later, a victim of either the economy, or common sense. No, I did not advise the owner he was practicing dentistry without a license.

Closer to home, this issue of the *Journal* carries the annual installment of Periodontal Abstracts. Careful readers will note that the writers have a subject in common: why implants fail. The researchers in each case sought to shed light on why bad things happen to good implants, under the heading Peri-implantitis. The seven residents in periodontics at Virginia Commonwealth University have, with great precision, distilled the findings of the research articles so that practicing dentists, like me, will comprehend why their carefully-restored implant-supported crown may be lost. If the thought of your patients' implants failing keeps you awake at night, by all means don't read these abstracts. But if you'd like to know more about this fascinating subject, read on. Special thanks go to Dr. Thomas Waldrop, Director of Graduate Periodontics at VCU, and Dr. Stephanie Voth, a resident in Periodontics, for their help in constructing this series of abstracts.

Finally, the previous issue of the *Journal* offered readers the chance to "opt out" of print copies and receive our publication online only. Despite a full page advertisement touting the benefits of less paper, with a clever graphic of an overstuffed mailbox, we convinced virtually no one to forgo print.

We'll repeat the offer in this issue, but the response tells me 1) our readers may be more technophobic than we estimated and 2) print publications will be with us for some time to come. Digital media may serve only to complement print, but not supplant it.

A flurry of failures has descended upon us: organized dentistry, with the backing of many other healthcare and civic organizations failed to convince Portland voters to adopt fluoridation; the North Carolina Board failed to convince US Circuit Court of the merits of its case (imagine, the Board requiring dental procedures be performed by dentists); implants sometime fail, for a multitude of reasons; and the *Journal* failed to convince more than a handful of readers to forgo a print copy in favor of a digital version using the same software as hundreds of other publications. But if, as Thoreau said, we "find compensation in every disappointment", our failures will yield rewards if we persist.

1 http://www.cleanwaterportland.org/12_reasons_to_vote_no

2 http://www.lexology.com/library/detail.aspx?g=88109592-46dc-4c47-b0ea-95528f6c0c31

Save the Date
Friday, August 16, 2013

CE on Practice Transitions
followed by the
VDA Career Fair

The VDA New Dentist Committee will be holding a career fair on August 16, 2013, at 5:30 p.m. at the Berkeley Hotel in Richmond. This event will benefit dentists who are looking to sell their practices and/or bring in associates or partners, as well as those dentists that are seeking to purchase a practice or become an associate or partner.

Also, we will have Jim Boltz, give a presentation on "Practice Transitions" before the Career Fair. This will take place at the Berkeley Hotel in Richmond, from 2:00 -5:00 p.m.

More Information:

CE Program: http://www.vadental.org/pro/events/1061

Career Fair: http://www.vadental.org/pro/events/976

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HIL2SW&LTMDET*

By: Kerry K. Carney, DDS

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I used to think I was fluent in English. But every day I feel more and more like I may be a member of an "endangered linguistic group."

It is not modern spoken slang nor the abbreviated transcription of texting that defeats me. Those are puzzles that lend insight into the generation and technology that produced them. It is English as used by institutions that taxes me.

The realization of my tenuous hold on English comprehension came while trying to research information for this editorial. The topic was simple enough. I have been hearing hints and rumors of the "Medical Device Excise Tax" (MDET). Created by the Affordable Care Act (federal health care reform) in 2010, the MDET went into effect on Jan. 1, 2013. What could make a better topic than a 2.3 percent national tax that has the potential to affect every dental practice?

In order to become as informed as possible on the MDET, I turned to the FDA and IRS websites. As it turned out, that was not the best place to begin a journey of understanding.

When one initially hears the term "medical device," one might assume that could only mean fixed and removable prosthodontics. One would be wrong. A surprisingly long list of "medical devices" on the FDA site included, but was not limited to, the following:

- dental X-ray position indicating device
- X-ray film holder
- dental amalgam
- dental amalgamator
- dental amalgam capsule
- resin bonding agent
- articulation paper
- dental handpiece and accessories
- pit and fissure sealant and conditioner and (lest one forget)
- ethylene oxide homopolymer and/or carboxymethylcellulose sodium denture adhesive.[1]

The list included just about everything one could imagine in a dental office. According to the ADA Excise Tax Alert, though the FDA list may include as many as 180,000 taxable medical devices, based on IRS definitions, the total number of devices specific to dentistry is approximately 130.[2]

A catalog of 130 devices begins to sound a little daunting. This tax may impact every kind of dental practice from pediatric dental specialists to oral and maxillofacial surgeons and every general dentist in between.

Most of the narratives on the topic of the tax are quick to quote a reassuring sentence from the IRS: "The medical device excise tax applies to manufacturers and importers and generally does not apply to individual consumers."[3] This probably means that the tax will be incurred by another party (like dental supply houses or dental laboratories). That probably means that the tax will be passed on to the dentist as an additional cost to supplies, equipment and lab fees.

Alarmists might conclude this will result in an across-the-board increase in equipment and supply costs of 2.3 percent to the dentist. However, things are seldom as simple and clear-cut as we assume, infer or prefer. As is the case with many aspects of the ACA, the details of the MDET and its impact on dentists have yet to be finalized.

The regulations allow for some relief in the form of a "retail exemption." Though the IRS list included dental floss, items that could be purchased over the counter by a consumer might be part of the retail exemption. These items would not be subject to the tax and should not carry a tax-related cost increase to the dentist.

It seems many items may be excluded but it is hard to say exactly which items those might be. The IRS clearly states, "the new tax does not apply to sales of eyeglasses, contact lenses, and hearing aids," these are items that require a prescription rather than simple over-the-counter purchase, but they are carved out. Trying to figure out exactly what will be taxed and what will be exempt is a challenge.

As elucidated on the IRS website:

The new tax also does not apply to the sale of any other devices that are of a type generally purchased by the general public at retail for individual use … In general, the final regulations provide a facts-and-circumstances approach to evaluating whether a type of device qualifies for the retail exemption. Specifically the final regulations suggest factors to consider in evaluating whether a particular type of device qualifies for the retail exemption. The factors enumerated in the final regulations are non-exclusive; additional factors may be relevant to determining whether a given type of device qualifies for the retail exemption.

The final regulations also identify several categories of medical devices that qualify for the retail exemption (the retail exemption safe harbor). The retail exemption safe harbor includes devices in the FDA's online in vitro diagnostics (IVD) Home Use Lab Tests (Over-the-Counter Tests) database, devices that the FDA describes as "OTC" or "over the counter" in certain official FDA classification or product code heading or descriptors, and a number of devices that qualify as durable medical equipment, prosthetics, orthotics or supplies for which payment is available on a purchase basis under the Medicare Part B payment rules."[3]

It was about this time that I realized: though the words in the previous paragraph looked like English, I did not understand them.

The IRS speak, with its run-on sentences, was confounding enough but next I began to lose my grasp on simple nouns. The meaning of the word "device" was beginning to escape me. As the ADA Excise Tax Alert warns, "device" is used as a term-of-art since many "devices" would be more commonly described as "products," "materials" or "substances." The short translation here is: "Device" is legal jargon not tied to common usage. (I was actually hoping that term-of-art had something to do with portraits by the Dutch Masters.)

Dental supply houses and dental laboratories probably perceive the same tax/cost quagmire as dentists. A reasonable business practice would be to recover their increased cost of doing business by passing it on to dentists. The ADA Alert advises dentists to review "… manufacturer and vendor price lists and invoices to make sure that the 2.3 percent tax is not being applied as a general cost increase with respect to all items, but is only being applied in cases where the law so requires."[2]

That is sound advice but not much comfort for anyone who has tried unsuccessfully to have the "fuel surcharge" removed from invoiced products when the price of gasoline drops.

This cursory look at the MDET leaves me feeling pessimistic about my competence with my mother tongue. However, I have become a Leibnizian optimist when it comes to the MDET. Surely, third-party payers will allow me to pass my increased cost on to them … oh wait, what is this bag I am left holding?

Editor's note: CDA and ADA will continue to provide members with information on the medical device excise tax as it becomes available in the CDA Update and at cda.org.

* How I Learned to Stop Worrying and Love the Medical Device Excise Tax

REFERENCES

1. CFR - Code of Federal Regulations Title, www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfcfr/CFRSearch.cfm?cfrpart=872.
2. Excise Tax Alert, www.ada.org/8053.aspx.
3. Medical Device Excise Tax, www.irs.gov/uac/Newsroom/Medical-Device-Excise-Tax.

Dr. Carney is the Editor-In-Chief of the Journal of the California Dental Association.

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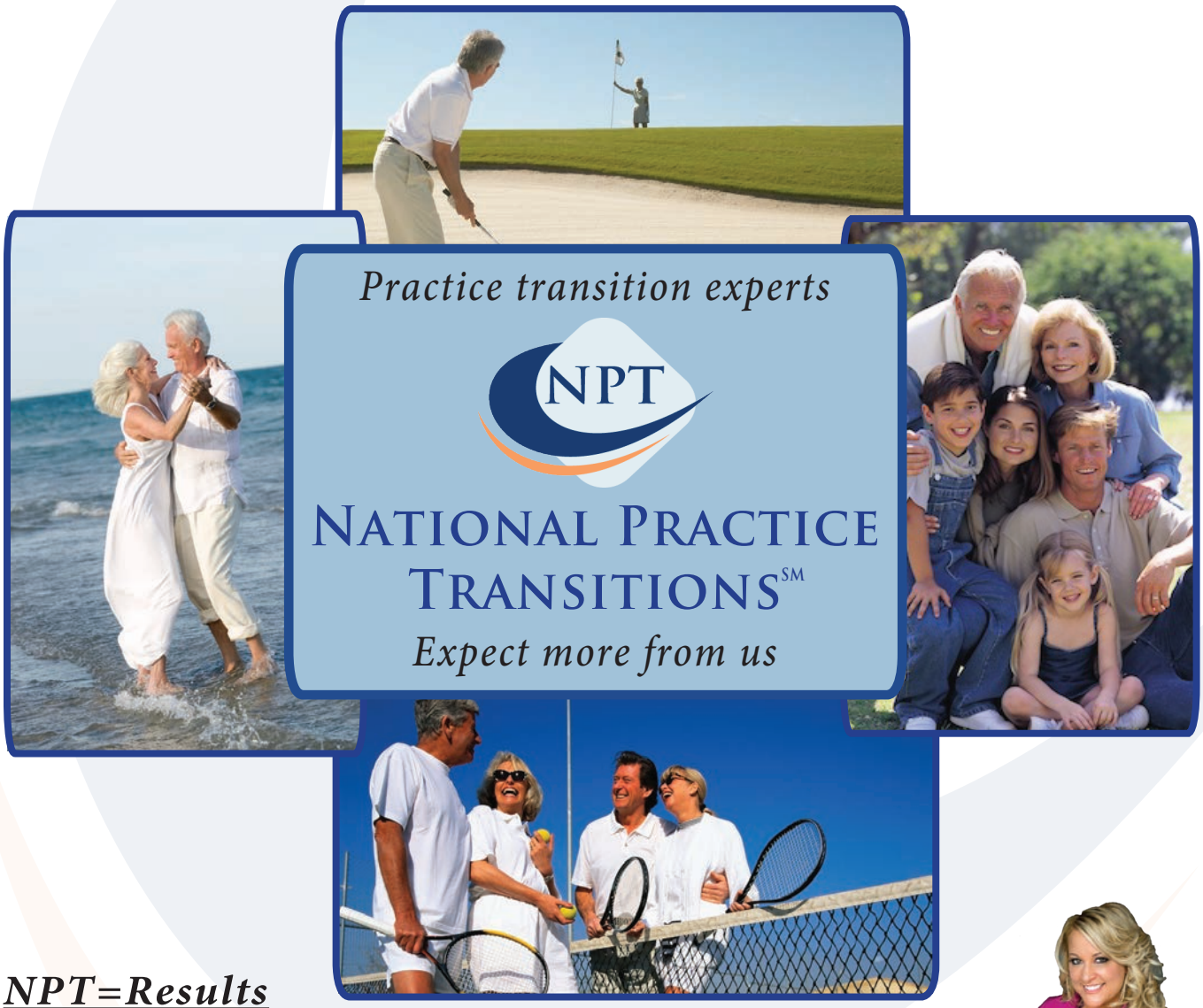

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MESSAGE FROM THE PRESIDENT

Dr. Kirk Norbo

Your association continues to move forward with programs structured to boost membership value. These ventures will be evaluated on a regular basis to ensure that they are meeting your needs.

Most of you are aware that the VDA advertising campaign is off and running. I would like to thank Dr. Mike Link and the PR task force for working so diligently to make this program a reality. The decision was made to send each of you 500 brochures to help market the campaign. Some members have asked how these materials should be utilized. I would suggest that in addition to making the brochures available to your patients, you might consider passing them out at various community meetings or events, hospital emergency rooms, urgent care facilities, your local chamber of commerce, banks or any other establishments that you may frequent. The largest percentage of the advertising budget will be used to fund TV commercials. The commercials began on May 13th in all media markets around the state. The advertisements are appearing on both broadcast and cable stations for several weeks and then will take a break during the summer months before going back on the air in September. Hopefully, you have seen them and are happy with the message we are spreading on your behalf. The public relations aspect of the campaign is ongoing and has included a press release about the campaign that was picked up by a number of media outlets. Requests for on-air interviews are also coming in from local stations that will give us more opportunities to spread the word about the connection between oral health and overall health. If our website activity is any reflection of the potential impact of the PR campaign we should be very optimistic. In the month of April before the program was launched, we had 202 hits on our website Find-A-Dentist tool. From May 13 – 31, less than 3 weeks into our advertising campaign, we had 2,893 hits on the Find-A-Dentist page on vadental.org. This dedicated effort to tell our story will put the VDA in the public's eye on a frequent basis and undoubtedly pay dividends to each member.

When you have an opportunity, please take time to visit our website at vadental.org. It has been updated and is much more attractive to the public. The push to give the website a new look was imperative in anticipation of increased activity created by the PR campaign. If you have any suggestions to further improve our website, contact Shannon Jacobs at the VDA office as she would really appreciate your input

One of the plans for this year was to add a business component to our website that would provide members a resource to help with professional development. The ADA simultaneously made plans to integrate the CPS (Center for Professional Services) into the ADA web site. The CPS is exactly what I had in mind for the VDA so we have put our plans on hold pending the launch of the ADA program this fall. We did not want to duplicate the ADA efforts, therefore, our plans are to enhance our web site by not only making the CPS available but also adding business information specific to VDA members. This should provide a tremendous member value, however, the project will probably not be unveiled until next year.

Our membership market share is hovering between 66 – 67%. The Membership Committee has provided our members with several ways to pay their dues to help make VDA membership affordable to all Virginia dentists who would like to be part of our organization. We continue to have a strong presence at the VCU School of Dentistry that has translated into a good conversion rate of the students to VDA members. The group that continues to be overlooked is the one that includes practitioners who move into our state from other areas. These potential members are hard to identify and in many cases have not joined the VDA simply because they haven't been asked. If you are aware of any new dentists in your area who are not members, help us contact these people so that we may encourage them to join.

Continue to look at the VDA Services endorsed vendors and enlist their services when possible. There are several exceptional companies that can deliver quality products to you and your practice. Since 1997, the VDSC has been able to provide over $2.6 million to the VDA and related entities to support programs like the MOM Projects, the Virginia Meeting, CE at all of the component societies, the VDA website, the new VDA office and the VCU School of Dentistry. Since all members have insurance, an easy way to support VDA Services is to contact B&B Insurance (877-832-9113, www.bb-insurance.com) to have a complimentary review of your insurance coverage. B&B Insurance has been working with the VDA since 2000 and with their expertise in the insurance needs of dental offices, they are here as a resource to help all members with their insurance needs. By supporting these vendors, you are supporting your association and helping to keep your dues as low as possible.

Bluefield College is still moving forward with its dental school plans. Dr. Frank Serio was recently named the inaugural dean. Dr. Serio is moving to Bluefield from the East Carolina University School of Dentistry where he served as an Associate Dean. At this time, CODA (Commission on Dental Accreditation) has not received an application from Bluefield College to develop a dental school but, given the fact that a dean has been hired, it should only be a matter of time.

The leadership of your association continues to explore opportunities to improve membership value so that you get the most for your dues dollars. If the VDA is to remain relevant to you and our profession, we must focus on making each member successful in the professional market place. The recent initiatives are designed to provide you with some much needed support and raise public awareness as to the important role VDA members play in the delivery of dental care to Virginia residents.

Trustee's Corner

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

IT'S ALL ABOUT ADVOCACY

Having just returned from the Washington Leadership Conference, I believe that an update on the conference would be appropriate for this article. All of the ADA trustees attended the conference and joined their delegation on their visits to Capitol Hill. Advocacy is always listed as the top one or two member benefits that the ADA offers

We began in earnest Monday afternoon with workshops for first-time attendees and talking points on how to be most effective with our legislators during our hill visits. We also were addressed by Dr. Faiella and Dr. Norman. Our day began very early Tuesday morning when we heard from the different members of Congress. They all addressed the different aspects of the Affordable Care Act and all did so from very different prospective and very different opinions. This should give you some clue on how confusing the ACA is and the difficulty we all may face when it is in full effect.

1. We heard from a very conservative Republican who believes the ACA should be repealed and we should start over with health care reform.
2. We heard from a very liberal Democrat who feels the ACA did not go far enough.
3. We heard from an independent who truly believes healthcare should be an unalienable right Thomas Jefferson should have included in the Declaration of Independence.

No one can claim that the ADA is not bipartisan in our lobbying efforts. Whether Republican, Democrat or independent, we support those who support our initiatives. This is definitely a good time to put in a plug for ADPAC. In order for our message to be heard and for us to speak as "One Voice", **we need your dollars**. If you have not contributed to ADPAC please consider doing so. This year we will have a new level that you will have an opportunity to give to. It is the Diamond Level that requires a $1000.00 gift. I am sure that you will hear more about this from the 16th District ADPAC member, Dr. Bruce Hutchison.

Some of the initiatives that we advocated for this year are as follows:

1. **The Dental Insurance Fairness Act**: This would require insurance companies to pay full benefits on both policies when, for instance, a husband and spouse are covered. Presently, some secondary companies will not cover the remaining portion of a claim when the primary carrier has paid even though the claimant is paying for the coverage. The secondary carrier should at least be paying the remaining balance up to 100%.
2. **Competitive Health Insurance Act (McCarran Ferguson)**: This bill would align the health insurance industry with the rest of American businesses. The scope of the bill this year has been narrowed to only include health insurance companies; and, our Washington office feels that the bill has a better chance of passing both houses of Congress.
3. **Medical Device Tax**: This tax -as I am sure most of you know- went into effect in January, of this year and is part of the Affordable Care Act. It is estimated to cost the dental industry $160 million dollars. This bill calls for the repeal of this tax. While there is broad support in both houses of Congress, there is concern for replacing the lost revenue this tax generates and whether the President would veto the bill if passed.
4. **Student Loan Interest Deduction**: This bill would increase the student debt deduction from $2500 to $5000 for singles and $10,000 for married couples with no cap. There are other student debt bills before Congress which the ADA Washington office is keeping a close eye on. Interestingly, I heard two reports today while watching television. Both lamented the coming student debt crisis and that student debt was already approaching one trillion dollars. I serve on the ADA Student Debt Task Force; and while I cannot share with you our report at this time, I can tell you there is a looming crisis with dental student debt approaching $180,000 to $200,000 on average per student. A report will be given to the House of Delegates this year with several action items to be acted upon -a topic for another article.
5. **Pro Bono Medical Care**: This bill would create a grant which would support national dental groups that coordinate care for the medically compromised and the under privileged patient to receive dental care by volunteer dentists. This program fits nicely with the new "Action For Dental Health" Initiative the ADA rolled out on Wednesday of the Leadership Conference.

Dr. Faiella launched the national campaign ***Action for Dental Health: Dentists Making a Difference*** during a press conference in Washington, DC. Dr. Faiella explained this nationwide campaign addresses the dental health crisis facing America today and all states have been asked to choose from a list of initiatives they have taken or can take action on. All of these initiatives will be collated and through the media and other resources be used to solidify the campaign and make sure to share the message that we are doing something positive to address the dental health crisis. There is a video[1] that helps crystalize our message and our approach to this campaign. Please take a moment to go to: **www.ada.org/action** and view it. You will be hearing much more about this. I am pleased that all three states in the 16th district are actively participating in the Action for Dental Health. Thank you.

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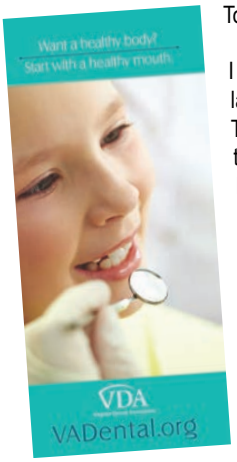
1 http://www.ada.org/8585/aspx

LETTERS TO THE EDITOR



To the Editor of the Journal:

I am sorry to say this, but there seems to be a general lack of respect among dentists for OSHA regulations. These regulations are looked upon as a burden, rather than a means of protection from illness and/or disease. Dentists don't seem to realize that those regulations are designed to protect us, and are not there to just harass and burden us with more bureaucracy. I venture to say that without OSHA we still would not be wearing masks and gloves. It has come to the point that breaches of OSHA safeguards aren't even recognized as such. The breaches have become the norm.

That is why I didn't know whether to laugh or cry when I saw a new pamphlet from the VDA: "Want a healthy body? Start with a healthy mouth." There are four pictures in that pamphlet, and three of them have glaring breaches of OSHA regulations, plus examples of a lack of concern about infection control and cross-contamination. *And no one at the VDA saw anything wrong!!!* As I said, these things have become the norm. People don't see them anymore. Because of that, the VDA seems to "endorse" sloppy health and safety concerns, rather than being an exemplar of what should be done.

Noted in the picture above the caption "Your dentist can detect early signs of diabetes and oral cancer":

The dentist has an open "V" neck jacket. The coat should be closed and up to the neck according to OSHA. Aerosol spray, generated by the air driven handpiece at the rate of 100,000 particles per cubic foot, comes from the mouth directly at the dentist. His neck and street clothes are now contaminated by all of the patients he sees that day. In addition he has scrunched his mask under his chin, thereby smearing his face with bacteria and viruses as he does so. And, of course his gloves are now cross-contaminated and need to be changed. Unfortunately, dentists NEVER do change their gloves before going back into the mouth of the patient. NEVER!!

Noted in the picture below "Go to VADental.org to find a VDA member in your area.": Both professionals are wearing short sleeved gowns, which, as I noted before, is against OSHA regulations.

The male has an open shirt, not covered by his gown. (see above)

Both are holding a tablet of some kind, using their gloved hands. Presumably, the male is going right back to the mouth with those same gloves because he is holding a mirror in his left hand. In a best case scenario, we could presume that the tablet is disinfected during clean-up for each patient. But dentists too often will pick up charts, etc. during treatment and cross-contaminate their gloves before going back to the mouth. Plus, not all tablets can be disinfected without damaging them. I am not sure about this one. Not a good choice for a picture.

Noted below the caption "Every member of your household should visit a VDA dentist every six months.": Again, the mask is under the chin, and a gloved hand is resting on the back of the chair.

Dentists don't seem to have a culture that respects sterility or occupational safety. It is up to our leadership to influence that culture for the good, not reinforce it for the bad.

I hope that you will bring this to the attention of those who produced this pamphlet, and to those who might be producing publicity for the VDA in the future. This should include those taking pictures of MOM and GKAS projects for publication in the VDA Journal. I hope that no pictures are allowed to be published that show short-sleeved participants or masks under the chin. Let's turn over a new leaf in our support of infection control.

Henry M. Botuck, DDS
Springfield, VA

To the Editor:

I was delighted to see in your opening remarks in the new VDA *Journal* a call for a "Summit" of VDA leaders to address the issue of the cost of dental education and student debt.

I also have written the VDA leadership asking for a "summit" on a variety of issues. (last summer) Dr. Brown, a very erudite dentist has issued alarms (his April Blog) that I have been addressing over the last year.

He calls it a crossroads in dentistry. I call it a crisis!! We may both be correct.

Thanks for issuing a call for VDA dental leadership to address some very pressing issues in dentistry, NOW.

Dr. Robert Allen
Hampton, VA

Dear Sir:

I just put down the latest issue of the Virginia Dental Journal, after having read the letter to the editor re: the new dental school project in Bluefield.

I am appalled at the pie in the sky reasoning of the authors of this epistle, and am just flabbergasted that this concept of the need for another dental school in the state of Virginia has progressed to this point. Certainly the dental health of the population of southwest Virginia is deficient, but I can guarantee you that trying to bring an influx of new dentists to this area in order to achieve a "normal" dentist to patient ratio in order to correct the dental health deficiency will NOT work.

Upon my release from the US Navy In 1975 I set up practice on the Eastern Shore of Virginia, am area very similar economically to southwest Virginia. As such I have first hand experience in practicing in economically deprived areas, and I can assure you that the Bluefield approach will be a failure simply because there is very little perceived need for dental care by the population of these areas. This is not a supply problem, but more so, a demand problem. Having endured the frustration of trying to educate a populace whose fundamental value system does not embrace proper dental care, I categorically state that this project will be a failure, and will only result in the ultimate migration of poorly trained dentists to seek opportunities to practice in more economically friendly areas of the state, which areas, by the way, are overpopulated with dentists already.

I implore that rationality be applied to this impending debacle, and I sincerely hope that someone will step up and see the light.

Cordially,

James A Pollard, DDS
Lynchburg, VA

Scientific

Dentists' Attitudes Regarding Diagnostic Codes in Dentistry

By: Mary A. Baechle, DDS; Charles Janus, DDS, MS, MS; Al M. Best, PhD

Abstract

Background: The purpose of this study is to examine dentists' demographic influences and knowledge, utilization and attitudes regarding diagnostic codes.

Method: 3600 dentists were invited to participate in an e-mail survey commenting on benefits, concerns and utilization of diagnostic codes, and to reveal biographical and demographic information. N=574 responses were thematically coded and analyzed using repeated-measures logistic regression.

Results: 126(22%) reported utilizing codes, with an adjusted model revealing field of discipline as significant, and 15% more concerns than benefits were cited, with efficiency being the most common (40%).

Conclusions: Correlations exist between utilization, knowledge, attitudes and respondent's demographic characteristics, with further studies warranted.

Introduction

With the exception of some specialists and general dentists in acute care facilities, most dentists submit only procedure codes to insurance companies for an estimation of benefits and reimbursement, with the American Dental Association's (ADA) Current Dental Terminology (CDT) codes being the most commonly used.[1] However, in addition to procedures or services physicians render, the diagnoses appropriate to the conditions requiring these services or procedures is also documented and utilized in filing insurance claims. Therefore, when patients need to have a procedure submitted to insurance under medical, it is important for general dentists to know and understand the codes more commonly used by physicians, which includes in addition to procedure codes, diagnostic codes.[1]

United States physicians currently use the three-volume International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) for reporting diagnoses and inpatient procedures.[2] As of October 1, 2014 a set of more extensive and precise codes, the ICD-10-CM, and the International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS) will replace the ICD-9 code set.[2,3]

A significant difference between procedure and diagnostic codes is that the former defines treatment or services rendered, while the latter describes the diagnosis or condition for which the patient may receive treatment.[4] The CDT code D2140, for example, denotes a one-surface amalgam restoration procedure but not the reason for the procedure.[5] This tooth could have a pre-existing restoration requiring replacement or caries with no previous restoration. Thus, while the procedure code denotes only what was done, the diagnostic code linked to the procedure code describes the reason the restoration was placed. In this example, it could be coded as primary dental caries, of pit and fissure origin, code 521.06, ICD-9-CM.[6]

Although currently there is no standardized set of diagnostic codes widely used in dentistry,[7,8] a set that has been proposed and developed for use is the Systemized Nomenclature of Dentistry (SNODENT).[9] Specific dental diagnostic codes are designed to provide detail for quality measurement the ICD-9 and ICD-10 codes cannot.[10] For example, there is no subcategory to describe a diagnosis of "broken removable prosthesis" in the ICD.[11] Thus, SNODENT was introduced in the early 1990s, and then reworked in 1998 when the ADA entered into an agreement with the College of American Pathologists intending "to create, publish and distribute a systematized nomenclature of dentistry containing dental diagnoses, signs, symptoms and complaints", utilizing "in part content contained in SNOMED V3.4."[9,12] SNOMED-CT, or, the Systematized Nomenclature of Medicine-Clinical Terms, "is one of a suite of designated standards for use in U.S. Federal Government systems for the electronic exchange of clinical health information and is also a required standard in interoperability specifications of the U.S. Healthcare Information Technology Standards Panel."[13] Although completed in 1999,[9] SNODENT continues to be developed and revised to meet interoperability guidelines compatible with the National Health Information Infrastructure, anticipating that one day it will be an integral part of an electronic health record (EHR), shared by multiple healthcare providers.[9,14] According to the ADA, the use of SNODENT codes "could allow for: national collection of data via clearing houses to analyze treatment outcomes, recording a complete oral risk assessment of the patient, [u]se of a single code for synonymous descriptive terms, improved claim processing to help reduce or eliminate narrative descriptions or other claim attachments" and "in-office monitoring of production and treatment".[15] However, at the present time, the U.S. Department of Health and Human Services has mandated that ICD-10 and CDT codes be used in dentistry.[16]

The purpose of this study, therefore, is to determine dentists' current knowledge, utilization of and attitudes toward the use of diagnostic codes in dentistry as well as their role in dental education, and, examine any demographic differences. The null hypothesis is that there are no correlations between dentists' utilization, knowledge and attitudes regarding diagnostic codes and their demographic characteristics.

