

VOLUME 95, NUMBER 4
OCTOBER, NOVEMBER & DECEMBER 2018

VIRGINIA DENTAL Journal

OFFICIAL PEER REVIEWED PUBLICATION OF THE  Virginia Dental
ASSOCIATION

MEET THE PRESIDENT DR. SAMUEL GALSTAN

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GO UNDER THE HOOD WITH OUR NEW EXECUTIVE DIRECTOR RYAN DUNN

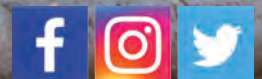
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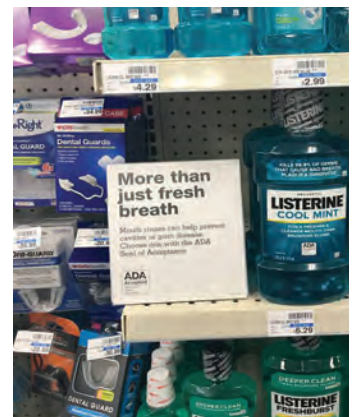
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POSITIONED FOR TRANSITION

Dr. Samuel W. Galstan

It is my pleasure to help lead the Virginia Dental Association as President in the coming year. I pledge to you that I will give my best effort to the VDA to continue to keep this organization great.

My wife and I practice general dentistry in Chester, about 20 minutes South of Richmond, and we have two sons. Our oldest son, Bailey is a senior at Clemson, and our youngest son, Berkeley is a second year at JMU.

I would like to thank my wife, my office, my colleagues at the Southside Dental Society and the VDA who have been very supportive to me over the years and helped encourage me to seek leadership in organized dentistry. I have always loved the VDA, doing volunteer work for the VDA and feel extremely lucky and blessed to be here today. The VDA has a long and storied history of being the primary voice for dentistry in the Commonwealth of Virginia. We will continue to be this, however, there will always be challenges ahead of us. We are also at a very interesting point in our history. We have been blessed to have Dr. Terry Dickinson as our Executive Director for nearly 18 years. Terry will be greatly missed. Please reach out to Terry and thank him for his excellent guidance that he has given to the VDA throughout his tenure. Also thank you to Bonnie Anderson who will be retiring at the end of the year and will also be greatly missed as well.

I encourage all of you to welcome Ryan Dunn, our new Executive Director, to our organization, and to help him hit the ground running. I would like to thank outgoing VDA President Dr. Benita Miller for an incredible job this past year. Benita has worked tirelessly, often times

behind the scenes, to best position our organization. Thank you Benita.

I have been humbled for many years as a member of the VDA by the exceptional leadership that we have in our midst. The VDA and our leaders are well respected regionally and throughout the country. One great thing about being a part of the VDA leadership is that this has made me aware of the incredible diversity in Virginia and in the VDA. Different people want different things. I don't think that we can make basic assumptions about what dentists want. We have to engage them and have conversations with them. The VDA is working on this and will continue to do so. The VDA has a great staff in place, and we have the two best lobbyists in Virginia working for us, so we are very well positioned to move forward. We have sound finances, and we are a well run organization. We have to fight for our members' interests and fight to remain the ones who control the destiny of our profession. We have to provide value to our members and relay and share our passions for our members. We won't ever rest on our laurels, or just do something because that is always how we have done it. We will continue to constantly examine and re-examine our organization so that we ensure that we remain relevant.

Everyone today is super busy and dentists need the VDA's help. We need to make our member's lives easier, to be the go-to reference that they can always count on, that in fact they feel that they couldn't imagine practicing dentistry without the VDA. I know that is how I feel.

Two of our main initiatives in the coming year will be to move insurance reform legislation forward, and to collaborate

with other groups and organizations to better integrate the VDA with the health community as a whole.

Next year our meeting will be coming back to Richmond, so please plan ahead and mark your calendars and bring your families and staff. It will be a great meeting.

I thank you for the trust that you have placed in me to allow me to help lead the VDA this year. I have asked some of you to help the VDA already, and I will be asking more of you. This should be a great year, and a lot of fun. Thank all of you for what you do to keep dentistry and the VDA great. Together we are all stronger.

Know a Non-Member? Have you heard about **Member Get a Member?**

YOU PROBABLY KNOW A NON-MEMBER IN YOUR COMMUNITY.

Maybe you've talked about membership or maybe you just don't know how to start that conversation. The ADA created their **Member-Get-A-Member** program for just this purpose— to help our champions recruit new members for the organization and arm them with the tools and resources they need.



HERE'S HOW IT WORKS:

- Contact your component and let them know that you're interested
- Your component will send you resources, talking points, and a list of non-members in your area
- Complete a recruiting form at www.ada.org/mgam
For each non-member you recruit, you'll receive a \$100 gift card from the ADA and a \$200 check from the VDA*

*Pending first payment by the new member.

You can recruit a maximum of 5 non-members a year— this is enough to pay for your dues!

And just FYI, the ADA is offering half-rate dues for most non-members— tell your a non-member colleagues to contact the VDA for an up to date dues rate offer



**STILL HAVE QUESTIONS?
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UPON FURTHER REVIEW

Dr. Richard F. Roadcap

Articles, or what we call “content”, arrive at the *Journal* in many forms. There are letters, guest editorials, informational content, reports, abstracts, and scientific manuscripts. Most of these can be proofread, copyedited, and published with nothing more than the approval of the editor and managing editor. Only scientific manuscripts require editorial review prior to publishing. By that, we mean review by at least two reviewers listed on page two, and the editor. We ask authors of these manuscripts to allow, by the terms of *Journal* policy, up to one year for approval or rejection. Seasoned scientific authors know that publication of a manuscript requires extensive review, modifications, revisions of text, and finally the approval of proofs by the authors of the final version prior to publishing.

Also, we require that manuscripts be original, i.e., not published elsewhere, and not submitted to any other publication for consideration at the time we are reviewing. Should the manuscript be declined, the authors are then free to submit it to another publication. We employ a so called single-blind review process, in which reviewers know the identity of authors, but authors do not know who is reviewing the submitted manuscript. We polled our reviewers and they overwhelmingly favored a single-blind review process. Some editors will make the case for double-blind review, in which neither authors nor reviewers know the identities of each other. It would seem to be less biased and perhaps, more objective, if reviewers did not know the names of the authors. However, internet search engines have made it easier to discern the identity of writers. For example, authors may reference their own work, or that of their colleagues, which would disclose much

information to the reviewers. Also, editors would have to redact large portions of manuscripts in an effort to hide authors’ identities. One of our editorial reviewers, when asked to choose between a single-blind and double-blind process, put it this way: “If an author is writing on the subject of oral pathology, for example, I would want to know if he (or she) has any training or expertise in that subject matter.”

We’re often asked, what’s the fastest way to get an article published? That would be in the form of a letter to the editor, or a guest editorial. Neither of these formats requires editorial review, as the author is merely expressing an opinion which requires no verification or investigation. The *Journal* staff would merely correct grammar and spelling, and publish the article or letter in its entirety. This is in no way meant to demean this form of correspondence, as letters and editorials can convey much in the way of information and instruction to the readers. Footnotes, references, and links to websites can accompany letters and editorials, and such content can be “fast-tracked” without the rigorous review process which accompanies scientific manuscripts. I often encourage writers to submit case reports or information on new products or procedures in the form of a letter, to expedite publication. Unfortunately we sometime received manuscripts that are “neither fish nor fowl”, as they invoke both science and research, but fail to do so in a disciplined manner. These are forwarded to editorial review, where they are most likely to be declined, and thereby cannot be used in our publication. I will often advise author(s) in advance of this likelihood, so they can reconsider the format of their article, and make other arrangements. Once we issue a rejection,

they must seek another publication for their composition.

It’s widely believed that the *Journal* does not accept memorials, but we welcome them and often solicit them in certain situations. For example, if a prominent member of the dental community dies, often we will search far and wide in seeking a colleague to write a memorial. Our policy is that memorials should be limited to 250 words, and allow them to be accompanied by an appropriate photograph. We will of course review memorials for accuracy, spelling, and grammar.

I’ll discuss one more category of article, the pending article, or work-in-progress. We’re frequently approached about designs or ideas for articles. The proponent will give us a concept, or idea, perhaps hoping that we’ll sign off in advance (although I really think they want me to write it for them). The idea is then mentioned at each meeting or chance encounter. At some point the proponent will no longer discuss it, and I’ll chime in, “How’s that article coming along?” or something to that effect. I’ll know that it’s time to drop the item from our spreadsheet when the “writer” avoids me at every opportunity. Management consultant and author Peter Drucker said “Plans are only good intentions unless they...degenerate into hard work.” He knew, as countless other authors have known, that the hardest part of writing is getting started, putting those first sentences or first paragraph on the page. Ideas lead to other ideas, and before you know it, the article. Make plans to start on your contribution to the *Journal*.



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CVS, YES; DIY, NO

Dr. Kirk Norbo, ADA 16th District Trustee

In an effort to improve the ADA's visibility as well as help the public find dental homes, the ADA entered into a contract with CVS last year. CVS has a reputation of being a health-conscious retailer as was evident from its decision to discontinue the sale of tobacco products in its stores. This had a big impact on its revenues but nevertheless, their board elected to place the health of its customers above financial gains of the corporation. The ADA realized that it is philosophically aligned with CVS when it comes to improving the health of our patients and has welcomed the opportunity to partner with this company.

The first advantage of entering into this partnership involves the ADA Seal of Accepted products. For any of you who shop at CVS, these products are displayed in a prominent place on the oral health aisle and make it easier for their customers to select items that have the ADA Seal. The fact that these products are being displayed together and have a higher profile on CVS shelves has had a direct impact on dental product manufacturers seeking ADA Seal status. From 2014 to 2017 there were an average of 12 – 13 submissions for ADA Seal approval made to the Council on Scientific Affairs. In 2018, 24 submissions have been made to date and 25% of these have been attributed to the CVS partnership. One thing that becomes crystal clear with this program is that the ADA Seal is a powerful marketing tool and the public trusts what our association endorses.

In addition to the ADA Seal program, CVS and the ADA expect to help pharmacy customers find dental homes. Our Find-a-Dentist campaign will provide a network of member dentists that can be accessed by CVS patrons when they visit the stores.

Based on the fact that only 36% of the adults in this country have visited a dentist in the last 12 months, there are many people who will search for dental remedies at retail stores such as CVS. It is our hope that CVS will serve as a great referral source for people seeking dental care and in turn direct them to ADA member dentists. I would like to thank those of you who have updated your ADA profiles. Over 60,000 of our members have done so nationwide and this action will position you to be more likely to receive referrals from CVS.

The one action CVS has taken recently that has created some Board of Trustees discussion is the incorporation of Smile Direct Club kits in 100 of its stores in 5 or 6 states on both coasts. The test of this do-it-yourself product began on August 1, 2018 and will last for 6 months. CVS will promote the Smile Direct Club product in its circulars and on CVS.com but will in no way associate the ADA with this DIY orthodontic kit. CVS is fully aware of the ADA position on DIY dentistry and has assured us that the Smile Direct Club kits will not be displayed on the oral health care aisle but will be found in the beauty aisle. After serious consideration, the ADA BOT recommended continuing the contract with CVS while launching an aggressive DIY educational campaign. Many of you may have seen the full page *Wall Street Journal* ad that discouraged DIY orthodontics. In

addition, future education plans will include: a multimedia news release and press release, top-tier paid media, media pitches to consumer and investigative publications on risks of DIY dentistry and face book live events containing targeted social content.

Moving forward, the ADA intends to grow its presence in CVS stores. Implementing stronger messaging that emphasizes our trusted recommendation to seek professional care by using our Find-a-Dentist feature as well as directing customers to use ADA Seal products will position our association to maximize this partnership with CVS. The ADA remains steadfastly opposed to DIY dentistry and will continue to educate the public on its risks.



ADA signage in a local CVS store

ARE YOU OSHA COMPLIANT?

A LOOK AT COMMON ISSUES WITH EYEWASH STATIONS

Dr. Henry Botuck

Eyewash stations are critical emergency safety equipment used to mitigate eye injuries when the eyes are exposed to physical or chemical irritants or a biological agent. I am willing to bet that most dental office eyewash stations are not OSHA compliant. In other words, you can't count on them to do the job properly. If you use chemicals that are caustic (some surface disinfectants, acid etch, sodium hypochlorite, EDTA, etc.), OSHA demands that you have an eyewash station in your office. And, if you have none, or a non-compliant one, you not only endanger yourself, your staff, and your patients, but you open yourself up to an OSHA fine (OSHA fines range between \$600 and \$12,471).

And, why am I so certain that most dental offices don't have OSHA compliant eyewash stations? Because most of us buy our eyewash stations from dental supply houses. I must state categorically that none of the dental catalogues that I have looked at offer an OSHA compliant eyewash station.

So, what are the characteristics of a compliant eyewash station? The station must be able to be turned on in one second, and with a single motion. It must deliver tepid water (between 60 °F and 95 °F) which requires a mixing valve be installed. It must leave both hands free, and be able to flush both eyes with not less than 0.4 gallons (1.5 liters) per minute at 30 psi, for 15 minutes. The nozzles height should be between 33 inches and 45 inches above the floor, and at least 6 inches from any wall obstructions. The station must be able to be reached, unobstructed (no doors to open, no equipment in the way, and not through a maze of hallways) within ten seconds.

These requirements correspond with ANSI standard Z358.1. No getting around it, this type of station will take a plumber to install and will be expensive. What is your vision worth?

The common eyewash stations that I see in dental offices are attached to the faucet spigot and require two hands to turn on the water and adjust the volume and temperature. A button in front must be pulled to allow water pressure to pop off two caps for the water to squirt up towards the face. Obviously, this is not one motion nor one second. The victim must waste time fiddling with the faucet handles to adjust the temperature. (The fingers of both hands must be free to hold the eyelids open.) If the temperature is uncomfortable, the victim may be inclined to stop flushing, prematurely. This eyewash station is not acceptable!

By the way, if you want to have a quart size squeeze bottle with saline or water in each room, that is fine. But they are for temporary use only, until you can get to the eyewash station. And, it should go without saying that someone should accompany the injured person to the eyewash station and remain with him/her for the fully required 15 minutes of flushing at the low velocity rate of 0.4 gal/minute.

If there is a sink already available in a good location, then a very attractive type of station is called a "side swing" unit. It is attached next to an existing sink. A mixing valve should be placed below the counter (for temperature control) so that a single pipe emerges next to the sink on the counter or from the wall. The water automatically goes on when you swing the unit over the sink. One motion. One second. When you swing it back, the water

is turned off. The station should be tested weekly.

You would think that with everyone wearing safety glasses that we wouldn't need eyewash stations. I was thinking just that when an "incident" occurred at a MOM project I attended. An assistant, who was wearing safety glasses, was putting instruments into the ultrasonic bath. She dropped an instrument into the bath and caused a splash. A drop of solution went into one eye, despite the glasses. I couldn't believe it. But it happened. She was rushed to the eyewash station and the eyes were flushed for 15 minutes. Fortunately, no infection resulted. Freak accidents do happen. For incidents like this, as it is in all infection prevention strategies, we always need to be prepared for the worst-case scenario.

Make sure you have an eyewash station that can do the job properly. If you look on line for your eyewash station, be sure to speak to the representatives of different companies and discuss your needs. Someone's eyesight (yours?) may depend upon it.

FIX THE GAITS

CLUES FROM WATCHING YOUR PATIENTS WALK IN

Dr. Marvin E. Pizer

Knowledge of our patients' physical and mental status provides our ability to serve patients most effectively. One of the first visual indications of a physical disability may be the patient's gait, as he/she enters to the reception (or waiting) room. Some patients appreciate the attention and assistance given by the doctor's secretary in the reception room, while other patients are less comfortable as they prefer to hide their disability.

Forgive my personal story, but over a year ago I fell and fractured the head of my femur and probably damaged the hip. For personal reasons I refused surgery and was admitted to this present situation for rehabilitation and recovery. I am at present an assisted living patient using a walker as I slowly walk around in this building. Curious as I am, I see my fellow victims using wheelchairs, rollators, canes, and walkers, and cannot but wonder about their disability and what produced the deformity. Be assured, I do not ask the patient!

With a background as a teacher in medical physiology and oral and maxillofacial surgery, I have had to satisfy my curiosity by observing the gaits of the patients which surround me. I am reporting what I have seen and read about.

ATAXIC GAIT – this patient makes irregular steps, sways, and appears “drunk”. This is seen in cerebellar disease and labyrinth disease of the inner ear.

SCISSORS GAIT – the large thigh muscles of the lower extremity in both legs are rigid and close together, like the blades of a scissors, explaining the gait. This is seen in patients with spastic paraplegia.

PARKINSON GAIT – this patient walks with head and body sharply inclined forward, with sharp, quick steps. “Pill rolling” is seen in the hands.

SPASTIC GAIT – a stiff, choppy walk. This is observed in neurological diseases, such as multiple sclerosis and amyotrophic lateral sclerosis.

HEMIPLEGIA GAIT – this patient drags the affected leg around in a semicircle when walking also, holds the arm on the affected side slightly flexed and stiff. This patient has paralysis on one side of the body from a massive cerebrovascular accident or major injury.

TABES DORSALIS GAIT – the patient walks with eyes facing the ground and with feet wide apart, raises the legs high

so feet will come down with a slap, as heel (or sometimes the entire shoe) strikes the ground. This is due to neurosyphilis, which is chronic and progressive deterioration of the spinal cord.

WADDLING GAIT – an over-elevated move of the hip – similar to the walk of a duck. This is observed in patients with progressive muscular dystrophy.

STAGGERING GAIT – a reeling and tripping gait – patient appears as if falling backward and losing his/her balance. This is due to an overdose of barbiturates.

Many of the injuries here are from falls. If our dental and medical professionals gave advice, especially to seniors, on how to reduce or prevent falls, maybe I would have fewer good people surrounding me.



UNDER THE HOOD

MEET THE NEW VDA EXECUTIVE DIRECTOR

Ryan Dunn

There are few things that compare to the sound of a finely-tuned V8 engine. That rumbling sound is intoxicating to me because it's the sound of precision, power and performance. Whether it is one of my vehicles, my dad's 1953 Ford hot rod or my mom's 1964 Chevelle Malibu SS, I've grown up around cars, trucks and tractors that have made me appreciate the design and respect the engineering and hard work that goes into creating a reliable automobile.

As someone who has represented the business community and has been engaged in Virginia politics for nearly 20 years, the reputation of the VDA is one that would win multiple "Motor Trend" awards. The VDA has been a reliable, high-performing association for many years. Dr. Terry Dickinson has organized a great team that has a reputation of delivering for its members with great efficiency. All qualities that make for a top-pick, award-winning automobile and also one of the best all-around associations in the Commonwealth.

To expand upon my story, I am a proud Virginian born, raised and currently living in Goochland with my bride of 12 years, Leigh and our two children, Virginia and Logan. Leigh and I met at the University of Virginia and dated while living in Northern Virginia. When presented with an opportunity to move back to the Richmond area, we took it. I am blessed to have had a lot of opportunities for professional and personal growth. Whether it was my time working in the United States Senate or during my roles with three different membership associations spanning more than 12 years, I have observed and experienced great leaders that have shaped my career.



Mr. Ryan Dunn

Most recently, I served in the role of Executive Vice President at the Virginia Chamber of Commerce managing the Chamber's lobbying and political efforts while also focusing on membership and non-dues revenue growth. During my eight years, the Virginia Chamber has grown its membership, tripled its revenue, increased its advocacy and influence and created Virginia's long-term, strategic plan known as Blueprint Virginia 2025.

As I begin transitioning to the VDA in 2019, I hope to build upon past success while exploring new initiatives that elevates each member's experience and benefits. I plan to spend my first year with the VDA developing relationships inside of the profession and identifying opportunities for growth and nimbleness while ensuring the success of our membership. During my initial introduction to the VDA membership it is abundantly evident that VDA members are committed to the association's

long-term success and are willing to advance new thoughts and ideas. I will continue to seek guidance and input from the membership and will work with you to develop a strategic plan that is aggressive, accurate and concise. The VDA will continue to serve its members while also leading the charge to protect and advance the dental profession in the Commonwealth.

I'd like to hear from our members on what you need to be successful. I encourage you, if you have a moment to spare between patients or time for a more in-depth chat, I'm ready to listen. Feel free to contact me at dunn@vadental.org.

Thank you for the incredible opportunity to lead such a well-respected organization. I appreciate your patience during this transition and I hope you're as excited as I am to make this organization perform like one of Detroit's finest V8 engines.

MEET THE PRESIDENT

DR. SAMUEL W. GALSTAN

WHY DO YOU WANT TO BE PRESIDENT OF THE VDA?

I think that we are at an exciting time at the VDA. There's a lot of momentum, with great changes ahead. I'm thankful for Terry Dickinson's leadership and Bonnie Anderson's many years of service. And I'm excited about Ryan Dunn's energy and enthusiasm. I waited to run for President because I knew it would be a considerable investment of time and energy. I also wanted to wait until my youngest son was in college so I could devote the necessary time. One last thing: I'm real passionate and excited to be President of the VDA. I feel it is an honor and privilege to have this position. I've had the good fortune of following and emulating leaders of the VDA of the past. I've had some great role models before me.

IF YOU COULD MAKE ONE CHANGE TO ORGANIZED DENTISTRY, WHAT WOULD IT BE?

I would find a way to be able to connect with every member and deliver what is valuable to them. I think that the biggest issue is making a connection (with members) and seeing what they want out of the organization, and see how we can best deliver that.

DO YOU HAVE ROLE MODELS OUTSIDE OF DENTISTRY? WHO ARE THEY?

I have three I'd like to talk about. The first is Ronald Reagan, "The Great Communicator". He's the first president I voted for. I've never missed an election since, and voted in every special election and primary. It is so important for us to vote. I was reading that Reagan, in his second election for President, received 525 of 538 electoral votes. Now the country is so divided. He was true to his



Drs. Sharone Ward and Samuel Galstan

values, and had an unfailing love for his country. He started and ended his terms with the same principles. The VDA is a lot like that; we remain true to our principles. The second is Thomas Jefferson (I went to UVA). He went out of his way to make this country better. He was good at bringing people together. The third would be my parents-in-law, who are deceased. They valued hard work, a love of family, keeping things in perspective, and keeping things in balance.

ONLY 62% OF VIRGINIA DENTISTS ARE MEMBERS OF THE VDA. WHAT CAN WE DO TO RAISE THIS NUMBER?

We have to communicate the value of membership. It's a no-brainer that every dentist (should) be a member of the VDA. We offer so much value. For everybody who is not a member, we need to do a better job of communicating this value. We need to have a way to form relationships

with them and tell our story. At the VDA people elect us and we move forward in good faith; we represent not only the dentists, but the people of Virginia and do what's best for them.

THE PUBLIC IS WELL AWARE OF THE OPIOID CRISIS. WHAT CAN BE DONE TO CONVINCING THEM WE'RE WORKING TO RESOLVE THIS?

I think we are well on our way. We have good coverage in the news media. Dr. (Benita) Miller wrote an op-ed for the Times-Dispatch. All of our dentists are communicating with patients and have frank discussions on how to manage pain. I think all of our members are writing fewer prescriptions. Pending legislation (on opioids) and the PMP are useful tools. My patients are very aware and supportive. I think we are doing a good job to get ahead of the issue, and put it in the open, and patients are understanding and respectful of that.