Materials and Methods

This research was approved by the Virginia Commonwealth University Institutional Review Board. Participants provided informed consent. A survey was created inquiring as to the respondents' use, understanding and opinion of diagnostic codes, including thoughts about benefits and concerns, and biographical and demographic questions.

E-mail addresses were acquired from the Virginia Dental Association, and a Virginia Commonwealth University alumni list, yielding a total of 4,503 addresses. The survey was posted using Inquisite® Survey System (version 9.5, Inquisite Inc., Austin, TX). The first invitation was sent in May 2010. A second invitation was sent June 2010. Subtracting invalid e-mail addresses the survey sample size is estimated to be 3,600. A total of 574 (16%) submitted a survey sufficiently complete to analyze. Analysis was completed using SAS software (JMP 8.0, SAS Institute Inc., Cary, NC). Zip code data was acquired from the U.S. Census 2000 P2 Urban and Rural zip code data.[17]

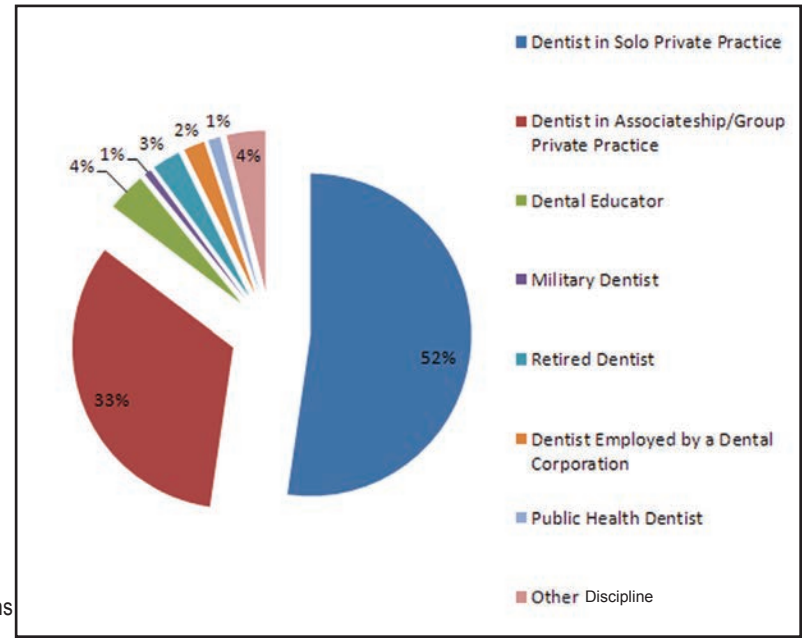


Figure 1

	N	%
Fee-for-Service	143	26%
Fee-for-Service Traditional Dental Insurance Plan/Indemnity Dental Insurance Plans	138	25%
Fee-for-Service Traditional Dental Insurance Plan/Indemnity Dental Insurance Plans Managed Care Dental Insurance Plan: Preferred Provider Organization	69	12%
Traditional Dental Insurance Plan/Indemnity Dental Insurance Plans	63	11%
Fee-for-Service Discount or Referral Dental Plans Traditional Dental Insurance Plan/Indemnity Dental Insurance Plans	32	6%
Fee-for-Service Discount or Referral Dental Plans Traditional Dental Insurance Plan/Indemnity Dental Insurance Plans Managed Care Dental Insurance Plan: Preferred Provider Organization	18	3%
Fee-for-Service Discount or Referral Dental Plans	17	3%
Fee-for-Service Managed Care Dental Insurance Plan: Preferred Provider Organization	14	3%
Managed Care Dental Insurance Plan: Preferred Provider Organization	11	2%
Discount or Referral Dental Plans	10	2%
Respondents Who Selected Two or More Of The Following: Fee-for-Service (No dental plan or insurance) Discount or Referral Dental Plans Traditional Dental Insurance Plan/Indemnity Dental Insurance Plans Managed Care Dental Insurance Plan: Capitation Dental Plan (Dental Health Maintenance Organizations) Managed Care Dental Insurance Plan: Preferred Provider Organization ("PPO") Managed Care Dental Insurance Plan: Exclusive Provider Organization ("EPO")	40	7%
Total	555	

Table 1

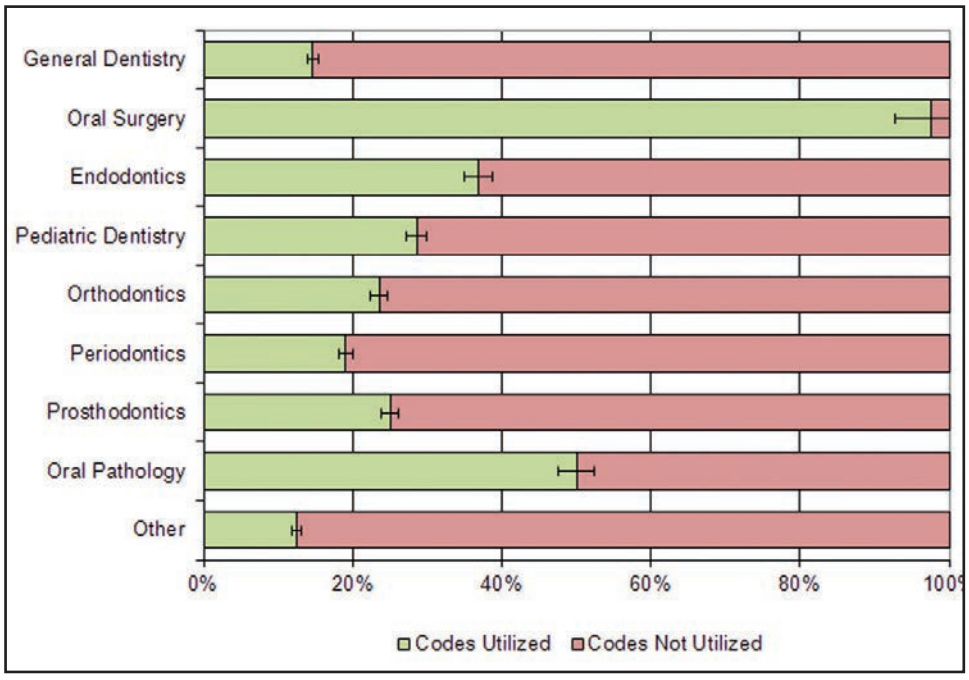


Figure 2

territory, population, and housing units in urbanized areas and in places of 2,500 or more persons" was used to designate a respondent's zip code as Urban.[17] Respondents' written comments were thematically coded and analysis accomplished using repeated-measures logistic regression.

Results

Of the 574 respondents, 97 (17%) reported female and 458 (81%) male; 2% did not respond. Respondents' birth year ranged from 1926–1983 and year of graduation from dental school ranged from 1955–2009. Decades in practice was calculated yielding: less than 10 years 71 (13%), 10–20 years 116 (21%), 21–30 years 172 (31%), 31–40 years 149 (27%), 41–50 years 42 (8%), and over 50 years 10 (2%).

Nearly three-fourths, or 420 (74%) respondents reported General Dentistry as their primary field of discipline with the remaining participants being: Oral Surgery 44 (8%), Pediatric Dentistry 22 (4%), Periodontics 22 (4%), Orthodontics 21 (4%), Endodontics 20 (3%), Prosthodontics 8 (1%), Oral Pathology 2 (<1%) and Other disciplines 8 (1%).

Over half, or 295 (52%) respondents reported Dentist in Solo Private Practice as their practice type, with other practice types as: Dentist in Associateship/Group Private Practice 186 (33%), Dental Educators 22 (4%), Retired Dentists 16 (3%), Dentist Employed by a Dental Corporation 12 (2%), Public Health Dentist 7 (1%), Military Dentists 4 (1%) and other 22 (4%) (Figure 1). A total of 464 (80%) respondents reported "Fee-for-Service" as the description of their primary practice business model with respondents' combinations of practice descriptions outlined in Table 1. Urban respondents we 93% of the total and Rural (37) were 7%.

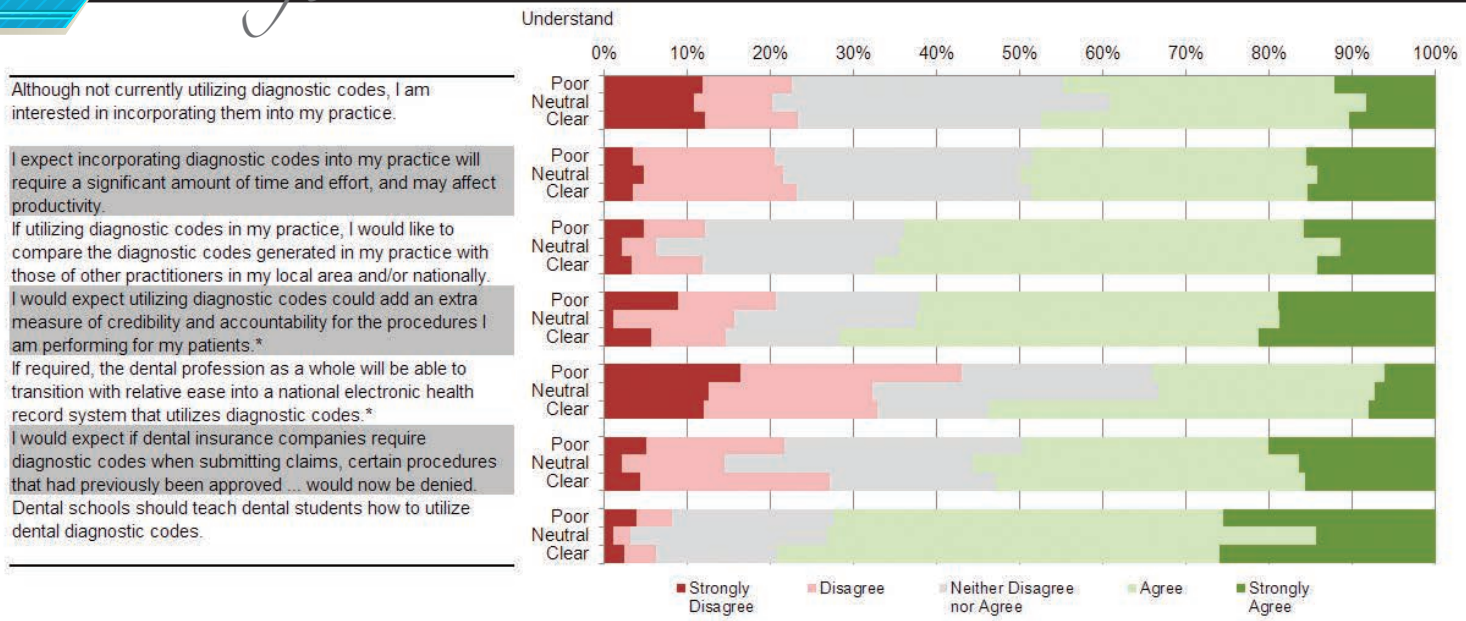
Only 126 (22%) respondents indicated they utilized diagnostic codes, 415 (73%) indicated they did not use codes, and the remaining 25 (4%) did not know.

Decades in practice was not significant (p=0.1842) as a predictor for the utilization of diagnostic codes, nor was primary practice description (p=0.5262) or zip code classification (p=0.0864). Univariate analysis, examining each variable independently from the others, revealed gender to be significant (p=0.0127), with a greater proportion of males using diagnostic codes than females, as well as field of discipline (p<0.0001) and practice type (p=0.0080). However, multivariate analysis of these three individually significant variables yielded only field of discipline as a significant predictor for the use of diagnostic codes (p<0.0001), with respondent percentages illustrated in Figure 2.

Practitioners were questioned as to their understanding and opinion of diagnostic codes (Figure 3). The first question asked about interest in incorporating diagnostic codes into practice. The three sets of bars represent groups of respondents who reported a poor, neutral or clear understanding of diagnostic codes. The shading in each horizontal bar correspond to the "strongly disagree" to "strongly agree" Likert scale with red indicating disagreement and green indicating agreement.

In regard to interest in incorporating diagnostic codes into practice, there was no significant difference between all three groups; respondents with a poor understanding of diagnostic codes have the same level of agreement compared to those with clear understanding (p=0.2486). The question about incorporation of codes into practice with time, effort and productivity concerns was not significant (p=0.7906). Additionally, there is no difference, depending on understanding, in wanting to compare codes generated in one's practice to locally or nationally generated codes (p=0.8207).

In regard to the use of diagnostic codes adding an extra measure of credibility and accountability, there was a significant difference between the three respondent groups in that the poor understanding group had more disagreement than the clear understanding group (p=0.0216). In regard to the ability of the dental profession to transition with ease into a national electronic health



Respondents' understanding of dental diagnostic codes: top row respondents do not have a clear understanding of dental diagnostic codes 258 (46%), middle row respondents have a neutral understanding 97 (17%), and bottom row respondents indicate they understand diagnostic codes 212 (37%)
*significantly different responses (p values < 0.05)

Figure 3

	Theme	Description	Utilize Codes	Gender	Decades In Practice	Field Of Discipline	Practice Type	Rural Urban
Benefits	Communication	Better Communication With Reimbursement Parties And Other Health Care Providers, Staff And Patients	0.350	0.068	0.546	0.612	0.623	0.293
	Data Tracking	Track: Disease, Trends In Procedures, Effectiveness of Procedures, Materials Use; Research	0.043	0.038	0.174	0.062	0.058	0.322
	Diagnosis	Provide More Accurate And Thorough Patient Records; Adequately Describing Conditions; Standardized Way Of Expressing A Diagnosis	0.007	0.966	0.447	0.640	0.908	0.417
	Efficiency	Efficient Data Entry; No Need For Written Claims, Just Send A Code; Faster Claims Processing	0.648	0.319	0.548	0.070	0.591	0.807
	Integration	Integration Into The Network Of Healthcare Providers; Better Integration Into The Field Of Medicine	0.919	0.913	0.707	0.811	0.550	0.591
	Justification	Justification Of Claims; Accountability; Credibility; Integrity	0.714	0.900	0.479	0.181	0.001	0.693
	Patient Care	Ultimately Lead To Better Patient Care	0.665	0.580	0.888	0.917	0.636	0.416
	Reimbursement	Better Reimbursement	0.586	0.007	0.736	0.712	0.357	0.047
Concerns	Communication	Hinders Communication Between Doctor And Patient; Insurance Personnel Do Not Understand Codes	0.175	0.469	0.763	0.040	0.140	0.509
	Data Tracking	How Recorded Data Will Be Used And By Whom	0.007	0.209	0.882	<.0001	0.415	0.228
	Diagnosis	Codes Are Not Clear; Not An Accurate Diagnosis; Restrictive; Does Not Describe Every Situation	0.129	0.399	0.160	0.940	0.475	0.624
	Efficiency	Learning And Using Codes Correctly; Confusing; Additional Work Time; Maintenance Support And Cost; Inefficient Method: Multiple Codes For 1 Tooth, Etc.	0.000	0.038	0.813	0.149	0.832	0.883
	Integration	Against Integration Into Network Of Healthcare Providers; Opposed To A National Electronic Health Record; Dental Profession Not Like Medicine, Do Not Need Regulation	0.453	0.493	0.711	<.0001	0.080	0.705
	Justification	Lack Of Trust Of Provider By Insurance; Codes Applied To Intentionally Misrepresent The Patient's Condition; Integrity of Insurance Company	0.590	0.139	0.220	0.165	0.043	0.578
	Patient Care	Will Distance The Patient-Doctor Relationship; Insurance Invading Patient Privacy; Insurance Controlling Patient Treatment; Affects Patients' Choices; No Patient Benefit	0.518	0.116	0.002	0.626	0.393	0.548
	Reimbursement	Possible Denial/Delay Of Claims	0.086	0.715	0.003	0.023	0.170	0.762

p values in red are significant

Table 2

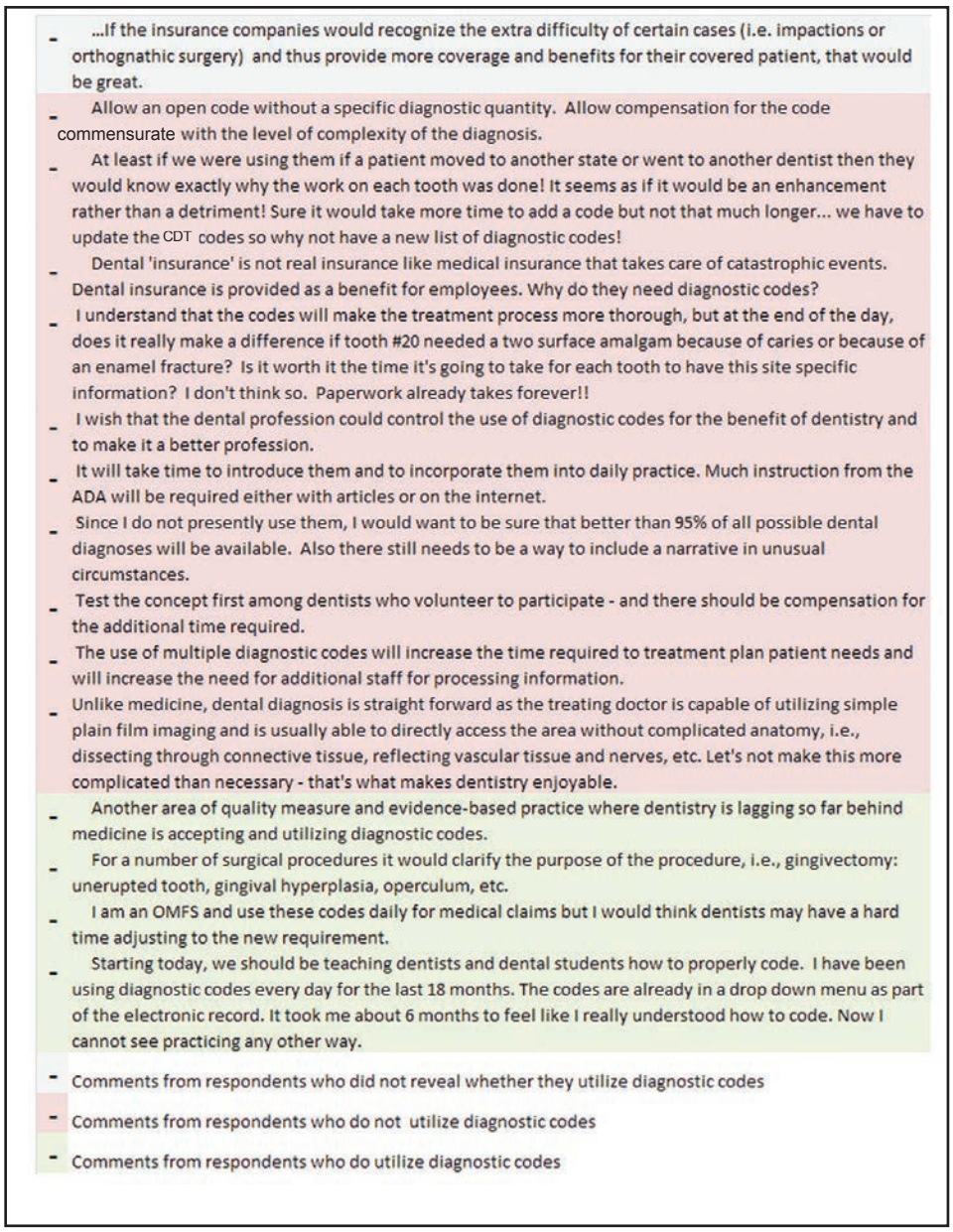


Table 3

record system that utilizes diagnostic codes, there was a significant difference (p=0.0004). That is, respondents with poor understanding of diagnostic codes agree less than those with a clear understanding. There was no significant difference, depending on understanding, regarding diagnostic codes and denial of claims, and teaching dental students to utilize dental diagnostic codes (p>0.1000). Three-fourths, or 427 (75%) respondents agreed or strongly agreed diagnostic codes should be taught in dental school, 104 (18.3%) were neutral, and 37 (6.5%) either disagreed or strongly disagreed. When these responses were collapsed into agreed, neutral, or disagreed, no significant relationship was found with any demographic variable (p>0.05).

The respondents' written comments yielded 8 categories, expressed as benefits and concerns. The most common benefit cited was diagnosis (28%). The least common benefit cited was integration (1%). A summary of statistically significant p values from analysis for the demographic and use variables versus thematic descriptions of benefits and concerns appears in Table 2. Significantly more individuals utilizing codes cited benefits, with diagnosis (p=0.0073) and data tracking (p=0.0432) the most commonly cited among this group. Significantly more males cited data tracking as benefits (p=0.0378) whereas significantly more females cited reimbursement issues as a benefit (p=0.0066).

As for practice type, respondents Employed by a Dental Corporation and those in Associateship/Group Private Practice cited the benefit of justification significantly more frequently than respondents in other practice types (p=0.001)

Overall, there was a total of 15% more concerns with the most common being efficiency (40%). Of the individuals utilizing codes, significantly more cited data tracking as a concern (p=0.0074). Those not utilizing codes cited efficiency as a concern (p=0.0002), and females cited efficiency as a concern (p=0.038).

Respondents in practice less than 10 years and those over 40 years cited reimbursement issues as a concern more frequently than other respondents (p=0.0031), while respondents less than 10 years and those in practice 21-30 years cited patient care as a concern (p=0.0020).

Prosthodontics and those in "Other Disciplines" cited communication as a concern significantly more frequently (p=0.0400), General Dentistry, Periodontics and Endodontics cited reimbursement issues as a concern (p=0.0227), and Dental Educators, Retired, and Other dentists cited justification as a concern significantly more frequently than other practice types (p=0.0430).

Rural respondents cited reimbursement issues as a benefit significantly more frequently than urban respondents (p=0.0472).

When all eight concerns were compared to the collective responses of four questions pertaining to utilizing diagnostic codes, analysis revealed reimbursement as the most important concern (p<0.0001). Of the 135 respondents who cited this concern the next most important concern was efficiency.

Regarding written responses from respondents (Table 3), there is no significant difference between the respondents who utilize diagnostic codes and shared additional thoughts and respondents who do not utilize codes, or do not know, but did share additional thoughts (p=0.4274).

Discussion

Correlations were found between dentists' utilization, knowledge and attitudes regarding diagnostic codes in dentistry and demographic characteristics, thereby rejecting the null hypothesis. In regard to utilization, Oral Surgery and Oral Pathology respondents had the highest percentages possibly because these specialties are more likely to submit insurance claims for "medical necessity" determinations that require diagnostic codes.[1] Regardless of the current lack of use among most dentists, studies have demonstrated that diagnostic codes are invaluable research tools, revealing oral healthcare trends,[18,19,20] which can lead to potential solutions, preventive measures and education.

With respect to respondents' understanding and opinion of diagnostic codes (Figure 3), the results indicate a measure of willingness on the part of respondents to adapt these codes. The results also suggest an association between understanding and both the relative ease of adapting codes and perceived credibility imparted by using codes. The results also indicate that concern exists over reimbursement, but that in spite of this concern, codes should still be taught in dental school. Furthermore, the American Dental Education Association (ADEA) supports the development and implementation of these codes to be used in dental education, practice and research, and advocates diagnostic codes as a means of developing clinical competency in dental students.[21] As stated by Kalendarian et. al, "a standardized diagnostic terminology has further advantages in the educational setting: it hones formal diagnostic skills, emphasizes the link between diagnosis and treatment, and enhances patient care."[11]

In regard to written responses, "diagnosis" was the most commonly cited benefit, with respondents believing it would contribute to a more accurate and thorough record. As stated by Miller, utilizing diagnostic codes help ensure certainty in recording the correct diagnosis, thereby further affirming that

"diagnosis dictates treatment."[22] More concerns were expressed than benefits, with reimbursement and efficiency the greatest concerns, and general dentists most frequently expressing reimbursement concerns. Unlike oral pathologists and oral surgeons, general dentists will render diagnoses on individual teeth and surfaces and at recall appointments these diagnoses are likely to change, thus significantly compounding record keeping time.

Concerns regarding efficiency and reimbursement were also commonly expressed in the respondents' written comments, of which a selection appears in Table 3. Many comments convey the need for piloting code implementation before it is launched, and also re-affirmed introducing diagnostic codes in dental school curricula.

Conclusion

Only 22% of respondents indicated using diagnostic codes and only field of discipline proved to be a significant predictor in a multivariate adjusted model. In regard to opinion questions about diagnostic codes adding "an extra measure of credibility and accountability" and the ability of the dental profession to "transition with relative ease into a national electronic health record system that utilizes diagnostic codes", there was a significant difference between respondents grouped by their level of understanding. Regarding attitudes toward diagnostic codes, dentists cite more concerns than benefits, with gender, practice type and utilization significant predictors for both benefits and concerns, while decade in practice and field of discipline were not significant for benefits, nor was rural/urban practice for concerns. Ultimately diagnostic codes may be implemented, and therefore these results suggest a need for further study on how diagnostic codes will impact dental practice in regard to office efficiency, reimbursement, research and treatment, how they should be introduced in dental school curricula and what programs are necessary to educate practicing dentists.

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This research was presented at the American Association for Dental Research (AADR) 41st Annual Meeting & Exhibition, Tampa, FL, March 2012.

Figure and Table Captions

Figure 1. Percentage distribution of respondents' practice types.
Table 1. Respondents' combinations of choices for primary practice description.
Figure 2. Utilization of diagnostic codes by field of discipline (including 95 percent confidence intervals).
Figure 3. Practitioners' opinions about diagnostic codes ordered on the Likert scale, organized by their understanding ranked as Poor, Neutral, or Clear.
Table 2. Summary of statistical significance for the demographic and use variables versus thematic descriptions of benefits and concerns.
Table 3. Respondents' notable comments and additional thoughts about diagnostic codes.

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- Integrate therapeutic regimens used to treat lichen planus.
- Demonstrate a logical approach to the diagnosis and treatment of Chronic Ulcerative Stomatitis and Benign Mucous Membrane Pemphigoid.

SPEAKER BIO:

Dr. John Svirsky is a board certified oral and maxillofacial pathologist at Virginia Commonwealth University (VCU) in Richmond, Virginia. He received his dental degree in 1973 from VCU and went on to complete a general practice residency at Long Island Jewish Medical Center/Queens Hospital Center, as well as an oral pathology residency at the Catholic Medical Center.

He is currently a professor of oral and maxillofacial pathology and maintains a private practice in oral medicine and oral pathology. Dr. Svirsky has developed a broad background in research, published numerous articles in the dental literature, and earned a master's degree in adult education. He is a sought after speaker with an international reputation as an informative and entertaining lecturer.

Dr. Svirsky is an honorary member of the Thomas P. Hinman Dental Society and has received a Presidential Citation from the American Dental Association for significant contributions to the health of the public and the profession of dentistry. In 2012 he received the William J. Gies Award from the Greater New York Dental Meeting for contributions to oral health. The MCV Alumni Association (MCVAA) of Virginia Commonwealth University has chosen Dr. Svirsky to receive the 2013 MCVAA Outstanding **Alumnus Award.**

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Bhavik Desai, DMD, PhD and John Svirsky, DDS, MEd

ABSTRACT

Radiolucent lesions encountered in the maxillo-mandibular complex can commonly be attributed to odontogenic infections, cysts and tumors of odontogenic origin. This case series describes clinical cases where patients presented with radiolucent bone lesions in the maxillary or mandibular bones. Initial clinical evaluation on these cases had entertained empiric diagnoses of odontogenic infection or central bony lesions as the etiology of radiographic findings. Past medical histories were non-contributory and review of symptoms did not suggest presence of significant systemic disease. In each case the lesions were biopsied and were found to be caused by accumulation of malignant monoclonal plasma cells. The final diagnosis was solitary plasmacytoma in two cases and multiple myeloma in the third case. Both conditions represent types of myeloproliferative B-cell disorders and should be considered while fabricating a differential diagnosis of radiolucent lesions in the jaw bones.

INTRODUCTION:

Multiple myeloma is a malignant neoplastic proliferation of plasma cells that most commonly involves the skull, ribs, vertebrae and pelvis (1). However, the lesions may also occasionally involve the jaws, with the mandible being the more common site (1). The resulting radiolucent lesions may be detected on routine radiographs of asymptomatic patients or during the evaluation of patients with pain of unknown origin. Prior to biopsy, these lesions are often considered to be odontogenic.

Solitary plasmacytoma represents a single lesion characterized by infiltration of malignant plasma cells with no evidence of corresponding lesions elsewhere in the body (2). This case series describes three patients who presented with radiolucent lesions in the jaw due to malignant plasma cell infiltration. One patient presented with a mandibular fracture, one patient reported toothache-like symptoms, and in one patient the radiographic findings were incidental.

CASE 1

A 57-year-old Caucasian female was referred to the Oral Pathology diagnostic service of the Virginia Commonwealth University School of Dentistry for evaluation of an asymptomatic lesion in the mandible in the tooth # 29-31 region (Figure 1). The referring clinician's initial tentative diagnosis was either a residual cyst or tumor of odontogenic origin. The lesion was an incidental finding on a routine dental radiograph; the patient was asymptomatic. The past medical history revealed that the patient had hypertension and hypothyroidism. The patient was taking aspirin, lisinopril, hydrochlorothiazide (HCTZ) and Synthroid®. Review of symptoms was negative for fever, pain, swelling, paresthesia, fatigue or weight loss. The patient was referred to an oral and maxillofacial surgeon for a biopsy.

Microscopic examination of an incisional biopsy revealed the presence of abnormal monoclonal plasma cells, leading to a diagnosis of plasmacytoma (Figure 2). The patient was promptly referred to an oncologist for management. Further systemic evaluation revealed no similar lesions in the body at that time, leading to a final diagnosis of the mandibular radiolucency as solitary plasmacytoma.

CASE 2

A 66-year-old African-American male was evaluated at the Emergency Clinic of the Virginia Commonwealth University School of Dentistry for a fracture of his right mandible not related to trauma of the area. The patient had been edentulous for 6 years and was wearing a mandibular denture. The medical history revealed that he had osteoarthritis, hypercholesterolemia and hypertension. He was surgically treated for lung cancer 12 years ago. Patient reported taking HCTZ, Lipitor® and Celebrex®. A review of systems was significant for pain in the right mandible for about 6 weeks, along with intermittent episodes of "throbbing" and paresthesia. The patient reported no fevers, shortness of breath, weight loss or gastrointestinal problems.

Radiographic examination revealed the presence of a significant radiolucency encompassing the right body of the mandible along with a fracture line superior to the radiolucency (Figure 3). The lesion was poorly defined with irregular margins and without any signs of secondary calcification. Differential diagnosis included central odontogenic tumor or cyst, central giant cell granuloma and a radiolucency secondary to a metabolic disorders such as hyperparathyroidism or histiocytosis. Biopsy of the lesion revealed the presence of malignant monoclonal plasma cells. The patient was referred to an oncologist. Further investigation revealed the presence of similar radiolucent lesions in the patient's long bones and a diagnosis of multiple myeloma was made.

CASE 3

A 54-year-old obese African-American male was referred to the Oral Pathol ogy service of the Virginia Commonwealth University School of Dentistry by an endodontist for evaluation of pain and tenderness in the upper right maxillary quadrant for approximately two months. The patient denied any triggering events and described his symptoms as a dull ache, with occasional sharp episodes of pain, that which was usually initiated by mastication. The past medical history

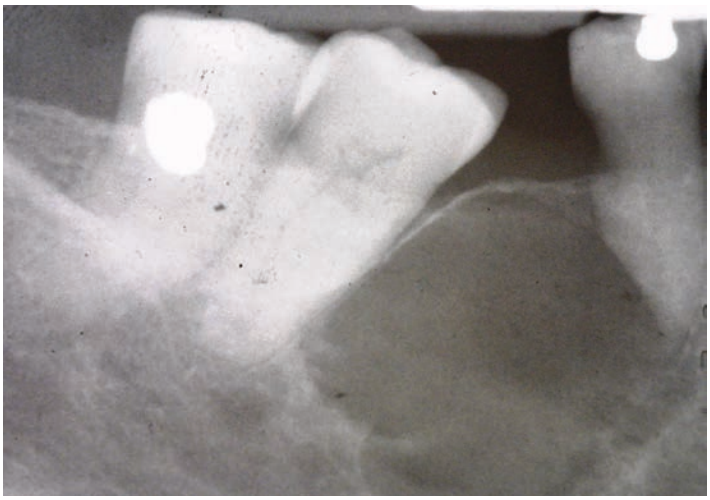

Figure 1. Radiographic examination reveals a 2.5 by 2.5 cm radiolucent lesion of the right posterior mandible showing cortication on the distal and irregularity on the mesial with some divergence of the teeth.

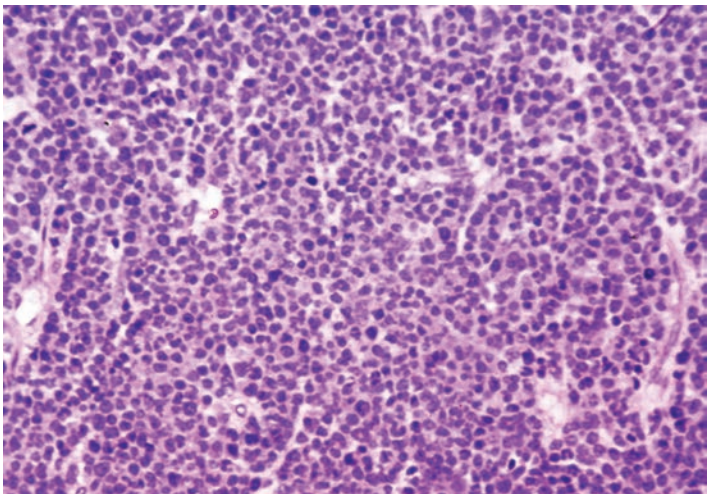

Figure 2. Hemotoxylin and eosin stained slide reveals a lesion composed of atypical plasma cells, showing varying degrees of differentiation and replacing the normal tissue architecture.

revealed that he had hypercholesterolemia and was taking Lipitor® and 81mg aspirin. Review of symptoms was positive for pain in the knee and ankle joints, and shortness of breath.

Dental examination revealed tenderness in the area of teeth # 2, 3 and 4. All of the involved teeth had amalgam restorations and were tender to palpation and percussion. There was no evidence of a bony expansion or soft tissue swelling. Radiographic examination revealed the presence of a poorly defined radiolucency associated with the apices of teeth # 2, 3 and 4, centered around # 3 (Figure 4). A preliminary diagnosis of odontogenic infection and abscess in the upper right quadrant was made.

Endodontic evaluation of the teeth, including thermal and electric pulp testing, were within normal limits and none of the teeth exhibited any evidence of coronal fracture or periodontal disease. The patient was referred for a biopsy of the lesion. Biopsy results were consistent with malignant monoclonal plasma cell proliferation and a diagnosis of solitary plasmacytoma of bone. The patient was referred to a hematologist-oncologist for management. Since the maxillary lesion was the only malignant plasma proliferative lesion detected, the patient's final diagnosis by the hematologist-oncologist was solitary plasmacytoma.

DISCUSSION

Commonly occurring solitary radiolucencies in the jaw bones of non-infectious origin include odontogenic cysts and tumors such as ameloblastoma, odontogenic keratocyst, myxoma, hemangioma and central giant cell granuloma. Less common causes of solitary radiolucencies in the maxillary and mandibular bones include solitary bone cyst, histiocytosis X, secondary metastatic tumors and hyperparathyroidism (3). A significant percentage of radiolucent lesions have been reported to have no accompanying symptoms and have been discovered on routine radiographic examination. In the three cases described in this report, the central bony radiolucencies were consistent with findings of multiple myeloma or solitary plasmacytoma. Both conditions represent malignant myeloproliferation of B-cells. This abnormal B-cell proliferation is also associated with amyloidosis and monoclonal gammopathy of undetermined significance (MGUS) (4).

Multiple myeloma is characterized by abnormal proliferation and dissemination of B-cells resulting in an accumulation of monoclonal immunoglobulin fragment in the bone marrow(5) Associated findings include increased propensity for pathologic fractures, anemia, renal insufficiency, infection and bleeding. The diagnosis of multiple myeloma is made on the basis of the clinical symptoms, elevated serum and urine levels of monoclonal protein, radiographic findings of bone destruction and bone biopsy(6). Therapy for multiple myeloma includes corticosteroids, bisphosphonates, chemotherapy and hematologic stem cell transplant (5).

The maxillofacial region is a common site of involvement of multiple myeloma. The lesions typically present as well-defined radiolucencies with non-corticated borders(7). Bony lesions of multiple myeloma have been documented at various sites in the mandible (8,9), maxilla (10), and the temporomandibular joint (11). Less common documented manifestations of multiple myeloma in the jawbones include labial swelling (12), oroantral fistula (13), tongue swelling (14), extensive gingival bleeding (15)}and atypical oral ulceration (16). Lower lip numbness has been reported secondary to multiple myeloma lesions in proximity to the mental nerve (17).

Solitary plasmacytoma, unlike multiple myeloma, is an isolated tumor of malignant plasma cells. It may present as a single lesion of the bone or as an extramedullary lesion (18). In the jawbones it occurs more frequently in the mandible than the maxilla. Solitary plasmacytoma progresses to the more disseminated multiple myeloma in about half of all cases (19). The most common sites of occurrence of solitary plasmacytoma are the vertebrae and long bones. Bones in the maxillofacial region are only involved in about 4% of cases (19). In the head and neck region, extramedullary plasmacytoma has been reported to occur in the nasal cavity, paranasal sinuses, oral cavity and oropharynx (19) or in the temporomandibular joint (20). Initially, extra-medullary plasmacytomas are often misdiagnosed as soft tissue abscess of odontogenic origin (21).

Symptoms of solitary plasmacytoma of the jaws have been reported as pain, swelling, tooth mobility, and paresthesia or anesthesia associated with the inferior alveolar nerve (22). Radiographically, the lesion typically appears as a single radiolucency which may be locally expansile (23, 24). It may be associated neurological symptoms if it is in close proximity to sensory nerves (24). A definitive diagnosis of intramedullary solitary plasmacytoma is based on histologic evidence of malignant plasma cells in a single lesion without generalized bone marrow involvement (25).

Some cases of multiple myeloma are associated with amyloidosis (26). Amyloidosis is defined as the extracellular deposition of proteinaceous hylanine material, labeled "amyloid" (27). Amyloidosis occurs secondary to accumulation of misfolded immunoglobulin light chain proteins in target organs (28). In the maxillofacial region, amyloidosis is usually localized and occurs most commonly in the larynx, oropharynx, trachea, orbit and nasal cavity (26). Macroglossia has also been documented in the literature as a form of local amyloid deposition (29) and periodontal disease has been implicated as a trigger for local amyloidosis (30).

Monoclonal gammopathy of undetermined significance (MGUS), formerly known as benign monoclonal gammopathy, is defined as the non-malignant proliferation of plasma cells along with deposition of monoclonal immunoglobulin (31). MGUS has been associated with renal failure (32), neuropathies (33) and with inflammatory arthritides (34). It has been considered a potential precursor or risk factor for multiple myeloma (35). In the dental literature, MGUS has been associated with amyloidosis (14, 26).

Central lesions of bones in the maxillofacial complex have been reported to

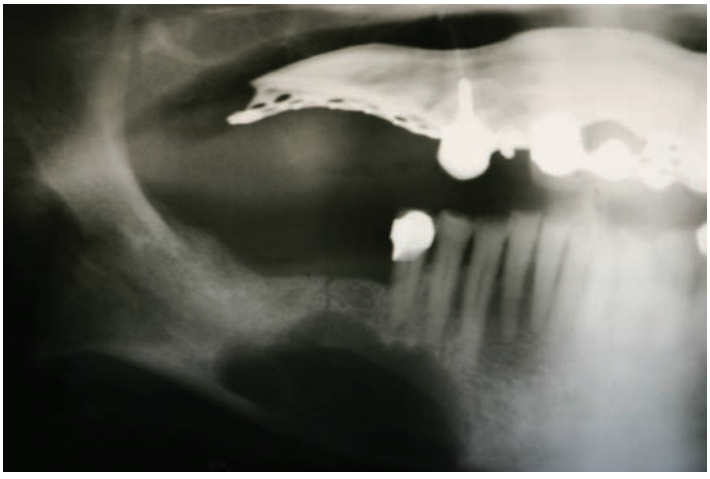

Figure 3. Radiographic examination reveals a 4.5 cm by 2.5 cm radiolucent lesion of the right body of the mandible showing with a vertical pathologic fracture to mandibular crest.

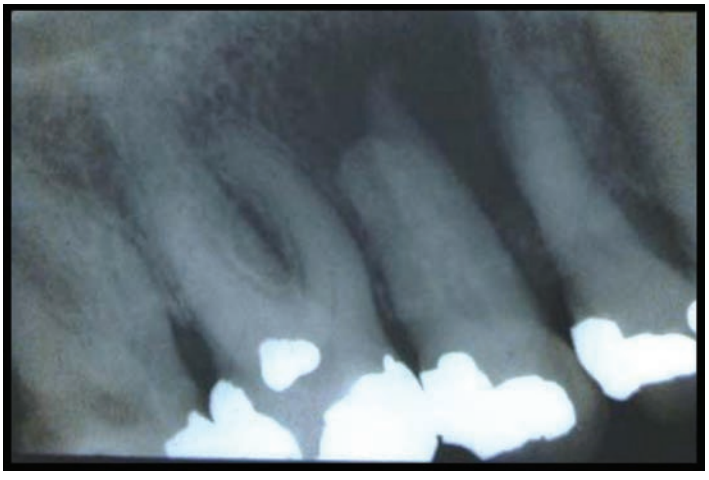

Figure 4. Radiographic examination reveals a diffuse non-descript radiolucent lesion of the right maxilla above teeth numbers 4 & 5 measuring approximately 2 cm by 2cm.

occur secondary to several hematological malignancies, either with or without accompanying symptoms (24). Biopsies remain the standard of care in the definitive diagnosis of conditions which do not follow the usual course of odontogenic infections. These cases illustrate the importance of a thorough radiographic analysis, including the use of high quality panoramic or CT imaging when indicated. The use of flow cytometry and fine needle aspiration may act as valuable clinical aids in the diagnosis of mixed and radiolucent lesions in the jaw bones (36). The three cases reported here demonstrate that the initial clinical presentation of malignant myeloproliferative diseases, such as multiple myeloma or solitary plasmacytoma, may be in the maxillofacial region. The dental profession needs to be aware of the possibility of malignant and benign disorders of plasma cells which may manifest as the sole or initial presentation of myelomatous disease processes.

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Periodontal Abstracts

American Academy of Periodontology Report, written by the Task Force on Peri-Implantitis, reviewed and approved by the AAP Board of Trustees. Academy Report: Peri-implant mucositis and peri-implantitis: A current understanding of their diagnoses and clinical implications. J Periodontol 2013; 84 (4):436-443

Purpose: Review the current knowledge concerning peri-implant mucositis and peri-implantitis to aid clinicians in their diagnoses and prevention.

Methods: The paper reviews the background, diagnoses, prevalence, and incidence, then highlights the following topic areas: etiologies, pathogenesis, risk factors, steps to follow in obtaining a diagnosis, and clinical implications.

Results: Peri-implant mucositis is a disease in which the presence of inflammation is confined to the soft tissues surrounding a dental implant with no signs of bone loss following initial bone remodeling during healing and is reversible. Peri-implantitis is an inflammatory process around an implant which includes both soft tissue inflammation and progressive loss of supporting bone beyond biological bone remodeling. Signs that determine the presence of peri-implant mucositis include Probing Depth (PD) >4mm, no radiographic bone loss beyond remodeling (if baseline radiograph is not present then use a threshold vertical distance of 2mm from the expected marginal bone level following post-implant placement), Bleeding on Probing (BOP) and/or suppuration.
Prevalence was 48% for peri-implant mucositis. Prevalence for peri-implantitis ranged from 6.61% - 36%. The inherent problem is that most studies use differing thresholds for PD and radiographic bone loss to define peri-implantitis which is what explains the variance of the prevalence. Etiologies include formation of a biofilm, gram-negative bacteria; thus, elimination of the biofilm from implant surface is the prime objective of treating peri-implant disease. Pathogenesis: similar markers are up regulated between peri-implantitis and periodontitis, but the rate of disease progression and severity of inflammation is greater in peri-implantitis cases. Risk factors include previous periodontal disease, poor plaque control, residual cement, smoking (very strong evidence), genetic factors (IL-1 gene polymorphism and peri-implantitis remains to be determined), diabetes (theoretically but no strong clinical studies proving), occlusal overload (associated with peri-implant marginal bone loss). Other areas to investigate include rheumatoid arthritis, connective tissue disease, increased time of loading, and alcohol consumption. Early detection of these two diseases is very important. There is no single diagnostic tool that can, with certainty, establish peri-implantitis. Suppuration, bone loss, progressive PD, and BOP (sign of inflammation) are among the diagnostic considerations.

Conclusions: The clinician's guide to peri-implant disease diagnoses and prevention: Identify risk factors associated with developing peri-implant disease, establish radiographic baseline at the time of implant placement, establish clinical and radiographic baseline at the final prosthesis insertion, employ methods that monitor implant health and determine inflammatory complications as part of a periodontal maintenance program and establish early diagnosis and intervention.

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Schrott AR, Jimenez M, Hwang J, Fiorellini J, Weber H. Five-year evaluation of the influence of keratinized mucosa on peri-implant soft-tissue health and stability around implants supporting full-arch mandibular fixed prostheses. Clinical Oral Implant Research 2009; 20 (10):1170-1177

Purpose: To investigate the necessity of peri-implant keratinized mucosa as a prerequisite for long-term soft tissue health and stability of dental implants and to determine if the same 2 mm threshold recommended for natural teeth also applies to dental implants.

Methods: The data for the present study was acquired from a 5-year prospective multi-center trial of the ITI® Dental Implant System. The clinical parameters that were measured included plaque accumulation assessed by the modified plaque index and bleeding measured using the modified bleeding index. Level of the mucosal margin evaluated in relation to the implant shoulder and the distance between the implant shoulder to the peri-implant mucosa (DIM) was measured in millimeters on the mid-facial aspect of the implants.

Results: A total of 58 patients with 307 implants finished the 5-year follow-up period. Plaque accumulation on buccal sites did not reveal any differences between sites with less than 2 mm of keratinized mucosa (KM). Plaque accumulation on lingual sites, in contrast, was statistically significantly different between sites with less than 2 mm of lingual KM. Bleeding scores on the buccal side did not differ between sites with less than 2 mm of KM and those with at least 2 mm of KM. On lingual sites, however, higher bleeding scores were significantly associated with reduced widths in KM over time. The presence of at least 2 mm of lingual KM significantly reduced the odds ratio for bleeding. Another clear association was found between the width of keratinized mucosa and buccal soft-tissue recession measured at the implant shoulder and the distance between the implant shoulder to the peri-implant mucosa. Sites with less keratinized tissue generally exhibited higher amounts of peri-implant recession.

Conclusions: In patients exercising good oral hygiene and receiving regular implant maintenance therapy, the existence of at least 2 mm of keratinized mucosa was beneficial for reduced lingual peri-implant plaque accumulation and bleeding, as well as buccal soft tissue recession for implants supporting full-arch mandibular fixed prostheses. Hence, lingual sites with insufficient keratinized mucosa should be of specific concern during maintenance therapy to detect early inflammatory changes. An increased soft tissue recession over time has to be expected at implants with insufficient keratinized mucosa.

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de Wall YC, Raghoebar GM, Huddleston Slater JJ, Meijer HJ, Winkel EG, van Winkelhoff JA. Implant decontamination during surgical peri-implantitis treatment: a randomized, double-blind, placebo-controlled trial. J Clin Periodontol 2013; 40 (2): 186-195

Purpose: To compare the microbiological, clinical, and radiographic effect of implant surface decontamination by a chlorhexidine 0.12%/cetylpyridinium chloride 0.05% (CHX/CPC) solution in comparison to a placebo solution in resective surgical treatment of peri-implantitis. The null hypothesis was that no difference would exist in reduction of counts of anaerobic bacteria on the implant surface between the two decontamination procedures.

Methods: Thirty systemically and periodontally healthy patients with 1) the presence of ≥1 endosseous dental implants with clinical and radiographical signs of peri-implantitis (bleeding and/or suppuration on probing, peri-implant probing pocket depth of ≥5mm and bone loss ≥2mm) were consecutively enrolled and randomly assigned to experimental or control groups. Pregnant patients, type I diabetics, implants with mobility, implants with bone loss exceeding 2/3 of the length of the implant, and implants with prior surgical treatment were excluded. Following flap reflection, complete degranulation, and mechanical instrumentation with Gracey curettes, patients were randomly assigned to a one-minute surface rinse with CHX/CPC solution or placebo. Flaps were apically repositioned and sutured. Patients in both groups rinsed with the CHX/CPC solution twice daily for two weeks post-operatively. Sutures were removed at two weeks. Patients were seen at 2 weeks, 3 months, 6

months, and 12 months post-operatively where they were reinstructed in oral hygiene techniques, and implants and teeth were supragingivally debrided. Microbiological parameters were recorded during surgery, before and after surface treatment; clinical and radiographic parameters were recorded before treatment, 3, 6 and 12 months after treatment.

Results: Nine implants in two patients in the placebo-group were lost due to severe, persisting peri-implantitis. Both decontamination procedures resulted in significant reductions of bacterial load on the implant surface, but the test group (CHX/CPC) showed a significantly greater reduction than the placebo-group (log 4.21±1.89 vs. 2.77±2.12, p = 0.006). No differences were detected between groups for the effect of intervention on bleeding, suppuration, probing pocket depth, or radiographic bone loss over time.

Conclusions: Implant surface decontamination with CHX 0.12%/CPC 0.05% solution in resective surgical treatment of peri-implantitis leads to a greater immediate suppression of anaerobic bacteria on the implant surface than a placebo-solution, but does not lead to superior clinical results. As this is only a 12 month study, the long-term microbiological, clinical, and radiographic effect of different surface treatments during surgical resective peri-implantitits treatment remains unknown.

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Khashu H, Baiju CS, Gupta G, Praful Bali P. Periimplantitis. Int J Oral Implant Clinical Research 2012; 3(2): 71-76

Purpose: A review to present the etiology, the pathogenesis and treatment of peri-implantitis.
Results: In regards to etiology, it is an infection that shows features common to chronic adult periodontitis. With regards to pathogensis, periimplantitis is 'infection-induced inflammatory process affecting the tissues around an osseointegrated implant in function, resulting in loss of supporting bone". There are two types of implant failures that have been identified: 1) Early: due to occlusal overload that affects the osseointegration and 2) Late: also known as periimplantitis which is a site-specific inflammation that involves microorganisms. Diagnosis of periimplantitis includes clinical markers (swelling and redness of marginal tissue, suppuration, bleeding and pocket formation), radiographic evidence of continued bone loss, especially after the first year of implant placement and mobility of the implant (sign of implant failure). For treatment, the following surgical protocol has proven reliable and predictable in the treatment of advanced periimplantitis lesions:

1. Systemic antibiotics equivalent to metronidazole 400 mg TDS for three days preoperatively
2. Preoperative one-minute mouthwash with 0.2% chlorhexidine
3. Full thickness flap elevation extending beyond the infected area to sound tissues
4. Comprehensive debridement and curettage down to fresh bone, including mechanical curettage of implant surface with carbon fiber curettes
5. Pack gauze strips soaked in 0.2% chlorhexidine around implant, into defect and under the mucoperiosteal flap. Leave in situ for 5 minutes
6. Remove gauze and wash defect with tetracycline solution 1 gm in 20 ml of sterile saline
7. Graft defect with hydroxyapatite bone mineral of allogeneic or xenogenic derivation rehydrated in the tetracycline solution
8. Trim and overlay graft with double layer of resorbable collagen membrane, rehydrated in tetracycline solution

1. The indications for implant removal are as follow:
    1. Severe periimplant bone loss (>50% of implant length)
    2. Bone loss involving implant vents or hole
    3. Unfavorable advanced bone defect (one wall)
    4. Rapid, severe bone destruction (within one year of loading)
    5. Nonsurgical or surgical therapy ineffective
    6. Esthetic area precluding implant surface exposure
    7. Demonstrates mobility.

Conclusion: Patients who have lost their teeth due to periodontal disease seem to be at greater risk for periimplantitis. This study has shown several anti-infective modalities that have shown clinical benefits. However, to date, there is insufficient evidence to support that this is the most effective method in treating periimplantiits.

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Att W, Ogawa T. Biological Aging of Implant Surfaces and Their Restoration with Ultraviolet Light Treatment: A Novel Understanding of Osseointegration. Int J Oral Maxillofac Implants 2012; 27(4):753-761

Purpose: The aim of this review was to evaluate the effects of aging on implant surfaces and to determine whether UV treatment can alter an aged implant surface.
Methods: The authors provide a review of recent in-vivo and in-vitro articles published in relation to the effect of aging and UV treatment on implant bioactivity and physicochemical properties. The majority of the studies evaluate commercially pure grade 2 titanium or titanium alloy samples in disk and cylinder forms with different surface configurations (machined, acid-etched, or sandblasted). In the investigations the titanium samples were placed in a sealed polymer-based container and stored in a dark room. The prepared surfaces were used for the experiments immediately after fabrication (new surfaces) or after storage under dark ambient conditions for periods of up to 4 weeks (old surfaces). Investigators then perform a series of experiments testing the 1.) Effects of aging and UV treatment on the physicochemical properties of implant surfaces, 2.) Time-dependent changes in the bioactivity of implant surfaces, and 3.) Effects of UV treatment on age-degraded bioactivity of implant surfaces.

Results: In comparison to newly prepared titanium surfaces, 4-week-old titanium surfaces (i.e., stored for 4 weeks after processing) required more than twice as much healing time to achieve a similar strength of osseointegration. The bone-implant contact percentage for the 4-week-old surfaces was less than 60%, as opposed to more than 90% for the new surfaces. In vitro, the 4-week-old surfaces showed only 20% to 50% of the levels of recruitment, attachment, settlement, and proliferation of osteogenic cells versus new surfaces. On the other hand, a series of recent papers reported the generation of highly cell-attractive and osteoconductive titanium surfaces by ultraviolet (UV) light treatment. The phenomenon, defined as photofunctionalization, caused fourfold acceleration in the process of osseointegration and resulted in nearly 100% bone-implant contact.

Conclusion: The results of this review suggest substantial impact on the implant world. Efforts to improve the bioactivity of implant surfaces have been primarily focused on modifications of the implant's surface topography or chemic composition. Studies reviewed in this article suggest that time-dependent aging of implant surfaces may often be overlooked. There is a strong possibility that the innate bioactivity of titanium implant products is much greater than that of commercially available products that have been aged for an unidentified period. With the demonstrated effectiveness of UV photofunctionalization in "rejuvenating" aged implant surfaces, the authors of this review speculate that this discovery will offer immediate and extensive applications in various implant therapies because of its simplicity, high efficacy, and low cost.
William Trahan DMD, Resident in Periodontics, Virginia Commonwealth University

Rams TE, Degener JE, Van Winkelhoff AJ. Antibiotic resistance in human peri-implantitis microbiota. Clin Oral Impl Res 2013; 00:1–9. Doi: 10:1111/clr.12160

Purpose: The aim of the study was to evaluate in vitro the antibiotic resistance of the pathogens found in human peri-implantitis lesions.

Methods: The study included 160 dental implants in 120 patients that were diagnosed as having peri-implantitis. The bacteria were sampled for culture analysis and testing of antibiotic resistance. Bacteria were sampled using the paper

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points inserted into diseased sites. Bacteria present were identified and antibiotic resistance testing was performed to evaluate susceptibility to 4 mg/L of doxycycline, 8 mg/L of amoxicillin, 16 mg/L of metronidazole, and 4 mg/L of clindamycin. **Results:** Of the 120 subjects with peri-implantitis, 71.7% had subgingival bacteria that were resistant in vitro to one or more of the test antibiotics. The study also found 28.3% of the subjects did not show any peri-implantitis bacterial test species resistant in vitro to any of the evaluated antibiotics.

Name of antibiotic	% subjects with resistant test species
clindamycin	46.7
doxycycline	25.0
metronidazole	21.7
amoxicillin(8mg/L)& metronidazole(16mg/L)	6.7

Conclusions: There was a wide range of antibiotic resistance in peri-implantitis bacteria that was found in the study. The greatest resistance was to clindamycin. Resistance to a combination of amoxicillin and metronidazole was rare. Thus it may be indicated to perform a microbiological analysis and antibiotic resistance testing before treating the patient with antibiotics.