> **PRESIDENT - CONTINUED ON PAGE 12**

YOUR PARTNER IN DENTAL PRACTICE IS YOUR WIFE, DR. SHARONE WARD. HOW DOES THIS IMPACT YOUR LIFE AS A DENTIST?

I had the wonderful good fortune of meeting my wife on the first day of dental school. She calls things the way she sees them and has the strongest ethics and values. It's been great to have her as a partner. We talk about issues every day, and what are reasonable solutions. It's been a joy to have her in the office working together. She does some procedures I don't do, and I do some things that she doesn't care to do. It's awesome to have someone in your office who's smart, thoughtful, and has a lot of insight.

RECENT GRADUATES ARE ENCUMBERED, ON AVERAGE, WITH NEARLY \$300,000 IN STUDENT LOANS. HOW CAN THEY BE CONVINCED MEMBERSHIP DUES ARE A GOOD VALUE?

I think for one thing the federal government makes an obscene amount of money on student loans. It's an issue we bring up every year at the General Assembly in Richmond and at the Washington Leadership Conference in D.C., but we get little response from the legislators. If you have \$300,000 in loans, that's an investment in yourself. VDA dues help protect this investment. Would you buy a house for \$300,000 and not have insurance on it? Your VDA dues bring a tenfold return. You can't be everywhere at once, and the VDA does so many things for us. They will receive so much value. The VDA makes life as a dentist and a person so much easier. Basically, this is insurance protecting your investment. We are much better at protecting you than anyone else.

DO YOU SEE RECENT CHANGES IN SPECIALTY RECOGNITION AS A THREAT TO THE VDA AND ORGANIZED DENTISTRY?

I have some concerns about not using the ADA definitions. For consumers the protection that there is someone who meets the requirements is a huge benefit. People want to know what they are getting into and who is seeing them and treating them. I value specialty recognition. It is very protective of patients' rights. I'm not sure how this will play out. The VDA will always support the ADA definition (of specialties), being fully informing and transparent.

WHY DID YOU SEEK A MASTER'S DEGREE IN PUBLIC HEALTH?

I'm interested in advocacy and politics, and decreasing barriers to access-to-care. As I was studying for my degree I found there was an abyss between public health and private practice. Dentistry will always be mindful of taking care of people who don't have access, especially children. MOM projects are like a Band-Aid on a gunshot wound. We need to figure out a way to change our public policy and our delivery of dental care. When I started my study, I didn't have enough knowledge in these subjects, and my passion is decreasing barriers to care. It's immensely more difficult than I ever imagined.

WHAT WOULD YOU LIKE TO BE DOING FIVE YEARS FROM NOW? IN TEN YEARS?

Five and ten years are one and the same for me. I'll still be in private practice, but doing more outreach and volunteerism. I can visualize doing some mentoring of younger members and doing more with study clubs. Also I would like to spend more time with my wife and two sons. One

thing that's important is Southside (Dental Society) is small enough to allow members to get into VDA leadership positions early on. Southside had some great leaders before. Early on I worked with (Dr.) Frank Farrington as one of my mentors. We started with Give Kids A Smile, we did five MOM Projects in Petersburg, and three in Emporia. The support of our members encouraged me to get involved. At one time we had a mobile van to do screenings at the mall. Even with a small group we always had lots of volunteers. One project leads to another – they become easier and more fun. These projects taught me all about collaboration and cooperation with other members.

My last point is three quotes I like to say to my sons;

1. "To whom much is given, much is expected"
2. "Just show up and have a good attitude."
3. and a quote from Ben Franklin, "Energy and perseverance conquer all things."

I try to walk the path that God has laid out for me. I feel blessed and honored to be President of the VDA. I have been humbled by the many incredible leaders ahead of me.



DO DENTISTS CARE ABOUT OUR PROFESSION?

Dr. Bruce Hutchison, Chair, VDA PAC

Over the past two years I've seen Virginia Dental Association members contribute less and less to VDA PAC. This concerns and confuses me- I just don't get it. Advocacy has always been rated as one of the primary reasons for membership and the most important thing that the ADA and VDA does for member dentists yet, less than one third contribute to VDA PAC *our* Political Action Committee. Two thirds of our own members just don't get it- and I can't for the life of me understand why. So, being the logical person I know myself to be, I came up with a few reasons that come to mind:

1. **Politics doesn't affect dentistry so it doesn't matter if we have friends in the legislature.** Fact: like it or not, politics takes money. To get elected in this day and age, state Delegates/ Senators need to raise large sums of money. Last year some local Delegate races cost over \$1,000,000 (for an office that pays \$18,000 a year).
2. **The insurance companies will leave us alone and won't interfere with the doctor- patient relationship.** REALLY? As a business owner, who is looking for legitimate and ethical ways to run a successful practice and offer the very best care to my patients, I don't see the insurance companies as being helpful. What I do expect is for insurance companies to continue to:
 - Pay less and less for covered services
 - Cover less and less for patients who have insurance
 - Deny more and more claims
 - Erode the doctor- patient relationship
 - Require more and more irrelevant information for claims
 - Try to convince the public that "cheaper" is more important than quality care

This is what I am seeing- and so are you. Who will fix it? We are under constant siege. We must advocate for our patients to have the coverage they are paying for. We are organized and have an obligation to ourselves, our profession and our patients.

3. **VDA PAC gives money to Republicans, and I'm a Democrat- or vice versa.** VDA PAC does not give to or support either party. We represent the "TOOTH PARTY" and support those who support our beloved profession, regardless of which side of the aisle they sit on. We focus on what is important to the dental profession and the patients we serve, period. Historically, we've supported each party.
4. **I don't care.** So who is looking out for your ability to practice dentistry the way you want to practice? Legislators make the rules that we must follow every day. They decide where and when you can open an office, whom you can treat, what materials you can use, how you dispose of those materials, and in general, what regulations you must follow. They make the decisions that affect everything you do directly and indirectly. You cannot afford to just allow legislators to make all the rules without input from your profession. The VDA and our lobbyists do that for you and me- EVERY DAY.
5. **Someone else will do it for me.** There is some truth there. Some of us do contribute yearly to VDA PAC and in large sums because we understand that maintaining this amazing profession is up to us, the dentists. We have to be our own advocates and the only way to do that is to support our PAC. We ask every dentist in Virginia to contribute at the Commonwealth Club level of \$285 annually. If you can't afford that, then pay \$10, or \$50, but be part of the solution or step it

up, show the profession you really care and join the Apollonia Club at \$1060. EVERYONE can do something.

6. **There are no outside threats to dental care in Virginia.** Really? Ever hear of mid-level providers? Or what about the threat of insurers mandating fees for procedures and services they don't even cover? What about insurers selling your name to other insurers without you allowing it- or even worse, without you even knowing it. Do you think a lesser trained person (2-3 years of community college) is capable of providing dental care like you and I do? Are you willing to let that happen? Are you willing to let third-party payors seize control by assigning benefits for dental services and further eroding your doctor-patient relationships? Is that in the best interests of the patients who depend on you for quality care?

The bottom line: Do you have passion for your profession? Do you love being able to treat patients with as little outside interference as possible? Do you care what happens to future dentists? Do you want our fellow citizens to continue to have access the best dental care in the world? We are the ones here and now who can make a difference. It is up to us to move this profession forward, to keep it the number one profession in America. The alternative is apathy, and the result of apathy is that our profession does become a trade, and that we can no longer treat patients the way we want to treat them (the way they deserve to be treated). We can make a difference. YOU can make a difference or we can sit by and watch our profession fall apart. I'm choosing to make a difference. Won't you join me to make a difference in our profession's future? Contact Laura Givens at givens@vadental.org to make a contribution today. By doing so, you are making a difference and helping to shape the future of dentistry!

VDA PAC UPDATE

Laura Givens, VDA Director of Legislative and Public Policy

Thank you so much to all members who have generously contributed this year! There are only a few weeks left to submit contributions for 2018 but we still have the potential to reach the goal and you can help with that. Have you made your contribution yet for 2018? You can view the current list of contributors in the VDA PAC page on our website at <http://www.vadental.org/advocacy/vdapac>. If you have not yet contributed, there is still time! A contribution form is found on the VDA PAC page of the website or you may call Laura Givens to make a

contribution over the phone at 804-523-2185 or email her at givens@vadental.org to be sent a form. Dues statements will be mailed in the next month or so for 2019 and we urge members to submit contributions when sending in your 2019 VDA dues payments.

The 2019 year promises to be a busy and promising year for dentistry AND is a year in which all 140 seats in the legislature are up for grabs. Virginia is one of the most



Political Action Committee

VIRGINIA DENTAL ASSOCIATION

expensive states in which to run in an election and your VDA PAC contribution will enable our profession's voice to be heard down at the Capitol in Richmond.

We urge all members to contribute to VDA PAC to help secure the livelihood of the practice of dentistry.

SEE WHERE YOUR COMPONENT IS AND WHAT YOU NEED TO DO TO MEET YOUR GOAL

Component	% of 2018 Members Contributing to Date	2018 VADPAC Goal	Amount Contributed to Date	Per Capita Contribution	% of Goal Achieved
1 (Tidewater)	33%	\$45,500	\$28,575	\$298	63%
2 (Peninsula)	41%	\$27,500	\$21,445	\$342	78%
3 (Southside)	37%	\$14,000	\$14,565	\$308	104%
4 (Richmond)	33%	\$67,750	\$56,805	\$348	84%
5 (Piedmont)	37%	\$30,000	\$24,685	\$318	82%
6 (Southwest VA)	50%	\$25,250	\$19,840	\$312	79%
7 (Shenandoah Valley)	35%	\$30,000	\$26,770	\$332	89%
8 (Northern VA)	32%	\$135,000	\$92,480	\$303	69%
TOTAL	35%	\$375,000	\$285,165	\$320	76%

TOTAL CONTRIBUTIONS:

\$285,165

AMOUNT NEEDED TO REACH GOAL:

\$89,835

2018 GOAL:

\$375,000

GENERAL ASSEMBLY PREVIEW: VDA BACKS NEW LEGISLATION

Laura Givens, VDA Director of Legislative and Public Policy

The VDA Board of Directors approved the Council on Government Affairs' recommendation to pursue legislation to be introduced to the 2019 VA General Assembly that will address problems associated with Silent PPOs.

A PPO is a type of health plan that contracts with providers (in this case dentists) to create a network of participating providers. PPO enrollees use a provider in the plan's network and pay an agreed upon amount for selected procedures. In a "silent PPO" the original plan rents its provider network to other payors of dental services (insurance companies, self-funded plans, or others) with whom the dentist never signed a contract – often without the dentist's consent. This practice is problematic for patients and the dental profession because, in some cases, the rental agreements take place without the dentist's knowledge or consent. Since the dentist is unaware of the arrangement, accurate cost and benefit information cannot be provided to the patient at the time of service. This may cause the patient to forgo benefits and treatment to which they are entitled. This also poses a dilemma for dentists as they end up being contracted to provide services in a network they never joined and often do not find out about the contract until they receive payment from a third party claiming the discount.

WHAT IS THE VDA LEGISLATION ATTEMPTING TO DO?

There are similar requirements in Virginia's current Worker's Comp Law. This legislation does not prohibit any contract transactions; it simply provides fairness and transparency by adding the following common-sense provisions:

- **Active Provider Notification** – This legislation would simply require the PPO network operator to notify the participating dentists prior to selling access to additional payors (insurance companies, self-funded plans, or others). These types of notifications routinely occur now.
- **Opt-Out Option** – If a PPO network wishes to grant others access to its contracted providers, the PPO network would be required to notify the participating dentist by first class mail and the dentist would have the ability to "opt-out" or disallow the contracting entity to grant access to other payors. Opt-out provisions are currently in use by networks and are very simple and effective.
- **PPO Identification & Patient Transparency** – Payors of dental services (insurance companies, self-funded plans, or others) must identify on the beneficiaries' ID card those network leasing/sharing arrangements in which the payor participates – allowing the dentist to give accurate cost/benefit info to the beneficiary BEFORE rendering services. Furthermore, the legislation simply requires that any plan that utilizes a rented PPO network to maintain the PPO dentists in all provider directories, advertising, websites, etc. as it does with directly contracted providers.

HOW CAN YOU HELP IN THE EFFORTS TO PASS THIS LEGISLATION?

- Contact your legislators and ask that they support this bill and sign on as a co-patron. Delegate Lee Ware (R-Powhatan), who carried our original non-covered services bill, has agreed to carry this legislation. We do not plan on having a Senate bill but that could change depending on the dynamics going into session. If you are contacting a Senator, please ask him/her to co-patron the House bill. Not sure who your Virginia legislators are? Visit <http://whosmy.viriniageneralassembly.gov/> to find your Delegate and state Senator.
- Attend the VDA Day on the Hill. This important event will take place on Friday, January 18, 2019 in Richmond. The morning begins with a breakfast at the Omni followed by visits with your legislators just a few blocks away at the Pocahontas Building. Register on the VDA website or by contacting Laura Givens at givens@vadental.org or 804-523-2185.

We look forward to seeing you in January and to working together towards a positive result through the 45-day General Assembly session. Let's make this happen!

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VDA LEGISLATIVE DAY ON THE HILL

MARK YOUR CALENDAR FOR JANUARY 18, 2019

Join us for one of the most important days of the year! Every January, dentists from around Virginia and VCU dental students gather in Richmond for the VDA's Day on the Hill. This event gives VDA members the opportunity to join together to inform policy makers about the profession.



Mark your calendar now for January 18, 2019. Block off your Friday morning- these few hours of your time will make a big difference for dentistry and your patients! We look forward to seeing you in Richmond. Registration opens in November. Contact Laura Givens at 804-523-2185 or givens@vadental.org with questions.

SUMMER ADVOCACY ACADEMY

PROVIDING STUDENTS WITH EDUCATION ON DENTAL ADVOCACY

Laura Givens, Director of Legislative and Public Policy

The VDA held a 3-day Advocacy Academy lecture series at the VCU School of Dentistry in August. This was the second time hosting this program and we were thrilled to have forty-five enthusiastic 2nd, 3rd and 4th year students participate. This educational program promotes the importance of organized dentistry, dental advocacy and political action. Speakers included VDA members Drs. Thomas Glazier and Bruce Hutchison; VDA lobbyists Chuck Duvall and Tripp Perrin; and special guest, Delegate Schuyler VanValkenburg (Virginia House of Delegates District 72). The speakers presented on both state and federal legislative processes as well as specific issues that our members are currently focusing on, have faced in the past and foresee addressing in the future. Each presenter was very informal, engrossing the students in open discussions to hear their questions and concerns. Students

were also informed of the opportunities for involvement in VDA advocacy efforts and activities as a student and eventually as a practicing dentist. We ended the week with a celebration at Wong Gonzalez in downtown Richmond, where the students mingled and networked with some of the speakers, VDA staff and VDA leaders over delicious food and beverages. It was invigorating to see the eagerness to be involved from this group of energized students. Their positive feedback reinforced the importance of planning such programs and events, which constructively engages members.





Virginia Dental
ASSOCIATION

DDS10

2019 NEW DENTIST
CONFERENCE



MARCH 1-2, 2019 | WILLIAMSBURG, VA

WILLIAMSBURG LODGE

FRIDAY, MARCH 1, 2019

- 12:00 PM** Visit with Exhibitors
- 1:00 PM** Welcome Session
Samuel W. Galstan, DDS, MPH, MAGD
- 1:30 PM** Mark E. Hyman, DDS, MAGD
- 5:00 PM** Networking Reception
- 6:30 PM** "Mission Possible" Dinner

SATURDAY, MARCH 2, 2019

- 8:00 AM** Breakfast
- 8:30 AM** Visit with Exhibitors
- 9:00 AM** Dr. John Olmsted
- 12:15 PM** Lunch with our Exhibitors
- 1:30 PM** Dr. Olmsted / Dr. McAndrew
- 5:30 PM** Happy Hour at a Local Restaurant

Register Now: www.vadental.org/newdentist

**MISSION:
POSSIBLE**



FREE SNACK-SIZED CE

MEMBERS TAKE A BITE OUT OF POPULAR DENTAL TOPICS

Sarah Mattes Marshall, VDA Membership Advocate

Earlier this summer, our Executive Director, Dr. Terry Dickinson, came up with an idea: why don't we host our own free CE series for members? After all, we have the space, we have the staff, and we have no shortage of amazing dentists who would love to gain some experience presenting CE courses.

We soon booked our first speaker, we set a date, and we launched registration (using the ADA's registration website, which allows members to track their CE to a transcript on their ADA profiles). We named the series "CE Bites" as our short, 2-hour courses scheduled throughout the year would allow members to take a "bite" out of a wide variety of topics.

CE Bites also allows us to create and test a way to provide low-cost CE to our members. We know that hosting CE conferences can be financially draining on a component's budget but we also know that high-quality CE is valued very highly by our members. We plan to share our results and hope that what we learn will help your component provide similar courses in future.

While we originally thought we would offer only courses geared to new dentists, we've decided to expand our invite list. Registration is limited to the first 20 people that sign up and we plan to open registration to the whole state.

Our first course, "The Strangest Things: Oral Pathology is Everywhere" was presented Friday, August 24 by Dr. Sarah Glass—it was well-received and a great start to our series. Future speakers and topics will be announced soon. If you can



Attendees of our first CE Bites course on August 24, 2018

make it to our office on a Friday morning at one of our upcoming dates below, we would love to see you!

Our next CE Bites dates are:

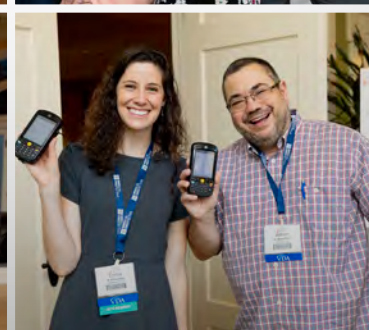
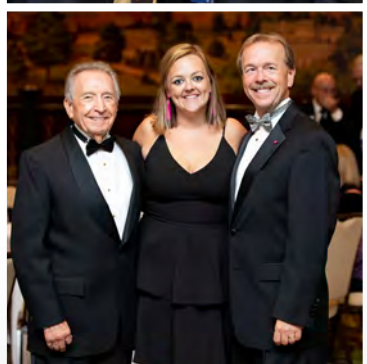
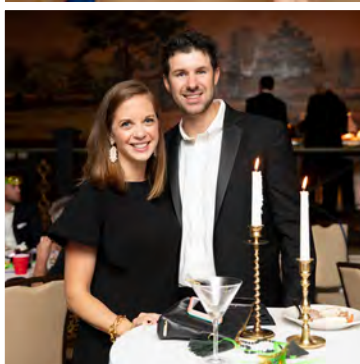
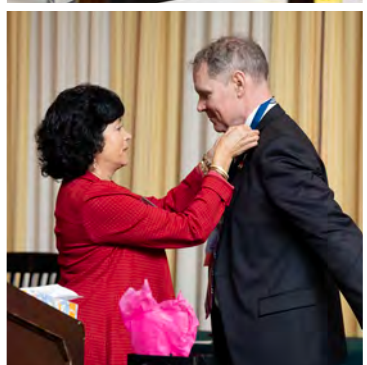
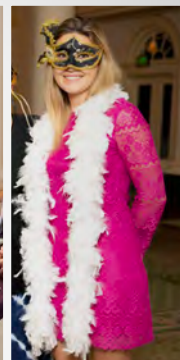
- **November 2**
- **December 7**

Keep an eye on the CE bites page, The Chatter, and Facebook for updates on registration, speakers and topics.

2018 VIRGINIA MEETING

YOU ARE WHAT MADE THE 2018 VIRGINIA MEETING A GREAT SUCCESS!







THAT'S A WRAP!

NOTES FROM THE 2018 VIRGINIA MEETING

Sarah Mattes Marshall, VDA Membership Advocate

The staff is back and unpacked from the 2018 Virginia Meeting. It certainly takes a village to put together (led by our fearless Director of Meeting Planning and Continuing Education, Megan Wyman) but we truly love getting to connect with you in person each year!

Here's some of the highlights from the Welcome Table and beyond:

- On Wednesday afternoon, we held a reception for our Executive Assistant, Bonnie Anderson, to thank her for her many years of service and to wish her well in her retirement. We will miss you, Bonnie! We also welcomed our incoming Executive Director, Ryan Dunn. We've had a lot of positive momentum over the past few years and while we're sad to say goodbye to Dr. Terry Dickinson, we're excited about the energy Ryan will add to our work.
- Thursday saw our Exhibit Hall open and our CE get underway. We love providing a one-stop shop to take care of your CE requirements and your networking with exhibitors and colleagues!
- We had a great New Dentist Reception on Friday and opened registration for the 2019 DDS10 -New Dentist Conference. Getting registration ready over the summer definitely helped as we already have 22 registrations!
- Dr. Benita Miller, our Immediate Past-President, said that Friday night's President's Party was the best ever. We certainly think it was a grand slam of an event!
- On Saturday afternoon as the CE was drawing to a close, we held our second annual Component Leadership Meeting. We talked about some new cost-saving tools from the ADA, our Ambassador Program and our efforts to engage new members, and even had a little brainpower left to talk about additional ways we could streamline and improve what we do for members.
- Saturday's Foundation Gala gave us the chance to honor Dr. Terry Dickinson's many years of service as well as the contributions of the Foundation's volunteers. We couldn't do it without you!
- Over the course of the meeting, we welcomed many new committee and council members. Our new President, Dr. Samuel Galstan, has been hard at work recruiting members for leadership positions and we're looking forward to the work we'll accomplish together with fresh perspectives.
- Friday and Sunday's House of Delegates meetings provide the space our members need to come together and vote on big issues for the future. We're an organization run by our members and we need these meetings to help shape the future of the VDA.

colleagues, discover your interests and point you towards volunteer and leadership opportunities or practice management resources. We come back from the Virginia Meeting full of ideas and ready to take on the next year.

We can't wait to see you all in Richmond next September. It's been 13 years since we were last in our hometown and we're working hard to make the 2019 Virginia Meeting our best yet!

As much as we strive to make the Virginia Meeting valuable to our members, it provides a ton of value for our staff. As we get to know you (whether it's at the Welcome Table, in the halls between courses, or over a glass of wine), we help you make connections with your

2019 | VIRGINIA MEETING



Virginia Dental
ASSOCIATION

SEPTEMBER 25-29, 2019

RICHMOND MARRIOTT DOWNTOWN, RICHMOND, VA

COME AND SEE why Richmond is a *Travel & Leisure* TOP DESTINATION
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We are pleased to announce...

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has acquired the practice of

Donald G. Trawick, D.D.S.

Midlothian, Virginia

Paraskevas P. Kourtsounis, D.D.S.

has acquired the practice of

Kenneth R. Giberson, D.D.S.

Fairfax, Virginia

Andrew W. Henritze, D.D.S.

has acquired the practice of

Denise J. Unterbrink, D.D.S.

Collinsville, Virginia

*We are pleased to have helped
in these transitions.*

Practices For Sale

Great Growth Potential in Fairfax

This general practice which is grossing \$550K and is in an excellent area of Fairfax. The 4 ops office is located in a well-maintained retail/business park and is equipped with digital X-ray and Dentrix software. This opportunity would be a great merger possibility or a satellite office opportunity. **Opportunity ID: VA-5471**

Fantastic Opportunity in Richmond/Bon Air Area

This well-established and recently renovated 1,700 sq. ft. Richmond area general practice office has 4 ops. The practice has a strong PPO/FFS patient base with a small percentage of Medicaid patients. This practice averages 40 new patients a month. The seller refers out most specialty services, leaving ample room for growth. **Opportunity ID: VA-5468**

New to the South Side of Richmond

This is a stellar general practice opportunity with all the "bells and whistles." The practice has 7 ops with well-maintained equipment. It is a long-established practice with a large active FFS/PPO patient base. After all debt service, the purchaser can expect to net well over \$400K. **Opportunity ID: VA-5425**

Chesterfield Listing

This long-established, 5 ops general practice has been a fixture in the community for over 30 years and annually collects \$350K-\$400K. The practice has a strong active patient base with 80% PPO, 10% FFS, and about 10% Medicaid. The office is nicely appointed, all digital, and uses SoftDent management software. This is an excellent opportunity for a practice merger or satellite location with the seller willing to help with the transition.