Anya Rost, DMD, Resident in Periodontics, Virginia Commonwealth University

Zigdon H, Machtei EE. The dimensions of keratinized mucosa around implants affect clinical and immunological parameters. Clinical Oral Implant Research 2008; 19 (4):397-392

Purpose: The aim of this retrospective clinical trial was to examine whether the width and thickness of keratinized mucosa (KM) is associated with the clinical and immunological parameters around dental implants.

Methods: Thirty-two patients (14 female and 18 male) and a total of 68 implants were included in the study, and each patient had at least one dental implant restored by a fixed prosthesis that had been in function for at least one year. All implants had the Osseotite® surface by Biomet-3i. Probing depths (PD), periodontal attachment levels (PAL), bleeding on probing (BOP), as well as the plaque and gingival indices were measured at three sites around each implant and a mean implant value was generated. The KM width, mucosal thickness (MTh) and mucosal recession (MR) were all recorded from the mid-buccal aspect by a single examiner. Peri-implant crevicular fluid (PICF) samples from the mesiobuccal of each implant were collected using paper strips before any periodontal probing and after the removal of supra mucosal plaque. Prostaglandin E2 (PgE2) levels were determined using the enzyme immunosorbant assay (ELISA) kit. Descriptive statistics were performed to characterize the subjects and the implants.

Results: Thin mucosa (<1 mm) was associated with two times greater MR compared with thick (>1) mucosa. Also, a positive correlation between MTh and PD was established. A negative correlation was found between KM width, MR and PAL. Also, a narrow mucosal band (<1 mm) was associated with three times greater MR and more periodontal attachment loss. KM width was positively correlated to PD, whereby implants with a wider mucosal band (>1 mm) presented with a higher mean PD. PgE2 levels in the present study were negatively correlated with KM width. However, on dichotomizing the data by KM width (thick >1, thin <1), no significant differences were found between narrow or wide mucosa bands regarding PgE2 levels.

Conclusions: The KM thickness and width around dental implants affects both the clinical and the immunological parameters at these sites. These findings are of special importance in the esthetic zone, where narrow and thin KM may lead to greater MR.

Stephanie Voth, DDS, Resident in Periodontics, Virginia Commonwealth University

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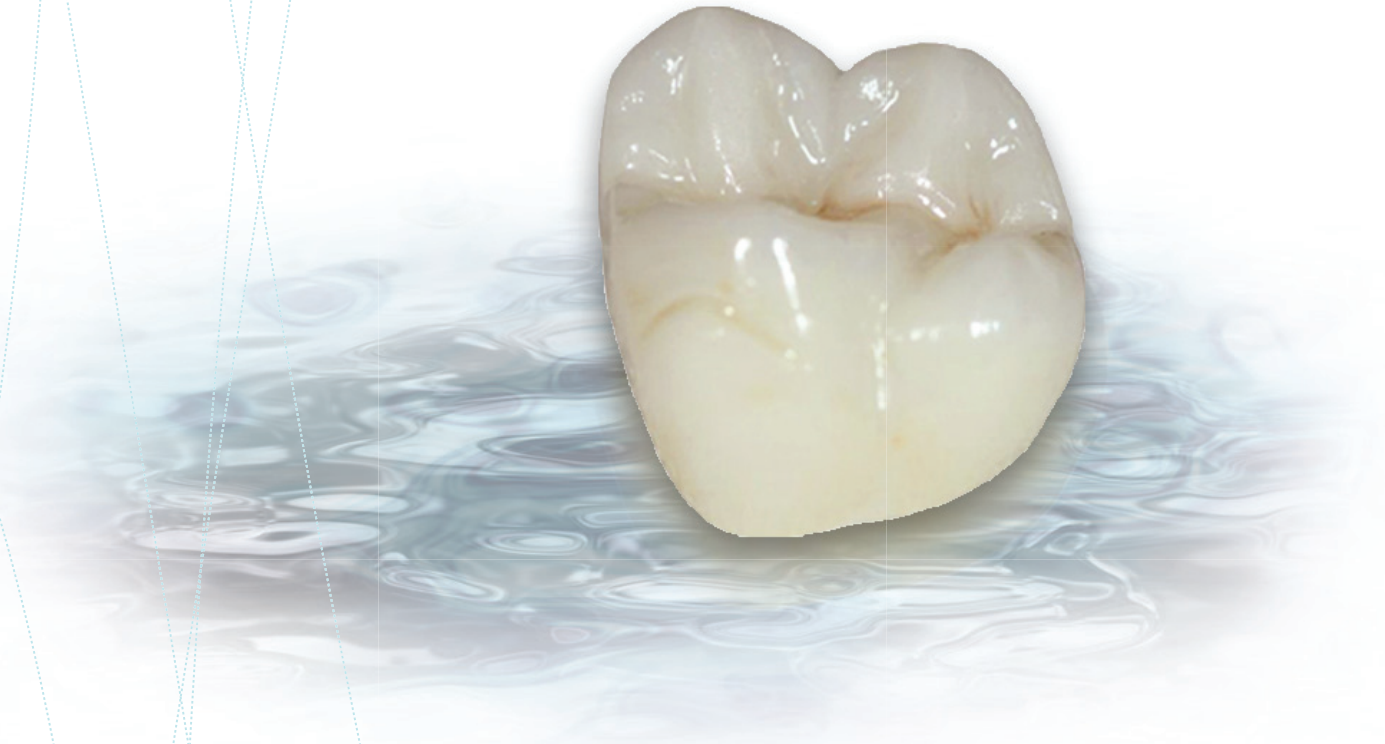

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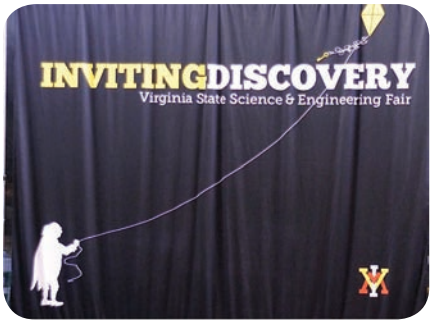
OOOTTAFAGVAH = ???

By: Dr. Matt Storm



Imagine, if you will, seeing tomorrow's technology, say twenty to thirty years into the future, but present in research today. This is really happening here in Virginia and other states as we speak via the State Science Fair competitions throughout the nation. The projects presented win first at high schools, then at the regional competitions, and are finally judged at the state level. Later the winner of these goes on to compete internationally in the many fields of science for the top awards in the International Science and Engineering Fair in Phoenix this year. In the past, research into ibuprofen to treat pancreatic cancer cells and using vitamin A smeared onto food (try donuts) to kill cockroaches were winners. True!

This year's state Science Fair Competition was held at Virginia Military Institute's Cameron Hall on April 6, 2013. Seventeen categories in science included animal science, biochemistry, planetary science, engineering, mathematics, physics and computers, to name only some. Over 300 projects were presented, and many of these required careful thought. Try these titles. "Effects of Biochanin A on Ivermectin Resistance in C. elegans" (treating parasitic worms resistance to the drug ivermectin), "Reprogramming Dental Pulp Stem Cells into Hepatocy" (taking dental pulp tissue, converting them into stem cells and then growing them into liver cells with the hope for complete liver organs), and "The effects of Phyto and Bioremediation on Oil Spills" (What worked better in cleaning the oil spills in the Gulf of Mexico? Cells that ate oil, or chemicals?) These are worthy of mention, but these were not the winners of the Virginia Dental Association Awards program.

So what does the VDA award? Many years ago the Virginia Dental Association established a program to reward these young scientists for their insight, organization and thoughtfulness for their science projects. For each of the twenty categories, a $100 award and a certificate of merit is given.
Only one of these is selected for the VDA Grand Award of $1500. This is the Dr. Bennett A. Malbon Prize. It is given not only for excellence in scientific research, but also for the individual's community service to help others. Presenting the awards to the winners was VDA President, Dr. Kirk Norbo. He directed his remarks not only to the students, but also their parents concerning excellence and quality, and the importance of these qualities in a dental career.

So ... who won with what? It was tough. Many of our award winners were so close to each other in talent. If it were a horse race, the top award would have been a photo finish! Dr. Jackson Payne presented the top award, the Malbon Prize to Vaibhav Tadepalli for his experiment "Can we use snails to repair ligaments?" Intriguing ideas and the means to test them. By harvesting a certain organ from snails and working with it, he manufactured the building blocks and their tethers of ligamental filaments. So the answer is, yes! Vaibhav Tadepalli received not only a plaque recognizing him for receiving the Malbon Prize, but also the check for $1500 for his endeavors. Of all the special awards honoring the students at the Science Fair from the other faculty and specialists judges, none comes close to this. Vaibhav was quite surprised.

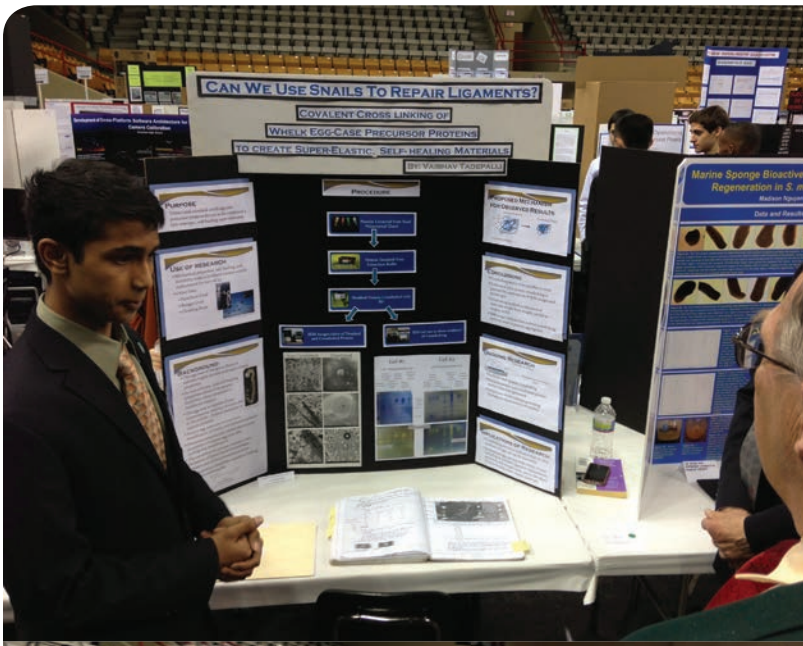
Two other entries almost claimed the top prize. Arjun Jaini used advanced chemistry in his project "A Quantum Mechanical Study of Tautomeric Trigger of Berman Cyclization" or in short, finding the cancer kill switch. This young man really knows his stuff. Enthusiastic and knowledgeable, he'll be back next year (he's a junior) with more research. David Lewis's project "The Effect of Hydrogen Ion Concentration of Eastern Oyster Filtration Rates" was nearly a winner. He showed acidity in water does affect the oyster's ability to filter their habitats into clean water. The other VDA award winners all had intriguing experiments and some are young enough to see a return appearance for next year's competitions.

The VDA would like to thank Dr. Tim Russell and his group of volunteers, doctors and dental students, for making this year's judging easy and enjoyable. Each one remarked how much they learned from being present and how enjoyable it was. This is noteworthy since many traveled hours each way from around the state to attend.

These judges were: Dr. Jackson Payne, Dr. Bill Burston, Dr. Matthew Storm, Dr. Leah Luck, Dr. Richard Zechini, Dr. Wallace Huff, Dr. Clay Devening, Dr. Leonard Jackson, Lyubov Slascheva D-1, Jeremy Jordan D-3, Brian Mahoney D-3.

Next year's State Science Fair will be again at VMI on Saturday, March 29, 2014. We look forward to more volunteers to assist at this even, but, believe it or not, you can be in on the ground floor at the regional, or even at the high school level. We need judges here too. Think about it. They are the future leaders in science. Why not with us?

Oh, by the way, the title of this article OOOTTAFAGVAH = ??? Its the old acronym for On Old Olympus Towering Top A Finn and German Viewed A Horse. Well, some of us remembered viewing a hop. First semester biology classes in zoology. Ahh, remember those days? These science fair projects are so far above this. Come join us next year!



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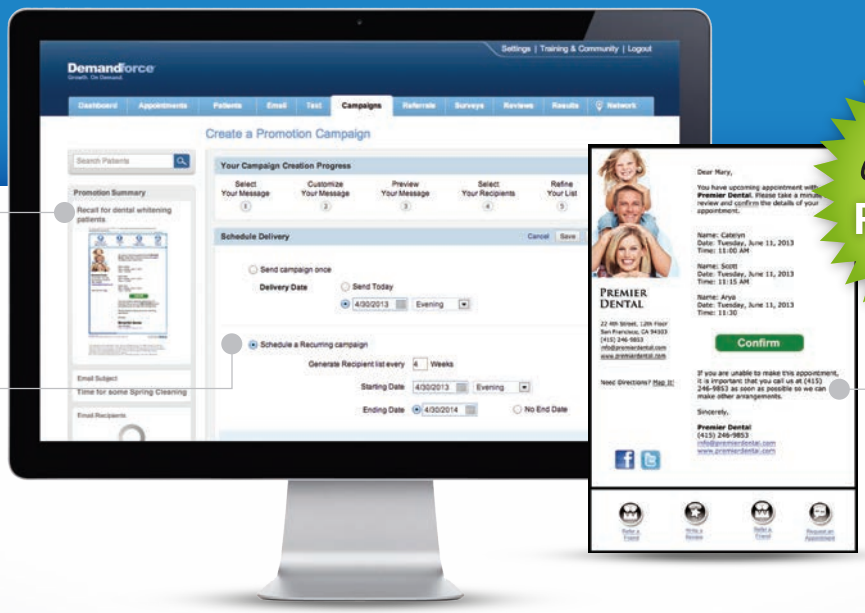

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VADPAC CONTRIBUTION UPDATE

See Where Your Component is and What You Need to Do to Meet Your Goal

Component	% of Members Contributing to Date	2013 VADPAC Goal	Amount Contributed to Date	Per Capita Contribution	Amount Needed to Reach Goal
1 (Tidewater)	32%	$45,500	**$30,798**	$254	$14,702
2 (Peninsula)	39%	$26,500	**$23,252**	$264	$3,248
3 (Southside)	48%	$13,000	**$13,266**	$235	$0
4 (Richmond)	34%	$66,000	**$58,431**	$289	$7,569
5 (Piedmont)	33%	$31,000	**$21,762**	$234	$9,238
6 (Southwest VA)	47%	$25,250	**$21,797**	$266	$3,453
7 (Shenandoah Valley)	36%	$30,000	**$22,459**	$261	$7,541
8 (Northern VA)	35%	$135,000	**$110,434**	$270	$24,566
TOTAL	35%	$372,250	**$302,014**	$259	**$70,236**

Total Contributions: $302,014

2013 Goal: $372,250

Amount Needed to Reach Goal: $70,236

Every year, VADPAC participates vigorously in the political process to make sure that dentistry's voice is heard and to ensure that the interests of your patients are foremost in the General Assembly's eyes. This money allows the VDA's position to be heard by the people who make the laws in the Commonwealth. **When have we been heard? Let me remind you….**

- In 2010 the General Assembly almost unanimously supported the VDA legislation restricting insurance companies from mandating fees for procedures for which they are NOT paying.
- In 1999, there was also a heated contest with big insurance companies, however; the General Assembly agreed with the VDA and granted dentists and oral surgeons the right to have their patients assign their benefits and didn't prohibit balance billing. Many other states have still not been able to win this battle against insurance companies.
- During the 2006 Session of the General Assembly, the VDA helped secure $11.7 million for the expansion of the VCU School of Dentistry.
- Tens of millions of dollars have been added to the Medicaid dental program to more appropriately serve the children of Virginia. The dental program has been removed from Managed Care Medicaid and is an autonomous fee for service program.
- Most recently, during the 2013 Session, the General Assembly approved both the VDA's "road map" budget language and the appropriation of $967,944 in General Fund money to continue operation of local Virginia Department of Health clinics in the fiscal year beginning July 1, 2014. The legislature also appropriated $696,362 in non-General Fund dollars for these programs for the same period.

VDA member contributions to VADPAC have helped make certain that dentist voices are heard. We must continue this level of giving in order to sustain the very positive reputation dentists have in the halls of the Capitol and protect the profession and your patients for future generations. Unfortunately, **only 35% of VDA members have contributed so far for 2013.** We thank all of the VDA members who have opened their wallets this year and in years past and we urge other members also to play a part in securing the livelihood of the practice of dentistry. Contribute today!!

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

Contact Laura Givens at givens@vadental.org or 804-523-2185 to contribute.

ADA Washington Leadership Conference

By Laura Givens, Director of Legislative & Public Policy

The ADA hosted its annual Washington Leadership Conference at the JW Marriott: May 13-15. VDA Action Team Leaders attended to present their views on federal issues important to the profession and its patients. The VDA would like to thank all Action Team Leaders who were able to attend and meet with their Representative and Senators. The Action Team Leaders participating were: **Dr. David Anderson, Dr. H.J. Barrett, Dr. Mark Crabtree, Dr. Terry Dickinson, Dr. Ralph Howell, Dr. Bruce Hutchison, Dr. Rod Klima, Dr. Ron Tankersley, and Dr. Gus Vlahos.**

Photo by Bill Geiger, courtesy ADA News

Conference attendees were briefed on the key issues to be discussed during their Capitol Hill visits and also heard from members of Congress and the Senate, as well as political analyst **Charlie Cook**.

During the meeting, the ADPAC Board presented the 16th District with an award for contributing the most money to ADPAC in 2012. **Dr. Bruce Hutchison**, ADPAC Board representative, proudly accepted the award on behalf of the district members (NC, SC and VA).

The issues at the forefront of Congressional lobbying this year are:

- **Repeal of Medical Device Excise Tax: HR523; S232**
  - These bills would repeal the excise tax on medical devices, which is part of the Patient Protection and Affordable Care Act. The dental industry estimates that the excise tax will increase the cost of dental care by $160 million annually. Medical device manufacturers, producers and importers are passing the increased cost on to dental providers. Patients may see treatment fees increase as a result of the tax, but much of these costs will be borne by dentists due to the nature of dental insurance.

- **Dental Insurance Fairness Act of 2013: HR1798**
  - **Representative Paul Gosar** (R-AZ), an ADA member, introduced this bill with bi-partisan support to help consumers receive the full value of their dental coverage. HR1798 requires that all health plans offering dental benefits provide uniform coordination of benefits. When a consumer is covered by more than one plan, the secondary payer should be responsible for paying the remainder of the claim (up to, but not exceeding, 100% of the amount of the claim). In the ADA's view, it is an unfair gain at the expense of beneficiaries for the insurance industry to do otherwise. Passage of this legislation would provide a more equitable system for dental patients, making dental care more affordable and accessible.

- **Coordination of Pro Bono Medically-Recommended Dental Care Act: S466/HR963**
  - This legislation creates a grant program (authorized at $2 million per year for five years) to support the coordination of medically- recommended dental care for low income individuals. Dental care will be provided by volunteer dentists at no cost to patients who have medical conditions such as diabetes, cancer, autoimmune disease, kidney disease or those who need heart or joint replacements or transplants. This legislation is needed because Medicare, which does not cover routine dental services, will not pay for the coordination of medically-recommended dental care, with many underserved patients thereby prevented from receiving needed care or having an existing chronic condition compromised for want of treatment.

Action Team Leaders and the VDA Legislative Committee will continue to monitor these issues, and the VDA will communicate with the Washington delegation as necessary.

VDA members are encouraged to participate in legislative and grassroots events like the ADA WLC, as well as the **VDA Day on the Hill in Richmond (January 17, 2014)** and by attending local fundraisers for incumbents and candidates in your respective districts.

VADPAC Fundraisers - Spring 2013

The VDA continues to ambitiously support campaigns for legislators and this year has been exceptionally successful. Two events were held in the spring and we are planning on hosting several more throughout the summer and fall, prior to the 2013 elections in the Commonwealth. We encourage everyone to contribute and attend VADPAC Fundraisers as they are a wonderful opportunity to gather socially with your friends and colleagues and meet with legislators in an intimate setting. VADPAC appreciates VDA member involvement in steering committees to make these fundraising events successful. Below are the fundraisers that we held this spring…

Delegate Beverly Sherwood Fundraiser in Winchester

The VDA hosted a fundraising event at the Winchester Country Club on May 15 in honor of Delegate Beverly Sherwood. Dr. Rick Taliaferro chaired the event with help from steering committee members Drs. Byron Brill, Ben Hanson and Bob Hall. Beverly Sherwood represents the 29th district in the Commonwealth. Dentists from her district and surrounding areas attended the event to show their support for Ms. Sherwood, a strong supporter in the General Assembly of dentistry and the interests of dental patients.

Delegate Bobby Orrock in Fredericksburg, VA

On May 23rd, dentists and friends gathered at the Ristorante Renato in Fredericksburg to express their support for Delegate Bobby Orrock. Drs. Stan Dameron, John Rose, David Huddle and Matt Caspersen helped with the event. Delegate Orrock, who represents the 54th district, chairs the House Health, Welfare and Institutions Committee, which is the focal point for all health care matters coming before the House of Delegates. VDA members from his district, which includes parts of Caroline and Spotsylvania counties, and members from surrounding areas attended the event.

Five Things Every Practice Should Do in Today's Economy

By Howard Farran, DDS, MBA, MAGD

The recession is over. It has been for two years. Patients who put off the filling they should have gotten three years ago are coming back in need of a root canal. The one thing every recession teaches the dental profession (but we often forget) is for as hard as things get during the recession, we're going to see an influx of patients due to massive pent-up demand. We've seen 10 recessions in the United States since World War II, and we're bound to see another. Those of us who weathered the storm and kept our practices open should feel fortunate, yes, but it also indicates that you did something right. Even two years out from this recession, many of us are still wary. We still hear a lot about tax increases and spending cuts. The uncertainty driven by recent economic times – especially for those who own small businesses – is almost palpable. Patients are coming back, but that does not mean we should rest on our laurels. Now is the time you need to reinvest in your business. Here are five things you should consider doing right now that I believe will create opportunity for increased revenue, better patient care and long-term success.

Take Ownership

Right now is an amazing time to purchase your own property. Since 2007, the cost of owning real estate has decreased. In some areas, you can buy buildings at almost half the cost of what they were six years ago. When you own your building you are no longer subject to the uncertainty of rent increases when your lease is up for renewal. Your monthly payments to the bank are set in stone for the next 20 to 30 years. Your monthly payments also build equity in a real, tangible asset that most likely will appreciate over time. This is a no-brainer. You need to own your own building.

Be Ready for Emergencies

Most hospitals have an emergency room where they can accommodate unscheduled patients in need of care. Many general dental practices do not. In fact, if a patient calls with an emergency, many dentists are ill-equipped to see them that same day and might not be able to schedule an immediate appointment. If a patient with a broken tooth calls a practice and hears, "We can fit you in the day after tomorrow," that patient hangs up and searches for a practice that will see him immediately. When you turn away an emergency patient, you lose the opportunity to get them out of pain that very day, and you lose the immediate bump in revenue (and you're certainly not going to earn that patient's repeat business either).

Dentists should invest in their business by creating an "emergency operatory" – a room that is always open and never scheduled – so patients needing immediate care can come in and get the treatment they need immediately. This is such a win-win situation: Patients get the care they need when they need to get out of pain, and practices that can accommodate these emergency patients see around $50,000 more in production each year.

Go Digital and Be Real

Automated messages and phone systems are not only annoying but they might be losing you business. I've practiced dentistry for more than 25 years and I've seen that if you increase the number of calls that are answered by a real, live person, you're going to increase the number of patients you see. Period. Unfortunately, most dental practices staff our front office phones from nine to five, taking an hour off for lunch. Yet, your phone starts ringing at 6 a.m. and you might get calls until 6 or 7 p.m. You need to find out if you are missing calls and opportunity. Invest in a digital phone system with Voice-over Internet Protocol (VoIP) where your calls are sent over the Internet not public "wires." This allows for more detailed telephone call tracking and management. Once you have VoIP, you can track and manage incoming calls, gaining a better understanding of when they are coming in, from where, and how long they last. VoIP can even track dropped calls – those where the patient terminates the call without leaving a message. Using this information, you can make sure that when the majority of incoming calls are made you have a friendly, helpful, live person picking up the phone, accommodating your patients and setting appointments.

Market Like Michael

When it comes to marketing, Michael Dell – founder, chairman and CEO of Dell, Inc. – is a legend. In March 2000 the NASDAQ was at 5,056. Then it popped and most Internet stocks plummeted. Instead of cutting his marketing budget to cut costs as his competitors did, Michael Dell increased his marketing budget threefold and launched the famous "Dude, You Got a Dell!" campaign. Many thought he was crazy, but just three short years later, Dell Computers overtook HP to become the world's largest computer maker. In any economy – good or bad – invest in your business by increasing your marketing efforts, especially online. Optimize your website, particularly for mobile devices. Make sure your SEO strategy is both effective and efficient. Invest in Google ads. Consider social media as an inexpensive way to create and maintain patient relationships that only costs you time, inspiration and effort. Connect with colleagues on sites like Dentaltown.com to find out which marketing tactics work for them. Reach out to your vendor partners to tap into free marketing resources they may have available.

Take Control of Your Money

It makes little sense to have your hard-earned money sitting in someone else's bank account instead of yours. If you choose to extend credit to patients yourself, you put your cash flow and retirement at risk. Remember, you are not a bank! Limit your accounts receivable to underestimated insurance. Everything else should be collected at time of treatment. If patients would like to pay over time, use an outside financing program like CareCredit. That way you get paid immediately, have the cash flow available to invest in real estate, an emergency room, and other overhead expenses – without stress – and you keep finances out of your patient relationships.

There's a saying I live by: you can either fly with the eagles or trot with the turkeys. It's your choice. You can either blame the economy for your practice's stagnant growth or you can take control and invest in your business, and in the items above, which will provide you with a positive return, now and for years to come.

Dr. Howard Farran is the founder, owner and chief executive officer of Dentaltown.com and Dentaltown Magazine. An internationally-known expert in practice management.

More than a tag line

By: Samuel W. Galstan, DDS, MPH; Member, VDA Public Relations Task Force

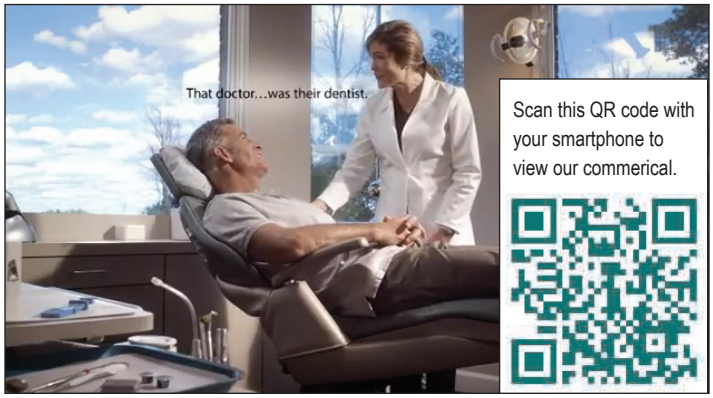
On May 15, 2013, the day of the VDA Public Relations launch, my wife was impacted three times by the VDA ad campaign. On this day, my wife, Dr. Sharone Ward, saw a patient who is a 51 year old truck driver, for a restorative procedure. As is our normal office protocol, Dr. Ward obtained a pre-op blood pressure before administering local anesthesia. Her patient's pre-op blood pressure was 200/120. She informed her patient that this was an extremely high blood pressure, and at that time the patient related that for the past several days the patient had been experiencing headaches and pain in the back of his neck. Dr. Ward did not give the patient any anesthesia, and instead called the patient's physician, who debated whether he should have the patient come to his office immediately, or to send the patient to the Emergency Department in the local hospital. The physician decided to have the patient come to his office. The patient's wife drove the patient to the physician's office, who obtained a second blood pressure of 210/127. While the patient had already been on blood pressure medication for the past several years, the patient was unaware that he had any issues with his blood pressure. However, the patient's physician said that the patient had been non-compliant. The patient told Dr. Ward that he had not been taking his previously prescribed blood pressure medication regularly. The patient's physician placed him on a stronger blood pressure medication, and referred the patient for further testing.

It is interesting to note that this same patient had been referred previously to his primary care physician years ago by Dr. Ward, who had obtained an elevated pre-op blood pressure reading then. At that time the patient was placed on a blood pressure medication. It is interesting to note that the patient's original discovery of elevated blood pressure was made by Dr. Ward several years previously, and that she made the follow-up diagnosis with this non-compliant patient.

High blood pressure (HBP) or hypertension affects about 1 in 3 adults in the U. S., an estimated 68 to 74 million people. Untreated high blood pressure is known as the "silent killer" because many times there are no symptoms or warnings signs. Untreated HBP increases the risk for heart disease and stroke, two of the leading causes of death in the US. It also increases the chances of kidney damage, vision loss, erectile dysfunction, memory loss, fluid in the lungs, angina and peripheral artery disease. A condition known as hypertensive crisis exists when systolic BP readings of 180 or above and diastolic readings of 110 or more are obtained, necessitating emergency medical treatment. Individuals with readings of 140/90 or more may run the risk of serious long term damage and adverse health consequences (Centers for Disease Control and Prevention, 2013), (American Heart Association, 2013).

Later that day, the VDA pamphlets that are part of the Public Relations campaign arrived at our office, with the tag line: "Want a Healthy Body, Start with a Healthy Mouth". Dr. Ward commented that it was a weird coincidence, that pamphlets emphasizing whole body health being related to regular dental care arrived on the day that she diagnosed a patient with extremely unhealthy and life-threatening high blood pressure. Dr. Ward asked if the ADA was paying for the pamphlets, and I told her no, this is a VDA initiative, and that the VDA felt so strongly about this education campaign that the VDA was paying for this with an additional dues assessment.

Later that evening while watching television, Dr. Ward saw a VDA Public Relations television commercial for the first time. In this commercial, the announcer said that: *"Did you know that your dentist could help diagnose early warning signs of diabetes, oral cancer and high blood pressure? So if you want a healthy body, start with a healthy mouth, and visit a VDA member dentist every six months"*. A copy of this commercial can be viewed on the VDA's website (www.vadental.org). In Dr. Ward's case, talk about a VDA dentist possibly saving the same patient's life TWICE! VDA member dentists have been impacting healthy outcomes in our patient's lives for a long time, now; it is just a matter of telling our story. Later that week, a patient who recently had a heart transplant, and



another patient with multiple medical complications commented that they had both seen the VDA commercials, and that they both thought that the VDA ad campaign and VDA dentists were providing a great service to their patients and the community.

I am so proud of the VDA for having the courage and foresight to initiate this public relations campaign. Some VDA members have complained about spending any additional money towards dues. However, I am thankful that the VDA has had taken the initiative for this public relations campaign. While many are concerned about organized dentistry's decrease in market share, I am excited that we have finally taken a bold move forward. I think that this will be money well spent. We all need to do a better job of telling the VDA's story, as well as telling the public and all dentists in Virginia about the value of VDA membership!

References:

American Heart Association, (2013). Retrieved on 5/19/2013 from: hhttp://www.heart.org/HEARTORG/Conditions/HighBloodPressure/AboutHighBloodPressure/About-High-Blood-Pressure_UCM_002050_Article.jsp

Centers for Disease Control and Prevention, (2013). Retrieved on 5/19/2013 from: http://www.cdc.gov/bloodpressure/

Virginia Dental Association, (2013). Retrieved on 5/19/2013 from: http://www.vadental.org

The patient involved in this case was contacted and agreed and consented to the release and publication of this information.

Dr. Sam Galstan is a member of the VDA Board of Directors (for Southside Dental Society), and is a member of the VDA Public Relations Task force.

Dr. C. Sharone Ward has been a VDA member dentist since 1989 who has practiced general dentistry in Chester, with her husband, Dr. Sam Galstan since 1990.

Too much MAIL?

Then get your Journal ONLINE!

Go to www.vadental.org/optout to request that you only receive your VDA Journal online.

A valid email address is required in order to submit your opt out preference.

Questions? Contact Shannon Jacobs, VDA Director of Communications jacobs@vadental.org or 804-523-2186.

Capitalizing on Your Team

By: Dr. James Schroeder

Companies listed as top employers have discovered their greatest assets are their co-workers. However, knowing something does not mean we apply it in our work place. Maybe you are a skeptic, and don't believe that an engaged employee working in their strengths can maximize not only your bottom line, but also patient and staff satisfaction. The Gallup Organization asked 198,000 employees if they routinely worked in their strength within 36 companies. The organizations with employees routinely answering "yes" to that question consistently outperformed their competitors. The book *NOW, Discover Your Strengths* is a must read! The revolutionary program shows you how to develop your unique talents and strengths – and those of the people you manage. Almost a third of our gross revenue is directed toward staff, yet our leadership in development of their strengths and skills is often lacking.

Our professional training and demands of patient care often result in these critical areas not receiving the attention they deserve. Leadership in these areas will impact our practice growth, satisfaction and staff retention.

How do I find time and energy to deal with these important components of my business?

Pass it on to an office manager without clear expectations and the necessary people skills? Discuss your plan with a staff member while walking down the hallway or over the patient while delivering care, making a point to leave other team members out of the conversation? Just implement your ideas with limited communication to the team? Maybe you have not experienced the result of the above half- hearted efforts at addressing improvement or team engagement. I have had the privilege of stumbling in all these areas over 35 years of practice. In that journey, I have discovered some strategies that promote engagement and allow team members to take responsibility for action. While interviewing staff for Leadership by Design workshops the two most common complaints are the doctor won't follow through on necessary change or address the difficult employee. "He or she does not care what I think or what I could offer." One of the most desired qualities in the workplace is to be valued. I have found that, if it is all up to you, it will frequently fall short of your desired outcome and the staff loses confidence (nothing is going to change).

Try this for summer office meetings!

Allow me to propose the office meeting initiative that engages staff, improves morale and gives team members the sense they are valued. Is that an oxymoron? Look around your office – are team members valued by you and do they value each other? Perhaps you already have great, productive, energizing meetings; if so read no further. Congratulations! Send me what you are doing for future tips to our readers. Being valued is a top priority of people in the workplace.

Following is an outline for summer rejuvenation and creating team ownership:

- Announce (both verbally and in writing) to the team your desire to tap into the talents and ideas of each team member.
- The summer theme will be "How can we set ourselves apart?" solutions through action meetings.
- Set the framework for the action gatherings. Have a standard agenda and let the staff fill in the details to be discussed. Block out office time, not the lunch hour. Do this for the next three months – it shouts that you believe this time is important.
- Establish the attitude everyone is responsible for creating a thriving culture. Often I see a victim mentality, that it is someone else causing problems. This often kills the spirit of the effort. If it is one individual address it in private. (See *Virginia Dental Journal*, October 2012, "Difficult Conversations") A chief complaint I hear from staff is the doctor addresses everyone about a problem when the problem is only with one individual staff member.
- All team members are expected to talk and nobody interrupts. Often meetings are dominated by a single individual. Allow people to speak without criticism and be heard with respect. Create a goal that everyone builds on the skill of better listening to patients and to each other.
- Have established sections on the agenda:
    1. Equipment, maintenance and repair needs to bemore productive. This is also a time to get everyone on the same page.
    2. Supplies, materials and procedure set up and sterilization protocol.
    3. Listening and understanding staff and patient issues to develop higher level communication skills.
    4. Scheduling success and where can we improve should have an open conversation, and do not throw people under the bus. Allow 10-15 minutes for each of the four categories above. If more time is needed assign it to a few team members for further discussion and action with a deadline for completion. Avoid one issue or one person dominating the meeting with no conclusions.
    5. *Always have a time slot for celebration. There is always someone or something to celebrate. Celebrate when people show a random act of kindness, a beautiful case, or a special occasion.*
    6. Identify someone responsible for taking notes and delivering them to all team members the next day. The notes will cover each issue and identify action items that are assigned to people during the conversations. Each action item has a completion date and prevents the same issue from coming to the table month after month.

This is a skeleton outline for engaging your team for all areas of growth, marketing, procedures, staffing and more efficient operations. Please take the time to check out the books I have listed. Depending on your leadership skills and style it may require some practice. I guarantee it will pay dividends. Please call with questions. It is not without its bumps, but it will give you an edge in a rapidly changing profession that requires greater collaboration along with decisive leadership.

Bibliography:

Buckingham, Marcus, and Donald O. Clifton. Now, Discover Your Strengths. New York: The Free Press, 2001.

Nicholas, Michael P. The Lost Art of Listening. New York: Guilford Press, 1995.

Kouzes, James M., and Barry Z. Posner. The Truth about Leadership. San Francisco: Jossey-Bass A Wiley Imprint, 2010.

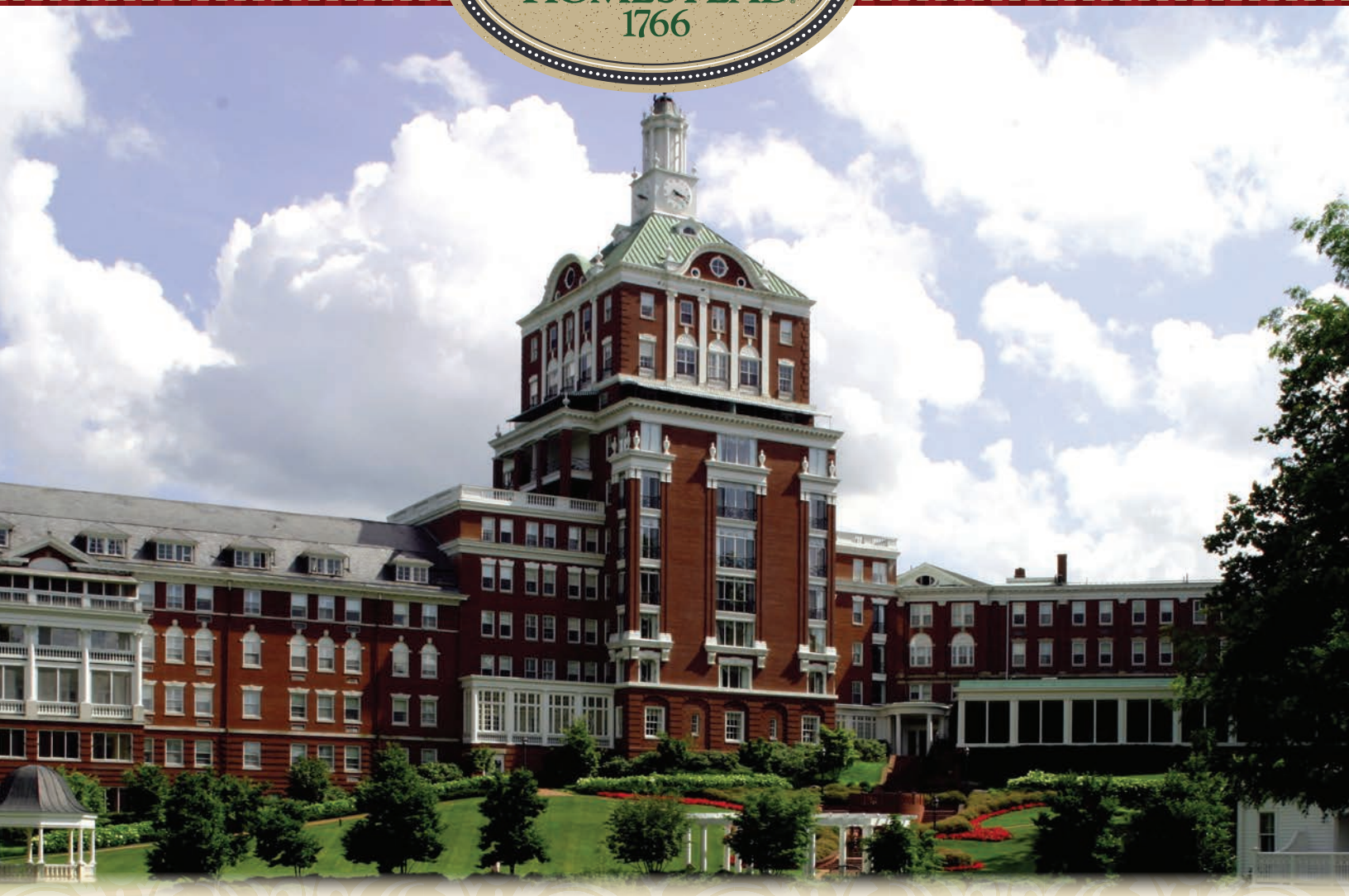
Dr. James Schroeder practiced in Richmond. Please email him your experiences and questions to be addressed in future columns.
drjimschroeder@gmail.com
He may be contacted at (804) 307-5108.

THE Virginia MEETING®

A Program of the Virginia Dental Association

SEPTEMBER 18-22, 2013

THE HOMESTEAD 1766



DATES TO REMEMBER:

Pre-registration Deadline:
August 30, 2013

Onsite Registration:
September 18-22, 2013

REGISTER TODAY!

Online at www.VADENTAL.org/PRO

Phone - 1-877-205-1943 between 9:00am-6:00pm

Mail - Use the registration form on pgs 39-40.

2013 Virginia Meeting - Complete Schedule of Events

Wednesday, September 18, 2013

Code	Course Title	Speaker/Event Host	Time	Credits	Cost
n/a	Registration Open	VDA	10:00am - 5:00pm	0	various
n/a	VDA Board of Directors Meeting	VDA Board of Directors	7:00am-Noon	0	n/a
W32	Annual VDA Golf Tournament	VDA	12:30pm start	0	$195
n/a	VDA Board of Directors Dinner	VDA Board of Directors	6:30pm-9:00pm	0	n/a

Thursday, September 19, 2013

Code	Course Title	Speaker/Event Host	Time	Credits	Cost
n/a	Registration Open	VDA	7:00am-5:00pm	0	various
n/a	House of Delegates - Registration	VDA - House of Delegates	7:15am-8:00am	0	n/a
n/a	Business Meeting/HOD Opening Session	VDA - House of Delegates	8:00am-10:00am	0	n/a
T1	Common Sense Endodontics: Where Sophistication & Simplicty Meet	Dr. Barry Musikant	8:00am-11:00am	3	$0
T2	Blood, Spit, and Fears: A Painless OSHA Update	Laney Kay	8:30am-11:30am	3	$0
T5	Why Are Women So Strange and Men So Weird?	Bruce Christopher	9:00am-Noon	3	$0
n/a	Cascades Gorge Tour	VDA	9:30am	0	$31
n/a	Reference Committee Hearings	VDA	10:30am-Noon	0	n/a
T6	Boxed Lunch Pick Up	VDA	11:30am-2:00pm	0	$21
T8	Treatment Planning in the Esthetic Zone	Dr. James Wooddell & Dr. Joe Passaro	1:30pm-4:30pm	3	$0
n/a	Reference Committee Hearings	VDA	12:30pm-2:00pm	0	n/a
T9	Let's Do It! SEO, Social Media and Online Marketing	Susan Richardson	2:00pm-5:00pm	3	$75
n/a	Town Hall w/ ADA President-Elect	Dr. Charles Norman	2:15pm-3:15pm	0	n/a
T10	Bambi vs. Godzilla	Bruce Christopher	2:00pm-5:00pm	3	$0
T11	Expanding Your Practice Through Early Childhood Dental Care	Dr. Tegwyn Brickhouse & Sarah B. Holland	3:30pm-5:00pm	1.5	$0
T33	Ping Pong Tournament	VDA	3:30pm-8:30pm	0	$15
n/a	Exhibit Hall Open	VDA	5:00pm-6:30pm	n/a	n/a
T12	Opening Reception	VDA	5:00pm-6:30pm	0	$0
n/a	ACD Dinner	ACD	6:30pm-10:00pm	0	n/a
T13/A	Dinner with Dr. Elvis Presley	VDA	6:30pm-9:00pm	0	$40/$20

Friday, September 20, 2013

Code	Course Title	Speaker/Event Host	Time	Credits	Cost
n/a	Registration Open	VDA	7:00am-5:00pm	0	various
F34	AGD Breakfast	AGD	7:00am-8:00am	0	$0
n/a	Exhibit Hall Open	VDA	8:00am-5:00pm	0	n/a
F14	Opening Session: The Psychology of Success: Secrets the Superstars...	Bruce Christopher	8:00am-9:00am	1	$0
n/a	VDA Election (Voting Station Open)	VDA	8:30am-2:00pm	0	n/a
F15	Products for Your Patients: How to Use and What to Choose!	Rebecca Wilder	9:30am-12:30pm	3	$0
F16	Creating Predictably Successful Endodontics - Part 1 (cost for both days)	Drs. Besner, Portell & Palmieri	9:30am-5:00pm	6	$195
n/a	Exhibitor Clinics	Various	9:30am-4:45pm	0	n/a
F17	360 Slam-Dunk Guide for Successful Teams	Dr. Mark Hyman	9:30am-5:00pm	6	$0
F18	Blood, Spit, and Fears: A Painless OSHA Update	Laney Kay	9:30am-12:30pm	3	$0
F7	Healthcare Provider CPR	Tidewater Center For Life Support	9:30am-1:30pm	4	$65
F19	Treating the Worn Dentition	Dr. James Wooddell & Dr. Joe Passaro	9:30am-5:00pm	6	$0
n/a	Cascades Gorge Tour	VDA	9:30am	0	$31
n/a	Skeet Shooting Tournament	VDA	10:00am Start	0	$117

2013 Virginia Meeting - Complete Schedule of Events

Friday, September 20, 2013 - *continued*

Code	*Course Title*	*Speaker/Event Host*	*Time*	*Credits*	*Cost*
F20	Are We Having Fun Yet? Humor and Peak Performance in the Dental...	Bruce Christopher	10:00am-1:00pm	3	$0
F21	Boxed Lunch Pick Up	VDA	11:30am-2:00pm	0	$21
F22	Gourmet Safari	VDA	11:00am-1:00pm	0	$55
F23	Lunch with Hall of Famer Darrell Green	Darrell Green	Noon-1:30pm	1	$50
F35	Pierre Fauchard Lunch	Pierre Fauchard Academy	Noon-1:30pm	0	$35
F25	Valuing or Purchasing an Existing Dental Practice	Stephen Trutter & Brian Cogan	2:00pm-5:00pm	3	$0
F27	Systemic Disease and Oral Health: News You Can Put Into Practice	Rebecca Wilder	2:00pm-5:00pm	3	$0
F46	Heartsaver CPR	Tidewater Center For Life Support	2:30pm-4:30pm	2	$50
n/a	16th District Meeting	16th District	4:30pm-5:30pm	0	n/a
F39	VDA New Dentist Reception	VDA	5:00pm-6:00pm	0	$0
F37	MCV/VCU Reception	MCV/VCU	5:30pm-7:00pm	0	$0
F36/A	President's Party	VDA	7:00pm-10:00pm	0	$55/$30

Saturday, September 21, 2013

Code	*Course Title*	*Speaker/Event Host*	*Time*	*Credits*	*Cost*
n/a	Registration Open	VDA	7:00am-2:00pm	0	various
n/a	Exhibit Hall Open	VDA	8:00am-Noon	0	n/a
S38	ICD Breakfast	ICD	7:30am-8:30am	0	$30
S3-S4	Invisalign Clear Essentials One	Dr. Ben Miraglia	8:00am-5:00pm	8	$1695
S26	Healthcare Provider CPR	Tidewater Center For Life Support	8:00am-Noon	4	$65
n/a	VDA Election (Voting Station Open)	VDA	8:30am-2:00pm	0	n/a
S28	Hands of the Trained Are Easily Explained: Medical Emergencies in the...	Linda Cannon	8:30am-11:30am	3	$0
S29	Building a Successful Dental Practice	Stephen Trutter & Brian Cogan	9:00am-Noon	3	$0
S30	WOW! Complete Dentures In An Hour	Drs. Wallace, Alouf & Miller	9:00am-4:00pm	6	$0
S44	Composite Resins in Today's General Practice - A Practical Review	Dr. Gary Radz	9:00am-Noon	3	$0
n/a	Cascades Gorge Tour	VDA	9:30am	0	$31
S31	Creating Predictably Successful Endodontics - Part 2 (cost for both days)	Drs. Besner, Portell & Palmieri	9:30am-5:00pm	6	incl.
S40	Drugs in Dentistry, Including Herbals and Natural Products	Dr. Richard Wynn	10:00am-5:00pm	6	$0
S41	Gourmet Safari	VDA	11:00am-1:00pm	0	$55
S42	Boxed Lunch Pick Up	VDA	11:30am-2:00pm	0	$21
S43	VDA Fellows Lunch	VDA Fellows	1:00pm-2:30pm	0	$45
S47	Composite Resins in Today's General Practice (Part Two)	Dr. Gary Radz	1:30pm-4:30pm	3	$150
S45	1st Annual M.O.M. Awards Dinner	VDA Foundation	6:30pm-10:00pm	0	$50

Sunday, September 22, 2013

Code	*Course Title*	*Speaker/Event Host*	*Time*	*Credits*	*Cost*
n/a	House of Delegates Registration	VDA	7:15am-8:00am	0	n/a
SUN24	Past Presidents' Breakfast	VDA	7:00am-8:00am	0	$0
n/a	Annual Business Meeting	VDA	8:00am-9:00am	0	n/a
n/a	House of Delegates Meeting	VDA	9:30am-Noon	0	n/a
n/a	VDA Board of Directors Meeting	VDA Board of Directors	12:15pm-2:00pm	0	n/a

Important Registration Information

PLEASE READ THE FOLLOWING IMPORTANT INFORMATION PRIOR TO COMPLETING YOUR REGISTRATION.

Refund and Cancellation Policy: All refunds must be submitted in writing. Conference badges and materials must accompany request. All refunds are subject to a 20% per registration fee that will be processed within 15 business days to the primary registrant. Refunds will be processed back via the original method of payment within 10 business days for receipt of request.

Dentist Registration: Dentists must register as dentists. If registering as a VDA member, membership dues must be paid in full prior to registering. To pay your dues or to inquire about membership status, contact Leslie Pinkston at the VDA. 804-523-2189.

YOU MUST REGISTER FOR ALL EVENTS/SESSIONS WHICH YOU PLAN TO ATTEND. Each conference badge will contain a bar code, which tracks all courses and events that you have registered for. Upon entrance to any course or event, your badge will be scanned. By doing so, we are able to eliminate the need for any tickets, as well as track CE credits for each attendee. You may make changes to your registration at any time. If changes are made onsite, VDA staff will print a new badge for you so that the barcode reflects these changes.

Registration Materials: Badges and tickets will be mailed to registrants who register on or before the August 30, 2013 deadline. However, unlike in previous years, you will NOT receive registration materials until 1-2 weeks before the meeting. This will allow you to edit your registration preferences during the entire pre-registration period. Open your registration envelope immediately to ensure badges and materials are correct. Each registrant will receive his or her own registration packet via US Mail. Materials for registrants outside the US will be held for pick-up under the registrant's name at the VDA registration desk.

Badge Reprint Fee: Duplicate registration packets or badge request may be subject to a $25 per person fee. Please keep your registration materials in a safe place to avoid this fee. **This fee will NOT apply for badges reprinted due to a change made to your registration onsite.**

Non-Solicitation Policy: With the exception of exhibitors operating within their designated booth space, no attendee, exhibitor, or speaker may solicit business on the exhibit floor or in any other Virginia Meeting area. Violation of this policy will result in expulsion form the conference.

Classroom Comfort: Per fire codes, once a course is full, attendees will not be allowed to sit on the floor or bring chairs in from other rooms. Lecture space is limited and available on a first-come, first-served basis. No children are permitted in lectures or workshops. Set electronic devices to "silent" during courses.

Course Disclaimer: The VDA makes every effort to present high caliber speakers in their respective areas of expertise. Speaker presentations in no way imply endorsement of any product, technique, or service presented. The VDA specifically disclaims responsibility for any materials presented. Speakers may be subject to change due to circumstances beyond our control.

Onsite Registration Hours:
Thursday, September 19, 2013: 7:00am-5:00pm
Friday, September 20, 2013: 7:00am-5:00pm
Saturday, September 21, 2013: 7:00am-2:00pm

Virginia Meeting Mailing List Opt Out:

The Virginia Meeting will be compiling a mailing list of attendees. The lists will include only mailing addresses provided to the Virginia Meeting when you register. Lists will be available to any Virginia Meeting Exhibitor for a small fee. These lists are strictly to be used to send out pre-conference promotions to you. If you would like to opt out of this mailing list, simply select opt-out on the registration form in the brochure. Note: This mailing list is strictly information provided to the VDA during meeting registration. It is entirely separate from our membership database.

SAVE Money

Save money by registering during our "Early Bird" Registration

Any attendee who registers on or before June 30, 2013 will automatically receive our early-bird pricing discount. Please be aware that your registration must be at Custom Registration, the VDA Central Office, or completed online by June 30, 2013 to receive the discount. Post marked registration will not be accepted under this pricing so please allow ample time if you choose to mail your registration.

Virginia Dental Association (VDA) - Guidelines Regarding Commercial Support and Conflict of Interest

The VDA, in planning continuing education programming for the Virginia Meeting, will adhere to the following policies:

1. Program topic selection will be based on perceived needs for professional information and not the purpose of endorsing specific commercial drugs, materials, products, treatments, or services.
2. Funds received from commercial sources in support of any educational programs shall be unrestricted and the Council on Sessions shall retain exclusive rights regarding the selection of presenters, instructional materials, program content and format, etc.
3. Any and all commercial support received shall be acknowledged in program announcements, brochures, and the on-site program.
4. Commercial support shall be limited to: (a). the payment of reasonable honoraria (b). reimbursement of presenters' out of pocket expenses; and (c). the payment of the cost of modest meals or social events held as part of an education activity.
5. Presenters shall be instructed to avoid recommending or mentioning any specific product by its trade name, using generic terms whenever possible. When reference is made to a specific product by its trade name, reference shall also be made to competitive products.
6. Speakers will be required to disclose any potential bias to commercial supporters of any activity related to the Virginia Meeting.

The Virginia Dental Association (VDA) shall:

1. Be responsible for the content, quality, and scientific integrity of all CE activities.
2. Assure that presentations give a balanced view of all therapeutic options.
3. Assure that commercial exhibits do not influence planning nor interfere with the presentation of CE activities.
4. Be responsible for making ultimate decision regarding funding arrangements for CE.
5. Assure that commercially supported social events at CE activities do not compete with not take precedence over, the educational events.
6. Have a policy on conflict of interest and assure that all CE activities conform to this policy.

Free Course Policy CHANGE

IMPORTANT: The VDA is pleased to offer many courses at the Virginia Meeting free with your registration cost. We are also delighted to offer the service of tracking all CE credit that you receive at the Virginia Meeting. This has led to some changes. Please read the following policy carefully.

In order to receive CE credit, you must:

- Register for the course. In the past, attendees had the option of attending free courses without registering for them, provided that there were remaining seats available 10 minutes prior to the course. **Starting this year, you MUST register for any course that you plan to attend. This will allow you to earn CE credit for your time in the course.**
- Check in with the course monitor. Upon entrance, present your badge and the course monitor will scan it. All registered attendees will be granted immediate access to the course. If you are not registered, you will be asked to return to the registration table where you will be allowed to register if the course has space available. Please wear your badge at all times while in the conference center or at Virginia Meeting events as this badge will be used as your "ticket" to all courses and events.

A record of your total Virginia Meeting CE credit will be mailed to you within 10 business days following the meeting.

Registration

How to Register:

****PLEASE NOTE: You MUST register for any course, activity, or event you would like to attend in order to be granted access.**

We have made substantial upgrades to our registration process! Starting this year, all CE records will be recorded electronically and sent to you immediately following the Virginia Meeting! We will also be eliminating paper tickets by scanning all attendees into courses using a barcode printed on each badge. We recommend that you pre-register in order to guarantee space in your preferred course, activity, or event. Onsite registration will still be available and you may make changes to your registration at any time during the pre-registration period or once you arrive at The Homestead. We are thrilled about this opportunity and feel confident that it will enhance your Virginia Meeting experience!

Online:

Visit www.vadental.org/PRO to register. We recommend this method as it provides you with a quick easy way to register your dental team for the Virginia Meeting. You will receive an email confirmation of your registration – and you may log back in at any time and easily make changes to your registration (This is a change from our previous system, which required you to contact VDA staff to make changes after your initial registration was processed).

By Phone:

Call 1-877-205-1943 between 9:00am-6:00pm EST. Representatives from Custom Registration will be standing by to assist you at any time. For this method, payment can only be processed by credit card.

By Fax:

Fax your registration to 817-277-7616 and the staff at Custom Registration will be happy to process this for you.

*Please include all credit card information (VISA, MasterCard, or American Express).
*Please print clearly.

By Mail:

Mail your registration form and payment to:

The Virginia Meeting
c/o Custom Registration
2020 E. Randol Mill Rd., Suite 307
Arlington, TX 76011

*Please include all credit card information (VISA, MasterCard, or American Express).
*Make checks payable to The Virginia Dental Association.
*Please print clearly.

Questions?