Opportunity ID: VA-5371

Go to our website or call to request information on other available practice opportunities!

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FINANCES AFFECTING YOUR MOOD?

HOW FINANCES PLAY INTO STRESS

J. Saunders Wiggins, CFP®, AIF®, CEO/President, ACG

Anxiety is defined as a feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome.

The focus of this article is on financial anxiety. What part does our financial picture play in creating anxiety? And what we can do to reduce financial stress.

A LOOK AT FINANCIAL ANXIETY FACTS

A recent survey by the American Psychiatric Association found that 39 percent of Americans feel more anxious than they did a year ago. And money is one of the leading causes of anxiety in adults. According to the same study, **more than 25 percent of survey respondents say they feel stressed about money most or all of the time.**

According to another study, the American Institute of Certified Public Accountants found that a third of Americans delayed a major life decision in the past year for financial reasons.

Lending Tree surveyed 1,000 adults and found that nearly 43 percent listed “unexpected expenses” as their primary concern. Thirty-four percent listed “making ends meet” as a primary concern and 29 percent were most concerned about “health care costs.”

According to a recent study from Bankrate.com, 61 percent don’t know how much money they’ll need to save for retirement.

Data from the same study also showed a concerning trend. Americans may be forgetting the lessons they learned from their experiences during The Great Recession. The data shows that for adults:

- following a monthly budget fell from 58 percent in 2015 to 39 percent in 2018
- starting or increasing their savings rate fell from 44 percent in 2015 to 36 percent in 2018
- charging less on credit cards fell from 50 percent in 2015 to 30 percent in 2018

- starting or adding to an emergency fund fell from 35 percent in 2015 to 30 percent in 2018

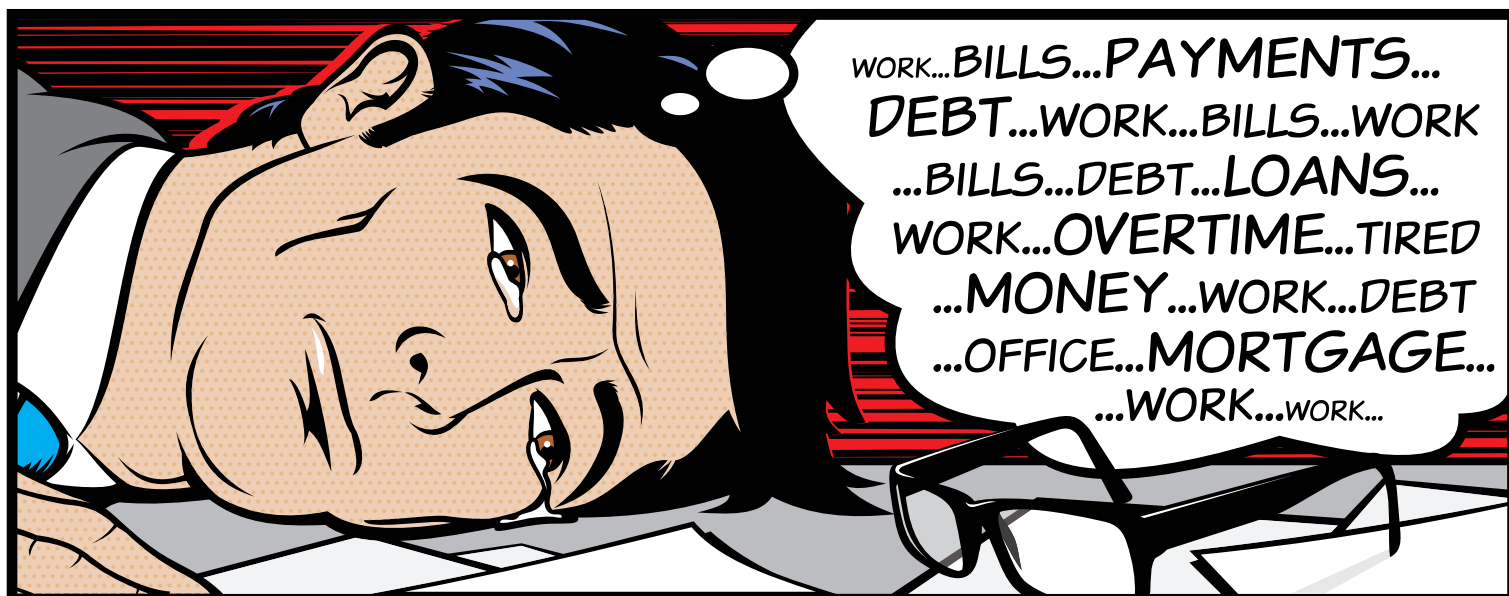
There are many factors that create financial unease. Whatever the cause for financial stress, the survey results are clear. Adults stress about money matters and may not know how to approach their concerns.

STEPS TO REDUCE FINANCIAL STRESS

If you are stressed about your finances, you can take control. Listed below are a few steps you can take that don’t require a financial advisor:

- Avoid consumer debt.
- Prepare a monthly budget - Tracking your income and expenses is critical for a healthy financial picture.
- Establish a financial safety net equal to eight-to-12 months of expenses.

FINANCES - CONTINUED ON PAGE 26 >



< FINANCES - CONTINUED FROM PAGE 25

- Save and invest 10 to 15 percent of annual income. This general rule will go a long way towards relieving monetary stress while at the same time achieving a secure retirement. Take full advantage of any match provided by your employer.

It's true, financial planning and investing can be complicated. Maybe you are confident in planning for retirement on your own. Perhaps your financial picture is too complex or you don't have time. If so, it is time to work with a financial professional.

The first step is to understand the difference between a broker, an agent and an advisor. Yes, there are differences. In simple terms, the fiduciary standard stipulates that an advisor must always act in the "best interests of the client." Brokers, insurance agents and other financial representatives are only required to follow the "suitability standard," which states that the products offered need only be generally suitable for the client, even though it may not be in the particular client's best interest.

The best way to find out whether your adviser is a fiduciary is to ask if they are a Registered Investment Advisor (RIA). RIAs are required by law to act as a fiduciary and put their clients' interest first.

Next, it's important to understand how your advisor, broker or agent is getting paid. Are they charging a flat fee, an asset-based fee or are they receiving commissions?

Credentials are important too. There are many credentials in the financial industry, but two stand above most others.

Certified Financial Planner™, or CFP® professionals, must complete a rigorous program that focuses on just about every aspect of your financial life. To become a CFP® practitioner, one must be a college graduate and take other college-level courses in financial planning. They must also pass a challenging certification test and have at least three years of work

experience to earn the designation. Once a professional has received a CFP® certification, they must abide by a stringent code of ethics that ensures they act as fiduciaries.

Holders of the Chartered Financial Analyst®, or CFA® designation, must complete a graduate-level program that focuses on investment analysis and portfolio management. To attain the designation of CFA® charterholder, one must pass three exams taken over a three-year period and have at least four years of industry experience. CFA Institute emphasizes high ethical and professional standards that each charterholder must follow.

WHAT ROLE DO TAXES PLAY IN FINANCIAL ANXIETY?

No doubt, taxes take a big bite from your income. Just the word alone, "taxes," can cause feelings of unease. The best results for tax planning come when your advisor and CPA work together on your behalf to create a tax plan. If you are a business owner, one of the best ways to reduce your tax bill is to ensure that your 401(k) plan is properly designed to provide you with the biggest tax break available. Establishing a tax plan creates confidence in dealing with your finances, which ultimately reduces your anxiety.

FINANCIAL STRESS AND RETIREMENT

Advisors that focus on retirement planning have many tools that develop retirement income and expense projections. These planning tools consider the impact of investment market volatility, inflation, health care costs, unexpected expenses and many other factors. These tools will identify if you are on track for a successful retirement or if you need to reduce expenses and save more.

Whether you are working with an investment advisor or managing your accounts on your own, it is important to know that investing while in the distribution phase is markedly different than investing to accumulate wealth. In order

to meet your retirement income needs, it's important to establish a disciplined distribution plan. The consequences of either a severe market decline or unsustainable account withdrawals can be difficult, if not impossible, to recover from once they have already happened. This is particularly true during the early years of your retirement.

Through awareness and proper planning, it is possible to balance enjoying life today while saving for tomorrow, without financial anxiety. The result is not only a secure retirement but also feeling less stress during your working career.

Editor's Note: Sandy Wiggins joined ACG in 1988 and currently oversees the ACG executive team. For more than 25 years, he has helped clients turn their financial goals into actionable wealth management strategies. Throughout his career, Sandy has gained in-depth experience helping owners of closely held businesses develop, implement and maximize their wealth management and tax strategies – while aligning their business financial life with their personal assets. He also brings a deep understanding of effective business-succession planning strategies and is dedicated to assisting clients with their families' multigenerational wealth management. Find out more about ACG at www.acgworldwide.com/vda or by calling 804-323-1886.

DID YOU KNOW?

A SERIES FROM THE VIRGINIA BOARD OF DENTISTRY

ADVERTISING OF FEES

Did you know that advertising of fees pursuant to this section is limited to procedures that are set forth in the American Dental Association's "Dental Procedures Codes," published in Current Dental Terminology in effect at the time the advertisement is issued?

18VAC60-21-80.E of the Regulations Governing the Practice of Dentistry



TREATMENT

Did you know that a dentist is responsible for conducting his practice in a manner that safeguards the safety, health and welfare of his patients and the public by treating according to the patient's desires only to the extent that such treatment is within the bounds of accepted treatment and only after the patient has been given a treatment recommendation and an explanation of the acceptable alternatives?

18VAC60-21-60.A(3) of the Regulations Governing the Practice of Dentistry

DENTIST-PATIENT RELATIONSHIP

Did you know that a bona fide dentist-patient relationship is established when examination and diagnosis of a patient is initiated?

18VAC60-21-50.A of the Regulations Governing the Practice of Dentistry

TRANSFERRING RECORDS

Did you know that records shall not be abandoned or otherwise left in the care of someone who is not licensed by the board except that, upon the death of a licensee, a trustee or executor of the estate may safeguard the records until they are transferred to a licensed dentist, are sent to the patients of record, or are destroyed?

18VAC60-21-90.G of the Regulations Governing the Practice of Dentistry

PATIENT RECORD REQUIREMENTS

Did you know that every patient record shall include an itemized patient financial record as required by §54.1-2404 of the Code of Virginia?

18VAC60-21-90.B(9) of the Regulations Governing the Practice of Dentistry



WHAT ABOUT INSTAGRAM?

SHOULD I USE INSTAGRAM TO MARKET MY PRACTICE?

Kelsey Leavey

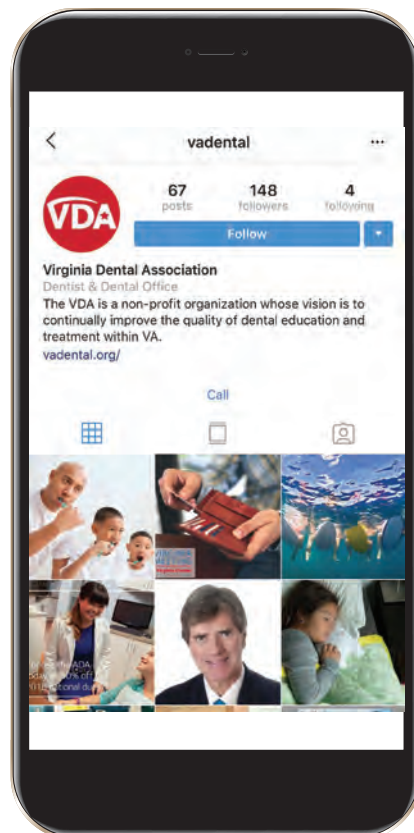
Instagram has experienced unprecedented growth over the last couple of years, reaching 1 billion monthly active users for the first-time last June. The sheer size of the platform's user base might have you wondering: Is now the right time to start using Instagram as a marketing tool for my practice?

Before you determine if Instagram should be a part your practice's marketing mix, you need to understand the two ways in which the platform is currently being used – content shared to the Instagram feed vs. Instagram stories. Typically, content shared to the Instagram feed, is carefully curated. This content lives on your profile forever (unless you decide to delete or archive it) and should capture the best of what your practice has to offer. Instagram stories have a 24-hour shelf life and are generally used to show a more authentic, real-time and often behind-the-scenes view of a company or business.

WHAT TO KEEP IN MIND BEFORE STARTING YOUR PRACTICE'S ACCOUNT

HIPAA and patient privacy are always major concerns for any marketing tactics your practice may use. For Instagram in particular, two common violations stand out – the posting of images, videos and personally identifiable information of patients without written consent and the sharing of images/videos in which personal health information is visible. Both of these common mistakes can be avoided by putting in place a policy to ask for patient permission when capturing content, making sure computer monitors are turned off and paperwork is out of site.

Aside from potential HIPAA violations, you'll want to consider the time investment

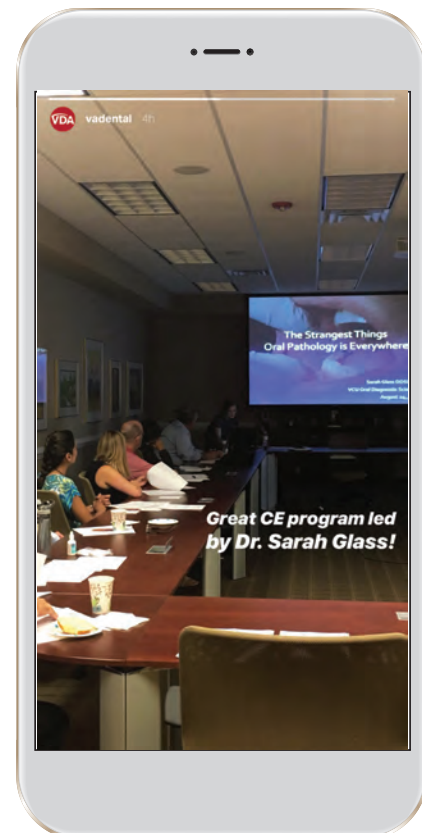


Instagram Profile Content

Instagram requires of staff members. You do not want to spend time creating your account, only to abandon it a few weeks later. Because Instagram relies on visuals, you'll need to dedicate more time to creating, editing and sharing content than you would on other platforms – where it's as simple as typing up a status update. Follow the Virginia Dental Association and the American Dental Association for Instagram inspiration.

QUICK TIPS FOR BEING SUCCESSFUL ON INSTAGRAM

Use a scheduling tool. Creating engaging content is only half the battle. After you've



Instagram Story

put careful thought into capturing photo and/or video to share on the platform, you have to post it. I recommend finding a scheduling tool that fits your needs, allowing you to schedule batches of content at a time. Scheduling tools like Buffer or Later offer free plans that give users a no-cost way to be consistent with Instagram updates. Bonus: Buffer and Later also allow you to schedule content for other platforms, making them a one stop shop for all your social content needs.

All photos are not created equal. While you by no means need a professional photographer to help you create an

Instagram content, you should put care into the images you capture. If you are using your phone to snap photos on the go, here are a few tips to ensure your content is Instagram ready.

- Use your phone's standard camera app -- these photos will be clearer and more defined than photos taken in the Instagram app
- Wipe off your camera -- if the images are coming out cloudy or hazy, see if cleaning the lens helps (use a microfiber cloth, the one that comes with a pair of glasses for the best results)
- Remove your phone case -- if any part of your phone case covers/protects the camera lens on the back of your phone, remove it when you take photos
- Find a filter that works for you (or go #nofilter) and stick to it, this will make your feed more cohesive -- remember less is more in most cases
- Lighting can make or break your photo, stay away from taking photos in front of windows and in dark spaces
- Tap to focus -- in your camera

app, you should have the ability to tap the screen which will tell your camera what area of the photo to focus on, if there are people in your photo tap their faces before snapping

- Upgrade your phone -- if you follow the steps listed above and still aren't happy with the quality of the photos you're capturing it might be time to upgrade to a newer model

Opening additional lines of

communication. Adding another social platform to your practice's social media strategy also means opening a new line of communication with current and potential patients. Be ready to respond to comments and messages in a timely manner.

Instagram for business. Instagram offers tools to businesses using Instagram, these include the ability to add buttons to your profile -- email, call and directions -- analytics and the ability to advertise. Even if you do not plan to advertise or access your analytics right away, change your practice's account to a business account so those tools will be available to you when you're ready. You can also connect

your business Instagram to your Facebook account, which will allow you to moderate comments from your computer or through the Facebook Pages app.

Instagram can be a great way to diversify your marketing tactics, giving your practice another way to reach current and potential patients directly. But remember, the time, effort and resources needed to sustain an engaging Instagram presence is a little different than what it takes to update your Facebook status. Develop a game plan before you get started, and stick with it, growing a community -- both on social media and in real life -- doesn't happen overnight.

Kelsey Leavey is a public relations and social media specialist at The Hodges Partnership, a strategic communications firm based in Richmond that excels in public relations, content management and social media. She works with clients to tell their stories through traditional and digital media. She can be contacted at kleavey@hodgespart.com.

INSTAGRAM LINGO



STORIES

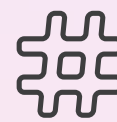
Horizontal photo or video content that is visible to users for 24 hours.

Stories can be adorned with emojis, location tags, mentions of other accounts, stickers and GIFs.



GEOLOCATION TAG

Photos can be shared with a location tag that shares where the photo was taken, if your practice has a Facebook page that lists its address a location tag should already be created for you. Both your practice and other users can use this tag.



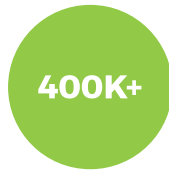
HASHTAG

A way to group content together on a particular topic, hashtags can be searched and explored by users to find new accounts and content to engage with.



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ETHICS COMMITTEE, A MEMBERSHIP RECRUITER?

Dr. William J. Bennett

I'll bet you had never thought of our state and component Ethics Committees as having a role in membership recruitment. We really hadn't either. This all changed when Cathy Griffanti, Executive Director of the North Virginia Dental Society [NVDS], made a call to the VDA. The NVDS became aware in 2016 that some area dentists were advertising as being members of the ADA/VDA/NVDS on their practice websites and promotional material when in fact they were not active members. The total number of individuals with misleading print or on-line presence has numbered 173 dentists. The American Dental Association's Principles of Ethics and Professional Code of Conduct Section 5.F addresses false and misleading advertising. Virginia's Regulations Governing the Practice of Dentistry Section 18VAC60-21-80 addresses it as well. Misleading promotion is ethically and legally not permissible.

The NDVS Ethics Committee, chaired by Dr. Garrett Gouldin, sent a letter to these practitioners to make them aware of the misleading promotional information. If no response or change occurred, a follow up call was made. The VDA Ethics Committee was brought in to help with those who failed to respond to NVDS efforts. At the VDA level certified letters are issued. The efforts of all correspondence and calls were to encourage renewal of membership for the many benefits received both in the practice of dentistry and professional relationships. The efforts have now expanded to all component societies with Ethics Committee members working across the state to address these concerns. The result of contacting lapsed members has been that over 50% have renewed their memberships thus far. The

job is not yet completed. The majority of individuals indicated that they had just lost track that they had not renewed, or even looked at their website recently. Regardless of the reason, we are pleased to have them back as members, and most now use the VDA's automatic membership option. Presently, monitoring of website information for 2018 non-renews is taking place.

The VDA and component Ethics Committees are quite proud of efforts in maintaining a high ethical and professional standard for Dentistry in Virginia. The ADA's Golden Apple Award was awarded to the VDA in 2014 for our foundational efforts. A protocol was established for addressing Ethical concerns or complaints regarding fellow professionals. Our protocol has been utilized by the ADA as a template for other states. All matters begin at the local level using regional peer colleagues. Hopefully, a simple call or letter will resolve any concern or issue. If unresolved, an appeal for assistance is presented to the VDA Committee for a decision. If still unresolved at the state level, the matter is presented to the ADA for final resolution.

Maintaining the high public regard of Dentistry is critical to the profession. The goal of our Ethics Committees is to be advisory and educational in nature so that correction of professional behavior can be accomplished quickly and effectively. Ethics Committee members consider advising VDA members of an ethical or legal issue a service to membership. We want no dentist to have a major ethical or legal issue. Advising lapsed or non-members has turned out to be a way to recruit renewal or new membership.

Striving for the highest level of professionalism should be the goal of any professional. Ideally professions are self-regulated. If they don't self-regulate, another entity will take on the role. The ADA has the Gold Standard for professional dental conduct. As members we must abide by these standards. Even more importantly, any standard must be upheld to be maintained and mean something to the members, to other professionals and to the community and public. Having the Ethics Committee ensure continued compliance with ADA principles makes it possible for the public to recognize the importance of ADA/VDA membership. Membership in an organization with high standards provides added trust to the public and to other dental professionals. In our profession to be considered as a Fellow in honorary groups such as the American College of Dentists, International College of Dentists, American College of Pediatric Dentists, American College of Periodontology, Southeastern Academy of Prosthodontics and others the dentist must be a member of the ADA.

Be proud to be a VDA member and encourage non-member colleagues to renew or join. The Ethics Committees will appreciate the assistance in our newly found recruitment role.

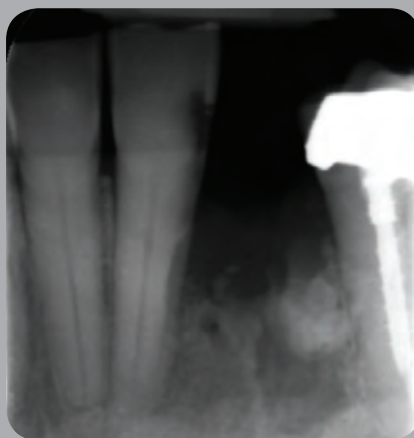
PATHOLOGY PUZZLER

DR. JOHN SVIRSKY

INSTRUCTIONS: What is your clinical impression of each of the following cases?
Answers are revealed on page 42.



CASE ONE



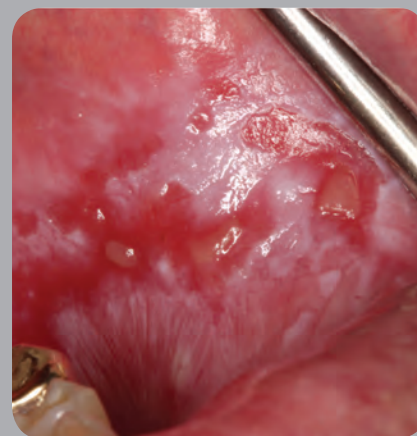
A 70-year-old white female on bisphosphonates.

CASE TWO



A 61-year-old male with mildly painful sloughing lesions. He also had gingival lesions that bled on brushing and scattered blood filled bullae.

CASE THREE



Painful lesion in a 63-year-old white male that has been increasing in severity.

CASE FOUR



Non painful lesions on a patient that do not rub off.