*Call us at (804) 288-5750
*Email Carter Lyons, Director of CE and the Virginia Meeting at lyons@vadental.org

THE Virginia MEETING®
A Program of the Virginia Dental Association

Registration Sponsored By: VDA SERVICES

Please use the next 2 pages to register for the 2013 Virginia Meeting. Please note that EACH registrant will require a SEPARATE form. Please feel free to make copies of this form as needed.

Virginia Meeting mailing list opt out
(see page 35 for details)

☐ Yes, I would like to opt out of the Virginia Meeting mailing list. Leave blank if you would like to be included in meeting communications.

VDA Golf Tournament
Code W32 - Additional Information

Handicap: _____

I would like to be grouped in a team with the following players:

_____

_____

	Registration Type	On/Before June 30	July 1- August 30	Onsite Sept 18-22
☐	First Time Attendee Dentist	$160	$210	$260
☐	VDA Member Dentist	$245	$295	$345
☐	ADA Dentist (non-VDA)	$345	$395	$445
☐	Local District Member Dentists (4th, 6th, 16th Districts)	$245	$295	$345
☐	VDA Member Dentist (1st year out of dental school)	$47	$60	$73
☐	NON Member Dentist	$530	$565	$600
☐	Active Military Dentist (non-VDA)	$245	$295	$345
☐	ODDS Member (non-VDA)	$245	$295	$345
☐	Retired Life VDA Member	$0	$0	$0
☐	Assistant - VDAA Member	$55	$60	$65
☐	Assistant - Non-VDAA Member	$65	$70	$75
☐	Spouse/Guest of Registrant	$30	$35	$40
☐	Guest (ages 12 and under)	$7	$10	$12
☐	Student (Dental, Hygiene, Assisting)	$0	$0	$0
☐	Office Staff	$55	$60	$65
☐	Lab Technician	$55	$60	$65
☐	Hygienist - VDHA, CDHA Member	$80	$85	$90
☐	Hygienist - Non-VDHA, Non-CDHA Member	$85	$90	$95
☐	Exhibitor	$0	$0	$0

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Specialty: _____ Component: _____ *Phone: _____

*Mailing Address: _____

Membership #: _____ *Email Address: _____

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** = Required Field*

PLEASE REGISTER FOR ANY COURSE, ACTIVITY, OR EVENT YOU WOULD LIKE TO ATTEND IN ORDER TO BE GRANTED ACCESS.

WED

	Code	Course Title	Speaker/Event Host	Time	Credits	Cost
☐	W32	Annual VDA Golf Tournament (see additional info - above)	VDA	12:30pm start	0	$195

THURSDAY

	Code	Course Title	Speaker/Event Host	Time	Credits	Cost
☐	T1	Common Sense Endodontics: Where Sophistication & Simplicty Meet	Dr. Barry Musikant	8:00am-11:00am	3	$0
☐	T2	Blood, Spit, and Fears: A Painless OSHA Update	Laney Kay	8:30am-11:30am	3	$0
☐	T5	Why Are Women So Strange and Men So Weird?	Bruce Christopher	9:00am-Noon	3	$0
☐	T6	Boxed Lunch - **Circle Type:** Club Ham Roast Beef Veggie None	VDA	11:30am-2:00pm	0	$21
☐	T8	Treatment Planning in the Esthetic Zone	Dr. James Wooddell & Dr. Joe Passaro	1:30pm-4:30pm	3	$0
☐	T9	Let's Do It! SEO, Social Media and Online Marketing	Susan Richardson	2:00pm-5:00pm	3	$75
☐	T10	Bambi vs. Godzilla	Bruce Christopher	2:00pm-5:00pm	3	$0
☐	T11	Expanding Your Practice through Early Childhood Dental Care	Dr. Tegwyn Brickhouse & Sarah B. Holland	3:30pm-5:00pm	1.5	$0
☐	T33	Ping Pong Tournament	VDA	3:30pm-8:30pm	0	$15
☐	T12	Opening Reception	VDA	5:00pm-6:30pm	0	$0
☐	T13	Dinner with Dr. Elvis Presley - Adult	VDA	6:30pm-9:00pm	0	$40
☐	T13A	Dinner with Dr. Elvis Presley - Child Ticket (ages 6-12)	VDA	6:30pm-9:00pm	0	$20

Friday

	Code	Course Title	Speaker/Event Host	Time	Credits	Cost
☐	F34	AGD Breakfast	AGD	7:00am-8:00am	0	$0
☐	F14	Opening Session: The Psychology of Success: Secrets the Superstars...	Bruce Christopher	8:00am-9:00am	1	$0
☐	F15	Products for Your Patients: How to Use and What to Choose!	Rebecca Wilder	9:30am-12:30pm	3	$0
☐	F16	Creating Predictably Successful Endodontics - Part 1 (cost for both days)	Drs. Besner, Portell & Palmieri	9:30am-5:00pm	6	$195
☐	F17	360 Slam-Dunk Guide for Successful Teams	Dr. Mark Hyman	9:30am-5:00pm	6	$0
☐	F18	Blood, Spit, and Fears: A Painless OSHA Update	Laney Kay	9:30am-12:30pm	3	$0
☐	F7	Healthcare Provider CPR	Tidewater Center For Life Support	9:30am-1:30pm	4	$65
☐	F19	Treating the Worn Dentition	Dr. James Wooddell & Dr. Joe Passaro	9:30am-5:00pm	6	$0
☐	F20	Are We Having Fun Yet? Humor and Peak Performance in the Dental...	Bruce Christopher	10:00am-1:00pm	3	$0
☐	F21	Boxed Lunch - **Circle Type:** Club Ham Roast Beef Veggie None	VDA	11:30am-2:00pm	0	$21
☐	F22	Gourmet Safari	VDA	11:00am-1:00pm	0	$55
☐	F23	Lunch with Hall of Famer Darrell Green	Darrell Green	Noon-1:30pm	1	$50
☐	F35	Pierre Fauchard Lunch	Pierre Fauchard Academy	Noon-1:30pm	0	$35
☐	F25	Valuing or Purchasing an Existing Dental Practice	Stephen Trutter & Brian Cogan	2:00pm-5:00pm	3	$0
☐	F27	Systemic Disease and Oral Health: News You Can Put Into Practice	Rebecca Wilder	2:00pm-5:00pm	3	$0
☐	F46	Heartsaver CPR	Tidewater Center For Life Support	2:30pm-4:30pm	2	$50
☐	F39	VDA New Dentist Reception	VDA	5:00pm-6:00pm	0	$0
☐	F37	MCV/VCU Reception	MCV/VCU	5:30pm-7:00pm	0	$0
☐	F36	President's Party Adult	VDA	7:00pm-10:00pm	0	$55
☐	F36A	President's Party Child	VDA	7:00pm-10:00pm	0	$30

Saturday

	Code	Course Title	Speaker/Event Host	Time	Credits	Cost
☐	S38	ICD Breakfast	ICD	7:30am-8:30am	0	$30
☐	S3	Invisalign Clear Essentials One - Dentist	Dr. Ben Miraglia	8:00am-5:00pm	8	$1695
☐	S4	Invisalign Clear Essentials One - Staff (8 staff admitted for free w/ S2)	Dr. Ben Miraglia	8:00am-5:00pm	8	incl.
☐	S26	Healthcare Provider CPR	Tidewater Center For Life Support	8:00am-Noon	4	$65
☐	S28	Hands of the Trained Are Easily Explained: Medical Emergencies in the...	Linda Cannon	8:30am-11:30am	3	$0
☐	S29	Building a Successful Dental Practice	Stephen Trutter & Brian Cogan	9:00am-Noon	3	$0
☐	S44	Composite Resins in Today's General Practice - A Practical Review	Dr. Gary Radz	9:00am-Noon	3	$0
☐	S30	WOW! Complete Dentures In An Hour	Drs. Wallace, Alouf & Miller	9:00am-4:00pm	6	$0
☐	S31	Creating Predictably Successful Endodontics - Part 2 (cost for both days)	Drs. Besner, Portell & Palmieri	9:30am-5:00pm	6	incl.
☐	S40	Drugs in Dentistry, Including Herbals and Natural Products	Dr. Richard Wynn	10:00am-5:00pm	6	$0
☐	S41	Gourmet Safari	VDA	11:00am-1:00pm	0	$55
☐	S42	Boxed Lunch - **Circle Type:** Club Ham Roast Beef Veggie None	VDA	11:30am-2:00pm	0	$21
☐	S43	VDA Fellows Lunch	VDA Fellows	1:00pm-2:30pm	0	$45
☐	S47	Clinical Applications of Composite Resins - Learning Predictabilty...	Dr. Gary Radz	1:30pm-4:30pm	3	$150
☐	S45	1st Annual M.O.M. Awards Dinner	VDA Foundation	6:30pm-10:00pm	0	$50

☐ I am attending the "1st Annual M.O.M. Awards Dinner" and would like to make a donation to the VDA Foundation.
Please note: If you are NOT attending the dinner and would like to make a donation visit www.vdaf.org.
Circle the amount you would like to donate: **$50** **$100** **$150** **$200** **$250** **$300**

Sun

	Code	Course Title	Speaker/Event Host	Time	Credits	Cost
☐	SUN24	Past Presidents' Breakfast	VDA	7:00am-8:00am	0	$0

Registrant's Name: _____ Total: $_____

Payment Options: Check: Make Payable to VDA - Mail to: Virginia Dental Association

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Plenty of Fun To Be Had!

Annual VDA Golf Tournament

In Memory of Dr. Donald Martin

Wednesday, September 18, 2013

12:30pm shotgun start

Cascades Course

The Cascades Course at The Homestead is annually considered the finest Virginia mountain golf course and has been the home for many PGA Tours and USGA championships.

Opening Reception

Thursday, September 19

5:00pm-6:30 p.m.

Catch up with friends and colleagues while getting your first glimpse at our more than 90 exhibitors and all of the products, services, and meeting specials they have to offer!

Dinner with Dr. Elvis Presley

Thursday, September 19

6:30pm-9:00pm

Join "Dr. Elvis Presley" and his band, Bluevelvis as they bring you a night of music, fun, and laughter while you enjoy an Italian dinner and relax after a day of continuing education!

PRESIDENT'S PARTY

Friday, September 20, 2013

7:00-10:00 p.m.

Don't miss this chance to celebrate with VDA President Dr. Kirk Norbo! All of the following are included with the purchase of your ticket:

· Two drink tickets (21+ only)
· Opportunity for a photo with Dr. Norbo
· Unlimited use of our photo booth
· A dinner of heavy hors d' oeuvres

Come dressed in your cowboy hats and boots to go with our backyard barbecue theme!

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Schedule of Events

PATTERSON DENTAL

Thursday

Exhibit Hall Open	5:00pm - 6:30pm
Opening Reception	5:00pm - 6:30pm

FREE Margaritas (limited supply) sponsored by Patterson Dental

Friday

Exhibit Hall Open	8:00am - 5:00pm
Donut Booth (Morning)	8:00am - 11:30am
Boxed Lunch Pick-Up	11:30am - 2:00pm
Donut Booth (Afternoon)	2:00pm - 4:30pm

Saturday

Exhibit Hall Open	8:00am-Noon
Donut Booth	8:00am-11:30am

Virginia Meeting Exhibitors

As of June 20, 2013

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One Mind Health	9:30am - 9:45am
Smile Reminder	10:00am -10:15am
Fortress/Asset Protection Group	10:30am - 10:45am
Hiossen Implants	11:00am-11:15am

Location will be included in our onsite materials.

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Golf at the Homestead

By: Meredith Norbo

In September The Virginia Meeting will be held at the beautiful and historic Homestead Resort in Hot Springs. The Homestead is rich with golf history and is essentially a shrine to golf legend Sam Snead. Snead served as assistant and head professional at the Homestead for many years while also winning 7 majors and 82 tournaments overall on the PGA Tour. Naturally the home courses of a golfing legend would be ranked in America's top 100 golf courses. This is perfect for those attending the Virginia Meeting since the most important agenda item is, of course, the VDA Annual golf tournament.

The tournament will be played at the Cascades course, which is one of the most enjoyable and challenging courses you can play in Virginia. Designed by William Flynn, who also designed Cherry Hills and Shinnecock Hills, the Cascades is not too long, and will require you to play smart tee shots using long irons or fairway woods. Fairways are narrow, tree-lined, and have a fair amount of undulation. Pack your creativity in your bag! Small greens require a honed short game to really score. Sometimes putting with a fairway wood off the green is all you need to get the ball close or in.

A favorite piece of Sam Snead memorabilia is located in the Cascades clubhouse. It is an unbelievable scorecard of 18 consecutive 3's recorded on the Cascades course. The question is, will your team best Slammin' Sammy's score? Get your teams together for fun and great golf action. Sign up at http://www.vadental.org/pro/events/virginia-meeting
The course will be waiting!

Editor's Note: Ms. Norbo lives in Purcellville

The Cascades Course's Clubhouse was once the summer home of New York stock trader Jakey Rubino.

Dances with Birds

By: Richard F. Roadcap, D.D.S., Editor

Birds of prey are antisocial – it's their nature. They don't like people, animals, other birds, and even members of their own species, if territory is at stake. So how did the ancient sport of falconry, in which falcons and other species were trained to capture food for their owners, develop? History records the development of the sport as early as 2000 B.C. in the Middle East and Asia. The first falconers most likely sought small game as a food source, but a sport soon developed. Invading Huns introduced falconry to Europe around 400 A.D. Interest peaked in the 17th century, as it became the domain of royalty and noblemen. In fact, commoners were not allowed to own the birds, creating an exclusiveness which remains to this day.

Not long ago I spent an afternoon at the Homestead's falconry academy, learning how to handle large birds with sharp beaks and talons. Our instructor, Linda – an experienced falconer – introduced the class to their stable of raptors. Not only falcons are used in the sport, but also hawks and owls. "Delilah", a Eurasian Eagle Owl, occupied one roost, and there were also three Harris's Hawks, as well as falcons from Asia and Africa. So why would a misanthropic creature gather food for humans? As Linda explained, the first step is tolerance. The bird will "tolerate" us if we provide a reliable food source. In this case (don't read on if you're squeamish) it's euthanized baby chickens. In other words, an exchange of food allows them to survive.

The next step is trust. Birds of prey will "trust" the falconer to always provide food (no tricks), and to never (never!) harm them. Linda cautioned us not to touch or pet the birds as they are threatened by touching and will retaliate. Students who had disregarded her advice suffered the consequences. She chose an immature female Harris's Hawk, "Ruger" to demonstrate the first two principles of falconry. Although only six months old, "Ruger" was skilled in most aspects of flight, food retrieval, and as we found out later, aerial acrobatics.

Despite a four-foot wingspan, an adult Harris's Hawk weighs only two pounds. Falconers weigh their birds daily, and now use digital scales. Two ounces overweight, and a bird is satiated (and won't hunt). Two ounces under could mean a weak, or ill, bird of prey. Thus, daily weighing is critical. As we left the roost and circled the grounds, "Ruger" followed close at hand, alighting in the branches of a white oak, landing on fence rails, and always returning to Linda's gloved hand for a reward. Harris's Hawk (*Parabuteo unicinctus*) is native to the deserts of the Southwest US. They're favored by falconers for their ease of training, and their habit in the wild of hunting in packs. Often one Harris's will flush out prey while another seizes it.

Show time! First, she glided down from the tree to snatch a baby chick. What else? Linda held the food right behind my head and whistled. I barely felt my hat move as "Ruger" planed across my head to the expected reward. Later two classmates stood a foot apart and the raptor folded its wings (remember, the wingspan is four feet) and sailed between them with injury to none of the parties involved. Linda pointed out birds of prey have eyesight eight times better than humans, allowing them to gauge narrow openings at great distance without harm.

I asked, if tolerance and trust were the first two steps, was there a next step? Linda said no, that was it, but then said "Oh, yes…learning when they're ready to fly!" Puzzled, I asked her to explain. Intuition, and a sixth sense derived from experience tell the falconer when a bird will always return to an outstretched left hand. Extending the left arm is one of the sport's many traditions. If you'd like a taste of a 4,000 year-old art, call the Homestead activities desk (800-838-1766, option 4). You'll gain a new understanding of avian (and maybe human) behavior.

The editor practices general dentistry in Colonial Heights.

Fishing in Bath County

By: Mark M. Neale, D.D.S.

Spending time on the streams of Bath County is one of the most relaxing respites a person can have. You can either fly fish or walk the many hiking paths or simply commune with nature. Personally, I have had the great fortune to have been able to do this since 2001 when I first visited the Homestead on a regular basis, enjoying the many activities available in the area. Visitors at the Homestead Resort will have access to many activities, including hiking, horseback riding, ATV and Segway travel, sporting clays, trap and skeet, tennis, golf, swimming in heated outdoor and indoor pools, the spa. The list goes on to include the winter sports of ice skating, skiing and snowboarding. The Homestead has a private fly fishing stream with guide services as well. But this is not what I really want to tell you about. The one I enjoy the most is the availability of the many streams which have stocked and natural trout in them. I have spent many hours simply being at peace with nature and my surroundings while fly fishing in the mountains, miles from anyone else, totally at peace in mind and soul.

The Allegheny Mountains are the western part of the Appalachian Mountain chain. The Blue Ridge Mountains make up the eastern portion. The western range is the watershed for the James River starting with the origins of the Jackson River. The streams that feed the Jackson are some of the most scenic areas in the state. The Jackson boasts spawning beds for rainbow, brown and native brook trout. These fish are beautiful in appearance and a delicacy most of us appreciate when we are fortunate to dine on them in restaurants. Personally, I have never kept a trout that I have caught from any stream but have always returned the fish to its natural habitat, so that others may enjoy the beauty and sport of seeing and experiencing the fish in the same way.

Fly fishing is not like fishing in the rivers, bays or the ocean in Virginia. Mountain trout are a very opportunistic. They have learned to survive in harsh surroundings by using as little energy as possible to eat, for eating is one of their main objectives. A trout is intelligent (as far as fish go) and will pick a spot in the streambed that gives them an advantage to gather and pick up food without having to move hardly at all. In short, a trout will wait for the food to come to them rather than swim around and look for food as most fish do. Because of this trait, trout fishing is much like hunting. I liken it to turkey hunting. The first thing you do when you are out is study the types of food that are available, perhaps turning over some rocks to see what fly larvae are available that day or simply what insect might be ready to hatch on the stream. I then try to mimic some type of aquatic life that might be present in the stream that particular time of year, serving as a tasty food source for the trout. In summer, fly patterns that mimic ants, bugs of all types, beetles, grasshoppers and even mice will take trout.

All of these require good observation skills and the patience to look (hunt) for that particular spot in the stream. It's a spot where you think a trout would be waiting for all this bounty without having to do so much as to gulp in some surface water to take the next meal. Most of the time, you are sight fishing; that is, you are seeing the fish under the water waiting for the next meal to come along. Other times you will observe where the trout are feeding by watching them break the water. Locating these areas are easy to do once you know what you are looking for and you'll soon find that catching and releasing the fish will allow you to come back days later and perhaps catch the same fish again. Areas of a stream where trout might be holed up can be easy to spot once you understand how water works around objects, and where fish like to find shelter under branches of trees and overlying river banks.

Bath County has many areas that can be fished with relative ease. The Homestead Resort has a well-managed stream for guests on its upper Cascades Gorge stream. Here you will find stocked trout that the resort has placed for the enjoyment of their guests. The resort also has a guide service as well. (Call 1-800-838-1766, option #4.) The rest of the county is a smorgasbord of large to small streams, some stocked by the state on a regular basis and others which are all natural. Streams I have fished and find outstanding are all within 20-30 minutes of the Homestead Resort. They include that segment of the Jackson River in the area of Warwick Mansion and the National Forest at Hidden Valley. Just above this is an area around what is locally called the Swinging Bridge. North of this is an area known as Poor Farm which is well known to local and visiting fishermen. Back Creek near the Dominion Power reservoir is another more isolated area which is always good the first two or three weeks after stocking.

The Homestead area now boasts a new adventure with the arrival of Natural Retreats. This is an outdoor company, originally from the UK, which now handles the rental of area homes and cottages for use by guests. It has set aside designated stretches of the Jackson for guided fishing whole-day or half-day trips. If you're new to this area, I would strongly advise you contact them and set up a guided trip to acquaint you with the area and to get you on fish immediately. Will Hodges is the staff person and he can help you with any questions you might have.

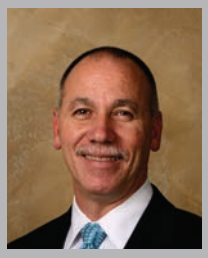
As for me, I hope that I will always be able to spend my days traversing the mountains streams and trails. It is my part of heaven here on earth. As many of you have heard before, "A bad day of fishing is better than a good day at the office." Hope to see you at the Virginia Meeting this September. Bring the family and enjoy yourself in a part of the state that is too beautiful to miss.

Editor's Note: Dr. Neale practices general dentistry in West Point.

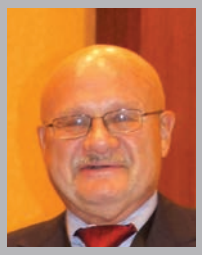
2013 VDA Elected Leadership Candidates

Visit the VDA website at www.vadental.org/pro for details on each of this year's candidates. **Voting will begin online in August.**

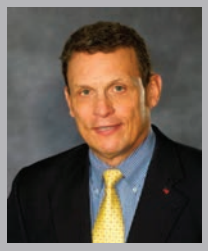
Dr. Michael Link
Candidate for the office of:
President Elect



Dr. Steven Forte
Candidate for the office of:
Secretary/Treasurer



Dr. David Anderson
Candidate for the office of:
ADA Delegate



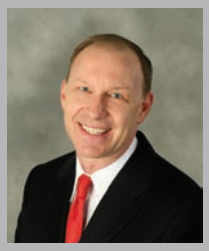
Dr. Fred Certosimo
Candidate for the office of:
ADA Delegate

Dr. Ralph Howell
Candidate for the office of:
ADA Delegate

Dr. Michael Link
Candidate for the office of:
ADA Delegate

Dr. Ted Sherwin
Candidate for the office of:
ADA Delegate

Dr. Michael Abbott
Candidate for the office of:
ADA
Alternate Delegate



Dr. Vince Dougherty
Candidate for the office of:
ADA
Alternate Delegate

Dr. Paul Olenyn
Candidate for the office of:
ADA
Alternate Delegate

Dr. Edward Weisberg
Candidate for the office of:
ADA
Alternate Delegate

What you need to know about the ADA Delegation

By: Dr. Gus C. Vlahos; ADA Delegate and Vice-Chairman, Virginia Delegation

Every spring the names of individuals who are running for a position on the ADA delegation are listed in the VDA *Journal*. The 20 members on the ADA delegation represent the Virginia Dental Association as a part of the 16th district of the ADA House of Delegates. The 16th district is comprised of Virginia, North Carolina and South Carolina for a total of 50 delegates. The duties of the delegation include additional meetings in Virginia to set the agenda for the upcoming year and discuss resolutions or policies the ADA will consider on the house floor. Each fall the 16th district also meets a few weeks prior to the ADA Annual Session to discuss the resolutions and come to a uniform decision.

For the members of the delegation the ADA Annual Session is a working meeting. Participation in any CE or even attending the exhibit fair is unlikely with such a tight schedule. The first day starts off by meeting with the 16th district to discuss issues or changes to resolutions that may have arisen since the last meeting. That same day the first session of the House of Delegates begins. Reference committees are held on the second day. The delegation attends these meetings to voice their opinions on the issues as decided by the group at meetings prior. Once reference committee reports are completed the 16th district meets again to discuss these reports and any changes to the resolutions. The following day the ADA house meets in an all day session where voting on resolutions takes place. Depending on the issues presented that year the discussion on the House floor can become quite lively. The ADA leadership which includes the President-elect, Vice-president, and Speaker of the House are also elected on this day. The meeting concludes on the fifth day with voting on any remains resolutions. The last item on the agenda is voting on the budget and setting of the dues.

The 16th district has been a key district in the ADA House as we have been privileged to have many members elected to leadership positions. The members elected this fall will serve in the ADA delegation in the year 2014. This is a great opportunity to have a voice in your profession and set policy that will continue to govern the ADA. If you are considering running for an ADA delegate position please speak to one of the current delegation members on more details of the role.

Dr. Gus Vlahos is an ADA Delegate and Vice-Chairman of the Virginia Delegation. He practices general dentistry in Dublin.

Infection Control – Resources for Your Practice

By Dr. Garland Gentry, Chair, Infection Control & Environmental Safety Committee

The recent news of infection control breaches in the U.S. is an important reminder for all dental professionals to understand current guidelines and regulations. There are many resources available to provide dental professionals with the information to protect patients and themselves. Depending on the course of the ongoing investigation and the associated media coverage, expect to get questions from patients. The ADA is a great resource for many topics, from waterline safety to fire safety and more. That is one of the benefits of ADA membership.

ADA members can go online to the ADA website and reference: *ADA Policy Statement on Bloodborne Pathogens*, *Infection Control and the Practice of Dentistry*, *ADA Statement on Infection Control in Dentistry*, and *Monitoring Sterilizers*. Other resources include the revised edition of the *ADA Practical Guide to Effective Infection Control*, a 40-minute DVD and workbook. In addition, the ADA Council on Dental Education and Licensure has a safety checklist available for dentists and their staff to use as a guide to inspect the safety of equipment and supplies at www.ada.org/1692.aspx.

The Centers for Disease Control (CDC) has developed special recommendations for use in dental offices. They are currently in the process of conducting research and revising the 2003 guidelines. The new published guidelines are expected within the next year. In the meantime, their website has numerous resources available online at www.cdc.gov.
The Organization for Safety, Asepsis, and Prevention (OSAP) also provides excellent information on proper infection control, and patient and provider safety at www.osap.org.

The ADA News also has an article which can be found at www.ada.org/8459.aspx, which includes talking points that dentists can use if their patients express concerns about safety.

Dr. Gentry is Chair of the Infection Control and Environmental Safety Committee and practices in Forest.

Paperless by 2014?

By: Ben Waldman, Regional Manager for DEXIS

For the past 20 years the dental industry has been fixated on the move to "Paperless" offices. This mania has accelerated in the past few years as the calendar marches ominously towards 2014.

Like the Mayan Calendar deadline of December 2012, January 2014 seems to loom large in the minds of many dentists as the end of the world as we know it. As the modern mythology is told, all dentists will have to go "Paperless" by January 2014 or else.

Or else what? Nobody seems to know the answer to this question and as 2013 is now half over, it's probably time to discuss what are the real requirements for dentist and what solutions are at hand.

Federal Paperless Mandate

First, let's put to bed some of the half-truths and non-truths surrounding the paperless requirements.

Unless you are a dentist whose practice is heavily reliant on Medicaid or Medicare reimbursements (and most private practice dentists are not), then there is absolutely no state or federal regulation or law that requires that your office go "Paperless".

None! Zero, zilch, nada, squadoosh.

All of the doom and gloom, Chicken Little panic that you hear notwithstanding to the contrary, the law is very clear. Private practice dentist whose Medicaid patients make up less than 30% of their annual patient visits are neither eligible for the incentive payments nor subject to any negative fee adjustments or penalties. Indeed, even if Medicaid makes up a substantial portion of your patient load, only the HER Incentives apply to dentists. All negative fee adjustments (penalties) that were contemplated in the original legislation for non-participation were eliminated. It is one of the few "good-news, bad news" stories where there is only good news.

Now that we have dispatched with the myth of a "Paperless" requirement, we can now address the important questions of whether there are any real advantages for private practices in going paperless; what those advatages are and what are the steps involved for a practice that wants to embark on the Pathway to Paperless.

First though, we should define terms here. What exactly does it mean to go "Paperless"?

What does Paperless Mean?

"Paperless" is a term that is thrown around quite a bit in the healthcare industry without much attempt at definition. The working assumption is that a paperless office is one that doesn't keep it's patient charts on paper. The current folklore is that this is somehow inherently easier and better for dentists. While it is certainly true that many offices who have converted their charting from pencil and paper to computer are satisfied with the transition, it is also true that there is a significant investment in time and money that must be considered before ditching paper charts just for the sake of going "Paperless".

Where then is the "Paperless" transition happening?

Even as the vast majority of private practice dentists continue to keep paper charts, the use of film for patient imaging (i/o and facial photos, radiographs, pans and cephs, and CBCT) is disappearing rapidly. Over 80% of dental offices have some form of digital imaging implemented. So, for most offices, going "Paperless" means ditching film and going digital. Really we should stop saying "Paperless" and talk about going "Filmless".

Advantages of Film-lessness

The advantages of digital imaging over physical films are easy to understand in dentistry. Digital imaging is diagnostically superior to film, easier and faster for the clinical team, improves the patient experience and is less expensive than film.

Since 2000, the peer reviewed literature in our industry is increasing clear – digital radiography and photography are diagnostically equal to or superior to film images. The ability to enlarge, sharpen, change contrast and visually enhance the image in front of the patient are clear advantages of digital over film. Affordable high-definition computer screens are a vast improvement over the time light-boxes that have plagued patient comprehension for decades.

Imaging software has evolved form difficult menu-driven software behemoths to simple single-click operating systems that can be used on laptops, tablets and event iPads. Assistants and Hygienists enjoy time savings with digital imaging systems – FMX's can be imaged in less time and there is no time in the darkroom.

Patients are increasingly skeptical of dental practices that are not computerized. Patients are accustomed to digital imaging in their private lives and expect to see it implemented in professional offices they frequent. Studies show that dental treatment acceptance increases 14.2% where digital imaging is used.

The investment in computes, software, sensors, cameras and training are now comparable to the lifelong cost of film, chemical, mounts, and processor maintenance and repair. Digital images are easily duplicated, transmitted and archived, while film is expensive and time consuming to duplicate, often-times lost when transmitted for insurance purposes and almost never backed up by dentists. Add to this the fact that most American dental schools use digital imaging as a training modality and have a compelling advantage for digital imaging in dental over film.

How do I get on the Pathway to Paperless?

If you are not yet "Paperless" or "Filmless" and want to realize the advantages that this transition will bring you, I would recommend you availing yourself of the many CE Courses offered on this subject. You can also ask your preferred dental dealer representative to sit down and give you some guidance. Most dealer representatives – especially those specializing in Equipment and High Technology – have taken practice "Filmless" and can provide you references and identify which use cases and appropriate for your practice.

Other "Paperless" Technologies

Once an office transitions their imaging system from film to digital, there is a natural tendency to see what other practice systems might benefit from a digital upgrade. My experience in many hundreds of practices around the state shows that most practices are finding great productivity gains in the areas of digital patient communication and marketing as well as in the area of digital modeling and restorations. These will be subjects that can be explored in a future column.

ADA Member Benefit: Tools to Navigate Ethical Conduct

By Karen S. McAndrew, DMD, MS

Ethics in dentistry upholds our profession on a level above the legal rules and regulations that define dental practice. How do we define ethics in dentistry? In an effort to establish guidelines for ethical behavior in dental practice, the ADA Council on Ethics, Bylaws and Judicial Affairs has established *Principles of Ethics and a Code of Professional Conduct*. This document addresses all aspects of dentistry and dental practice within a set of guidelines. Topics range from patient treatment and advertising to announcing educational credentials and marketing. It sets the standards by which we practice in order to uphold the high standards of the dental profession while incorporating perceptions on marketing and social media and keeping up with the changes in technology and communication.

The ADA has established that "members of the ADA voluntarily agree to abide by the ADA Code as a condition of membership in the Association. They recognize that continued public trust in the dental profession is based on the commitment of individual dentists to high ethical standards of conduct." The practice of dentistry is often a daunting task as we deliver patient care, run small businesses, and are stewards to our community. Many resources are available to help navigate the sometimes ambiguous code by which we run our practices and treat patients. As an ADA member benefit, a new ethics hotline (http://www.ada.org/news/8223.aspx) has been established to address questions from ADA members on situations and concerns involving ethical questions and standards in dentistry. This confidential hotline allows ADA members free access to legal interpretation of questions addressing ethical dilemmas encountered in everyday dental practice. Visit the ADA website (http://www.ada.org/194.aspx) for detailed information on resources for professional conduct.

On a local level, the VDA has recently established procedures for addressing ethical complaints. The Ethics Committee, led by chairman Dr. Bill Bennett, is tasked with providing direction and outcomes on handling potential ethical dilemmas on a state level. The goal of this committee is to educate members and encourage individuals to correct issues that infringe on the ethical standards established by the ADA code of ethical conduct. The committee recently passed the "Outline of Procedures for Hearings Before the Ethics Committee of the Virginia Dental Association".

Dentistry is evolving and incorporating new applications and technology. Working together, we can uphold the high standards and status of dentistry in this changing approach to patient care, delivery and communication. Dentistry will continue to be viewed as a trustworthy, ethical profession.

Dr. McAndrew specializes in Prosthodontics and currently practices in Richmond.

Don't be scammed....

By: B. Ellen Byrne, DDS, PhD, Senior Associate Dean, VCU School of Dentistry

In 2009, the number of first-time, non-medical users of psychotherapeutics (prescription opioid pain relievers, tranquilizers, sedatives and stimulants) was similar to the number of first time marijuana users. Treatment admissions for prescription painkillers has increased more than four-fold over the past five years, while emergency room visits involving illicit drugs such as heroin and cocaine has remained stable. The problem is so large that an advisory panel to the US Food and Drug Administration has voted 19-10 to recommend placing tighter restrictions on hydrocodone, an ingredient found in popular prescriptions drugs including *Vicodin*®, *Norco*® and *Lortab*®. If the panel's advice is adopted by the FDA, it would put hydrocodone on par with prescription painkillers like oxycodone, morphine and methadone-all drugs with high abuse potential that can lead to severe physical dependence. The time line for the FDA to act on this recommendation is unknown. The Drug Enforcement Administration (DEA) would make the ultimate decision on whether to reschedule the drug. Changing hydrocodone from Schedule III to Schedule II would require that a patient present a hand-written prescription for the pain killer, rather than placing a call to the pharmacy and no refills would be allowed. In Virginia, there are laws which allow emergency dispensing of small quantities of schedule II drugs; however, changing the hydrocodone drugs to Schedule II would have significant impact on what and how health care practitioners prescribe. This vote sends a strong message to the public and health care practitioners about the potential for abuse with this drug.

Some interesting facts that have driven this decision:

- Drug overdoses now kill more Americans than motor vehicle crashes.
- Enough painkillers were prescribed in 2010 to medicate each American adult every four hours for one month
- Deaths from prescription painkillers have reached epidemic levels in the past decade
- Roughly one in 20 people in the US reported using prescription painkillers for non-medical us this past year.

A helpful tool to monitor prescription drug use (and possible abuse and diversion) is the Prescription Drug Monitoring Program. This type of program is available in almost every state. They are in important tool that can be used to address prescription drug abuse and diversion. They can help prescribers avoid being scammed by "doctor shoppers". A doctor shopper is a person who requests care from multiple medical practitioners, often simultaneously, without coordinating care or informing the multiple health care providers. The Prescription Monitoring Programs are systems which collect controlled prescription data. This data is centralized by each state. The goal of this data base is to promote the appropriate use of controlled substances for legitimate medical use, while deterring the misuse, abuse and diversion of controlled substances.

In Virginia, all pharmacies, non-resident pharmacies (mail-order) and dispensing physicians must report controlled substances to the Department of Health Professions within 7 days of dispensing. This information is made available to prescribers and pharmacists for their patients, investigators of licensing boards and certain law enforcement agents if they have an open investigation. A patient may access their own prescription history. The patient must be over 18 and provide a notarized request by mail or in person.

As a prescriber or dispenser, you can discuss the contents of the report with the patient, another health care provider treating the patient or the dispenser who dispensed or will dispense the medications to the patient. You should make a note in the patient's chart about your conversation and decision about prescribing.

You may not use this data base for any type of employment purpose. Prescribers may not release the actual or copy of the report to anyone including the patient. This is prohibited by 54.1-2525 of the Code of Virginia. It is considered a Class 1 misdemeanor. The Prescription Monitoring Programs reports on drugs in Schedules II, II and IV.

Drugs, substances and certain chemicals used to make drugs are classified into six (6) distinct categories on schedules dependent on two (2) facts:

1. Drug's acceptable medical use
2. Drug's abuse or dependency potential

Schedule I are the most dangerous of all drugs with high abuse potential and no currently accepted medical use. Examples include: heroin, lysergic acid diethylamide (LSD), marijuana (Cannabis), 3,4-methylenedioxymethamphetamine (ecstacy).

Schedule II drugs are defined as drugs with high abuse potential, less than Schedule I, with use potentially leading to severe psychological or physical dependence. Examples include: cocaine, methamphetamine, methadone, oxycodone (*Oxycontin*®, *Percocet*®, *Percodan*®), dextroamphetamine/amphetamine (*Adderal*®), methylphenidate (*Ritalin*®, *Concerta*®), lisdexamfetamine (*Vyvanse*®) No refills allowed. A patient must have a new prescription written each time.

Schedule III drugs have less potential for abuse than drugs in Schedule I and II, have accepted medical use and use may lead to moderate or low physical dependence or high psychological dependence. Examples include: anabolic steroids, hydrocodone/codeine, when compounded with a non-steroidal anti-inflammatory drug or acetaminophen (*Vicoprofen*®/*Vicodin*®/*Tylenol#3*).

Schedule IV drugs have a low potential for abuse relative to the drugs in Schedule III, have an accepted medical use and abuse may lead to limited physical dependence or psychological dependence relative to the drugs in Schedule III. Examples include: the benzodiazepines such as alprazolam (*Xanax*®) diazepam (*Valium*®), triazolam (*Halcion*®), carisoprodol (*Soma*®).

Schedule V drugs have low potential for abuse relative to drugs in Schedule IV, have an accepted medical use and abuse may lead to limited physical dependence or psychological dependence relative to the drugs in Schedule IV. Examples include: diphenoxylate (*Lomotil*®), pregabalin (*Lyrica*®)

Schedule VI drugs are any drugs not contained in Schedules I, II, III, IV or V and bears the legend "Caution: Federal Law Prohibits Dispensing without Prescription." Not all states have this Schedule. Virginia does recognize this schedule. Examples here include all prescription medications.

- Use the Prescription Monitoring Program, sign up at http://www.dhp.virginia.gov/dhp_programs/pmp/
- Program Phone # 804-376-4566
- Email: pmp@dhp.virginia.gov
- Access to other programs in neighboring states
- West Virginia: https://65.78.228.163/
- Kentucky: http://chfs.ky.gov/os/oig/KASPER.htm
- North Carolina: http://www.ncdhhs.gov/mhddsas/controlledsubstance/index.htm
- Tennessee: http://health.state.tn.us/boards/Controlledsubstance/faq.shtml

While there is no "typical" doctor shopper, there are some common characteristics:

- Demanding and insists on only one type of medication will work for them
- Reports textbook signs and symptoms
- Vague and hard to diagnose complaints
- No regular doctor
- Pays in cash, no insurance or doesn't always use insurance
- Makes appointments later in the afternoon, close to closing time and/or Fridays
- Claims that drugs or prescriptions were lost or stolen
- Fails to keep follow up appointments and/or fails to keep appointments with specialists
- Has prescriptions filled at multiple pharmacies, many located far from home

Ways to help prevent being "scammed":

- Photo copy identification at regular intervals. It is easy for a patient to dodge the system by providing different names
- Perform Prescription Monitoring check on patient at various intervals
- Make notes in patient's chart if suspicious
- Communicate between other health care providers (physicians, pharmacists)
- Record amount of medication prescribed and number of refills in the patient's chart
- Write the number of pills/capsules or ounces in both script and numbers
- If you approve a refill over the phone to a pharmacy, record that in the patient's chart
- Do not leave the "number of refills" space blank
- Never sign prescription blanks a head of time
- Document inquiries from pharmacists

In summary, all prescribers have a responsibility to minimize the potential for drug misuse and diversion while correctly prescribing for patients in need of such analgesics. The dentist should not prescribe without first examining and evaluating the patient. The quantity prescribed should be consistent with the pain level and the anticipated time the pain will last. The Prescription Monitoring Program should be used to verify drug-use history and assist, where appropriate in safe, responsible prescribing.

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Dr. Byrne is the Senior Associate Dean at the VCU School of Dentistry.

MOM: A Student's Point of View

By: Mary Catherine McGinn, VCU School of Dentistry, Class of 2014

An empty gym, an open cafeteria, a large tent – this is how it all begins. After a few hours of setup, we will have transformed this empty space into a functioning dental clinic. We have two trucks that go with us to every project, and this is where all of our supplies are stored. We set up everything from portable dental chairs, dental units, sterilization, and supply tables between the dental chairs. The layout for each project varies slightly, but the three main treatment sections include: oral surgery/extractions, restorative, and hygiene. By the end of the day, we will have triaged patients that will be waiting in line bright and early for services the next morning. These Missions of Mercy projects are full-day events, and we begin seeing patients by 7:00 a.m. the morning of the project. Typically, there is a constant flow of patients, and the waiting areas are filled for all of the three different treatment areas. When patients arrive, we try to address their chief complaint. This ranges from wanting all of their teeth extracted for dentures to a filling or cleaning. If a patient needs services in more than one area, we have the patient decide which one thing they would like to have done the most. For example, if a patient needs multiple extractions and multiple fillings, they must choose between the two based on what is more urgent. Our goal is to provide at least one service to as many people as possible. Throughout the project, we see as many patients as we can before taking everything down, and leaving the space just as it was before we got there.

For every project, VCU School of Dentistry brings dental, dental hygiene, and pre-dental students to volunteer for the event. Students are given a rotation schedule, where the day is divided into three rotations. The rotations are assigned based on where the students are in the dental school curriculum. For example, D1s (first year dental students) get to assist dentists doing restorative procedures and take radiographs. D2s have a local anesthesia rotation, where they anesthetize the patients for their procedure right before they are seated in the dental chair. D3s and D4s are the students performing the extractions, along with specialty residents and dentists from the local community. We are fortunate to have residents from oral surgery and periodontics departments volunteer as well. Additionally, faculty or local dentists and oral surgeons supervise all of the dental students on the project, and this is a wonderful learning opportunity. Volunteering in the community exposes us to a diverse patient pool, and we work with different practitioners, showing us other perspectives for performing the procedures.

I have been fortunate to be a part of the projects since I was a pre-dental student, and I have continued to volunteer as a dental student. Throughout my involvement, I have participated in most of the different tasks involved in the project ranging from running "spit buckets," sterilizing instruments, and pulling teeth. Personally, I have learned a lot about dentistry at each of my levels of involvement. As a pre-dental student, I figured out the dental instruments by being on rotation as the "instrument police" and making sure that everyone was wearing clean gloves. I gained experience with radiographs as a D1, and I probably learned the most about local anesthesia on my MOM project rotations as a D2. As a D3, I was able to apply all of the information we were taught in oral surgery about extracting teeth with the patience and guidance of D4 students, residents, and dentists. Having gone to the projects for so many years, I have gained an appreciation for how much work and dedication it takes from everyone involved with the project to make it a success. Each of us plays a part, whether it is big or small, that helps the project run smoothly. I am always impressed by the support from the local communities as well. They do a wonderful job hosting us, and they always make sure we are well fed!

As I begin my final year of dental school and reflect over the past three years, my involvement with the MOM projects has been one of the most meaningful and rewarding parts of my dental school career. I have gained a wealth of clinical experience from these projects, but more important, I feel that I have been a part of a positive impact on the people in these communities. Of all the patients and stories I have seen and heard at these projects, I always think of two specific patients that I was involved in treating. These two patients were so thankful and appreciative for the services we provided them, but they probably have no idea how thankful I was for them. They both reminded me why I decided to be a part of such an amazing profession where we can work with patients of all ages, be involved in the community, and have the ability to make a difference in people's lives.

Mary Catherine McGinn is in the class of 2014 at the VCU School of Dentistry.

Missions of Mercy
Virginia Dental Association Foundation

Looking ahead:

NEW MOM Site for 2014 - Suffolk, VA (March 8, 2014)!
Watch for more information on the VDA Foundation website.
www.vdaf.org

Join the MOM Team!

Upcoming MOM Projects

WISE MOM July 19-21
ROANOKE MOM September 13-14
GRUNDY MOM October 5-6
HOMELESS CONNECT November 14

Volunteers Register Online at www.vdaf.org

We wish to thank you for your continued support and look forward to seeing you at a 2013 M.O.M. Project.

My Mission of Mercy

By: Eric Biagioli; Manager, MSDA (Maryland) Charitable and Educational Foundation

Behind Joshua Nordstrom, another volunteer, the line proceeds to grow.

On the afternoon of Thursday, March 14th, I departed on a trip to Salisbury that, according to my GPS, would take two hours and thirty-nine minutes. I was headed for the Mission of Mercy dental clinic, where I was scheduled to begin working the following day. In the meantime, early arriving volunteers would be setting up the Wicomico Youth and Civic Center where it was to take place. I had never experienced an event like this myself. I was told, however, that it would be a massive charitable event with many volunteers from all walks of life. And, above all, that it would be very touching. The clinic was designed to provide free dental care to many hundreds of patients over the course of two days, helping as many individuals as possible. As an employee of the Maryland State Dental Association's Charitable & Educational Foundation—a charity involved in sponsoring the event—I had a very active interest in what those two days would bring.

I neared the Civic Center around 2:30 p.m., having decided to preregister in order to earn myself some extra minutes the next morning before my 4:00 a.m. shift. I had volunteered for these early hours since I really wanted to be out there with the patients—to see what they would see, to be part of the process with them from start to finish, to relate to them, and perhaps to bring a smile to their faces before the dentists had their turn at doing the same. As I pulled in and saw the scale of the facility, my anticipation grew. It was bigger than I had imagined, and it was clear that many would be helped. I headed inside and completed my registration, headed over to the pep rally where I recognized a few faces, then quickly headed to my hotel to get as many hours of sleep as my early morning would permit.

I woke up at 3:00 a.m. and, compelled as much by my eagerness to get the day started as by my frustration with the late night giggling of the girls in the next room, had no thought of trying to sleep off the next thirty minutes my alarm had been set to allow for. I left my room and, armed with three hours of sleep and pockets stuffed full of things I'd later lose or realize I had no use for, headed for the Civic Center. I pulled in around 3:35 and was again greeted with a sight that grew my anticipation; in the low light of the building's entranceway there were hundreds of people already waiting in line! I stepped out of my car into the piercingly frigid morning air, and began walking toward the entrance to look for other volunteers. As I approached, I realized two things: one, that I was definitely the first volunteer on site. And two, that I felt more out of place with every step. I meandered into a semicircle of heavily clothed attendees who spoke softly amongst themselves and seemed to give me slightly more attention than they were giving each other. It was clear that many had camped out overnight despite the intense cold, and in fact were still camping out, having not yet woken up or left their sleeping bags. After a few dawdling moments a group of individuals rounded the corner of the facility, walking toward me with such purpose that made it plainly obvious they were also volunteers.

As it turned out, Dick Van Gelder and Lynne Peverley (community leader for the clinic and coordinator, respectively) were part of this group. Despite the intense stress of their roles and the early hour, I found both of them to be very happy, energetic, and friendly. They gave the now growing group of volunteers a concise briefing on their roles, and set off to their next task while leaving us to ours. We were to set up our tent, keep the people in queue informed, and in general try to keep the mood positive amongst the freezing and tired patients to be.

We set up the tent around 4:30 a.m., and I began to realize how much the line had grown since the time I had arrived. Previously it had stopped a bit past the white food trailer, and it was now stretching down the entire length of the building, stopping just before rounding the corner.

At that moment the attendees needed some information, distraction from the cold, and some entertainment. Luckily for me, I at least *believed* myself capable of providing those things. I set out into the crowd, and found my apprehensions immediately disappeared. I spoke with those in the front of the line, and was amazed to hear that they had been waiting since 8:00 p.m. the previous night. I moved along the line for the remainder of the morning providing information, cracking cheesy jokes, and offering any help that I could. I shared laughs and formed bonds with many people that morning, which fostered a hope that none of them would be turned away—a hope made unrealistic by the overwhelming number of people. One young lady expressed her fears of exactly this, to which I attempted to comfort her by jokingly suggesting that I would give her hand warmers the next morning if she were turned away that day. The facility started taking patients in at 6:00 a.m., and things really started moving. The attendees were great—many just seemed to be waiting for someone to come around and give them any excuse to smile, while others seemed to have no trouble finding excuses to do so on their own. One particular section of the line could be seen laughing and rocking out to their music. It was truly awesome to share in their experience, and to see how amazingly grateful they were. Even when the line had to be cut off, and many people who waited many freezing hours were sent home, I could hear the voice of one of the displaced attendees shouting his thanks to everyone involved for the opportunity. He was one among many, and the need for increased access to care in the region was well demonstrated by the line which had, at its peak, wrapped well around the building and along the adjacent street. It was shortly before noon, and my next shift began inside in 15 minutes. And though I didn't want to leave the people in line, I was eager to see the inside of the facility and speak again with the patients who I had met earlier in the morning.

I headed inside and was immediately greeted with a bustle of activity. Patients were being guided all around, but before beginning I needed to attend to my

stomach. Entering the break room, I had the pleasure of encountering a few dentists with whom I work closely, and I very quickly observed how invested they were in helping the public. Their dedication to providing care for these needy patients was profoundly communicated by their haste. Their focus was so great that they spared no time for cordialities, instead eating their meals and speeding back to the clinic floor. I was impressed, and so I followed their lead with a quick lunch. I then headed back out into the facility and began walking the floor, performing various tasks as a "floater". Seizing upon the freedom of my new position, I went to explore the treatment room, the heart of the action. I was immediately struck by the scale of the venue and intensity of the activity. I was surrounded by patients in queue, volunteers of all sorts, dentists, hygienists, and many others, all moving with a focused purpose. The first thing I noticed in the room was MFDH representative Lilian Marsh, in a yellow shirt, working hard to conduct the flow of patients. Deeper inside the treatment room patients were getting anything from a cleaning to oral surgery, and some even had dentures made on the spot. There were volunteers, hygienists, dentists, dental students, and companies like America's Dentists Care Foundation all working together in a flowing collaboration. As time passed, I felt more and more instrumental in keeping things on track and flowing smoothly. From providing updates to event administrators to catering to the needs and inquiries of individual patients, I felt very connected to the people and the event. As my shift ended, I reluctantly (though also wearily) departed the facility shortly after 5:00 p.m.

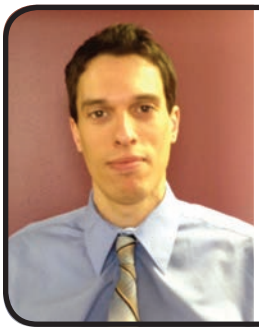
I had dinner at a local restaurant, and sometime between courses my battery neared zero. Regardless of my absolute exhaustion, I was lucky enough to find myself at the event's scheduled happy hour that night, where I experienced the most touching and memorable moment of the entire trip. It must have been after 8:00 p.m. when I had a second dinner with a dentist and his wife, both of whom I was meeting for the first time. Having informed them of the position I held as a line manager that morning, they began to ask me questions. I realized that the dentists were in a sort of bubble on the clinic floor, so focused on their work as to be largely unaware of what else is going on at the event. It was this unawareness that led the dentist to ask "…we did have to cut the line off, and send some people home. But, we did serve nearly everyone who was in line, correct?" They hadn't, though they had served many hundreds of people. There were so many in need of care in the area; it was unfathomable that all would have made it through. He couldn't have known this, and so I had to tell him that many were turned away. It was this moment that became the most touching of the entire experience for me, the moment that I saw the sorrow on his face at the thought of having turned people away. The moment extended in time where he stared blankly at his plate, and never found a response or another question. I returned to my newly requested hotel room, hopefully floors away from giggling, and put the empathy of that compassionate dentist in my pocket to bring out the next day, and many days forward.

I arrived on site sometime around 6:00 a.m. the next morning after dealing with a late cab driver and a much more acceptable five hours of sleep. Things were already in motion, and it was just as dark and cold as the previous morning. The first thing I did was hunt down the young lady I'd met to give her the hand warmers I had jokingly promised. I was excited to give them to her, and I knew it would make for an entertaining conversation. However, when I found her at the forefront of the line jumping up and calling my name, I realized my hand warmer delivery was a little late. She had been waiting since 10:00 p.m. the previous day, and with her position in line she would no doubt soon be inside the facility. So much for being the hero!

I spent the entire second day running around performing various duties similar to those I had the day before. I met even more interesting, fun, and happy patients who were simply a blast to talk to and provide assistance for. It was also a joy to

meet the other volunteers, kind hearted people that came from all over to help others due naught but to their kindness and generosity. From the hygienist from York I was graced to share lunch with to the local high school kids who popped in at the end of the day to help pack up all of the equipment, I felt surrounded by great people. Most had headed home as the day concluded, I had stayed to help pack up the equipment throughout the building when I ran into Dr. Mark Horner. I was excited to see that not only had he provided the charity of treating patients, but he was also working just as hard to help pack up the facility. I spoke with him about the day's events but, with a ride waiting to pick me up, I had to leave the others to finish packing around 6:00 p.m.

Feeling exhausted, I stepped out of the front entrance to greet my ride when I saw two tall and heavily dressed men, one of which was holding a rag to his mouth. As I walked by, they turned their attention toward me. Then, in a deeply appreciative and sincere tone, one said "thank you… I can eat again" and the other "…I can smile again". I cannot express in words how genuine their appreciation was at once again being able to do what most take for granted. My ride arrived, and I headed home. When I got there, I immediately registered to volunteer for the next Mission of Mercy clinic this August.



Mr. Biagioli is the Manager of the Charitable and Educational Foundation at the Maryland State Dental Association.

The line peaks, and goes out of sight, mid morning on Friday shortly before I headed inside.

New MOM Project in Charlottesville

By Anne Cressin, Project Coordinator

At the Charlottesville Free Clinic excitement had been building for months and the big day finally came: A Mission of Mercy (MOM) Dental Day in Charlottesville. While many MOM projects happen in rural communities and Charlottesville may seem to be an affluent community where one would not expect dental care to be an issue, the Charlottesville MOM served 357 patients at this one and a half day event. These patients were adults, working and unemployed; from the local area, surrounding counties and beyond. Many had not seen a dentist in years. They all needed dental care; had no affordable option to receive that care, and were willing to wait in line with patience and gratitude. With an unexpected change in the initial registration process due to a potential storm, one patient offered his assistance, exchanging his place in line to help assure that things continued to run smoothly.

Of the 357 people seen, 101 patients were between the ages of 28 and 37, 72 between the ages of 38 and 47 and 72 were between the ages of 48 and 57. 456 teeth were extracted (355 standard and 101 surgical). 463 surface composites were done, with this being the most common procedure. eight patients were able to get a root canal completed and 77 people received a general cleaning from a hygienist and 269 prescriptions were written with many patients receiving both antibiotics and pain medication. The initial incentive for doing a MOM project in Charlottesville wasn't just to serve the patients on the waiting list at the Free Clinic. It was also to bring attention to the need. With grant money from the Charlottesville Area Community Foundation Future Fund, space offered gratis by Covenant Church, and support from the Shenandoah Valley Dental Association, the VDA gave the go-ahead for this particular MOM project. The Charlottesville Free Clinic put together an outstanding team of volunteers who met several times over nine months planning carefully for a well organized event.

The VCU School of Dentistry came and set up the whole operation, providing the dental chairs, equipment and supplies. Dentists, Dental Students, Pharmacy staff and students, Hygienists, Dental Assistants, Nurses, college students, and community volunteers all signed up with enthusiasm to participate. Over 400 individuals were willing to share their skills and time to assure that folks were treated well and taken care of. Each patient completed registration, went through Medical screening, had their medical issues addressed, talked with a dentist about their options for care, got x-rays as necessary, received treatment and were discharged with prescriptions to be filled at a local pharmacy; all at no cost to the patient and with volunteers having had a valuable experience.

It was a lot of work, and a lot of fun with patients and volunteers both gaining something. And there are still patients waiting and more MOM projects to come throughout the state. Meanwhile, the Charlottesville Free Clinic Dental Clinic continues to see patients for basic dental care and maintains a waiting list while they contemplate repeating the MOM experience, knowing that once again, people would come seeking much needed dental care and leave with a smile and hope in their heart.

Northern Virginia MOM Celebrates 10 Years

By: Dr. Peter Cocolis

Red shirt M.O.M. Team Champions: JoAnn Knox, Tom Wilson, Cathy Griffanti, Dr. Peter Cocolis, Andrea Lomrantz, Mike Grable, Jerry Prentice, Dr. Emily DaSilva, Dr. Ted Corcoran, Dr. James Willis, Dr. Vince Dougherty, Dr. Paul Olenyn, Dr. Fernando Meza. Seated: Dr. Howard Kelley, Elenore Yee, CDA, and Catherine Johnson, RDH. Not pictured: Dr. David Anderson and Betty Peebles

This year marked the 10th Anniversary of the Northern Virginia Missions of Mercy Project (MOM). The Project was held March 15 and 16, 2013 at the Northern Virginia Community College, Medical Education Campus in Springfield. This is an amazing accomplishment for our society and members. For the last several years, we have been supporting this Project through our own funding via the Ellen S. Flanagan Memorial Fund and donations from corporations such as Kaiser Permanente. This year was no exception and we were able to run the Project extremely efficiently through the generosity and hard work of many volunteers—both dental and non-dental.