CASE FIVE



Non-painful expansile lesion of the right maxilla in a 26-year-old patient.

CASE SIX



Granular lesion in a 58-year-old white female.

ORAL HEALTH CONFIDENCE IN LONG-TERM CARE FACILITIES

A PILOT STUDY

Joanna Marie S. Acosta, B.S., MHMS,^{1*} Julie M. Coe, D.D.S, M.S., M.B.A.,²
Caroline K. Carrico, Ph.D.³

ABSTRACT:

BACKGROUND:

This study assessed the confidence of direct patient care professionals (DPCPs) in completing section L (Oral/dental status) of the Minimum Data Set and identified self-reported barriers.

METHODS:

A cross-sectional study of 285 long-term care facilities (LTCFs) in Virginia was conducted, and an electronic questionnaire was sent to their DPCP. Twenty-six facilities responded. DPCP respondents self-reported their abilities and barriers to correctly complete section L. Responses were summarized using descriptive statistics.

RESULTS:

Nineteen responses were analyzed. Seventy-nine percent of respondents did not undergo an oral health training course, and 32% did not even have a training manual to guide them. Overall, respondents felt comfortable with completing section L, but a majority wanted more dental professional collaboration.

CONCLUSIONS:

Respondents have limited oral health training, and more collaborative efforts with dental professionals is desired. Oral health care professionals' guidance would enhance the DPCPs' confidence and lead to more valid data on section L.

INTRODUCTION

Residents living in long-term care facilities (LTCFs) are one of the most vulnerable populations when it comes to having poor oral health (7). This is mostly due to a variety of reasons including limited access to oral care, substandard daily oral hygiene, and an imbalanced diet consisting of mostly refined sugars (7). The need to take prescription medications for geriatric ailments also predisposes this particular population to have xerostomia, which may also contribute to their inadequate state of oral hygiene (5).

Of the estimated 1.75 million senior Americans living in LTCFs, most of them rely on their nurses to provide them with

overall care, including oral care (6). To aid in the direction of providing good caregiving strategies pertaining to preventative oral health care, a federal mandate was established to ensure that nursing homes who received federal reimbursements followed a particular set of guidelines regarding oral health care to residents so that an acceptable standard of oral hygiene would be maintained (15). LTCFs who received funds from the Centers for Medicare and Medicaid Services (CMS) must report oral health assessment data using the Minimum Data Set (MDS), which is a detailed documentation of the overall health conditions and diseases found in residents of nursing homes or LTCFs so

that appropriate treatment planning and everyday care is delivered (6, 11). The latest MDS version 3.0 reports relatively specific problems within the scope of determining oral health status under section L: Oral/dental status (6). Under section L, DPCPs are responsible for items such as examining chewing abnormalities and pain, reporting of ill-fitting prosthetic devices, noting of obvious tooth decay, mouth ulcers, or broken teeth, and defining the health status of a resident's gingiva (Table 1). Although it appears that these LTCFs have their residents' oral health statuses under close watch, a huge caveat to reporting MDS values is its validity.

Oral and dental health assessment (section L) of the MDS report.

Section L	Oral/Dental Status
L1. Dental	
Check all that applied in last 5 days:	
<input type="checkbox"/>	a. Broken or loosely fitting denture or partial (chipped, cracked, uncleanable, or loose)
<input type="checkbox"/>	b. No natural teeth or tooth fragment(s) (edentulous)
<input type="checkbox"/>	c. Abnormal mouth tissue (ulcers, masses, oral lesions, including under denture or partial if one is worn)
<input type="checkbox"/>	d. Obvious cavity or broken natural teeth
<input type="checkbox"/>	e. Inflamed or bleeding gums or loose natural teeth
<input type="checkbox"/>	f. Mouth or facial pain, discomfort or difficulty with chewing
<input type="checkbox"/>	g. None of the above were present
<input type="checkbox"/>	h. Unable to examine

*Adapted from the Centers of Medicare and Medicaid Minimum Data Set, Version 3.0 Report².

Table 1

Nursing staff, or any health worker providing direct care to the residents, are the ones who complete the MDS oral health assessments, not dental professionals (6). An important factor that contributes to an incorrectly performed oral health assessment is the lack of proper dental education and training of nurses to recognize such oral health problems (15). An evidence-based study demonstrated that although scientific literature reports having about 80% - 96% LTCF residents who have oral health problems, actual MDS reports portray higher occurrences of diabetes and dementia with low occurrences of oral health needs (14). These data sets suggest that there is a lot less recognition by nurses of oral diseases than ones that are more easily diagnosed such as diabetes, dementia, and nutritional deficiencies (1, 14). There is a need to further assess the oral health care competency and the determinants of that competency in direct patient care providers (DPCPs) evaluating residents for oral conditions for the MDS report.

Continued examination of MDS reporting of oral health by nurses will help to address inconsistencies in MDS reporting of oral health statuses in resident. In addition, it will hopefully assist in discovering the reasons for the apparent underreporting of oral health conditions on the MDS. Aside from the lack of oral health education of nurses as confirmed

by many published studies, other barriers hindering oral health competency may be revealed. This research to be conducted will examine the basis of the DPCPs' oral health care knowledge in correctly identifying MDS oral health concerns. Training on oral health may already be in place to help educate the DPCPs, but this study will help to explore its current adequacy. Discovering the sources of this knowledge will help to fill the knowledge gap in understanding the factors affecting the quality of MDS reporting in section L.

MATERIALS AND METHODS

A cross-sectional study surveying DPCP managers working in LTCFs in the state of Virginia was conducted in July 2016. DPCP managers are defined as the health care professionals in charge of overseeing the direct, clinical care of LTCF residents, such as the Administrative Director of Nursing (ADON) or other equivalent title. The survey (Table 1) served as a tool to determine the competency and confidence of DPCPs in collecting MDS dental health data in residents living in LTCFs, as self-reported. This study was reviewed and approved exempt by the Institutional Review Board at Virginia Commonwealth University (HM20006516). Data was collected from DPCPs who were employed by LTCFs that were part of the Virginia Health Care Association (VHCA) network, an organization that encompasses most of the LTCFs in Virginia. This allowed

data collection across a wide variety of LTCF types, with varying degrees of facility accommodation and resident populations. Each VHCA organization received a single written email request to send the electronic survey to the intended population, the DPCP members, of their organization. If the survey was not initially sent to the intended individual, such as the administrative clinical director, director of nursing, or other appropriate employee who oversees the clinical direction of the long-term care facility, they were instructed to forward the questionnaire to the appropriate party. This list of members from the VHCA organization served as the population for the survey participants.

SURVEY DESIGN

A comprehensive electronic questionnaire was sent to the LTCFs with specific direction for DPCPs to complete the form. The questionnaire was sent using the PHI-sensitive REDCap tool to ensure the privacy and discretion of all research data and its participants. The survey was developed for the purpose of this study and had not been previously validated. The questions were tested internally for clarity prior to sending to study participants.

Participants who completed the survey self-assessed their abilities in correctly completing MDS reports for the section L in their residents. The demographics and extent of their oral health care training was self-reported as well. Some questions that were included in the questionnaire were the participants' professional titles within their long-term care facility, length of experience in the field, personal clinical interaction with residents and firsthand experience in completing the MDS report, and level of oral health education and/or training. Among other items in the questionnaire was a Likert scale based on the participants' confidence in recognizing certain conditions based on what they have to report on section L, such as the ability to recognize an ill-fitting denture, loose teeth, cavities, etc. Limitations and possible ways to improve were also in the questionnaire, and participants were required to select which limitations and

<LONG-TERM CARE - CONTINUED FROM PAGE 35

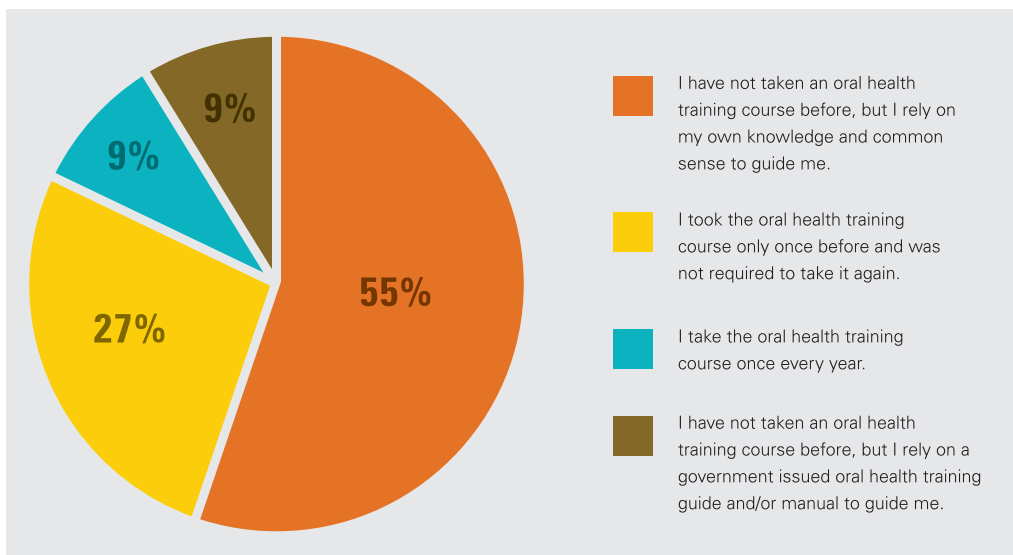


Figure 1. Level of oral health training and education of DPCPs based on total of 19 responses.



Figure 2. DPCPs' perceived confidence in section L reporting based on a total of 19 responses.

benefits would apply to their long-term care facility in terms of MDS reporting of section L. These reports were analyzed for quantitative data. The goal was to determine the competency and comfort levels of DPCP staff members in correctly identifying oral health problems on the MDS report. Then, a comparison of their oral health educational training was examined. Ways to improve (or maintain) oral health competency and training of DPCP staff was also considered.

After data collection was completed, statistical analyses included descriptive statistics. All analyses were performed in SAS EG v6.1. Inclusion criteria included: VHCA participants who were familiar with MDS reporting and had participated in oral health examinations for the purpose of completing section L. Exclusion criteria included participants who identified as dental professionals, whose oral health training far exceeded others (ie. dental professionals) and could lead to bias. Inclusion criteria were those participants whose long-term care facility participated and were familiar with MDS reporting, had personal firsthand experience with completing section L reporting, had clinical experience with oral health examinations on residents but were not themselves dental professionals. Exclusion criteria for the study were any respondents that: 1.) were not familiar with the MDS report; 2.) had not personally performed an oral health examination for the purpose of completing section L; and 3.) were dental professionals. The purpose of the exclusion criteria was to diminish biases from respondents who had no experience in completing section L and also those whose oral health training far exceeded others (ie. dental professionals). After exclusion criteria were applied, 19 responses were analyzed.

RESULTS

The VHCA network consisted of 285 total LTCF organizations in the state of Virginia. Of the population of 285 that were sent electronic questionnaires, there were 26 respondents (9% response rate). At least 2 LTCFs reported to the investigator that they were unable to participate in the survey because they were not CMS-certified organizations. This meant that since they were not certified under CMS, they did not qualify for CMS reimbursements that would have been afforded by completing the MDS report; therefore, it was assumed that they did not complete such MDS records.

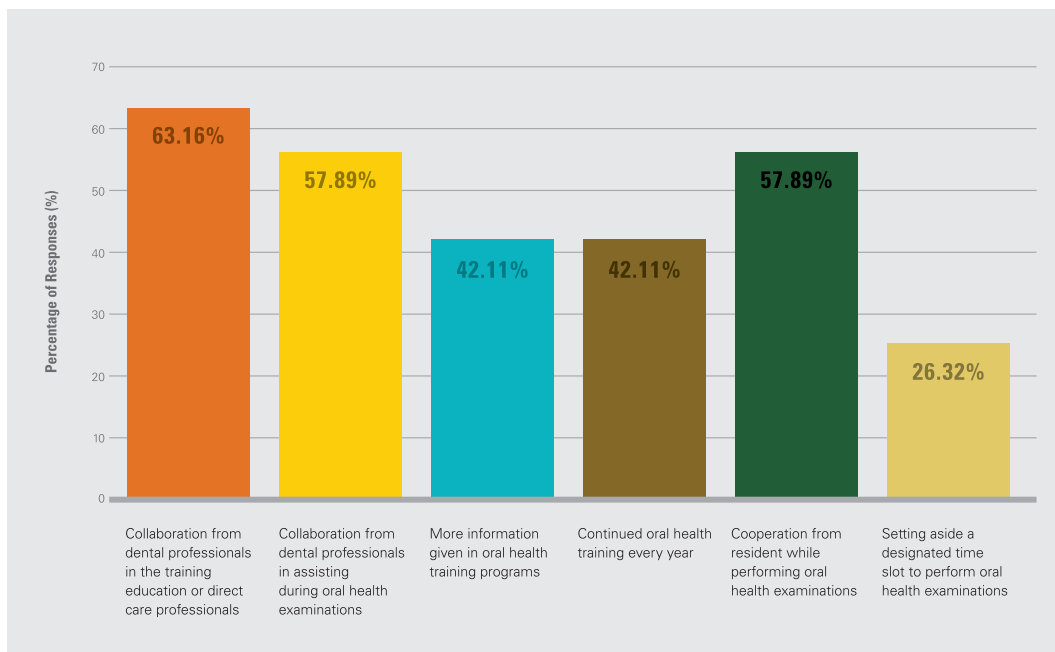


Figure 3. Needs indicated by DPCPs for successful completion of Section L based on a total of 19 responses.

Of 26 total respondents, an overwhelming majority of those who performed the oral health examinations for section L were registered nurses or licensed practical nurses (84%), with some other professionals such as speech pathologists (5%), or dental professionals (10%) also doing the oral examinations. In describing the types of registered nurses and/or licensed practical nurses, the majority of those were MDS coordinators (63%), and others included directors of nursing (16%), administrators (11%), and staff nurses (5%). From this population of 26, 7 respondents had not personally performed a section L screening. Forty-seven percent of respondents had more than 10 years of experience with working in LTCFs. These respondents represented facilities with residents aged 66-85 (84%) with 101-150 beds (47%). One facility reported an average age of 50-55 and 2 reported 86-90 years old. In terms of facility size, 7 reported 100 or less beds (37%) and 16% have 151-200.

Seven participants were removed from further analysis based on the exclusion criteria (Exclusion criteria: Not responsible for screening patient and completing the MDS report.) When asked about their oral health training background and education, approximately 79% of them had not taken an oral health training course, and 32%

were not provided with an oral health training manual as guidance for proper oral examination procedures. Sixteen percent of respondents took an oral health training course once before but were not required to take it again, and those who took a course every year were the minority. Thirty-one percent believed that they needed more training, 21% were undecided and 47% thought they have had enough training. Sixty-eight percent felt comfortable in performing oral health examinations in residents, while 26% were undecided and 5% were uncomfortable with it.

In accordance with the list of oral health deficiencies to identify on section L, most respondents agreed that they were comfortable with identifying all oral conditions (ie. broken or ill-fitting dentures, abnormal mouth tissue, loose natural teeth, etc.) except for the identification of obvious cavities in the residents' dentitions. Twenty-six percent were not confident in identifying obvious cavities, 21% were undecided, and 53% were confident in their ability to recognize cavities. This was the only category where the respondents' confidence in identifying a certain oral

health concern was not as clear. Majority (63%) agree that the MDS tool alone is an insufficient tool to identify oral health concerns in residents (Figure 2).

In spite of most respondents' confidence in their delivery of oral health examinations and identification of oral health concerns, 63% did not feel as though they received adequate instruction and communication from dental professionals to guide them through instructing residents with complete dental homecare, while 11% were undecided and 26% believed their communication from dental professionals was adequate. Sixty-three percent desired more collaboration with dental professionals in the training and education of DPCPs, and 58% wanted more dental collaboration in assisting during oral health examinations.

There were other factors that the respondents believed would help increase the accuracy and competency of completing the oral health examinations. Those included more information given in oral health training programs (42%), continued oral health training every year (42%), cooperation from resident while performing oral health examinations

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(58%), and setting aside a designated time slot to perform oral health examinations (26%) (Figure 3). Factors that hindered the performance of oral health examinations that the respondents agreed upon were as follows: lack of cooperation from the resident (68%), inadequate time frame to perform oral health examinations (16%), inadequate direction from dental professionals in how to perform oral health examinations (37%), inadequate direction from LTCF administration in how to perform oral health examinations (11%), and overall uncertainty in how to perform oral health examinations (21%).

DISCUSSION**DPCP response from survey**

Most of the DPCPs who responded to the survey were MDS coordinators, and by definition, these were usually registered nurses who had been appointed in the active involvement of the care planning of LTCF residents and facility regulation (10). According to their job description, these individuals were also in charge of completing the MDS, had strong skills in clinical judgement and a thorough understanding of the MDS 3.0 process (8). This type of knowledge and understanding was most likely the reason why most respondents were MDS coordinators, and why they were deemed the most appropriate person to complete the survey.

Although most respondents felt comfortable with identifying the itemized concerns on section L, the majority of them agreed that they would like more direction and assistance from dental health care professionals during both the training process and the actual oral examination of the resident. The DPCPs had a high level of confidence in their abilities to examine their residents' oral health, but there remained an uncertain measurement of their competence in doing so. This observation probably stems from the many years of experience in caring for residents in LTCFs that most of these respondents had, and so they felt very comfortable in examining their residents' health in general. The nurses caring for individuals living in long-term care facilities have

developed skills in caring for the geriatric community; therefore, they were confident in their comprehensive care, including that of oral health. Even so, only approximately 3% of advanced practice nurses specialize in elderly adult care, while less than 1% have certifications in geriatric nursing (18). It is likely that the nurses caring for the residents developed skills in geriatric care throughout the years as opposed to having a specialized training background with the elderly population.

CHANGES TO MDS

Changes made between the MDS version 2.0 to the updated MDS version 3.0 were initiated for the very purpose of accommodating more detail about oral health concerns¹³. The previous version limited the identification of oral health conditions and also did not consider pathology groupings (13). Changes were made in collaboration with the American Dental Association (ADA) (13). The revisions were a big improvement, but staff still depended upon fundamental oral health training in order to thwart difficulties in performing oral health examinations (13). The MDS form itself was new and improved, but it still did not account for the competencies of its users. Training, in this case, oral health training, was still a necessity in the interest of obtaining the best, most accurate screening of oral health conditions. In this study, users' familiarity with MDS was evident in their confidence to perform oral health examinations, but their interest in collaborating with dental professionals also indicated a need to focus their oral health examination skills to a more correct standard. Slightly more respondents did not feel that they needed more information on the oral health training programs currently provided, but they still wanted direction from dental professionals. For example, the identification of obvious cavities, an item that truly calls for some dental training, was the singular item on section L that divided the respondents in terms of their confidence levels. It acknowledges that the LTCF staff, in addition to their desire to collaborate with dental professionals, are committed to

more training, even though most do not think that training should be conducted every year. From this data, one can assume that the training manual may not be sufficient for section L.

ORAL HEALTH TRAINING

When it came to oral health specifically, the lack of formal oral health training and even an oral health training manual did not set a standard of care for performing oral health examinations in LTCFs. The absence of an oral health training process in most of the respondents' careers in LTCFs set little accountability for these DPCPs to adhere to the standards of oral care that is deemed appropriate as set forth by the dental profession. Under the federal mandate, Requirements for States and Long Term Care Facilities (2016), LTCFs are required to "provide education and training in the maintenance of oral health" (12). However, the interpretation of education and training to be provided by the LTCF is ambiguous by the text of the statute since it could mean something as simple as educating the resident on how to brush and floss their teeth instead of mandating an oral health training program for LTCF workers. It would be beneficial to consider revising the definition of the federal mandate to include specifications in order to have a more organized and standardized approach in how to educate DPCPs in appropriate oral health examination procedures. Oral care practices by nurses are not presently evidence-based practices, and there is no regulation of a "mechanical component" to them (3). As it stands, the statute could mean anything in terms of how loosely the LTCFs wished to incorporate the law into their practices. Most of the LTCFs surveyed in this study failed to offer a 'best-practice' protocol that would have been met with the establishment of a formal oral health training program. Though the registered nurses that normally performed the residents' oral examinations cannot be expected to adhere to the level of oral care and knowledge when compared to dental professionals, there should be an awareness of the minimum standards of how to properly examine

and search for oral health conditions. Other studies have suggested that using the MDS alone as a detection tool for oral health concerns is inadequate, and nurses are unable to identify many oral health concerns by using it (4). Most of the respondents from this research study agreed, and more should be done beyond the scope of the MDS tool if oral health concerns were to be of high priority in maintaining the overall health of LTCF residents. Based on those concerns, it is suggested that the current MDS version 3.0 has more room for growth and expansion as far as obtaining important health information on residents living in long-term care facilities. More studies need to be conducted to determine where exactly the weaknesses of MDS 3.0 are, but since users are reporting that it is inadequate at least for section L as a detection tool, more improvements should be made to it in the future. Aside from the use of the MDS report as a detection tool for section L, perhaps DPCPs should seek more reliable oral health resources such as a supervising dental professional or an accredited oral health training manual to help with the recognition of oral health conditions they are expected to be able to determine and report.

VARIATIONS IN ORAL HEALTH TRAINING

Some of the study's respondents expressed the presence of some level of oral health training and/or government-issued oral health training guide. However, other respondents had neither resource to guide them. It begs the question of who provides the oral health training manuals and/or courses in the state of Virginia: Is it the Centers for Medicare and Medicaid Services (the writers of MDS)? Is it the ADA? Is it the American Nurses Association? Or is it the LTCFs themselves? Further research is necessary to discover the sources of oral health training information in Virginia. In other states such as California, The Pacific Center for Special Care at the University of the Pacific School of Dentistry partnered with the ADA and the American Health Care Association to provide a video

directed to nurses or other DPCPs whose duties include completing section L (19). In Maine, the Maine Department of Health and Human Services created an MDS training manual but it has very limited information on oral health training (17). It merely states what the purpose of section L is, and it does not provide detailed steps on how to accurately capture data for it (17). The different degrees of oral health training resources across states and even within the state of Virginia itself varies tremendously. In an attempt to provide other outlets of oral health information outside of federally-regulated programs, a non-profit organization called Oral Health America launched a website in October 2013 (9). Their website provides LTCF workers with video training programs on helping geriatric residents with a daily oral hygiene regimen, even those with dementia (9). Resources such as this, if given directly to DPCPs in LTCFs, could be extremely beneficial in increasing the standard of oral health care for residents. In this study, more than half of respondents felt they needed more cooperation from the resident while performing the oral health examination, and many of them agreed that they relied on the resident to tell them about their oral health problems. With additional resources and training, dependence on the resident and a more skillful oral examination approach could help alleviate those difficulties. Other studies have also shown that nurses who have attended dental in-service training have produced more accurate oral examination results (20). Having more competent DPCPs is likely to generate more precise data on the MDS, care for residents in LTCFs can be more closely monitored, and problems may be addressed more quickly for an increased standard of care.

FEDERAL REGULATION OF ORAL HEALTH TRAINING PRACTICES

There is a profound need for federally standardized oral health training. It is a work in progress and more research on training resources needs to be conducted, but at the time this study was conducted,

there have been congressional movements to fund grants from the presidential budget to support the education and training of primary care professionals in the delivery of care to those in underserved communities (16). In April 2016, members of the Health Professions and Nursing Education Coalition (HPNEC) submitted Titles VII and VIII of the Public Health Service Act which was administered through the Health Resources and Services Administration (HRSA) (16). Although the act does not directly affect DPCPs working in LTCFs currently, it supports the training of future health care workers in interdisciplinary care including geriatric nursing education and the expansion of primary care dental training. It will help encompass the much-needed education of health care workers in areas such as specialized care in the elderly as well as dentistry that often overlap the medical and nursing professions.

LIMITATIONS AND FUTURE RESEARCH

The limitations of this study include the small size of the sample population, which may cause some degree of sampling bias and may not represent the general population of LTCFs. There may also be response bias wherein only motivated individuals seeking aid within their LTCFs for dental care for their residents are the ones who are most likely to respond. Another limitation is that not all LTCFs in the state of Virginia participate in CMS reimbursement; therefore, they are not eligible to participate in this study because they do not perform section L reporting on their residents. Though the number of responses in this pilot study were small, it still captures a glimpse of the need for further regulation of oral health education and collaboration with dental professionals in LTCFs to enhance the standard of care for their residents.

Future studies could explore even further the reasons why DPCPs feel that they need to include dental health professionals in their oral health training, what has since prevented them from doing so before and why dental professionals seem to be rarely

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involved in nursing protocols that require recognition of oral health conditions and/or diseases. Additionally, more explanation as to the source of their oral health education training and protocol could be clarified through gathering qualitative data from participating DPCPs of this study.

CONCLUSION

According to the results of this pilot study, there seems to be a discrepancy between the MDS users' high confidence in completing section L and their competence (ie. lack of training) to correctly do so. Additionally, there are varying degrees across states and within the state of Virginia in how to train LTCF workers to identify items on section L. Even if the DPCPs were confident in their oral examination technique, there was no resource informing them of the 'right' or 'wrong' way of performing oral health examinations or even how to look for oral conditions professionally. Perhaps as a result of the unstandardized data collection for section L, many survey respondents wished to seek collaboration from dental professionals who could provide the skills necessary in correctly identifying these items. Currently, there is no standard best-practice protocol in how nurses gather the data for section L. Nurses who gather the data may have varying degrees of oral health training and some may be able to recognize oral health diseases better than others. This study produced a small sample size; however, its statistical power lies in the fact that it recognizes the need and desire from DPCPs at long-term care facilities to establish a relationship with dental health professionals to aid in the comprehensive care of individuals that have oral health concerns. Respondents recognized the importance of interdisciplinary collaboration, and many educational programs across the country have begun to incorporate this type of training into their curriculums. Health care is slowly addressing the value of collaborative care efforts, and the geriatric population living in LTCFs would certainly benefit from such partnerships (3). In the meantime, a deeper understanding of LTCF training protocols in completing

all sections of the MDS, including section L, would be a good place to start in terms of initiating combined care practices bridging the nursing and dental professions together. Under the direction of dental professionals, nurses may be able to achieve an appropriate standard practice for oral health examinations. It would allow DPCPs working in LTCFs in the state of Virginia to not only maintain a high level of confidence in their data collection of section L, but also a high level of measurable oral health examination competency.

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LIFE/RETIRED MEMBERSHIP

EVERYTHING YOU NEED TO KNOW

Sarah Mattes Marshall, VDA Membership Advocate

This time of year I receive calls from retired and/or life members with questions about their membership status. Some of them had no idea that they were just one form away from free dues until we talked!

In the likely event that there are more of you out there, and others nearing these milestones, I thought it might help to define the various stages and associated fees.

LIFE MEMBERSHIP

Members who are 65 or older and have at least 30 years of consecutive membership with the VDA or 40 total years split among several state associations.

There are two types of life membership:

- **Active Life Membership**
Members who meet the requirements for life membership, but are not yet retired. This provides a 25% discount off the price of full active dues.
- **Retired Life Membership**
Members who meet the requirements for life membership and are no longer in practice. Member dues are FREE.

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If you've retired but haven't attained life membership, you still qualify for a 75% discount off of full active dues.

TAKING ADVANTAGE OF THIS BENEFIT:

Whether you qualify for life membership or not, if you've retired or about to retire and want to receive the appropriate discount to your dues, contact me (mattes@vadental.org or 804.523.2189) for a Retired Affidavit form. More information on membership, check out this resource from the ADA: <https://goo.gl/8Y1s85>

In parting, I want to challenge each of our retired members to reach out to me directly about volunteer opportunities. We value the knowledge and experience you bring to the table and are looking to create more opportunities for you to share that information within our dental community and across the commonwealth.

PATHOLOGY PUZZLER ANSWERS:

CASE ONE

MRONJ. With a history of bisphosphonates and a lesion that appears as dead bone both clinically and on radiograph, MRONJ must be your most likely diagnosis. The name has been changed from BRONJ (bisphosphonate related osteonecrosis of the jaws) to MRONJ (medication related osteonecrosis of the jaws) to reflect the fact that other medications such as monoclonal antibodies in addition to bisphosphonates can cause necrosis.

CASE TWO

BMMP (Benign Mucous Membrane Pemphigoid). The patient showed lesions that were suggestive of an epithelial slough and would probably exhibit a positive Nikolsky sign (epithelial separation

of tissue by rubbing with a tongue blade or blowing air). The patient also showed a blood filled bulla which was highly suggestive of pemphigoid. Patients with this disease characteristically present with the complaint of bleeding gums upon brushing. The patients will typically show a good response to doxycycline which typically cuts down on the bleeding upon brushing and the occurrence of eye lesions.

CASE THREE

Erosive Lichen Planus. Due to the pain from ulceration and the lichen planus appearance, this patient was treated with Clobetasol propionate .05% gel, dexamethasone elixir .5mg/5ml and "Magic Mouthwash".

CASE FOUR

Leukoplakia. Diagnostic biopsies indicated. These lesions can be anything from hyperkeratosis to dysplasia to squamous cell carcinoma.

CASE FIVE

Odontogenic myxoma. This expansile 4cm by 3 cm radiolucency in the posterior right maxilla shows wispy trabeculae with a suggestion of being multilocular. My differential would include an ameloblastoma in addition to the myxoma.

CASE SIX

Oral cancer. The granular and pebbled appearance is typical and characteristic of a squamous cell carcinoma. Gingival carcinomas are originally thought to be reactive or inflammatory lesions.

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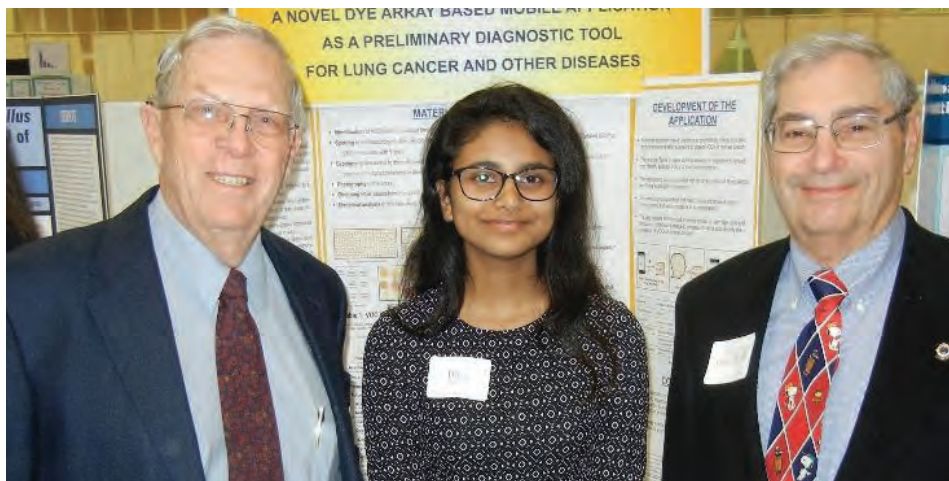
Dr. William Burston

The 2018 Virginia State Science and Technology was held on April 14 in Roanoke's Berglund Special Events Center. This year 263 students presented nearly 200 outstanding projects which had been previously reviewed at local fairs in schools around the State. Drs. Mitchell Bukzin and William Burston represented the Virginia Dental Association while attempting to select those projects which represented the best science and most relevant issues. The VDA generously provides funds for presenting a grand prize of \$1500 and several category prizes of \$100. It is our hope that we can show the best and brightest of students throughout Virginia that our profession remains at the forefront of dedication to the advancement of health through basic science and its technological applications.

The winner of the Malbon Prize this year, we are proud to announce, is a young woman from Hayfield Secondary School, Ms. Divya Kranthi. Ms. Kranthi is a "Young Lion" through which she volunteers her time for community service. Her project "A Novel Dye Array Based Mobile Application as a Preliminary Diagnostic Tool for the Detection of Lung Cancer" impressed the judges with its novel approach and the use of basic science to further diagnostic medical arts.

OTHER PROJECTS AND STUDENTS OF NOTE WERE:

- Engineering Materials and Bioengineering: Alternative to Echocardiography: Using Deep Learning to Diagnose Heart Murmurs. **Sylesh Suresh, Ankit Gupta, George Tang** of Thomas Jefferson High School for Science and Technology



L-R: Dr. William Burston, Ms. Divya Kranthi and Dr. Mitchell Bukzin

- Engineering Electrical and Mechanical: Artificial Spinal Cord for Paraplegics. **Nithin Dass**; Thomas Jefferson High School for Science and Technology
- Physics and Astronomy: Capacitance of N-Sided Polygons. **Luke Mrini, Sagada Penano**; Lake Braddock High School
- Cellular and Molecular Biology: Immunomodulation of Enhanced Neuronal Regeneration, **Neha Damaraju**; Thomas Jefferson High School for Science and Technology

WINNING PROJECT ABSTRACT: A Novel Dye Array Based Mobile Application as a Preliminary Diagnostic Tool for Detection of Lung Cancer

Four volatile organic compounds strongly linked to lung cancer, were short-listed from published papers. These compounds belong to different chemical

groups. Authors have developed dye based arrays to reliably detect these four volatile organic compounds. However, the current process of detection involves a series of steps including spectrometric scanning of the array using sophisticated equipment. A simple, rapid, affordable and non-invasive test would be ideally preferred as a preliminary test to detect pulmonary conditions including lung cancer. I developed a dye array based mobile application, which enables reliable detection of at least the chosen four major VOCs. The dye spots in the array react to the volatile organic compounds present in exhaled breath, resulting in a change in color. Based on the analysis of the change in RGB (Red, Green, Blue) values of the dye spots on the array, the app indicates whether or not a person is at risk of inflammatory or pulmonary disorders and diseases including lung cancer.

Use of Intravenous Acetaminophen in Postoperative Pain Management After Partial and Full Bony Impacted Third Molar Extractions: A Randomized Controlled Trial

ATENCIO I, ET. AL. | J ORAL MAXILLOFAC SURG. 2018 76(7); 1414-1417

The current opioid epidemic is finally causing alarming concerns on a national front. As such the use of opioids for postoperative pain management has been under much scrutiny following surgical intervention especially in the Oral and Maxillofacial Surgery realm. Thus the search for alternative postoperative regimens of pain control has become an attractive subject for research. Despite many technologic advances in the Oral and Maxillofacial Surgical techniques, complete absence of post-surgical pain is impossible. In past times hospitals and practitioners measured a 5th vital sign, pain, with a goal to eliminate or at least minimize it. There are many articles with in depth pain management regimens with a myriad of pharmaceuticals to accomplish such. These pharmaceutical interventions also have their side effects as we all know. NSAIDs can lead to gastric ulcers, platelet dysfunction, kidney injury, and have even been implicated in poor long bone healing. Opioids, a mainstay for postoperative pain management due to their binding to mu receptors and an alternative path within the CNS, can cause, constipation, nausea, vomiting, respiratory depression and carry a high potential for tolerance, dependence and abuse. Another analgesic mainstay has been acetaminophen and has been available since 1955. Paracetamol is an IV medication that is a precursor to acetaminophen and has been extensively used and studied in Europe. In 2002 an IV acetaminophen became available in the United States. There have been several studies showing a decrease in reported pain scores, a decrease in time to meaningful pain relief and decrease in morphine-equivalent consumption. The aim of this study was to evaluate whether the use of postoperative IV acetaminophen, in

addition to standard-of-care medications, reduced postoperative pain scores after partial or full bony third molar extractions. A randomized placebo-controlled trial of patients undergoing third molar extractions was performed at Case Western Reserve University oral and maxillofacial surgery offices under IV sedation in similar fashion. A total of 72 patients were enrolled, consented and met inclusion criteria for the study. These patients were randomly divided into 2 even groups. Thirty-six patients in the placebo group (N=36) received IV 0.9% saline solution and the 36 patients in the experimental group (N=36) received IV acetaminophen. These patients and practitioners were blinded to which team the patients were assigned at random, by a practitioner not of the investigative team selecting a number from a box and directing them to which covered IV container that they were given. The containers were of the same shape, size and covered by an opaque paper to conceal its contents. Patients were then given a pain scale to fill out following the administration of their assigned medication, which was given by IV infusion over a 15 minute period following the surgery. The patients then recorded their pain scale on a written numerical pain scale and study staff recorded verbal pain scores via telephone at 4 and 24 hour intervals. Statistical analysis was completed and analyzed. There was no significant difference in the 2 groups at the immediate postoperative pain scale with a median pain score of 0. There was no significant difference in at the 4 hour postoperative mark with a mean pain score of 6.0. There was no significant difference at the 24 hour postoperative mark with a mean pain score of 4.1. Therefore, use of IV acetaminophen has

insufficient evidence for use in decreasing postoperative pain. Of note, many other studies have shown in the past that postoperative oral acetaminophen has been effective to reduce postoperative pain significantly compared to placebo, therefore the use of oral acetaminophen in postoperative pain management should be considered for multimodal analgesic relief of pain.

DR. VANCE P. HALL; CHIEF RESIDENT, ORAL AND MAXILLOFACIAL SURGERY, VCU MEDICAL CENTER

Managing Xerostomia and Salivary Gland Hypofunction

PLEMONS JM, AL-HASHIMI I, MAREK CL | JADA. 2014; 145(8): 867-873

Xerostomia is a condition also referred to as “dry mouth” that is often associated with salivary gland hypofunction but can stem from multiple etiologies. Salivary gland hypofunction is often noted by a quantifiable decrease in salivary flow and can be caused by various medications, autoimmune or systemic conditions, or radiation therapy. Xerostomia can present in very mild to very severe forms which cannot only be debilitating to the patient’s oral health but can also greatly impact their systemic health. It is important to understand and to educate patients on the role of saliva not only as aiding in digestion but also its role in maintaining a relatively neutral pH guarding the oral environment against various microbial colonization and caries formation. Providers should also understand that without proper saliva patients may experience altered speech, dysphagia or odynophagia, and dysgeusia.

Oral health care providers should be knowledgeable of the signs and symptoms of dry mouth. Common findings include erythematous mucosa, loss of tongue papillae, cracked lips, and traumatic lesions on the mucosa or tongue. Many patients with severe hyposalivation will often report constantly drink fluids often times after waking up from sleep. Oral candidiasis and cervical root caries are also common findings in this patient population.

After xerostomia is properly identified oral health care providers should then begin to investigate the etiology of the disease. Approximately 4 million people, 90% of which are women, in the United States have been diagnosed with Sjogren syndrome which is an autoimmune disease leading to dry eyes and xerostomia. Other symptoms often associated with Sjogren are chronic fatigue and joint pain. Other common medical conditions include:

graft-versus-host-disease, amyloidosis, sarcoidosis, HIV or Hepatitis C, lymphoma and many other major auto-immune or chronic inflammatory diseases. Another common etiology of xerostomia is radiation to the head and neck where within a few weeks the salivary glands will become increasingly fibrotic and will likely suffer from permanent xerostomia. Probably the most frequent cause of xerostomia is related to medications. Some of these medications are direct anticholinergics while others are side effects of the medications. Categories of medications that should alert a provider to possible association with xerostomia are anticholinergics, antihistamines, ACE inhibitors, Angiotensin II receptor blockers, various alpha and beta blockers, antidepressants, antipsychotics and muscle relaxants.

As oral health care providers it is of extreme importance to not only recognize the signs and etiology of xerostomia but also to effectively carry out the appropriate diagnostic tests and treatment according to the given etiology. A thorough history always aids in diagnosis. One can also measure both stimulated and unstimulated whole salivary flow by having a patient tilt their head forward and collecting saliva which should be at least at a rate of 0.1mL per minute for unstimulated flow and 0.7mL/minute for stimulated flow. The practicality and compliance with this test may be somewhat challenging. Blood test also may be obtained to test patients for rheumatoid factor or Anti-SS-A or anti-SS-B antibodies. Biopsy of minor salivary gland may also be indicated in some circumstances as often times a diagnosis can be made histologically for certain conditions. It is recommended that a multi-disciplinary approach is taken for proper treatment of xerostomia starting with patient education regarding the importance frequent dental visits and importance of

topical fluoride use. Patient education and prevention should also focus on limiting tobacco use or quitting. Temporary symptomatic relief in some cases may be accomplished through simply intermittent water sipping throughout the day. Patients also may benefit from sugar free candies in order to stimulate saliva in order to maintain a constant pH of the oral environment to decrease risk of caries. Typically, 1.1% topical fluoride dentifrices and gels are helpful in those experiencing severe xerostomia. Candidiasis may be treated with nystatin or clotrimazole either as suspensions or lozenges. Systemic antifungals include fluconazole and itraconazole typically for a 7 to 14 day course. It is also important to effectively communicate with the patient’s physician who is treating them for their associated medical comorbidity. If the patient’s xerostomia is severe enough it may warrant treatment with sialagogues if there are no other medical contraindications to do so in that patient. Both pilocarpine at a dose of 5mg q.i.d and cevimeline hydrochloride at a dose of 30mg t.i.d are cholinergic and will aid in salivary flow. These medications may not be effective in those with very severe hyposalivation. In addition, pilocarpine and cevimeline should be used with caution in those with narrow-angle glaucoma, uncontrolled asthma, and those on beta-blockers. Common side effects of these medications are sweating, nausea, diarrhea and rhinitis. Oral health care providers often are involved in the care of patients with xerostomia and salivary gland hypofunction and it is of extreme importance that these patients are properly diagnosed and managed in order to provide a better quality of life for this patient population.

DR. DANIEL HAWKINS; RESIDENT, ORAL AND MAXILLOFACIAL SURGERY, VCU MEDICAL CENTER

Effects of Leukocyte-Platelet-Rich Fibrin (L-PRF) in Different Intraoral Bone Grafting Procedures: A Systematic Review

DRAGONAS P, ET. AL. | INT J ORAL MAXILLOFAC SURG <https://doi.org/10.1016/j.ijom.2018.06.003>

In the early 2000s the use of leukocyte-platelet-rich fibrin, or L-PRF, surfaced as a therapy to promote healing and improve outcomes following surgeries in the oral cavity. L-PRF is prepared by simple centrifugation of the patient's own venous blood, allowing harvesting of an autologous dense fibrin network with incorporated platelets, neutrophils, and macrophages. This study aimed to evaluate the efficacy of L-PRF when used in ridge preservation, ridge augmentation, and maxillary sinus augmentation. The question asked by the review was, "Does the addition of L-PRF enhance bone regeneration and soft tissue healing, and reduce postoperative complications, in systemically healthy patients undergoing [these procedures]". The authors searched seven databases for randomized and non-randomized controlled clinical trials which utilized L-PRF either with or without bone grafting materials. Studies using other platelet derived or biological healing adjuncts were excluded, resulting in a final selection of 17 publications. For ridge preservation, sockets treated with L-PRF were observed to have slightly less horizontal ridge

reduction when compared to natural healing in two of three studies, and less horizontal ridge reduction when compared to β -tricalcium phosphate with type I collagen in another study. A randomized controlled trial demonstrated a modest increase in horizontal bone preservation when using L-PRF with demineralized freeze-dried bone allograft versus DFDBA alone. In regards to soft tissue healing for ridge preservation procedures, one of three studies reported improved healing when considering bleeding, suppuration, tissue color, and tissue consistency. Post operative pain was observed to be reduced in two trials when assessed 3 and 5 days following extraction. In regards to ridge preservation, only one study was included which demonstrated a significant reduction in resorption of palatal autogenous block grafts when placed with an L-PRF membrane. Soft tissue healing and postoperative complications were not addressed by any trials studying ridge augmentation. When addressing maxillary sinus augmentation, L-PRF did not show a significant clinical difference compared to absorbable collagen membranes

when used as a barrier in two studies. L-PRF used in combination with bone grafting materials did not demonstrate superior bone formation when compared to bone grafting materials alone in sinus augmentation in five studies. An improvement in soft tissue healing was reported in one study when L-PRF was placed over the lateral window compared to a collagen membrane, but this difference was not statistically significant. Similarly, one trial reported fewer postoperative complications when L-PRF was placed versus not; however, this was not statistically significant. In conclusion, L-PRF was observed to be useful in some intraoral surgical procedures, but may not offer a significant advantage when compared to other grafting or membrane materials. Additional studies are necessary to further explore its efficacy and indications of when it should be used.

SEAN ECCLES, DDS; RESIDENT, ORAL AND MAXILLOFACIAL SURGERY, VCU MEDICAL CENTER

Superior Border Versus Inferior Border Fixation in Displaced Mandibular Angle Fractures: Prospective Randomized Comparative Study

SINGH V, KHATANA S, BHAGOL A. | INT J ORAL MAXILLOFAC SURG. 2014; 43(7):834-40.

A randomized control study with the aim of comparing open reduction and internal fixation (ORIF) of displaced mandibular angle fractures greater than 2 mm. Treatment approach compared placement of a single monocortical miniplate at the superior border of the angle via an intraoral

approach versus an inferior border plate with minimum two holes using an extraoral approach. Inclusion criteria was an angle fracture of the mandible with displacement of inferior alveolar canal > 2mm. Exclusion criteria included infected fractures, comminuted fractures, age less than 16,

and edentulous patients. Clinical and radiographic assessment of patients were done both pre-operatively, post-operatively, and at 1 week, 4 weeks and 12 weeks of follow up.

Patients were randomly placed in two groups. Group A, included patients undergoing ORIF via intraoral approach and placement of plate along the external oblique ridge. Group B patients were treated with ORIF via an extraoral approach and placement of plate at the inferior border of mandible. Patients in both group placed in intermaxillary fixation post-op for 3-5 days and given a 3-day course of antibiotics. Parametric data recorded using t-test and non-parametric data analyzed using X2 analysis. A p-value < 0.05 was considered statistically significant. Treatment variables included time interval between injury and surgery, duration of surgery, complication rates, application of device, radiographic assessment, post-operative pain, post-surgery neurosensory dysfunction, occlusal discrepancy, wound problems and facial nerve paresis.

No statistical significance was noted between the time interval between injury

and surgical treatment in either group. There was a statistically significant result ($p = 0.00$) in duration of surgery between group A and B with group B requiring significantly less time for surgery. This could attribute to the direct access for reduction and fixation that is provided using an extraoral approach. There was a statistically significant value ($P=0.028$) between application of device between the two groups with group B having an easier application of device. There was no significant difference noted for pain except at 1 week follow up with a statistically significant decrease in VAS score for extraoral approach. No significant difference was noted for post-surgery neurosensory dysfunction, occlusal discrepancy, wound problems and facial nerve paresis. There was a statistically significant difference in radiographic assessment post-operatively with group B showing better alignment of the inferior border of the mandible compared to group A. All patients with an extraoral approach

had adequate reduction and lower border alignment. Four patients in the intraoral approach demonstrated gaps at the lower border. Even though this difference was significant, none of these four patients developed complications and gaps filled in eventually.