We treated 844 people with a value of over $355,000. This was a new record for us. Over 600 people volunteered to help these needy patients over the two day event. The clinical support came from more than 200 Northern Virginia Dental Society members as well as many local organizations. Therefore, I would like to spend a moment recognizing those who are to be thanked for their special efforts in organization and time in developing this Project. When you see some of these "red shirt" champions, please give them a word of thanks. Many have been on the committee for 10 years and have made the Project what it is today. Without the help and expertise of each of these professionals, we would not have the Project and be able to meet the need in our community as we do today.

Tom Wilson, Director of the Northern Virginia Dental Clinic, was instrumental in ensuring all materials and instruments were available. He also was on-site before everyone on both days to make sure the signs were up for parking and the clinic area was available and ready for patients. Tom is one of our original champions.

Catherine Johnson, RDH, again championed the hygiene department for the two days. With her exceptional organization and "can-do" attitude, she managed and orchestrated our most successful hygiene effort yet. In fact, hygiene closed first on Saturday for the first time in our recorded history!

Our Oral Surgery clinic was championed by Dr. Ted Corcoran and maintained a steady pace. Due to the efforts of all our surgeons, the oral surgery clinic was well staffed and ran at utmost efficiency.

Our endodontic department was led by Dr. Fernando Meza for both days. He was accompanied this year by Drs. Bob Argentieri, Thao Bui-Nguyen, Tawana Feimster, Joshua Fein, Chad Kasperowski, Lawrence Kotler, Brian Lee, Loken Patel, Michael Picchardo, and Neil Small and with their combined efforts, they gave us our largest number of endodontic procedures completed to date at a MOM Project!

The triage department, which helped handle in increased patient flow, did a fantastic job under the direction of Dr. David Anderson. Dave is another of our original champions and has been one of our strongest driving forces since inception. The restorative clinic was chaired by champions Drs. Vince Dougherty and Paul Olenyn. They helped maintain the flow of the clinic for what seemed like the most smooth and relaxed atmosphere we've ever seen.

The restorative area was also maintained by Eleonore Yee, CDA, who spent many hours prior to the event and during the two days organizing instruments and then keeping the tables well-stocked. Also, Dr. Emily DaSilva took up any role necessary this year to ensure the restorative area was taken care of as well as stepping into triage when extra hands were necessary. Well done all!

We were once again assisted by Brett Brocki from CareStream Dental as well as Ben Waldman and Tom Frances from Dexis. These two individuals returned this year in reprised roles and integrated their software into the Community College so that our radiology was truly state of the art. A huge part of the ability to coordinate these efforts came from Mike Grable of Baran Dental Lab. Mike has been our radiology MOM champion and maintained the communication between the college IT personnel, the clinical staff and the radiology experts. Without his efforts, our radiology efforts would not have run so smoothly and effortlessly.

JoAnn Pearson Knox was ever present as our non-dental volunteer coordinator and made sure our pharmacy was well-manned and prepared. She also helped make sure the patient lines kept moving to triage! JoAnn, another of our founding champions, retired from the northern Virginia area last year, but flew back from San Diego to help with this year's project.

Andrea Lomrantz, from Northern Virginia Family Services, ran the busy patient registration and check out areas with ease. She worked closely with the northern Virginia jurisdictions in setting up the pre-registered patient appointment times and did an awesome job keeping patient flow moving. Betty Peebles of Team Placement maintained and enhanced the undertaking for the Project in patient education and child care. She and her team kept people relaxed during long wait times and provided oral health care education while they were awaiting treatment. Also, the patient's very much appreciated the care provided their little ones while they received their treatment. Betty has been an integral part of the long-standing nature of our Project, taking on many different duties and defining each of them to create and enhance the experience for our patients and our volunteers.

Jerry Prentice of the Boy Scouts Order of the Arrow undertook the food service to volunteers this year. With the help of the adult scouts and local Boy Scouts, they fed over 600 volunteers over the two days. They were also instrumental in helping clean up and move all the equipment out of the NVCC MEC campus back to storage.

Cathy Griffanti and her wonderful staff at the Society's central office, coordinated the dental volunteers and much of the logistical details that helped ensure the Project's overall success.

I would also like to thank my Co-chair, Dr. James Willis, for his energy and enthusiasm as I hand the MOM reigns over to him next year. His insight and hard work helped make our Project a wonderful achievement and will continue to do so in the future.

We were happy to see some of the area legislators at our MOM this year including Congressman Gerry Connolly, Senators David Marsden and Barbara Favola, and Delegates Eileen Filler-Corn and Mark Keam.

All of this would not be possible if it weren't for the home given to us by the Northern Virginia Community College, Springfield Medical Campus and the state-of-the-art dental facility. Dr. Howard Kelly, Clinic Director, was an integral and essential part of the planning of this event. He and his staff worked tirelessly on this event to give two days of their spring break to ensure all clinical needs were met. It is truly an honor for the Northern Virginia Dental Society to be able to partner with the Northern Virginia Community College. Thank you to Dr. Kelly, his staff, the staff of the Northern Virginia Community College Springfield Medical Campus, and Provost Brian Foley.

Unfortunately, with over 600 volunteers, it is easy to miss someone in the process; everyone who participated did a fantastic job. This event was such a success due all the volunteers who gave of their time, efforts and talents. Thank you all for your participation and to the continuing success of the MOM Project, without you, there would be no MOM.

Piedmont Dental Society Sponsors Moderate Oral Sedation Course

By Stephen Alouf, DDS, President - Piedmont Dental Society

Many of you may be aware of the recent Virginia Board of Dentistry rules requiring Dentists administering moderate oral conscious sedation medications to patients to have a permit issued by the Board. This was something I readily agreed to and sent in my check and application along with all documentation required. I soon found out that I was not alone in my disbelief that the courses I took previously and a 7 year history of safely sedating apprehensive dental patients did not meet those guidelines required by the ADA for teaching Pain Control and Moderate Enteral Sedation to Dentists and Dental Students, which is what the Board now requires to obtain a permit.

Quickly, I needed to find a course that met those guidelines and my search kept turning up Dr. David Canfield, a dental anesthesiologist of the Aesthesia Education and Safety Foundation in Texas. Dr. Canfield teaches courses that meet and exceed the board requirements for many states. Upon hearing my story and realizing there were many more Virginia dentists in this same situation Dr. Canfield agreed to come to Salem and present a moderate sedation Training course sponsored by the Piedmont Dental Society. In all we hosted around 18 dentists at our 3 day course. The course included lecture and 40 clinical experiences with discussion including 16 live patient sedations for a total of 26 hrs. The lecture component included the areas required by the Guidelines. It also included video experiences of sedation as well as other issues such as airway management, patient interviews, etc. State Board Rules were addressed as well as emergency management.

Additionally, a hands-on airway management session was included where all participants were required to manage an airway, ventilate and utilize other airway items under the teaching supervision of an anesthesiologist

Participants were required to do pre-anesthesia work ups, sedation medication selection and administration, patient monitoring and take the patients through recovery and dismissal. There were four sedation reversals demonstrated on these live patients as well. The course was very informative and exceeded my expectations. I would like to thank Dr. David Canfield and Dr. Perry Marcel for their excellent instruction, my brother Gregory Alouf MD for use of his lecture facility, my wonderful team members for all their help and the attendees who helped make this event a success. Dr. Canfield has agreed to return to Virginia June 20th in Centreville to conduct this same course which will be sponsored by the Northern Virginia Dental Society.

Welcome New Members

Tidewater Dental Association
Dr. Sheryle L. Hamlett – Norfolk – Virginia Commonwealth University – 1983

Dr. Krystie Morrissey – Virginia Beach – University of California, San Francisco – 2008

Dr. Eric Niver – Virginia Beach – New York University – 2007

Dr. Amr M. Sheta – Norfolk – University of Cairo, Egypt – 1995

Peninsula Dental Society
Dr. Joy L. Phelps –Toano – Harvard School of Dental Medicine – 2006

Dr. Maynard P. Phelps –Toano – Harvard School of Dental Medicine – 2006

Dr. Bryan H. Wendell – Newport News – SUNY at Buffalo – 2011

Southside Dental Society
Dr. Qin Wang – Colonial Heights – Shandong University of Stomatology, China – 1987

Richmond Dental Society
Dr. Parthasarathy A. Madurantakam – Henrico – Virginia Commonwealth University – 2012

Dr. Sonali Rathore – Glen Allen – BVP Dental College, Pune, India – 2000

Dr. Irina Volkova – Richmond – Virginia Commonwealth University – 2010

Shenandoah Valley Dental Association
Dr. Courtney E. Ashby – Remington – Virginia Commonwealth University – 2012

Dr. Aaron J. Stump – Charlottesville –Indiana University – 2010

Northern Virginia Dental Society
Dr. Sooyeon C. Ahn – North Bethesda, MD – University of Pennsylvania – 2010

Dr. Ahmad Al Attar – Vienna – Virginia Commonwealth University – 2005

Dr. James A. Bronson – Arlington – Midwestern University – 2012

Dr. Liliana Calkins – Great Falls – Howard University – 2010

Dr. Mark P. Gerald – Oakton – Virginia Commonwealth University – 2011

Dr. Farhad Hakim – Herndon – Howard University – 1999

Dr. Sok Woong Daniel Han – Bethesda, MD – University of Pennsylvania – 2007

Dr. Sylvie M. Ho – Annandale – University of Maryland – 2008

Dr. Mehrdad Ijadi – Falls Church – Centro Escolar University, Philipines – 1987

Dr. April Johnson-Toyer – Springfield – University of Maryland – 2007

Dr. Sheila Mazhari – McLean – Nova Southeastern University – 2012

Dr. Quoc V. Nguyen – Fairfax – Virginia Commonwealth University – 2004

Dr. Hune June Park – Fairfax – Tufts University – 1999

Dr. David D. Tsang – Fairfax – University of Pittsburgh – 2010

Dr. Abraham Younoszai – Springfield – NOVA Southeastern University – 2010

Board of Directors - Actions in Brief

April 12, 2013

I. The following is reported as information only.

A. Resolutions considered:

1. Approved: Background: There is a problem with access to care with younger populations. A major concern for existing providers to low income children is making first contact and with keeping appointments.

   Resolution: The VDA supports a pilot project by Kanopi Health in Prince William County to establish teledentistry to determine success with the model.

2. Approved: Background: The Ethics Committee has created a Procedures Manual outlining procedural steps and to serve as a checklist when the Committee is confronted with an accusation of unethical conduct against a VDA member in good standing. The Manual has been reviewed by legal counsel.

   Resolution: The VDA Board of Directors approves the Ethics and Judicial Affairs Committee's Procedure Manual for use in hearings conducted by the Committee.

3. Approved: The 2015 Virginia Meeting will be held at the Marriott Waterside Hotel in Norfolk, VA.

4. Referred to the Governance Review Task Force: The New Dentist Committee proposal that the Committee have a subcommittee titled "Mentorship Subcommittee." The duties of the subcommittee are to continue to plan lunch and learn functions at the dental school focused on practice transtions. The Mentorship Subcommittee will report directly to the New Dentist Committee.

Photos are from April Meeting

L-R: Dr. Kirk Norbo, VDA President, Alex Barton, Dr. David Sarrett, Dean, VCU School of Dentistry

Dr. David Olive, President, Bluefield College

Dr. Carole Pratt, Consultant, Bluefield College of Dentistry

Dr. Karen West, Dean, University of Nevada - Las Vegas School of Dentistry

In Memory of:

Dr. Eldridge Anderson	Northern Virginia Dental Society	Herndon	January 1, 2008
Dr. Clark A Cheney	Northern Virginia Dental Society	Clifton	December 24, 2011
Dr. Barry McNair	Northern Virginia Dental Society	McLean	March 8, 2013
Dr. James Midkiff	Piedmont Dental Society	Roanoke	May 7, 2013

Dental Direct Reimbursement and Assignment Continues On in Virginia

By: Cork Coyner, Benefits Administration, Inc. & Elise Rupinski, VDA

In September of 2012 the VDA House of Delegates elected to disband the VDA's Direct Reimbursement Committee. Despite many years of effort and active promotion, the idea of a self-funded dental benefit had simply not been able to compete in the dental benefit market in Virginia. While there were at times thousands of employees in Virginia covered by Dental Direct Reimbursement and Assignment plans, the program was not able to capture a significant portion of the market and hence the decision was made to divert limited resources to other important VDA initiatives. Despite the end of the Direct Reimbursement Committee and any VDA financial support for the program, there are still a number of employers in Virginia (the VDA included) that use Direct Reimbursement plans for their dental benefit. Employees covered by a Direct Reimbursement program still have a significant impact in Virginia as they represent fee-for-service patients that visit providers here in the Commonwealth.

Benefits Administration, Inc. (BAI) is pleased to report that at least 29 employers in Virginia still use Dental Direct Reimbursement and Assignment. These employers have over 1,200 employees throughout Virginia and in several other states. BAI currently serves as broker for most of these groups and continues to encourage new employers to consider the Direct Reimbursement model for their dental benefit. During 2012, these groups, by our knowledge or estimate, used over $1,020,000 in dental services. These fees are paid to dental providers, for the most part, without any discounts being required. These groups are using one of at least four third-party administrators (TPA's) or are self-administering their Dental Direct Plans. The majority of these groups have been using Dental Direct for 10 years or longer, compared with an average longevity of only three years with insured dental plans. This is strong evidence that Dental Direct is meeting the needs of employers and their employees and that satisfaction with their plans remains high.

Unfortunately, most human resource managers today continue to be concerned with what will happen to their health insurance plans. The changing regulations of the Affordable Care Act and establishment of health insurance exchanges are absorbing most of the time these HR managers have to devote to their employee benefits. Consequently, they spend little or no time on their dental plans and have minimal interest in considering changes to them. While many HR managers are concerned about the new Federal excise taxes on their health plans and the onerous, time-consuming requirement to begin filing IRS Form 720 as early as July 31 of this year, thankfully, the new tax and IRS filing do not apply to their Dental Direct Reimbursement plan or other dental plans.

It is important to note that while the VDA no longer actively promotes Dental Direct Reimbursement plans, they are still a viable option for employers. The simple plan designs, ability to visit any provider and the cost savings that can many times be realized in comparison to a fully insured plan make the self-funding option a very attractive one for many employers. Please remember to include Dental Direct Reimbursement and Assignment plans in your discussion with patients who are business owners and human resource professionals. Companies that are interested in finding out more about Dental Direct are encouraged to contact Mr. Cork Coyner of Benefits Administration, Inc. at 804-379-2218 or via email at ccoyner@benefitsadmin.net.

Protecting our profession

By: Jeremy Jordan, Associate Editor; Class of 2015, VCU School of Dentistry

As the adage says, one bad apple can spoil the whole bunch. Unfortunately, this same notion could just as easily contribute to the public perception of dentists. According to Vulture Entertainment News, produced by *New York* Magazine, fictional dentist Jeremy Jamm of NBC's television show, *Parks and Rec*, was voted The Best Villain of the Year. Not to be outdone, ABC offers up their version of a predatory dentist, via character Noah Werner, on their show *Suburgatory.* Although these fictional characters have little to do with dentistry--and provide a potentially facetious example--their popularity raises the question: are dentists being demonized?

Over the past several years, the media portrayal of dentists has been less than forgiving. Conspiracies suggesting the hazards of fluoride and amalgam use are enough to raise concern; however, some patients' concerns are legitimized by the news. Last year, *Frontline*'s "Dollars and Dentists" documentary painted a cold picture that implied dental professionals are becoming increasingly greedy and apathetic while dental disparities continue to grow. Likewise, dentistry returned to the headlines this past April after an Oklahoma dentist allegedly infected nearly sixty former patients due to use of instruments after improper sterilization. While these instances are few, it's important to realize that patients are cognizant of ethical behaviors and their importance in dentistry.

Ethics is the cornerstone of dentistry. The respect of dentists stems from the public's belief that dentists will always do the right thing. To be fair, this is exactly the reputation dentistry should be earning. As one of the few remaining self-governing professions, dentists are expected to not only provide high quality oral health care, but to provide it to patients with increasing standards of value and esthetics. Our goal is to provide this care and meet these expectations, while adhering to the code of ethics by which we've pledged to practice.

As a dental student, it's not difficult to be ethical--tests are proctored, patients are seen under the ever-watching eye of faculty dentists, and when questions arise about the best decision a resolution is never far away. After participating in my own White Coat Ceremony this past February, I've realized that ethics is an extraordinarily common theme. Students are continually encouraged to hold themselves to the highest ethical standard. Student exposure to ethics isn't at all limited. The VCU School of Dentistry boasts our own Student Professionalism and Ethics Association in Dentistry chapter, offers a course on ethics and professionalism, and a VCU student received an honorable mention in the 2012 ADA Student Ethics Video Contest. VCU has a long history of setting precedent for high ethical standards; the Dentist's Pledge was written by VCU faculty and students before being adopted by the American Dental Association in 1990.

Several months ago, I wrote an article for the American Student Dental Association's quarterly magazine, *Mouth*, discussing the Board of Dentistry's review process and how dentists can lose their license. After discussing this with a few faculty members, and gaining some invaluable insight, I recognize that ethical issues are complex and multi-faceted. Most ethical dilemmas fall in that gray area between right and wrong. While it's easy to condemn dentists suspected of unethical behaviors, it's harder to understand how these dentists go from ethical health care providers to being pressed with criminal charges. It's unlikely that, after years of hard work and thousands of dollars in tuition, these dentists set out with the intent to violate our code of ethics. Violations more likely begin with dentists making seemingly insignificant compromises of their integrity--from there, it's a slippery slope.

Ultimately, our profession's reputation rests on ethics and those tenets outlined in the ADA's Code of Ethics and Professionalism. Ethical behaviors, both in the office and out, influence not only our patients' perceptions of dentistry, but also our self-image. As students, we're fortunate to be learning from those far more experienced, but at the same time it's difficult to imagine making these decisions on our own. It's important that we establish ethical decision making as a habit now, so that in the years to come we can protect the reputation of the profession we've come to love. Luckily, ethics is a battle we'll never have to fight alone--organizations like ASDA, SPEA, and the ADA ensure that both students and dentists have access to resources, like the ADA's Ethics Hotline, that assist in managing ethical dilemmas. As dentists, our reputation is one of our most valuable assets. Advocating for ethics ensures that our reputations, careers, and patients remain safe.

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Oral Diagnostic Sciences at the VCU School of Dentistry

James Burns, D.D.S., Ph.D., M.S.Ed.; Laurie Carter, D.D.S., Ph.D.; John Svirsky, D.D.S., M.Ed.; Sonali Rathore, D.D.S., M.S.

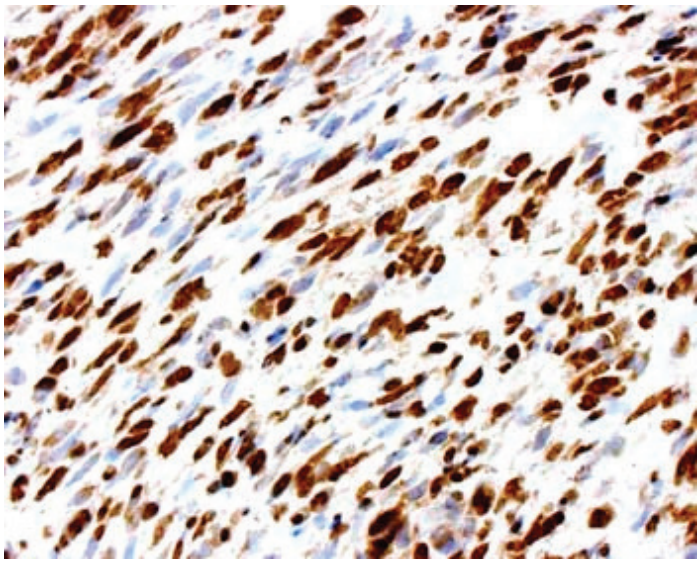

Figure 1: Immunohistochemical Desmin positive of a Sarcoma.

Question: What do Synovial Sarcoma (Fig.1), Dentin Dysplasia, Carotid Atherosclerosis (Fig. 2), Van Der Woude Syndrome, Metastatic Prostate Carcinoma and Pyostomatitis Vegetans (Fig. 3) all have in common?

Answer: They all initially were diagnosed by the Department of Oral Pathology at VCU's School of Dentistry.

Dentists increasingly are held accountable for early detection and diagnosis of an ever increasing number of head and neck disease processes. New technology, coupled with the increased emphasis on examination, biopsy and radiographic techniques taught in dental schools, has led to the new class of dental practitioner acutely capable of the early detection of head and neck abnormalities. The adage of "times are a'changing" certainly is true, and the Department of Oral Pathology is changing with these times. Effective May 2013, the departmental name officially change to the Department of Oral Diagnostic Sciences. Virginia practitioners and dental alumni will welcome this change as the support given by the department will increase in the areas of:

- Autoclave spore testing;
- Oral medicine referrals;
- Radiographic interpretation;
- Histopathologic diagnosis.

Autoclaving is a routine and effective method for sterilizing dental instruments. However, autoclaves can malfunction or perform suboptimally for a multitude of reasons, resulting in incomplete sterilization. The CDC and the ADA recommend at least weekly use of biological indicators (spore strips) to test the adequacy of sterilization cycles. Spore test strips can be ordered from VCU by calling (804) 828-1778 or emailing eathomasson@vcu.edu. The cost varies by the volume that is ordered (12 for $72; 24 for $117; 52 for $200).

Wikipedia defines oral medicine as follows: "*Oral medicine is concerned with clinical diagnosis and non-surgical management of non-dental pathologies affecting the oral and maxillofacial region, such as oral lichen planus, Behçet's disease and pemphigus vulgaris. Moreover, it involves the diagnosis and follow-up of premalignant lesions of the oral cavity, like leukoplakia or erythroplakia and of chronic and acute pain conditions such as paroxysmal neuralgias, continuous neuralgias, myofascial pain, atypical facial pain, autonomic cephalalgias, headaches and migraines. Another aspect of the field is managing the dental and oral condition of medically compromised patients. For example, cancer patients who suffer from related oral mucositis, bisphosphonate-related osteonecrosis of the jaws or oral pathology related to radiation therapy. Additionally, it is involved in the clinical diagnosis and management of dry mouth conditions, such as Sjögren's syndrome, and non-dental chronic orofacial pain conditions, such as burning mouth syndrome, trigeminal neuralgia and temporomandibular joint disorder.*"

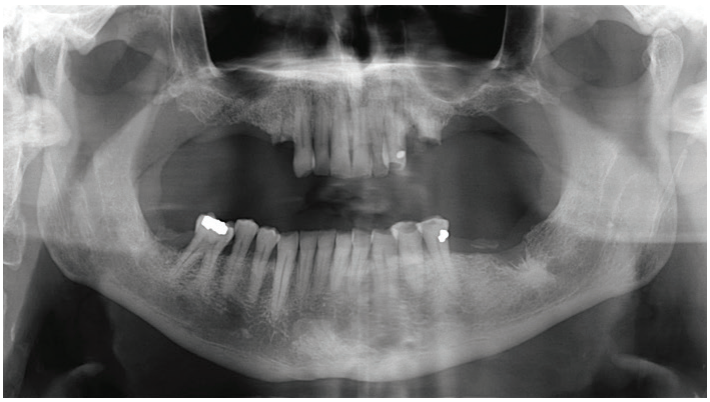

Figure 2: Bilateral carotid calcification in this 65 year old male.

Although the VCU School of Dentistry has seen oral medicine patients for years, it always has been on a low-key referral basis. Recently, Drs. John Svirsky and Bhavik Desai have formalized the referral process so that these types of patients can benefit from the various services available at VCU. The increased activity has not only benefited the patients, but has supplied teaching cases for the future education of our students and residents. If you have patients interested in treatment at the VCU Oral Medicine Clinic, you can refer them by calling (804) 628-0310 for an appointment.

Radiographic technique and interpretation have made great strides since oral and maxillofacial radiology became the ninth ADA-recognized dental specialty in 1999. An oral and maxillofacial radiologist (OMR) is a dentist specialized in the acquisition and interpretation of radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region. There are a myriad of systemic conditions that present with findings on panoramic and intraoral radiographs. Imagine referring the osteopenic patient to his or her primary care physician for bone densitometry based on findings on the dental X-rays leading to treatment that will prevent an osteoporotic fracture. Imagine referring the patient with calcified atherosclerotic plaque on the panoramic radiograph to his or her primary care physician for cerebrovascular evaluation that leads to treatment to prevent a stroke. While there is a wide array of imaging modalities available for various diagnostic investigations, OMRs urge their colleagues to follow the Principles of Justification and Optimization. Recalling that all ionizing radiation has the potential to create biological damage and in following the "First, do no harm" motto, we need to limit exposures to those instances in which we must gain diagnostic information beyond what we can see during our clinical exam. A public health concern is the explosive increase in the number of CT scans ordered in the U.S. annually. This number has risen about 10 percent annually over the last 15 years. In 2006, the latest year for which numbers are available, 200,000 people submitted themselves to a whole body CT scan just to look for early signs of disease. Every credible medical group has condemned this practice.

If a dentist can indicate why he or she is ordering a specific imaging study on a particular patient based on a clinical exam, the procedure is justified. Administrative radiographs are not an acceptable standard of care. The OMR also works

to put patients' safety, health and welfare first by optimizing imaging protocols to use the least radiation necessary to produce diagnostic-quality images for each examination (ALARA). Dr. Laurie Carter offers a Radiation Safety Certification continuing education course at the VCU School of Dentistry for dental assistants to satisfy the requirements of the Virginia Board of Dentistry. Information can be obtained by contacting Ms. Pamela Flynn at (804) 828-0869 or pflynn@vcu.edu. Further information about optimizing the use of radiation in imaging patients can be found at www.imagewisely.org. In addition, the department is preparing to launch a cone beam CT (CBCT) diagnostic interpretation service to facilitate consultation and over-reads for your CBCT datasets. Prior to launch time, further information regarding logistics will be provided.

The cornerstone of the department has been and continues to be the rendering of histopathologic diagnosis of submitted surgical biopsy specimens. The first oral biopsy diagnosed by the department (Medical College of Virginia at that time) was a papilloma on December 9, 1949. In the next calendar year a total of 16 specimens were processed and diagnosed. The service grew over the years, and, in the calendar year 2012, a total of 8,279 specimens were diagnosed. These specimens were submitted as follows:

- 60 percent by oral and maxillofacial surgeons;
- 30 percent by general dentists;
- 6 percent by periodontists;
- 4 percent by endodontists.

Of the 8,279 specimens, 94 (1.14 percent) were malignancies. The most common malignancies were Squamous Cell Carcinoma (70.2 percent), Verrucous Carcinoma (8.5 percent), Basal Cell Carcinoma (6.4 percent), Lymphoma (4.3 percent), Malignant Salivary Gland Neoplasms (Mucoepidermoid Carcinoma and Polymorphous Low Grade Adenocarcinoma) (4.3 percent) and metastatic malignancies (Pancreatic, Lung and Myeloma) (3.2 percent). Additionally, the use of immunohistochemical stains over the last decade has shown increased usage in difficult to diagnosis cases.

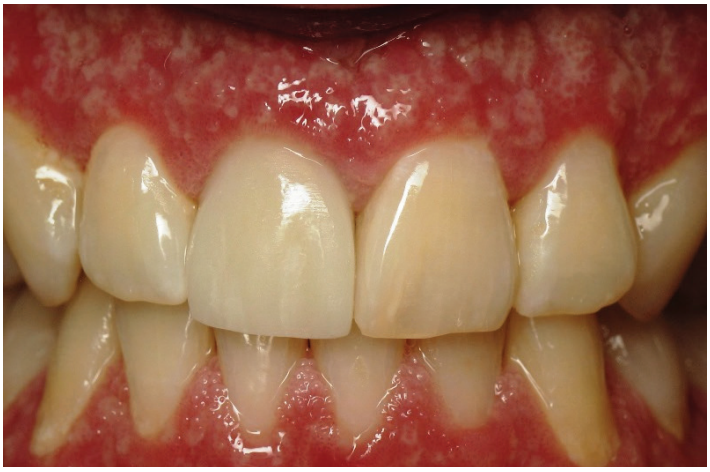

Figure 3: Maxillary gingival manifestation of Pyostomatitis Vegetans

In summary, the "new and improved" Department of Oral Diagnostic Sciences can provide a number of invaluable functions to dentists and other health care providers. They may include the following services:

- Aiding practitioners in providing thorough and comprehensive treatment for their patients, thus expanding their quality and quantity of life;
- Providing legal documented evidence concerning a lesion;
- Providing an oral cancer registry from which research information on the biologic nature of lesions may be garnered, including age, sex, prognosis and etiology.

For more information, please visit www.oralpathology.vcu.edu.

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