Overall, this study concludes that ORIF via intraoral approach and ORIF via extraoral approach are both satisfactory methods of fixation and no significant complications developed from either group. There was no difference in complication rates between the two approaches. However, the extraoral approach demonstrated better radiographic assessment and shorter duration of surgery.

DR. SOHEIL ROSTAMI; RESIDENT, ORAL AND MAXILLOFACIAL SURGERY, VCU MEDICAL CENTER

Do Postoperative Antibiotics Decrease the Frequency of Inflammatory Complications Following Third Molar Removal?

MORROW AJ, DODSON TB, GONZALEZ ML, CHUANG SK, LANG MS | J ORAL MAXILLOFAC SURG. 2018; 76(4):700-708

The use of prophylactic antibiotics in third molar removal has been a highly debated topic. Risk of postoperative inflammation is generally low, with the largest risk associated with immunocompromised patients. In their study published in the Journal of Oral and Maxillofacial Surgery in 2018, Morrow et. al aimed to estimate the rate of postoperative antibiotic use and also the rate of postoperative infection as well as measure the association between the two. Their null hypothesis was that "isolated postoperative antibiotics would not statistically have an effect on postoperative inflammatory complications after third molar extraction". The inflammatory outcome was defined

as surgical site infection (SSI) or alveolar osteitis (AO), taking the degree of third molar disease (caries, infection etc) as well as operative difficulty into consideration. In their prospective cohort study, 1,877 patients (5,613 third molars) treated by 105 oral and maxillofacial surgeons were evaluated. Of these patients, 61% received post-operative antibiotics. Morrow et. al found that there was a statistically significant decrease in SSI/AO in the postoperative antibiotic group ($P=0.4$). While this study only focuses on post-operative antibiotics, it mentions other studies that have found significant decreases in inflammation rates using pre- and perioperative antibiotics as well.

They use supporting research articles to reinforce the idea that no matter the regimen of antibiotic use (type versus dose versus timing), any antibiotic use can help reduce the postoperative inflammatory process. While the use of antibiotics in third molar surgery has shown to be beneficial, clinical judgment should play a large role when considering antibiotics.

DR. MICHAEL MCADAMS; RESIDENT, ORAL AND MAXILLOFACIAL SURGERY, VCU MEDICAL CENTER

Risk Factors and Etiopathogenesis of Potentially Premalignant Oral Epithelial Lesions

PORTER S, ET. AL. | ORAL SURG ORAL MED ORAL PATH ORAL RAD. 2018;125(6):603-611

The purpose of this article is to provide a review of the possible causes of premalignant lesions that can lead to oral squamous cell carcinoma (OSCC). Much research has gone into determining the underlying causes of oral cancer and unfortunately some of the information is contradictory. However, at this time there is substantial evidence that lifestyle factors such as tobacco, alcohol, and betel nut use are likely causes of oral epithelial dysplasia which can transform into OSCC. These lifestyle factors along with sexually transmitted HPV (human papilloma virus) are able to be correlated with the vast majority of OSCC, however other factors such as Oral lichen planus, Scleroderma, and numerous genetic diseases have also been identified.

The most common cause of potentially premalignant oral epithelial lesions (PPOEL) is tobacco use. Tobacco use has long been known to cause oral leukoplakia which has been shown to transform into OSCC in both smokers and smokeless tobacco users. One large cross-sectional study in Hungary showed that 3.7% of the study population displayed oral leukoplakia and that 88% of those with a positive screening were tobacco users. Another Taiwanese study showed that cigarette smokers present a 2.7 relative risk of developing oral leukoplakia or cancer. Interestingly, other research has shown that 10 years after smoking cessation, the risk of oral cancer seems to be similar to that of a never-smoker. Research shows similar results for cessation of smokeless tobacco as well.

Alcohol should also be considered an etiologic risk factor of PPOELs as studies have shown that protein adducts with aldehydic end products are expressed in oral leukoplakia and OSCC. A study in India showed that alcohol, even among

non-tobacco users, has been shown to be carcinogenic and that the effects are additive. This means that oral cancer risk seems to be related to overall alcohol consumption (drink years) as opposed to the number of drinks per day. Also, it is well known that tobacco in conjunction with alcohol consumption increases the risk of PPOEL exponentially.

Areca Nut, which is unpopular in the USA but extremely popular in other parts of the world, has shown to cause oral submucous fibrosis (OSF) in 3.72% of its users. Twenty-four percent of patients with OSF will display oral leukoplakia which is a predictor of later OSCC.

The oncogenic types of HPV (16 and 18), which are transmitted sexually, are associated with development of OSCC. However, it should be noted that this association applies to the posterior tongue, tonsils, and upper pharynx rather than the middle and anterior oral cavity. An early meta-analysis showed that HPV is 3 times more likely to be detected in PPOELs and 4.7 times more likely to be identified in OSCC than normal mucosa. It is still to be determined whether the HPV itself is responsible for the histological tissue changes or if the metaplastic changes are triggered by additional carcinogenic exposure such as tobacco or alcohol in the setting of active HPV infection. Nevertheless, HPV has shown a consistent correlation with OSCC of the posterior pharynx and oral cavity.

Some other more uncommon risk factors for development of PPOELs include chronic mucocutaneous candidiasis, particularly in those who are immunocompromised. This has been shown to be independent of tobacco or alcohol exposure. This must not be confused with acute pseudomembranous

candidiasis which shows no proof of driving the evolution of PPOELs. Oral Lichen planus has also been identified as a potentially malignant disorder with 1.09% chance of malignant transformation with the tongue being the most common location for this to occur. Finally, associations with OSCC formation has been identified in patients with Scleroderma and some genetic disorders including Fanconi Anemia, Bloom Syndrome, and Dyskeratosis Congenita.

Keeping all of these possible etiologic factors in mind during the subjective medical history exam can aid and alert the clinician when a positive finding during an oral cancer screening occurs. However, all patients regardless of past medical or social history should undergo a thorough oral cancer screening at each visit as early detection has been shown to be the most important factor in oral cancer treatment survival.

DR. MARK GARDNER; RESIDENT, ORAL AND MAXILLOFACIAL SURGERY, VCU MEDICAL CENTER

Efficacy of Corticosteroids Versus Placebo in Impacted Third Molar Surgery: Systematic Review and Meta-Analysis of Randomized Controlled Trials

ALMEIDA R, LEMOS CAA, DE MORAES SLD, PELLIZZER EP, VASCONCELOS BC. | INT J ORAL MAXILLOFAC SURG. <https://doi.org/10.1016/j.ijom.2018.05.023>

The aim of the study was to perform a systematic review of the literature to determine the efficacy of corticosteroids in the control of postoperative pain, edema, and trismus after extraction of impacted mandibular third molars. The meta-analysis compared 17 randomized control trails and included 730 patients ages 15-35. Each of the studies compared the administration of a steroid during the pre-operative or post-operative period against a placebo group. There was variation between the studies with regards

to route of corticosteroid administration, dose of corticosteroid, and duration of treatment. The corticosteroids included dexamethasone (9), betamethasone (2), methylprednisolone (5) and prednisolone (1). Of the studies considered, 16 of 17 found the use of corticosteroids to have a positive effect with regard to the control of the pain, edema, and trismus associated with the surgical removal of impacted mandibular third molars. With the exception of the submucosal route, the route of administration did not seem

to influence the results, making the oral route an easy and cost effective option. The administration of a corticosteroid in the preoperative phase was superior to its use in the postoperative phase for the control of trismus. A single preoperative dose of dexamethasone was the most commonly utilized intervention among the trials.

DR. LAUREN KAPLAN; RESIDENT, ORAL AND MAXILLOFACIAL SURGERY, VCU MEDICAL CENTER

Efficacy of Buccal Infiltration Anesthesia with Articaine for Extraction of Mandibular Molars: A Clinical Trial

RAYATI F, NORUZIHA A, JABBARIAN R. | BR J ORAL MAXILLOFAC SURG. 2018; 56(7):607-610

Utilization of the inferior alveolar nerve (IAN) block for pulpal and lingual soft tissue anesthesia during mandibular molar extractions has multiple drawbacks including complexity of administration, a high failure rate, and postoperative complications including trismus, hematoma formation and paresthesia, to name a few. This study assessed the efficacy of 4% articaine versus 2% lidocaine in obtaining adequate pulpal and soft tissue anesthesia during mandibular molar extractions when deposited as a local infiltration at the buccal vestibule. This was a double blinded controlled clinical trial comparing pain scores at the mesial, distal, buccal and lingual sides of mandibular molars following local infiltration of the previously mentioned anesthetics in 133 patients. Pain was measured via subjective responses of "yes" or "no" during probing

or dissection. Any sensation reported during the entirety of the procedure was considered a failure. If sensation was reported, inferior alveolar nerve blocks were then administered. Findings were consistent with the current consensus that to achieve adequate mandibular molar anesthesia for extractions, an inferior alveolar nerve block is superior to buccal infiltration given limitations of diffusion through thick cortical bone. Articaine was, however more successful in obtaining pulpal anesthesia (18/72 subjects) when compared to lidocaine (1/61 subjects). This study highlights the importance of honing one's skill for obtaining pulpal and lingual soft tissue anesthesia using the inferior alveolar nerve block, as buccal infiltration is limited in its capabilities to do so. Although complication rates are

higher with the IAN block, its efficacy is far superior to local infiltration for the purposes of mandibular molar extractions.

CHRISTOPHER LOSCHIAVO, DMD; RESIDENT, ORAL AND MAXILLOFACIAL SURGERY, VCU MEDICAL CENTER

Surgical Outcomes for Suture-Less Surgery in 366 Impacted Third Molar Patients

WAITE PD, CHERALA S. | J ORAL MAXILLOFAC SURG. 2006; 64(4): 669-73

Several techniques have been described for the surgical removal of impacted third molars. Most surgeons agree that factors such as length of operation, difficulty of impaction and amount of trauma inflicted are important factors in developing post-operative complications. The authors of this study wanted to investigate the post-operative complications associated with primary versus secondary closure techniques of the third molar mucoperiosteal flap.

This retrospective study reported the surgical outcome of a single practitioner's third molar procedure and compared it to results in existing literature. The standard surgical technique started with a 20 second rinse with chlorhexidine. A pre-op dose of 900 mg IV clindamycin, as well as 8 mg dexamethasone, was given. Anesthesia was then induced with 5 mg midazolam, 100 mcg Fentanyl and/or propofol and local anesthesia was then administered. A small V-shaped incision was then made, with one limb extending from obliquely from the distobuccal line

angle of the second molar and the second limb extending down vertically, being careful to avoid the gingival sulcus of the second molar. No attached tissue was removed. The flap was then elevated towards the distal and lingual. The tooth was then sectioned and removed. All sockets were inspected and lightly curetted. The mucoperiosteal flap was then allowed to fall into natural position and sutures were not placed.

Of the 366 patients enrolled in the study, 93 experienced at least one complaint after third molar surgery. The incidence of mandibular third molar alveolar osteitis was 8.7%. The complaint of pain, which was identified as a score of 3/10 or higher on visual analog scale, occurred in 66 patients. Maxillary third molars had an incidence of post-operative pain in 4.61% of patients and mandibular third molars had an incidence of 5.9%.

The authors argue that in the posterior dental arch, the anatomy of the ramus, tuberosity and buccal mucosa will allow

for passive closure of the mucoperiosteal flap. They also argue that tight closure over a large bony socket does not facilitate adequate drainage or oral hygiene. In the author's words, "suturing may create a one-way valve that allows food debris to enter the socket but not easily escape." This may lead to inflammation, alveolar osteitis and possible infection. They also note that the placement of sutures increases time of surgery, soft tissue trauma and increases cost of surgery. If the authors were to open one packet of plain gut suture for each patient in the study, the cost would have been \$1098.00!

Overall, the authors propose an alternative method of managing a third molar mucoperiosteal flap that decreases overall time and cost of surgery, while demonstrating minimal complications.

DR. BALRAJ KANG; RESIDENT, ORAL AND MAXILLOFACIAL SURGERY, VCU MEDICAL CENTER

Dental Implants in Patients with Osteoporosis: A Systematic Review with Meta-Analysis

DE MEDEIROS F, KUDO G, LEME BG, ET. AL. | INT J ORAL MAXILLOFAC SURG. 2018; 47(4): 480-491

Osteoporosis is common skeletal disease especially in the aging population. It is characterized by low bone density in human bone and tissues due to an imbalance of bone remodeling leading to an overall decrease in bone volume and quantity. Dental implants are a highly effective option for patients who are totally or partially edentulous to help recover their chewing function. There is little

known about the interactions between osteoporosis and implant survival but there is evidence that implants placed in low density bone (type IV bone) are at higher risk for failure.

This study is a systematic review that was performed to evaluate survival rate of osseointegrated implants in patients with osteoporosis. The researchers asked two

questions during their literature review. The first was whether or not implants in patients with osteoporosis would have the same survival rate as patients without osteoporosis. The second was whether patients with osteoporosis have similar peri-implant bone loss compared to patients without osteoporosis. The

database search led to a total of 582 articles, from which 15 articles were chosen for quantitative analysis yielding a total of 8,859 patients and 29,798 implants with the average patient age being 63.03 years. Ten articles included patients with and without osteoporosis: 702 implants were placed in patients with osteoporosis with 33 failures (4.70%) and 4114 implants were placed in healthy patients, with 147 failures (3.57%). There was no statistically significant difference between the two groups. When comparing patients instead of individual implants there was still no

statistical difference between the two groups: 11 of 118 (5.85%) patients with osteoporosis had implant failures while 17 of 348 (4.89%) healthy patients had implant failures. Although there were no differences in failure rates there was a significant difference in peri-implant bone loss with the osteoporosis group on average having 0.18mm increased bone loss.

In conclusion, implants placed in patients with systemic osteoporosis did not present higher failure rates than those placed in

patients without osteoporosis although they did have greater marginal bone loss. While the bone loss was greater whether or not that is considered to be clinically significant is up for debate. An increased loss of 0.18 mm of bone over 1-7 years would be an acceptable amount in clinical practice for most providers.

DAN TRAN, DDS; SENIOR RESIDENT, ORAL AND MAXILLOFACIAL SURGERY, VCU MEDICAL CENTER

Hyperbaric Oxygen Treatment Did Not Significantly Affect Radiation Injury in the Mandibular Area of Rats

SØNSTEVOLD, T ET AL. | ORAL SURG ORAL MED ORAL PATH ORAL RAD. 2018; 125(2): 112 - 119

Head and Neck cancer, specifically squamous cell carcinoma, is a prevalent and deadly disease, specifically when untreated. The mainstays of treatment are surgical resection and radiotherapy. As such, while access to high quality medical care in the United States continues to grow, health care providers often find themselves treating more patients with a history of radiation therapy to the jaws from squamous cell carcinoma of the head and neck. Radiation therapy is postulated to cause sclerosis of the intima of blood vessels, causing their lumens to functionally shrink after therapy. Traditional training in these patients is to provide hyperbaric oxygen (HBO) prior to invasive surgery of the jaws, i.e. dental extractions, to account for the increased oxygen demand necessary for healing.

This study was conducted in male rats of a certain species which were standardized for environment. The rats were divided into either a series of control groups or one of four treatment groups. The treatment groups received standardized radiation therapy to the anterior mandible. All of the treatment groups received 5 individual

sessions of 15 Gy of radiation every other week for a total of 8 weeks.

The first treatment group received HBO therapy every weekday for the 2 weeks between radiation treatments starting immediately after the first dose. The next group received their radiation therapy as described then received HBO for 6 weeks immediately after. The third group received HBO every weekday for 6 weeks starting 6 weeks after the last radiation dose. Finally, the last group received HBO 3 days per week after a 6 week lag following radiation therapy. Ultimately, the rats in groups 1 and 2 were sacrificed 6 weeks after radiation therapy. Groups 3 and 4 were sacrificed 6 weeks later due to the lag week following radiation therapy in those groups.

Results were interpreted in several ways: First, gross appearance of the radiation sites was inspected. As with other studies, the rats suffered from alopecia and dermatitis in all the treatment groups with no change in any of the HBO groups. Next, salivation of the irradiated animals was quantified and no improvement in output

was noted in any of the HBO groups. The submandibular glands were histologically examined next, with no change seen in the radiated versus HBO groups. Gingiva and periodontal membrane were analyzed which showed hyperkeratinization, fibrosis, inflammation, and fewer blood vessels. Those changes were not reversed or improved by HBO. Tooth formation was evaluated, with changes seen in radiation groups not improved by HBO. Finally, vascular density was analyzed. None of the post-radiation changes were improved by HBO.

In a series of irradiated rats compared to the same rats who completed HBO therapy, very little benefit was evidenced from the addition of HBO. There were ultimately 2 animals in group 3 who showed unaffected tooth formation. Overall, the impact of these findings is uncertain. More studies are needed with larger populations and in humans.

CHRIS ABERNATHY, DMD; RESIDENT, ORAL AND MAXILLOFACIAL SURGERY, VCU MEDICAL CENTER

Does an Association Exist Between the Presence of Lower Third Molar and Mandibular Angle Fractures? A Meta-Analysis

RUELA W, DE ALMEIDA VL, LIMA-RIVERA, LM ET. AL. | J ORAL MAXILLOFAC SURG. 2018; 76(1): 34-45

One of the more frequently held conversations in an oral and maxillofacial surgeon's office is the concept of observation versus extraction of third molars, and the risks/benefits/alternatives to both treatment modalities. The risks associated with observation of impacted third molars have been studied at length; several examples being risk of infection, localized periodontal disease, development of pathology, becoming symptomatic, and possible damage to adjacent teeth. Although increased risk of mandibular fracture has been mentioned previously, this study sought to provide statistical evidence showing an increased incidence of mandibular fracture in the setting of impacted wisdom teeth.

The study was completed as a systematic review and meta-analysis of analytical observational studies, looking at mandibular fracture rate in relation to varying degrees of impacted third molars (degree of impaction described according

to the Pell and Gregory classification—a commonly used system that describes vertical/horizontal impaction in relation to the ascending ramus and vertical degree of impaction). An electronic search was completed in PubMed, Scopus, Scielo, Google Scholar, OpenGrey, Caribbean Health Science databases, the results of which were reviewed by two analysts. The primary predictor variable was mandibular fracture in the presence of impacted third molars, the second outcome variable being the degree of impaction based on the Pell and Gregory system.

The initial search revealed 411 previous studies, however this was reduced to 16 studies after inclusion/exclusion criteria was applied. The association meta-analysis which included all selected studies showed patients with impacted lower third molars are 3.16 times more likely to have a mandibular fracture. A proportion meta-analysis was completed using 5 of the studies which revealed

overall rate of mandibular angle fractures was 51.58% with levels III and C (greatest degrees of impaction according to Pell and Gregory) being the most likely associated with fracture (59.84, 63.67% respectively).

The evidence provided by this study by itself is not significant enough to require prophylactic extraction of all impacted wisdom teeth, however the 3.16 times increased risk of fracture should definitely be considered when discussing recommended treatment with a patient (especially with deeply impacted third molars). Every case of impacted wisdom teeth is unique to each patient, and it should be the practitioner's responsibility to know and discuss the risks of any suggested management.

CHARLIE BOXX, DDS; RESIDENT, ORAL AND MAXILLOFACIAL SURGERY, VCU MEDICAL CENTER

Immediate Function Dental Implants Inserted With Less Than 30 Ncm of Torque in Full-Arch Maxillary Rehabilitations Using the All-on-4 Concept: Retrospective Study

MALO P, LOPES A, DE ARAUJO N, FERRO A. | INT J ORAL MAXILLOFAC SURG. 2018; 47(8): 1079-1085

The approach for proper implant placement leading to subsequent success varies among different providers. Some of the variables include implant insertion torque, surgical technique, size of implant placed, and choice of immediate versus conventional load among others. Most clinicians aim for an insertion torque greater than 30 Ncm to achieve primary stability, because low insertion torque has been previously considered to be a

potential risk factor for implant failure. This study assessed the short-term implant success rate and marginal bone loss in full-arch fixed maxillary rehabilitations supported by implants in immediate function with the All-on-4 treatment concept placed with insertion torque of less than 30 Ncm or greater than or equal to 30 Ncm. A total of 332 implants were placed in 83 full-arch maxillary rehabilitations, with 120 implants inserted

at an insertion torque of less than 30 Ncm and 212 implants inserted with an insertion torque of greater than or equal to 30 Ncm. Evaluations were performed at ten days, two months, four months, six months and one year. Implant success was defined as fulfilling the professed function as support for reconstruction, stability of implant upon testing, no signs

of infection, no radiolucent areas around the implants, good esthetic outcome for restoration, and allowed fabrication of an implant-supported fixed prosthesis, which allow for adequate hygiene and patient comfort. Marginal bone loss was assessed using periapical radiographs on the day of surgery and at one-year of function to evaluate marginal bone levels. The case majority of rehabilitations had one implant inserted with an insertion torque of less than 30 Ncm and three implants inserted with an insertion torque greater than or equal to 30 Ncm. After compiling the data it was found that the cumulative implant success rate for implants inserted with less than 30 Ncm was 98.3% and

97.5% for implants inserted at greater than or equal to 30 Ncm. The mean marginal bone loss at one-year was 1.14 mm for implants inserted at less than 30 Ncm and 1.39 mm for implants inserted at greater than or equal to 30 Ncm demonstrating a significant difference ($P < 0.001$). Although the majority of full-arch rehabilitations included both high and low insertion torque implants, the sample size included five patients that had all four implants inserted with low insertion torques. This state did not effect the survival or marginal bone loss of the implants. Unfortunately the assessment of the low insertion torque implants did not receive long-term follow up; however it can be concluded that

implants inserted with less than 30 Ncm of torque in the All-on-4 concept demonstrate comparable short-term success outcomes and less marginal bone loss compared to implants inserted with greater than or equal to 30 Ncm of torque.

MICHAEL THEISS, DDS; RESIDENT, ORAL AND MAXILLOFACIAL SURGERY, VCU MEDICAL CENTER

Effectiveness of Irrigation with Chlorhexidine After Removal of Mandibular Third Molars: A Randomized Controlled Trial

E CHO H, DAVID MC, LYNHAM AJ, HSU E. | BR J ORAL MAXILLOFAC SURG. 2018; 56(1):54-59

The use of perioperative chlorhexidine in conjunction with the extraction of third molars has been the subject of much study. In this article, the use of chlorhexidine as a rinse (i.e. "swish and spit") versus as irrigation (i.e. direct injection with a curved syringe) was examined to determine the effect on postoperative pain, swelling, trismus, infection, alveolar osteitis, wound dehiscence, and food impaction 48 hours and seven days postoperatively.

The study was performed in South East Queensland, Australia, between 2014 and 2016, and it was based out of three private dental practices. One hundred patients were randomly selected via a sealed envelope method to be either in the chlorhexidine rinse group or the chlorhexidine irrigation group. The original patient pool from which the random selection was completed consisted of patients who were otherwise healthy, without history of radiotherapy, diabetes, organ transplant, bisphosphonate use, steroid use, or history of smoking. The study was single blind, as the participants

knew their respective intervention (swish versus irrigate), but the providers who met with them in follow-up were unaware of their intervention status. Efforts were made to control for difficulty of teeth according to Freudlisperger score, and the procedures were isolated to mandibular third molars that required flap elevation and removal of bone. Follow-up evaluation was completed at 48 hours and seven days post operatively, where the provider examined the patient for objective and subjective complaints, which were standardized and quantified for statistical analysis between the swish and injection group.

Of the original 100 participants, 47/50 completed the irrigation protocol and 48/50 completed the rinse protocol with 5 patients being lost to follow-up. Results from the study revealed that the irrigation group experienced significantly less alveolar osteitis, frank infection, food impaction, and facial swelling at postoperative day seven per definitions and criteria established by the study. Pain was also significantly lower in the irrigation

group at postoperative day seven, but was insignificantly higher in the irrigation group 48 hours postoperatively. Additional outcome variables of trismus and wound dehiscence were equivocal.

Applying the results of this study, researchers concluded that routine irrigation of sockets post operatively lessened the extent of complications associated with third molar extraction. Limitations included the lack of a saline control group and the use of only healthy patients. Additionally, all mandibular third molar sites in this article were closed primarily, so the study did not address the effects of these interventions on open sockets. Further research may address these deficiencies to further augment the understanding of the role of chlorhexidine rinsing and irrigation with respect to the extraction of third molars.

DR. CHRISTOPHER RAY; RESIDENT, ORAL AND MAXILLOFACIAL SURGERY, VCU MEDICAL CENTER



Foundation

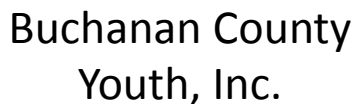
VIRGINIA DENTAL ASSOCIATION

2017-18 Sponsors and Supporters...

Thank You for Your Generosity!

The generosity of our Sponsors and Supporters helps ensure that we not only improve the oral health of thousands of Virginia each year, but it also helps make the VDAF a stronger and more sustainable organization.

We **TRULY APPRECIATE** the companies, foundations, and individuals who fully embrace our mission to provide access to dental care for underserved Virginians.





MOM TURNS 100

A NEW LOCATION IN WISE

Dr. Ronald N. Vranas

Missions of Mercy (MOM) just celebrated its 100th event this past July with another free dental clinic in Wise County, VA. For nearly two decades, this southwest Virginia location has been home to yearly MOM projects. Nearly 24,000 southwest Virginia residents have received free dental care valued at \$20.3 million over these twenty years.

2018 marked the first year that the Wise County Fairgrounds did not play host to the MOM project. For the first time, there were no patients sitting in the hot sun waiting for their number to be called. Gone were the beads of sweat streaming down sunburnt faces. Gone were the torrents of water coursing through “Tarp City” from sudden rainstorms that threatened to shut the system down and stop a handpiece or an overhead light source in the middle of treatment. This year, patients and providers alike were housed in an air conditioned, state-of-the-art convocation center on the UVA-Wise campus only a few miles away. Everyone could sit bug, heat, and rain-free with a beautiful lake view just outside the floor to ceiling windows. What an upgrade! To be honest, when I arrived from Richmond with my family in tow and saw the new facility, I felt nostalgic about our prior experiences of braving the elements together. That was until the next day when I heard a large boom and looked up from my patient to see a huge rainstorm outside. Yet there we were dry as a bone, handpiece whirring ... and treatment continued, uninterrupted and comfortable.

Within the walls of this new facility, many stories of hope were playing out. Like the mom that had her whole mouth rebuilt over a few hours--root canals, restorations and extractions--which allowed her to have the

confidence to smile just in time to watch her son graduate from Parris Island as a new United States Marine. Like seeing the relief on a young man’s face after he discovered that the pain he had been enduring for weeks was just relieved by multiple root canals and restorations rather than having extractions that would have left him toothless. These stories and many others like them play out at Wise every year.

As an endodontist in Richmond, I have been coming to Wise County with my family for many years and with each visit we look forward to meeting new people

and learning their story. It is always an honor to collaborate with and serve alongside the finest hygienists, dentists and specialists in Virginia and beyond. These providers drive for hours and even days to help. A special bond is formed because of our time spent together working for the common good of humanity. Please consider joining this growing group of individuals next year and become a part of the Wise story.

Editor’s Note: Dr. Vranas practices at Commonwealth Endodontics in Richmond.



UVA-Wise Convocation Center. Photo Credit: Tim Cox



A GIFT FOR MOM

ANTHEM BLUE CROSS AND BLUE SHIELD AWARDS \$35,000 GRANT

Tara Quinn, Executive Director, VDA Foundation

This year, the MOM program in Appalachia was once again grateful to have the support of the Anthem Blue Cross and Blue Shield Foundation (ABCBSF). The Foundation awarded a grant for \$35,000 to support the Mission of Mercy (MOM) dental clinics in Wise and Grundy, VA and to implement a Diabetes Prevention and Management Education Program in that region. The Foundation's support will also allow the VDAF to purchase supplies for 2018 MOM projects as well as help replace or repair mobile dental equipment.

"Anthem is proud to support the Virginia Dental Association Foundation," said Mau-

reen Dempsey, M.D., senior clinical officer, Anthem Blue Cross and Blue Shield. "Studies have shown that oral health can significantly impact the quality of our overall health. By working with the VDAF to support the Missions of Mercy, we can help those in need get access to dental care and in turn, positively impact overall health."

The Diabetes Prevention and Management Education aspect of the program aims to improve the health outcomes for adults with type 2 diabetes and for those at risk. For an even greater impact, the VDAF will partner with The Health Wagon to work with a select number of patients with type 2

diabetes to manage their chronic condition and improve their overall health. Materials on diabetes prevention/management and smoking cessation will also be provided.

Barry Isringhausen, president of the VDAF, stated, "There is an ever-growing body of research that clearly shows treatment of periodontal disease can be of significant benefit to diabetic patients as they manage this chronic disease. The VDAF is most grateful to the Anthem Foundation for its generous support of our work on this important health issue and we look forward to further collaboration with them on this project."

SIP SMART

VCU DENTAL HYGIENE STUDENTS EDUCATE AT SUMMER PROGRAM IN RICHMOND

Meg Dean and Becca Fields, VCU Dental Hygiene, 2019

We had the opportunity to be involved with the Summer Academics Club, which is an eight-week outreach program to provide academic assistance, ministry, health and nutrition information and safety education to youth and is held at Mt. Calvary Baptist Church in Richmond. Our goal was to provide engaging and meaningful education to the 30 students involved regarding their oral health. Each week, we visited the kids for an evening session. During the first week, we provided an overview on the importance of oral hygiene and its relationship to overall health. We discussed the impact nutrition plays on oral health and demonstrated our key points with a "SIP SMART" board depicting sugar levels in common drinks and what happens to a boiled egg when

left in coke overnight, telling the students the eggshell is similar to our tooth surface. The second week we engaged the middle and high school students in an hour long conversation discussing the importance of fluoride, pH and its levels in the mouth, acid foods, systemic diseases related to oral health, dentition eruption and purpose and much more. The third and final week, we brought disclosing tablets and taught the kids what having "pink" on their teeth means and discussed the roles of our teeth and basic nutrition for the Pre-K through elementary students. The students and chaperones were given oral hygiene bags with toothbrushes and toothpaste from the Virginia Dental Association and checklists for them to be able to put into practice the topics we discussed over the course of

our three sessions. We were so grateful to be a part of this experience and look forward to passing our resources on to the next class to continue this opportunity to educate these children in the Richmond community.





DIGITAL TECH AT VCU

CAD-CAM AND 3D DECREASE CHAIR TIME

Sebastian Viski, Associate Editor; Class of 2020, VCU School of Dentistry

Are you tired of tedious lab procedures, stone model discrepancies, poor bonding of impression material to the tray, and lengthy appointments? Then digital dentistry is calling your name. The VCU School of Dentistry incorporates the use of digital dentistry within the first year of dental school; specifically with Computer Aided Design-Computer Aided Manufacturer or simple CAD-CAM technology. Upon the first year of dental school, students are given lectures on the system's plethora of uses and functions. Usage of the CAD-CAM system begins the second year. VCU's second year fixed prosthodontics class provides rotations through the CAD-CAM lab. Dental students mastering the crown and bridge class are able to scan their own dental models and design their own crowns.

The real experience comes in the third and fourth years in which students access the use of CAD-CAM during clinical rotations. The work flow of CAD-CAM in the clinics begins with crown preps, virtual impressions, and designing of the crown during the morning clinic session, and sintering and delivery of the crown in the afternoon clinic session. Yes, that is right! Same day permanent crown production and delivery is achieved for the patients seen at VCU Dental Care. Compared to traditional alginate impression, virtual impressions are easier for both the provider and for the patient. CAD-CAM digital impressions are more accurate and only take about five minutes, as opposed to regular impressions in which the material is mixed and placed in the patient's mouth with a time limit to harden and correctly capture the negative copy of patient's teeth and soft tissues. Virtual impressions and digital designing are easy to use especially because the dental

provider possesses the knowledge of how the tooth was prepped and where the margins of the prep were placed. This decreases fitting errors. The patients love digitally scanned impressions and are happy to avoid messy, gag-inducing impression taking.

VCU SOD has the privilege of offering this technology to patients through Sompop Bencharit, D.D.S., Ph.D. who is the leader in digital dentistry application. Dr. Bencharit and his team not only focus on implementing the technology in the pre-doctoral clinics, but also collaborate with the school's graduate programs. With the help of the portable imaging scanner and lab's 3D printer, students can print almost any structure of the stomatognathic system. For example, a 16 year old female with an asymmetrical mandible recently presented to VCU's dental clinic. The symptoms and radiographic analysis were consistent with fibrous dysplasia of the left side of the mandible. Essentially, her normal bony tissue and marrow was replaced by fibrous tissue. The malformed tissue became weak and prone to expansion causing fractures, functional impairment, and pain. Dr. Bencharit and his team were able to scan and 3D print a copy of the mandible in his lab, and pass it onto the patient's oral surgeon to serve as an identical physical practice model prior to operating on the patient.

VCU's use of digital technology does not stop there: using this technology, students can print implant-guided stents for implant surgeries ranging from single implants to all-on-four cases. This technology can be further translated into use in private practice, allowing general dentists to allocate less time for a single crown appointment. Dentists in private

practice only need a two hour appointment to generate a single crown. The crown prep takes approximately 30 minutes, followed by five minutes for scanning, Nine to 15 minutes for milling, two minutes to achieve proper fit by making occlusal and interproximal adjustments, 25-30 minutes for sintering, and ten minutes to cement and deliver the crown. Digital dentistry allows dentists to make efficient use of their practice time; during the sintering process, most dentists can see a second patient for simple operative or hygiene checks.

CAD-CAM is not a replacement of our conventional methods; however, it bridges with modern dentistry to decrease patient chair time, decrease lab work and definitively increase patient satisfaction. When it is all said and done, digital dentistry is able to provide the highest quality of work in the shortest amount of time.

WELCOME NEW MEMBERS

THROUGH SEPTEMBER 1, 2018

Contact Sarah Mattes Marshall, Membership Advocate, to get involved.
804.523.2189 or mattes@vadental.org

Tidewater DENTAL ASSOCIATION

- Dr. Ryan Dodge – Suffolk – Marquette University School of Dentistry 2018
- Dr. Haley Julian – Norfolk – University of Tennessee Graduate School of Medicine 2018
- Dr. Kelsey Knuth – Chesapeake – University of Louisville School of Dentistry 2018
- Dr. Ryan Reitano – Virginia Beach – University of North Carolina Chapel Hill 2018
- Dr. Tanvir Singh – Townsend – Virginia Commonwealth University School of Dentistry 2018
- Dr. Michael Snyder – Chesapeake - Virginia Commonwealth University School of Dentistry 2018

Peninsula DENTAL SOCIETY

- Dr. Goutom Bhowmick – Hampton – New York University College of Dentistry 2018
- Dr. Patricia Flores – Williamsburg – Virginia Commonwealth University School of Dentistry 2018
- Dr. Isaac Goode – Williamsburg – Virginia Commonwealth University School of Dentistry 2018
- Dr. Rasha Hamouri – Williamsburg – Columbia University College of Dental Medicine 2018
- Dr. Devin McClintock – Williamsburg – State University of New York at Buffalo School of Dental Medicine 2016

- Dr. Hoang-Cam Nguyen – Williamsburg – Rutgers School of Dental Medicine 1993
- Dr. Ryan Shuck – Williamsburg – University of Michigan School of Dentistry 2018
- Dr. Corrie Swihart – Newport News – Indiana University School of Dentistry 2016

Southside DENTAL SOCIETY

- Dr. McAllister Castelaz – Carrollton – Boston University Goldman School of Dentistry 2017
- Dr. Travis Faber – Chester – Virginia Commonwealth University School of Dentistry 2018
- Dr. Katelyn Lindberg – Emporia – Virginia Commonwealth University School of Dentistry 2018
- Dr. Krystal Mattox – North Chesterfield – University of Maryland Dental School, Baltimore College of Dental Surgery 2018
- Dr. Ashley Pollard – Kenbridge – Howard University College of Dentistry 2013
- Dr. Kim Van – North Chesterfield - Virginia Commonwealth University School of Dentistry 2018
- Dr. Hanna Varno – North Chesterfield - Virginia Commonwealth University School of Dentistry 2018

Richmond DENTAL SOCIETY

- Dr. Abdullah Alawadhi – Richmond – Virginia Commonwealth University School of Dentistry 2015

- Dr. Nathaniel Armistead – Richmond – Virginia Commonwealth University School of Dentistry 2018
- Dr. Hina Asghar – Richmond – Virginia Commonwealth University School of Dentistry 2018
- Dr. Joseph Bartholomew – Richmond – University of North Carolina School of Dentistry 2018
- Dr. Abby Becherer Bartholomew – Richmond – University of North Carolina School of Dentistry 2018
- Dr. Erin Block – Midlothian – Virginia Commonwealth University School of Dentistry 2018
- Dr. Catherine Born – Richmond – University of North Carolina Chapel Hill 2015
- Dr. Sean Eccles – Richmond – Stony Brook University School of Dental Medicine 2018
- Dr. Erik Foisy – Glen Allen – University of Nevada Las Vegas 2014
- Dr. Matthew Gaynier – Richmond – Virginia Commonwealth University School of Dentistry 2018
- Dr. Matthew Graham – Richmond - Virginia Commonwealth University School of Dentistry 2018
- Dr. Toan Ho – Richmond - Virginia Commonwealth University School of Dentistry 2018
- Dr. Sara Holden --Richmond – Virginia Commonwealth University School of Dentistry 2018
- Dr. Matthew Holland – Mechanicsville – Virginia Commonwealth University School of Dentistry 2018

MEMBERSHIP

- Dr. Riley Hunsaker – Richmond – University of Utah School of Dentistry 2018
- Dr. Emma Jeffrey – Glen Allen – University of Pittsburgh School of Dental Medicine 2009
- Dr. Matthew Kittrell – Richmond - Virginia Commonwealth University School of Dentistry 2018
- Dr. Shannon Kittrell – Richmond - Virginia Commonwealth University School of Dentistry 2018
- Dr. Pedro Lam – Richmond – Virginia Commonwealth University School of Dentistry 2018
- Dr. Robert Lunka – Richmond – Virginia Commonwealth University School of Dentistry 2008
- Dr. Andrew Lusk – Richmond – West Virginia University School of Dentistry 2018
- Dr. Michael Marotta – Goochland – Virginia Commonwealth University School of Dentistry 2016
- Dr. Connor McCall – Richmond – Virginia Commonwealth University School of Dentistry 2018
- Dr. Clint Meadows – Richmond – Virginia Commonwealth University School of Dentistry 2018
- Dr. George Michos – Richmond – Virginia Commonwealth University School of Dentistry 2018
- Dr. Shawn Mitchell – Richmond - Virginia Commonwealth University School of Dentistry 2018
- Dr. Behnaz Movahed-Ardakani – Henrico - Virginia Commonwealth University School of Dentistry 2018
- Dr. James Musselwhite – Richmond – University of Michigan School of Dentistry 2014
- Dr. Shillpa Naavaal – Richmond – University of Illinois at Chicago College of Dentistry 2011
- Dr. Owais Naeem – Richmond – Virginia Commonwealth University School of Dentistry 2018
- Dr. Michael Ngai – Richmond – Virginia Commonwealth University School of Dentistry 2018
- Dr. Raymond Pandez – Richmond – University of the Pacific Arthur A. Dugoni School of Dentistry 2016
- Dr. Hayley Parks – Richmond – University of Tennessee College of Dentistry 2018
- Dr. Jennifer Qian – Richmond – University of Maryland Dental School Baltimore College of Dental Surgery 2018
- Dr. Adam Rice – Richmond – University of Michigan School of Dentistry 2018
- Dr. Soheil Rostami – Richmond – Virginia Commonwealth University School of Dentistry 2018
- Dr. Christopher Shim – Richmond – Virginia Commonwealth University School of Dentistry 2018
- Dr. Jennifer Shim – Richmond – Virginia Commonwealth University School of Dentistry 2018
- Dr. Mathew Stafford – Midlothian – Virginia Commonwealth University School of Dentistry 2012
- Dr. Michael Theiss – Richmond – Stony Brook University School of Dental Medicine 2018
- Dr. David Voth – Midlothian – Virginia Commonwealth University School of Dentistry 2018
- Dr. Madison Wallace – Richmond – Virginia Commonwealth University School of Dentistry 2017
- Dr. LaJoi Wiggins – Richmond – East Carolina University School of Dental Medicine 2017

- Dr. Allison Williams – Richmond – Indiana University School of Dentistry 2018
- Dr. Nicholas Yesbeck – Midlothian – Virginia Commonwealth University School of Dentistry 2018



Piedmont DENTAL SOCIETY

- Dr. Ryan Eckley – Roanoke – University of Maryland Dental School Baltimore College of Dental Surgery 2018
- Dr. Nikki Hartline – Danville – Ohio State University College of Dentistry 2018
- Dr. Andrew Hessler – Danville – Ohio State University College of Dentistry 2018
- Dr. Michelle Humble – Roanoke – Virginia Commonwealth University School of Dentistry 2018
- Dr. Derek Ibarra – Roanoke – University of Minnesota School of Dentistry 2018
- Dr. Richa Mehta – Roanoke – Virginia Commonwealth University School of Dentistry 2018
- Dr. Pratikumar Patel – Danville - University of Kentucky College of Dentistry 2015
- Dr. Preston Stewart – Evington – Loma Linda University School of Dentistry 2016



Southwest Virginia DENTAL SOCIETY

- Dr. Kyle Nield – Radford – Canada/Dalhousie University 2018



Shenandoah Valley DENTAL ASSOCIATION

- Dr. Hamzeh Al Qublan – Lexington – University of Maryland Dental School Baltimore College of Dental Surgery 2018
- Dr. Hesham Aref – Front Royal – Tufts University School of Dental Medicine 2016

MEMBERSHIP

- Dr. Bryant Ash – Winchester – Virginia Commonwealth University School of Dentistry 2018
- Dr. Christopher Barta – Charlottesville – Virginia Commonwealth University School of Dentistry 2014
- Dr. Surbhi Chandna – Charlottesville – University of Pittsburgh School of Dental Medicine 2018
- Dr. Justin Feehan – Haymarket – University of New England College of Dental Medicine 2018
- Dr. Lena Levesque – Berryville – Tufts University School of Dental Medicine 2018
- Dr. Nasser Malek-Mohammad – Charlottesville – Virginia Commonwealth University School of Dentistry 2018
- Dr. Richard Sykes – Arrington - Virginia Commonwealth University School of Dentistry 2018
- Dr. Katie Voth – Centreville – Virginia Commonwealth University School of Dentistry 2018
- Dr. Pedram Eisapooran – Reston – New York University College of Dentistry 2018
- Dr. Hassan Farooq – Leesburg – Loma Linda University School of Dentistry 2017
- Dr. James Hancock – Leesburg – University of California – San Francisco 2003
- Dr. Christy Hark – Alexandria – Howard University College of Dentistry 2018
- Dr. Fadi Hasan – Vienna – University of Colorado Denver School of Dental Medicine 2011
- Dr. Rasha Hussein – Fairfax – Virginia Commonwealth University School of Dentistry 2018
- Dr. Benzon Huynh – Chantilly – Temple University The Maurice H. Kornberg School of Dentistry 2017
- Dr. Hala Imam – Reston --Virginia Commonwealth University School of Dentistry 2018
- Dr. Lina Jameel – Springfield - Virginia Commonwealth University School of Dentistry 2018
- Dr. Jae-Woo Jung – Falls Church – Howard University College of Dentistry 2018
- Dr. Courtney Killough – Leesburg – Virginia Commonwealth University School of Dentistry 2017
- Dr. Yonghyun Kim – Manassas – Temple University 2001
- Dr. Arian Kohi – Vienna – West Virginia University School of Dentistry 2018
- Dr. Valerie LaScala – Vienna – Boston University Goldman School of Dentistry 2018
- Dr. Wichayapha Manorak – Alexandria – University of Pennsylvania School of Dental Medicine 2017
- Dr. Kyung Cheon Min – Stafford – University of Detroit Mercy School of Dentistry 2018
- Dr. Aseel Mukbel – Ashburn – University of California at Los Angeles School of Dentistry 2016
- Dr. Alexandra Murty – Arlington – New York University College of Dentistry 2018
- Dr. Shahnaz Nia – Vienna – Augusta University College of Dental Medicine 2016
- Dr. Van Nguyen – Annandale - Virginia Commonwealth University School of Dentistry 2018
- Dr. Linda Oh – Stafford – University of Detroit Mercy School of Dentistry 2018
- Dr. Gunita Pahwa – Aldie – New York University School of Dentistry 2016
- Dr. Karen Pettit – Alexandria – Virginia Commonwealth University School of Dentistry 2018
- Dr. Andrew Pham – Fairfax – University of Minnesota School of Dentistry 2016
- Dr. Geeta Poudel – Leesburg – University of the Pacific Arthur A. Dugoni School of Dentistry 2017
- Dr. Leen Qutachi – Sterling - Virginia Commonwealth University School of Dentistry 2018
- Dr. Jared Reardon – Vienna – State University of New York at Buffalo School of Dental Medicine 2016
- Dr. Emily Rosenberg – Arlington – University of Minnesota School of Dentistry 2016
- Dr. Ahmed Saad – Vienna – University of Southern California 2009
- Dr. Rakeb Tilahun – Fairfax – Howard University College of Dentistry 2018
- Dr. Justin Whiting – Arlington – University of Maryland Dental School, Baltimore College of Dental Surgery 2010
- Dr. Daniel Winokur – Fairfax – A.T. Still University Arizona School of Dentistry & Oral Health 2014
- Dr. Stephanie Wu – Vienna – State University of New York at Buffalo School of Dental Medicine 2016
- Dr. Steve Yopa – Sterling – Meharry Medical College School of Dentistry 2017



Northern Virginia D E N T A L S O C I E T Y

- Dr. Vida Adjepon-Yamoah – Ashburn – University of Colorado Denver School of Dental Medicine 2018
- Dr. Monisha Batra – Fairfax – Tufts University School of Dental Medicine 2018
- Dr. Preeti Batra – Vienna – Virginia Commonwealth University School of Dentistry 2016
- Dr. Jennifer Castro-Chabrier – Dunn Loring – NY-Lutheran Medical Center, Dept. of Dental Service 2011
- Dr. Bilal Chaudhry – Manassas – Virginia Commonwealth University School of Dentistry 2018
- Dr. Dana Culda – Fredericksburg – MA-VA Boston Healthcare System 2011
- Dr. Michael Cusumano – McLean – Virginia Commonwealth University School of Dentistry 2018

VDA BOARD OF DIRECTORS

ACTIONS IN BRIEF - JUNE 22, 2018

1. **Approved:** The Council on Government Affairs' resolution in support of hiring a dental benefits staff member, as an employee of the VDA, to assist VDA members with dental insurance issues and problems.

2. **Defeated:** The following resolution:
Background: The CE reimbursement of up to \$4,000 per component was lost when funds from the VDSC were reduced. This has been a financial hardship for most components and some have had to reduce the number of CE meetings to one per year.
Resolution: The Council on Finance recommends that the component CE reimbursement of up to \$4000 per component per year be re-instated.
Budgetary Impact: \$14.00 per member (full dues paying equivalent).

The Board discussed the above recommendation at length and found that not all components are in need of financial help for CE. However, if there are components that have a significant financial need, the VDA should be in a position to help with the total health of a component in mind. To have funds available, if a component demonstrates that financial aid is needed, \$8,000 will be added to the Board of Directors' discretionary fund as part of the 2019 budget.

3. **Approved:** Partial funding of the DDS position of the Foundation, for one year, in the amount of \$23,280. This will be reflected in the 2019 budget.

4. **Approved:** The 2019 Budget as amended by the Board of Directors.

5. **Approved:** **Background:** The Peer Review and Patient Relations Committee and the Board of Directors approved the ADA Peer Review Manual as the official guide for complaint resolution. Therefore, the following Bylaw amendment is needed:
Resolution: Amend the VDA Bylaws as follows:
Article VII, §6 - Names and Duties of Standing Committees
6. Peer Review and Patient Relations Committee
b. Duties: It shall be the duty of this Committee: (1) to maintain liaison with component peer review and patient relations committees; (2) to hear and act on appeals resulting from actions of component society peer review committees; (3) to exchange information concerning effective ways of handling patient grievances and peer review.; ~~and (4) to keep the peer review manual current by proposing new and appropriate changes to the Board of Directors.~~
In all original hearings, actions on appeal, and other matters brought to the Committee, the Committee shall ~~conform~~ **follow** the provisions of the **ADA** peer review manual. The Committee shall meet at least one time a year and additional meetings scheduled at the call of the chair.

6. **Approved:** The Council on Government Affairs' recommendation that the VDA pursue legislation to be presented to the 2019 VA General Assembly to address problems associated with Silent PPOs. The Council will provide specific language for the proposed legislation.

7. **Approved:** The Marketing Task Force request to be restructured as the Council on Marketing.
Background: The VDA defines a Task Force as a group appointed to address a single task that should be short term, hopefully a year or less. The Marketing Task Force (previously the PR Task Force) was formed in 2012 and is still characterized as a Task Force. The work of the group continues and the scope of work is broad so the group feels that a change to a Council would be more reflective of the long-term work being done by members.

Duties:
 - To lead all marketing, advertising, branding and public relations efforts of the Virginia Dental Association
 - To support the established communications strategy of the VDA and serve as a focus group and resource to the Communications Department
 - To foster relationships among members to strengthen the VDA community
 - To promote the importance of oral health and to educate the public about oral health concerns.
 - To promote the Association and its programs to members, potential members and the dental community at large.
Composition:
 - The group will consist of up to ten member dentists who are interested in or have expertise in marketing.

IN MEMORY OF:

<u>Name</u>	<u>City</u>	<u>Date of Death</u>	<u>Age</u>
Dr. Richard D. Barnes	Hampton	July 20, 2018	74
Dr. Walter Bechtold	Vienna	July 1, 2018	74
Dr. Irving V. Behm	Hampton	June 11, 2018	96
Dr. Carol P. Burke	Annandale	December 13, 2017	61
Dr. David B. Crouse	Virginia Beach	September 2, 2018	81
Dr. Lionel Felsen	Fairfax Station	June 22, 2018	80
Dr. George R. Keough	Corolla, NC	December 10, 2015	82
Dr. Thomas Spillers	Richmond	April 16, 2018	75
Dr. Dennis Throckmorton	Wytheville	August 23, 2018	64
Dr. Charles B. Williams	Yanceyville, NC	February 11, 2013	85



Stan Brock at RAM Expedition #954 with Sister Bernie Kenny of The Health Wagon, 2018.

STAN BROCK

Stan Brock, the founder of Remote Area Medical, died August 29 of complications from a stroke. He was 82. He was a familiar figure to dental volunteers at the Wise and Grundy Missions of Mercy. A native of Preston, Lancashire, England, as a young man he traveled to British Guyana in South America to work as a cowboy or vaquero. In 1968 he began a career in television as co-host of "Mutual of Omaha's Wild Kingdom", which appeared on NBC. He founded RAM in 1985 to provide free medical and dental care to underserved areas, first outside the US, and then later within this country.

AWARDS AND RECOGNITION



DR. RANDY ADAMS
VDA Leadership Award



BONNIE ANDERSON
VDA Honorary Membership



DR. ERIKA A. ANDERSON
VDA New Dentist Award



DR. CAITLIN S. BATCHELOR
VDA Presidential Citation



DR. DAVID E. BLACK
VDA Leadership Award
VDA Presidential Citation



DR. TERRY DICKINSON
2018 Dentaquest Health Equity
Hero Award



DR. VINCE DOUGHERTY
VDA Leadership Award



DR. SCOTT H. FRANCIS
VDA Presidential Citation



DR. MONROE HARRIS
Board of Trustees President
Virginia Museum of Fine Arts

MEMBERSHIP



DR. BRUCE HUTCHISON
VDA Presidential Citation



DR. FRANK IUORNO
VDA Presidential Citation



DR. MICHAEL S. MORGAN
VDA Presidential Citation



DR. ROGER A. PALMER
VDA Presidential Citation



DR. ANTHONY PELUSO
Simmons Award
Tidewater Dental Association



DR. ELIZABETH REYNOLDS
VDA Presidential Citation



BARBARA ROLLINS
VDA Honorary Membership



DR. TED SHERWIN
Emanuel W. Michaels Distinguished
Dentist Award / VDA Presidential Citation



DR. CYNTHIA SOUTHERN
VDA Presidential Citation



DR. RONALD L. TANKERSLEY
VDA Presidential Citation



DR. CASSIDY L. TURNER
VDA Presidential Citation



Classifieds

VIRGINIA DENTAL ASSOCIATION

VDA Classifieds allows you to conveniently browse and place ads on the VDA website and in this publication. VDA Members can advertise with VDA Classifieds for FREE. Nonmembers are also welcome to place ads for a fee. Please visit vdaclassifieds.org for details on advertising with us.



JOBS Dentists

6019 - Partnership/Ownership Opportunity

Virginia: Partnership/ownership opportunity in fee-for-service and PPO, "Awesome College town" 2 location, \$4M revenue practice, high income/profit potential, top 1% of private practices in the nation, seeking additional owner in main practices or founding partner of 3rd location, pay off dental school debt quickly!, email inquiries to: damon@reallifedental.com
Contact: Alicia, alici@bfc.services

6037 - DENTIST (Hampton)

Busy Hampton, VA office is actively looking for a full-time or part-time Dental Associate that provides excellent general dentistry. This candidate must be a friendly, outgoing and a motivated General Dentist with at least 2 years of experience, a team player and ready to work! Great earning potential! Must have an active Virginia License. Please forward your resume to familydentistry11@yahoo.com or call 202-909-3675 ASAP! Our state-of-the-art dental practice is searching for a skilled and experienced Dentist with excellent communication skills to join our professional team. The ideal candidate for this position has worked with patients of all ages, is proficient in performing regular checkups and complex dental procedures and is committed to the highest quality of patient care. Those who are qualified and in search of a long-term career opportunity in a cutting edge practice are encouraged to submit an application today. Diagnose and provide appropriate dental treatment to patients, including regular cleanings, root canals, surgical extractions, implants and cosmetic dentistry -Educate patients and parents of patients on maintaining proper oral health -Communicate with dental staff on our team regarding patient treatment plans -Prescribe medications

as necessary -Carefully document all medications, diagnoses, treatments and consultations -Supervise the work of professional, technical and administrative staff.

6041 - Full Time Associate Dentist

Established dental office in Charlottesville, VA is looking to bring on a full-time associate dentist. Position has ownership opportunities, as the owner is looking to reduce his schedule, and allow more free time. The Associate Dentist would be absorbing an established patient base, as well as maintaining our steady flow of new patients and hygiene exams. Must be able to do Implants, crowns, dentures, and restorative dentistry. We are offering \$450-\$600 daily minimum or 35% collections whichever is greater. Relocation assistance available. PPO, FFS, and Self pay only- No medicaid or Medicare. Contact: Jay, 434-975-6181, dentistrybydesignville@gmail.com

6045 - Associate Dentist - Waldorf, MD 25 miles from DC

Every patient is different — at Fusion Dental, we get that. That is why our full-service practices provide comprehensive quality care for the entire family. Fusion Dental has 7 practices conveniently located to Greater Washington DC, Maryland and Virginia. We offer all the services and specialties to maintain a healthy smile including preventative care, hygiene/cleanings, general dentistry, orthodontics/braces and Invisalign, oral surgery, endodontics/root canals, cosmetic dentistry/veneers, implants, crowns, bridges, partial dentures, complete dentures, teeth whitening/bleaching, and pediatric/children's dentistry. Our goal is to help our patients maintain healthier mouths for overall good health. Contact Kate Anderson at kateanderson@amdpi.com to learn more.

6052 - Experienced General Dentist - Northern VA

GENERAL DENTIST NEEDED FOR GROWING PRACTICE: Very successful, high-quality state-of-the-art, multi-specialty perio-pros dental office looking for highly motivated, open minded experience individual who wishes to focus on providing highest quality dentistry while improving skills and becoming more productive/efficient. Great work environment with experienced and friendly staff. Excellent income potential. Please send your CV to dradili@idealdentalsolutions.com.

6055 - Associate opportunity

Excellent opportunity for an associate at Eastern Virginia Family & Cosmetic Dentistry. Recently renovated, state of the art facility has served Hampton Roads community for over 35 years. Practice sees 60-100 new patients a month and has an outstanding team of professionals to help ensure dynamic growth. The ideal candidate will have an AEGD, GPR or two years of equivalent experience. Individuals with good communication skills, high clinical standards, commitment to exceptional patient experiences and an ability to work independently are encouraged to apply. Mr. Roger Hill of the Blair McGill Hill Group L.L.C. recently visited and assessed that this would be an "extremely attractive" opportunity. If you have a genuine interest please email your CV and with it please include a narrative of what led you into the profession and a ranking of the specialties which you enjoy most to least. Contact: Clay, evadental2016@gmail.com

6090 - Part time associate

Looking for a enthusiastic, motivated, associate dentist in a busy west end practice. Contact: Dr. K, 804-874-5005



JOBS Dentists

6059 - Associate Dentist- Lynchburg, VA

Well established state-of-the-art Dental Practice in Lynchburg, VA is seeking a full time associate general dentist. In practice for over 50 years, Riley Dental Associates provides comprehensive and cosmetic care to adults and children and offers a competitive compensation package accompanied by a highly trained staff. Please email curriculum vitae or inquiries to cyndi@rileydentalassociates.com.

6075 – Associate Dentist

We are looking for a seasoned dentist who wants to join a growing practice in the Fredericksburg, VA area. Our practice has long-standing patient relationships as we have been serving the community for many years. We are a team of highly committed and passionate professionals, who provide exceptional care to patients through high-tech, digital equipment and personal attention. If you are an experienced leader awaiting your opportunity to be a partner with a fully established and busy practice, this may be just what you've been looking for. Contact: Jen Porter, 571-589-8078, jen@lightwavedental.com

6087 – Dental Associate

Seeking an associate in a small town in the beautiful Shenandoah Valley (Augusta County, VA). Our family and cosmetic solo practice is two generation family owned since 1960 and our doctor is ready to slow down. Recently renovated six operator office with a large patient base is located in area with broad, clean industrial support. Seeking an experienced, compassionate, motivated and team-oriented person with eventual buy out possibility. Send CV today and join a great, experienced team as we are ready to hire the right person today.

Contact: Casey sdlr.dentistry@gmail.com

6089 – DDS/DMD

Team Placement is a dental staffing firm based out of Old Town Alexandria. We have been in building careers for over 36 years. We offer permanent, temporary, and temp-to-hire positions in all areas of dentistry. Team Placement

Service provides an environment where continuous employee development is encouraged, and diversity is welcomed and respected. We have an immediate need for a DDS/DMD (General Dentistry) in Richmond, VA, Are you available? or do you know someone who may be interested? We have Temporary, Permanent and Per Diem opportunities! Schedule: Wednesday ,Thursday and Friday 7:45am- 5:00pm or Thursday & Friday (same schedule) from Oct. - Dec. DUTIES/ RESPONSIBILITIES:(Essential Functions: Duties and responsibilities noted with bullets are considered to be the essential functions of the job). Performs routine and comprehensive oral examinations, using X-ray as required Makes diagnoses and develops treatment plans Perform emergency evaluations and treatments Provide oral health education Performs prophylactic and restorative dental work as necessary Prescribes medications as necessary Makes referrals when necessary Collaborates with interdisciplinary team including medical and behavioral health providers Supervises onsite dental team members including hygienists and dental assistants Documents in electronic health record Participates in quality improvement initiatives Provides feedback as necessary to help improve quality, safety, and operations Participate in clinic and organization wide meetings Demonstrates highest levels of professionalism and ethics Performs other duties as assigned/ required QUALIFICATION/EDUCATION and/or EXPERIENCE REQUIREMENTS: Graduation from an accredited dental program with a Doctor in Dental Surgery (DDS) or a Doctor of Dental Medicine (DMD) Current license to practice dentistry in the Commonwealth of Virginia and DEA certification Knowledge of infection control procedures and universal precautions Skilled in full range of primary care dentistry Able to work with all age groups, including children and the elderly Contact: Team Placement, 800-495-6767, recruiting@teamplace.com

6099 – Associate Dentist

We are looking for a bright goal orientated team player to join our growing dental group! The ideal candidate will be a general practice dentist that can provide

all aspects of general dentistry including endodontics, restorative, implants, extractions and prosthodontics (fixed and removable). Our practices are state of the art, paperless and fully digital with very experienced and knowledgeable teams to help ensure your success! We also offer a competitive benefits packet that includes health insurance and 401k matching in addition to a compensation package designed to reward stellar production. If this interests you, send your resume to swvadental@gmail.com. Recent graduates are also encouraged to apply.

6103 – Dentist

Our Richmond, VA office is actively looking for a full-time/part-time Dental Associate who provides excellent general dentistry. This candidate must be a caring, outgoing Dentist with at least 2 years of experience, a team player and ready to work! Great earning potential! Contact: Dr. Mike, 804-901-7855, happysmilesrichmond@gmail.com

6104 - Full time/Part Time Associate

Position for General Dentist We have full time/part time associate position available for a general dentist in Arlington and in Leesburg. The candidate should have a strong restorative, endodontic skills who is ready to do good dentistry. We are looking for a serious candidate who wants to grow with the office. These positions are available immediately. For further details, please call or text at 215-806-5935 or email at jobs.dmds@gmail.com

6105 – Associate Dentist

Steven L Lang DDS Inc. is looking for a general dentist to join our incredible team at our Portsmouth Virginia location. This is an established practice with a steady stream of new patients and a prime location right on Portsmouth Blvd . We are not a large dental chain, family owned, and enjoy having solid relationships with our providers. Excellent compensation and awesome team! The ideal candidate will be able to do comprehensive dental treatment including Sleep Apnea, Invisalign, Extractions, and some Root Canals. Interested doctors please forward your resume to Kathy Imbimbo at cdwsll100@gmail.com



JOBS Dentists

6020 - Community Health Center Dentist

Southside Community Health Center, a Central Virginia Health Services community health center, located in Alberta, VA seeks a dentist to provide primary dental services. We operate in an integrated model of care where we work with primary medical care providers as well to collaborate on dental needs of patients with chronic diseases.. Competitive compensation and generous benefit package is available. Position available immediately. EOE For more information on Central Virginia Health Services please visit our website at www.cvhsinc.org Job Type: Full-time. Contact: Lori Kelly, 434-581-4073 ext. 10737 lorikelly@cvhsinc.org



JOBS Staff

6031 - Dental Assistants - Richmond Area

We're currently seeking experienced full-time and part-time dental assistants for multiple openings. We want individuals who are passionate about people, have excellent chair-side manners, and have a positive, upbeat personality. Previous experience preferred with X-ray certification. Must be CPR trained. Experience with dental software is a plus. Excellent salary and work environments. Complete our Online Profile to be considered for current and future positions. <http://www.lbdtransitions.com/create-a-profile.html>

6036 - DENTAL COORDINATOR/FRONT DESK

DENTAL COORDINATOR needed ASAP to join our fabulous and growing team. DENTAL EXPERIENCE REQUIRED. Duties include: answering phones, scheduling appointments, computer experience, attention to detail, multi-tasking, insurance coordination and customer service. Full time and Part time hours available. Compensation depends on experience. If your interested please email your resumes to: familydentistry11@yahoo.com

yahoo.com OR call 202-909-3675 ASAP! Applicants must possess the ability to work in a progressive environment. Busy Hampton, VA office is actively looking for a full-time or part-time DENTAL COORDINATOR. This candidate must be friendly, outgoing and motivated.

6038 - DENTAL HYGIENIST

Busy Hampton, VA office is actively looking for a part-time Dental Hygienist that provides excellent dentistry. This candidate must be a friendly, outgoing and a motivated Dental Hygienist with at least 2 years of experience, a team player and ready to work! Great earning potential! Must have an active Virginia License. Please forward your resume to familydentistry11@yahoo.com or call 202-909-3675 ASAP! Our state-of-the-art dental practice is searching for a skilled and experienced Hygienist with excellent communication skills to join our professional team. The ideal candidate for this position has worked with patients of all ages, is proficient in performing regular checkups and complex dental procedures and is committed to the highest quality of patient care. Those who are qualified and in search of a long-term career opportunity in a cutting edge practice are encouraged to submit an application today.

6054 - Part-time Dental Hygienist

Established Dental Practice in Charlottesville, VA, is seeking a part-time licensed Dental Hygienist to work 2-3 days/week. We are a friendly, patient-centered team of professionals. Hours are Monday-Thursday, 8am to 5pm. We are flexible as to days worked. Compensation is competitive. A permanent position, after one year, part-time "perks" accrue. Contact: Judy, 434-984-5995, kasmussendmd@yahoo.com



Products & Services

6046 - Complete Carestream CAD/CAM System

I am interested in selling my Carestream CAD/CAM system. It's about 3.5 years old and in excellent condition. It has had regular maintenance and has minimal

use. I use the scanner, but rarely use the mill. I am happy to sell as a package or separate the pieces, so please let me know what you're interested in. I have a CS3500 scanner, a CS3000 mill, and a Vita Vacumat 6000M furnace as well as all the original software. Happy to give more details and send pictures to interested parties. Please let me know if you'd like to purchase as a complete package or individual pieces. Contact: Nick, 434-978-1510, nick@cbrdental.com

6050 - Brand New 3D Printer Package For Sale

This deal includes: Form 2 3D Printer Build Platform (Form 2) Resin Tank (Form 2) Dental LT Clear Resin Cartridge (Form 2) Dental SG Resin Cartridge (Form 2) Form Wash Form Cure All materials and equipment are BRAND NEW and have not been used. This product is great for digitally geared offices to make in-house cast models, surgical guides, mouth guards, etc. Contact: Sundas Idrees, 703-472-1491, info@pinnacleclinic.com

6098 - E4D, nearly new Nevo Scanner, 2 laptops, Mill, etc

Selling an E4D with barely used Nevo scanner (used for less than 15 units). Including cart with 2 laptops, Mill, Oven, and an assortment of ingots. In great condition, all components purchased from and been maintained by Henry Schein. Please contact for further information! Contact: McKenzie, 804-387-7108, mmrwoodard@gmail.com



Office Space Sale/Lease

6088 - Dental Practice for Sale

Southwest, Va. Pennington Gap, Va. Very busy practice (30+years) For Sale. 4 Large spacious operatories, digital x-rays, planmeca vertical bitewings, panelipse, cone beam. Operative microscope. Building for sale or rent. Dr. James Roberson Ph #276-546-4884 or 276-220-6462. Leave message if interested skjmroberson@hotmail.com



6025 - DENTAL PRACTICE FOR SALE | West Point VA

This charming West Point practice is a must-see!! Run a productive dental practice in beautiful community near the water. You'll take over a successful practice that's chartless, modern and currently operates on an abbreviated work schedule of just 3 days a week with collections over \$498,000! Complete our Buyer Registration Form today for details <http://www.lbdtransitions.com/buyer-registration-form.html>

6026 - DENTAL PRACTICE FOR SALE | Williamsburg, VA

MUST SEE!! GREAT SPACE -GREAT MARKET! Excellent opportunity for dentist wanting to grow to full-time practice or as satellite! Currently working just 2 days a week and producing over \$200k! Dentist ready to retire after many successful years. Practice has many amenities. Complete the Buyer Registration Form for details. <http://www.lbdtransitions.com/buyer-registration-form.html>

6027 - PRACTICE FOR SALE | Norfolk, VA

This is a unique opportunity for an enthusiastic dentist looking to step right into a high volume practice. Over \$700k in collections with 5 operatories and a doctor willing to remain on for next couple of years to ensure your successful transition and continued growth. This practice has

been a landmark for quality dental care for over 30 years and located in a stable productive market area. Interested to learn more? Complete our Buyer Registration Form.

<http://www.lbdtransitions.com/buyer-registration-form.html>

6028 - WEST END PRACTICE FOR SALE | Richmond, VA

Collections of 1.1 million with take home over \$500k. This well-established, solo-doctor dental practice sits in a coveted high density, upper income neighborhood surrounded by a lively commercial district. Qualified candidates must have advanced and broad range of skills and experience to take over this busy, comprehensive dental practice with strong loyal patient base. Additional details available for qualified candidates. Complete Buyer Registration Form if interested in learning more <http://www.lbdtransitions.com/buyer-registration-form.html>

6029 - CHART ACQUISITION | Newport News VA

Generate IMMEDIATE INCOME for your practice with acquisition of over 700 active patients for your practice!! This long-standing practice is currently collecting \$200k+ with semi-retired dentist working an abbreviated schedule. Don't pass up on this immediate opportunity. Includes strong referral program designed for immediate revenue generation. Complete our Buyer Registration Form for details: <http://www.lbdtransitions.com/buyer-registration-form.html>

6071 – SW VA Gem

Doctor leaving after many profitable years of practice at busy, well established office in beautiful SW Virginia. Area is well known as a great place for raising a family, beautiful college town, highly rated primary and secondary schools. Practice is on a major thoroughfare near shopping, close to rivers, trails and mountains. Four fully equipped ops, digital, chartless, strong hygiene program, great parking. Over 2000 sq ft, 5th op available. 2017 collections were 1.1M. Long term dedicated staff will stay with new doctor. Please email inquiries to Tom Bonsack, DDS, 410-218-4061, tom@midatlanticdentaltransitions.com.

6108 - IMMEDIATE OPPORTUNITY

Central VA Practice for Sale- IMMEDIATE OPPORTUNITY. This well-established family oriented general dental practice has a strong emphasis on esthetic restorative dentistry with a patient-centered approach. Transition assistance is available, if desired. Financing is pre-approved with good credit for 100%. High net profit with low expenses for the new owner with opportunity for serious growth. Great opportunity for expansion for a solo-practitioner or satellite office in the beautiful Blue Ridge Mountains. Contact: dentalpracticeforsale434@gmail.com

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